

**How Do First-Generation Chinese Immigrant Clients Experience the Cross-Cultural
Therapeutic Relationship with White British Therapists in the UK?
An Interpretative Phenomenological Analysis.**

A thesis submitted in partial fulfilment of the requirements for the Professional Doctorate in
Counselling Psychology of London Metropolitan University.

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Declaration

I hereby declare that the work submitted in this thesis is the result of my own investigations, except where otherwise stated.

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Abstract

Background/Aims: As one of the fastest-growing immigrant groups in the UK (Latham & Wu, 2013), research has shown that first-generation Chinese immigrants (FGCIs) are vulnerable to mental health problems due to migration and acculturation difficulties (Furnham & Li, 1993). However, they are under-represented in mental health services (GOV.UK, 2020) and tend to disengage prematurely when they seek psychotherapy (Pedersen et al., 2002). It is found that the cultural differences between therapists and clients and the potential challenges that these differences pose to the therapeutic relationship (TR) may cause poor treatment outcomes among Chinese immigrant clients in White-dominated societies (Chin, 1998; Sue & Sue, 2012). However, no studies specifically examining the TR between FGCI clients and White British therapists have been found. It is hoped that this study can address this gap by investigating how FGCIs experience cross-cultural TRs with White British therapists.

Method: This research employed Interpretative Phenomenological Analysis (IPA). Semi-structured interviews were conducted with six participants to explore their subjective experiences of the cross-cultural TRs with White British therapists.

Findings: Three Group Experiential Themes emerged from the analysis of participants' accounts: a) Pre-Cross-Cultural Psychotherapy Challenges (which discusses the difficulties faced by FGCIs before receiving psychotherapy), b) Cross-Cultural Therapy Experiences (which include the emotional barriers, language-related challenges, and the mixed impact of cultural differences during therapy), c) The Role of the Therapist (which explores the potential impact of therapists' personal attributes, cultural sensitivity, and therapeutic approaches on the TR).

Conclusion: The study revealed that FGCI clients may face multifaceted challenges when establishing cross-cultural TRs with White British therapists. It highlights the importance of therapists possessing cultural sensitivity and core qualities such as warmth and empathy to foster trust and connection with FGCI clients. The study also highlights the importance of helping FGCI clients explore the root causes of their emotional difficulties rather than merely solving practical problems.

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Glossary

Abbreviation

BPS:	British Psychological Society
CBT:	Cognitive Behavioural Therapy
CoP:	Counselling Psychology
FGCI:	First-generation Chinese immigrant
GAD:	Generalised Anxiety Disorder
GET:	Group experiential themes
GP:	General Practitioner
HCPC:	Health and Care Professions Council
HESA:	Higher Education Statistics Agency
NHS:	National Health Service
NICE:	National Institute for Health and Care Excellence
ONS:	Office of National Statistics
PET:	Personal experiential theme
PHQ:	Patient Health Questionnaire
TR:	Therapeutic Relationship
UK:	United Kingdom
US:	United States

1 Reflexive Statement Part One

The cultural and historical backgrounds of the researchers, and their values, are of importance to any type of study, and this is particularly true in more subjective qualitative research (Willig, 2008). The reflexivity of the researchers is paramount to enhancing the validity and reliability of any study (Schön, 1987), as it clarifies how the researchers' presuppositions, personal experience and cultural background may participate in the research process (Kasket, 2012). Therefore, the first part of my reflexive statement will be presented to clarify my subjectivity as a researcher, which might affect my literature review on how first-generation Chinese immigrant (FGCI) clients experience cross-cultural therapeutic relationships (TRs) with White British therapists.

I was born and raised in China and came to the UK in 2018 to study for my Master's degree in psychology. During my time in the UK, I have received therapy from White therapists. The first time this happened was when I was doing my Master's course, and I sought help from the counselling service to discuss my adjustment difficulties. In our first meeting, before my therapist officially started the session, I asked her, "Where are you from?" She answered, "This question is not relevant to today's session." I had conflicting emotions about the way my therapist responded. On the one hand, because I had a training background in psychotherapy, I could rationally understand that she might want to establish a sense of boundaries in counselling. Whereas, emotionally, I felt the way she answered my question transmitted a lack of warmth. I grew up in a typical collective culture deeply impacted by Confucianism (Fan, 2000), massively emphasising interpersonal harmony. Under the influence of such a culture, I subconsciously perceive that taking the initiative to start a conversation is a way to express friendliness and avoid embarrassment. In contrast, my therapist might have interpreted my behaviour as "inappropriate" or even "intrusive," and

hence she reacted with a “defensive” response. Such an experience inspired me to think about how a Chinese immigrant client without a training background in psychology or counselling would feel when they hear this kind of reply from their therapists, and what impact it would exert on the TR.

My second experience of working with a White therapist was a one-year-long psychodynamic therapy that I did for training purposes. One of the main issues I brought up in therapy was the feeling of guilt for being away from home for a long period of time, incapable of accompanying my elderly parents. The guilt could relate to Chinese culture’s emphasis on filial piety (Zhan & Montgomery, 2003). Females, in particular, seem to be given an innate responsibility to care for their parents’ needs. Nevertheless, my therapist interpreted my guilt as an emotion caused by the problematic separation-individuation (Mahler, 1972). I was slightly offended by the way the therapist interpreted this guilt without taking my cultural background into account. The two times working with White therapists stimulated me to contemplate how cultural differences may affect TRs. My curiosity about this question prompted me to explore this research topic.

I realised that my involvement in this topic might impact how I searched for and perceived the literature. This was mainly reflected in two aspects. First, I might have subconsciously sought out literature on cultural differences that hinder the development of TRs to validate my past experiences. Second, my presuppositions and the desire to have my personal experiences validated might have affected my critical thinking and deprived me of an impartial perspective. For example, in the literature review process, while reading the studies about other ethnic minority clients, it would have been comforting to find out that I was not the only one and there were others sharing experiences and perceptions similar to mine.

Moreover, my desire to maintain this sense of validation might have invoked obstacles to maintaining a critical attitude while reviewing this literature, such as laxness in recognising the limitations of research methodologies and in assessing the reliability and representativity of the study results.

Counselling psychology (CoP) emphasises the importance of personal reflexivity (Schön, 1987) and encourages counselling psychologists to be aware of their potential biases to minimise their impact (Kasket, 2012). Therefore, when reading the literature, I tried to look for the literature from an objective perspective, put aside or “bracket” my personal assumptions, and stay alert against preferences and prejudices. However, I was also aware that it was not easy to remain unbiased. Therefore, I kept a reflective diary throughout the reading process. I wrote down my assumptions in the diary and held them for discussion with my colleagues. This interactive process allowed me to hear different voices and recognise my own biases. Although I reminded myself to keep an open mind throughout my literature review, absolute objectivity was still hard to achieve, just as Milton (2010) suggests. I, therefore, noted that this literature review might contain my subjective involvement as a researcher.

Interestingly, the process of reading and searching the literature has been helpful for my clinical work. As Willig (2008) says, our subjectivity may influence the research process, while the process of research, in return, shapes us. The clients I have worked with come from diverse cultures. When engaging with them, I tried to place myself in their cultural context and proactively understand their difficulties, making me more culturally sensitive as a trainee counselling psychologist. My sensitivity to culture has been enhanced gradually by reading

the literature on cross-cultural TRs, which has allowed me to better embrace one of the identities of a counselling psychologist, a scientist-practitioner who allows empirical research knowledge to impact their practice (Moran, 2011). My experience in clinical work reminded me that not every individual perceives cultural differences in the same way. For example, one of my British clients once expressed that she preferred to work with therapists from different cultures because it allowed her to embrace different perspectives. This helped me read the literature more comprehensively (and this reflexivity is further detailed in the Research Methodology and Discussion section).

2 Introduction

2.1 The Chinese in the UK and Their Mental Health

The 2011 National Census revealed that there were 433,150 Chinese in the UK, accounting for 0.7 per cent of the population, which had increased by 176 per cent since 1991 (ONS, 2011). However, this figure is likely to be an underestimate, with the Minority Rights Group (2020) estimating that at least 100,000 Chinese working illegally in the UK were not counted by the Census. In the last decades, China has become the top country of origin for new immigrants coming to the UK (Latham & Wu, 2013). During the 2018/2019 academic year, 136,520 Chinese students studied in the UK, making up the largest cohort of international students (HESA, 2020). This number has increased by more than 500 per cent since 2001 (HESA, 2020). In addition to Chinese students, the number of Chinese investors and skilled migrants to the UK has increased dramatically (Latham & Wu, 2013). The rapid growth of new immigrants largely explains why the vast majority of Chinese in the UK are first-generation immigrants¹, comprising 68.7 per cent of the population, while second-generation immigrants represent 23.7 per cent (GOV.UK, 2020).

Migration is considered a stressful event (Stillman et al., 2009). Immigrants entering a new country often encounter persistent and multifaceted challenges linked to migration and acculturation, known as acculturative stress (Berry et al., 1987). This stress has been extensively recognised as potentially detrimental to the mental health of immigrants (Williams et al., 2003).

¹ According to Schneider (2016), the term “first-generation immigrants” refers to individuals who were born abroad and later immigrated to the UK, while the term “second-generation immigrants” describes those who were born in the UK to parents who were themselves born in another country.

FGCIs in the UK are at a higher risk of mental illness, as indicated by research (e.g., Close et al., 2016; Furnham & Li, 1993). A quantitative study by Furnham and Li (1993) found that FGCIs face more significant acculturative challenges and report a higher prevalence of mental health issues compared to second-generation Chinese immigrants. Similarly, a study by Huang and Spurgeon (2006) examined the acculturative stressors of FGCIs in Birmingham, UK, using a mixed-methods approach. The quantitative phase revealed that over 60% of respondents were at risk of anxiety or depressive disorders, primarily due to low English proficiency, social isolation, and challenges with legal and administrative systems. Qualitative findings further underscored the stress caused by the disparity between expectations and the realities of life in the UK, particularly in employment, where professionals felt underemployed, and those in catering endured long hours with limited social interaction. The study concluded that the process of adjusting to migration is both complex and prolonged, with significant implications for mental health. Despite the large and growing Chinese community in the UK (Latham & Wu, 2013) and the susceptibility of immigrants, particularly first-generation immigrants, to mental health problems, empirical studies on the demand for and the use of services in mental health among Chinese people in the UK remain scarce.

2.2 Chinese Immigrants' Utilisation of Mental Health Services in the UK

Statistics show that among all ethnic groups in the UK, Chinese adults are the least likely to use NHS mental health services (NHS Digital, 2024). In 2023, only 1,883 per 100,000 Chinese individuals used these services, significantly lower than the national average of 4,756 per 100,000. In contrast, the Mixed White/Black Caribbean group had the highest engagement, with 5,853 per 100,000. Research (e.g., Li et al., 1999; Shen, 2021) indicates that the main barriers preventing Chinese immigrants in the UK from accessing mental health

services include a lack of language skills and understanding of statutory services, a shortage of bilingual healthcare professionals, and cultural stigma associated with mental disorders. Shen's (2021) study particularly emphasises the cultural obstacles that hinder Chinese international students in the UK from seeking mental health support. Shen (2021) highlights that in Chinese culture, the stigma and shame associated with mental health issues, viewed as personal or familial failures, are significant deterrents. Furthermore, the strong belief in self-sufficiency and the collectivist nature of Chinese society, which prioritises group harmony and maintaining "face," further prevents Chinese international students from acknowledging mental health struggles.

However, further evidence suggests that even when Chinese immigrants begin to seek psychotherapy, they often prematurely disengage from treatment (Pedersen et al., 2002; Pui-Ling & Logan, 1999; Yee & Au, 1997). For example, one study by Lee and Mixson (1995) compared questionnaire data from 255 White students and 73 Asian students (60% of whom were Chinese) to explore differences in their experience of cross-cultural counselling on campus. The results found that Asian students gave lower ratings on the effectiveness of the counselling and the competence of counsellors and reported less willingness to continue working with their counsellors than Caucasian students.

One hypothesis for the high drop-out rate among Chinese immigrant clients may be due to the limitations of "talking therapy" in effectively treating this population (Arthur et al., 1999). Nevertheless, studies have shown that Chinese clients can respond well to working with counsellors of the same ethnicity (Ng & James, 2013). For instance, an evaluation report of a Chinese Youth Counselling and Family Therapy Project in the UK indicated that the psychological symptoms among Chinese adolescents and their parents had been significantly

alleviated after a period of counselling with a Chinese counsellor (Howard, 2006). Therefore, the notion that Chinese immigrant clients do not respond well to “talking psychotherapy” may not fully explain the high rate of premature termination in psychotherapy.

Another possible explanation is that poor treatment outcomes may result directly from the therapists’ unfamiliarity with Chinese culture (Yin, 2016). Despite efforts to diversify mental health practitioners in the UK and the US, most psychotherapy and counselling services are still provided by White therapists. In the UK, 95% of the 3,500 members of the CoP Division of the British Psychological Society come from a White background (Jones Nielsen & Nicholas, 2016). Additionally, 84% of practitioner psychologists registered with the Health and Care Professions Council (HCPC) are White, while only 5% identify as Asian (HCPC, 2023). Similarly, 87.5% of psychological service providers in the US are European American (APA Center for Workforce Studies, 2009). Given the UK’s large Chinese population and a limited number of therapists from ethnic minorities, cross-cultural psychotherapy is arguably inevitable.

Cultural differences between therapists and clients have long been recognised as a potentially vital variable influencing TRs (Qureshi & Collazos, 2011). With the development of globalisation, cross-cultural psychotherapy has become a common phenomenon, and there has been a wealth of research on it. However, no studies explicitly examining the TR between Chinese immigrant clients and White therapists have been found. Fundamental to CoP is the TR (BPS, 2005). Therefore, it is vital for counselling psychologists to carefully develop and maintain effective TRs and individualise them to the variations of each client’s cultural background and personal needs (Norcross & Lambert, 2011). It is hoped that this literature review can critically analyse and evaluate the relevant literature to meaningfully contribute to

informing effective professional practice when engaging with Chinese clients. In this literature review, the TR will be reviewed first, followed by literature on cross-cultural TRs, potential barriers to establishing the cross-cultural TR, and how this relates to studies of the TRs of clients from ethnic minority backgrounds, especially the Chinese.

It is worth noting that some of the studies cited in the introduction and the following literature review were conducted in the late 1990s and early 2000s. The reliance on these relatively “dated” studies primarily stems from the scarcity of recent empirical research on Chinese immigrants’ engagement with mental health services, particularly within the UK. However, this research gap is not entirely unexpected. As previously discussed, the stigma surrounding mental health issues within Chinese culture often discourages individuals from seeking professional support. This stigma also creates challenges for researchers attempting to recruit Chinese immigrant participants for relevant studies (Yin, 2016), which seems to further contribute to their underrepresentation in mental health research over time. Despite their age, these studies remain highly relevant, as they offer crucial insights into the potential challenges and barriers that Chinese immigrants may face in accessing and engaging with mental health services.

3 Literature Review

3.1 The Therapeutic Relationship

The definition and nature of the TR have evolved and changed over time (Lambert & Barley, 2001) since Freud (1958) first suggested the significance of the therapist-client relationship in the psychotherapy process. Currently, the most common conceptualisation of the TR is that it is composed of three interdependent components: the working alliance, transference/countertransference and the real relationship (Gelso & Carter, 1985). The

concept of the working alliance first appeared in Freud's (1913) early writings, where it was described as "positive transference." Bordin (1979) generalised the concept of the working alliance from a psychoanalytic construct to a pan-theoretical one. He believed that a work alliance revolves around three elements: goal, task, and personal bond. The working alliance is now considered one of the essential components of an effective TR (Greenson, 1965).

Transference configuration includes transference and countertransference. Transference is defined as a situation where the clients redirect feelings towards the therapists based on past relationship patterns, often unconsciously, and countertransference refers to the therapist's feelings and emotions triggered by the client (Gelso & Hayes, 1998). The real relationship refers to a transference-free, authentic connection between the patient and therapist, characterised by mutual genuineness and a realistic perception and experience of each other (Gelso, 2011). Although the terms "relationship" and "alliance" sometimes seem to be used interchangeably in the literature, this review considers that working/therapeutic alliance is a significant component of the concept of the TR.

The TR has received a significant amount of attention from theorists (e.g., Carl Rogers, 1957; Freud, 1913) and researchers (e.g., Lambert and Barrie, 2001; Norcross, 2010) in the past decades. The importance of the TR has been emphasised in different psychotherapy approaches (Clarkson, 2003). For example, Carl Rogers (1957), one of the founders of the humanistic approach, argued that meaningful positive personality change occurs only within relationships. He identified three core therapist attributes—congruence, unconditional positive regard, and empathy—as essential conditions for client change. These claims are supported by a substantial body of empirical evidence. Numerous studies (e.g., Horvath, 2000; Lambert & Barrie, 2001; Norcross & Lambert, 2011) have demonstrated that the

quality of the TR is one of the most robust predictors of treatment outcomes. Additionally, Castonguay and Beutler (2006) identified specific relationship factors, such as working alliances, empathy, positive regard, congruence, self-disclosure and management of countertransference, as empirically validated principles for therapeutic change.

3.2 The Cross-Cultural Therapeutic Relationship

Terms, concepts, labels and semantic relativism are a constant challenge in the general field of cross-cultural psychotherapy (also referred to as intercultural/ transcultural psychotherapy or multicultural counselling). The terms “races,” “ethnicities,” and “cultures” are frequently used interchangeably in the literature (Helms, 1994). This study takes the position that they contain different connotations and usages. “Ethnicity” usually reflects collective identities and cultural expression shared by groups from a particular geographical region (Brubaker, 2004). Modern science sees “race” as a psychosocial construct rather than an indicator of biological difference (Schaefer, 2008). However, it cannot be ignored that the race to which one belongs often profoundly influences one’s life experiences, social interactions, and worldview, commonly experienced as either a member of the local dominant or oppressed group (Helms, 2007). “Culture” is understood as a complex and diverse set of meanings, values, and practices acquired and shared by a group of individuals or a recognisable segment of the population (Rohner, 1984). It encompasses a way of life and provides a framework for perceiving and interpreting the surrounding environment and the world, which can be passed down through generations (La Roche & Maxie, 2003). Cultural identities, however, are not static. They are fluid and adaptable, particularly in response to personal transitions such as migration (Carter & Qureshi, 1995).

The trend to explore cross-cultural psychotherapy began with a push by African American psychologists at the 1969 meeting of the American Counselling Association, who argued that mental health providers must recognise the needs of racially and ethnically diverse groups (Rosenfield, 2017). However, in the following two decades, no clear theoretical model of cross-cultural therapy had been developed, and specific factors that account for therapeutic effectiveness could not be explained (Kim & Ahn, 2005). Based on this, Fischer et al. (1998) suggested that identifying common factors across different counselling approaches may be a helpful basis for effective cross-cultural therapy. As such, the TR, the most consistent and robust predictor of effective psychotherapy (Lambert and Barrie, 2001), has received attention from multiculturalists since then (Kim & Ahn, 2005).

A growing number of multicultural scholars agree and believe that the TR is an essential condition for effective cross-cultural psychotherapy (Allen-Mares & Burman, 1999; Franklin et al., 1993; Qureshi, 2005). Meanwhile, the formation of an intercultural TR can be more complex and challenging than that of an intracultural relationship (Qureshi & Collazos, 2011). Different theories explain why cultural and racial differences between therapist and client may impact the TR, which will be unpacked in the following section.

3.2.1 Theories of How Cultural Differences Impact the Therapeutic Relationship

One way to understand how cultural differences may impact the TR comes from the field of social psychology. According to Festinger's Social Comparison Theory (1954), individuals naturally compare themselves to others to evaluate their perspectives and self-concept. This comparison process allows people to gauge their beliefs and identities within a broader social context. Furthermore, Heider's Balance Theory (1958) suggests that humans have an intrinsic need for their worldview to be consistent and coherent, striving to maintain a sense of

cognitive balance in their beliefs and attitudes. Based on these theories, Byrne (1971) put forward the attraction paradigm, which argues that people tend to interact with others with similar views. Byrne believes that interacting with like-minded people confirms their ideas and reinforces the logic and consistency of their worldview. However, interacting with people with different perspectives may undermine the logic and coherence of how people view the world, which can lead to anxiety, confusion and even rejection. Meanwhile, the researchers (e.g., Condon & Crano, 1988; Montoya et al., 2008) argue that it is perceived similarity, instead of actual similarity, that predicts attraction in interpersonal interactions. Moreover, in Marks and Miller's (1987) research, it has been found that people perceive their views as more similar to those of in-group members than those of out-group members.

These theories and studies provide a solid foundation for understanding why it is widely believed that clients prefer to work with therapists they perceive to be similar in cross-cultural psychotherapy (Sue et al., 1991). Numerous studies support the idea that pairing clients with therapists of the same ethnicity will lead to stronger therapeutic alliances (Harrison, 1975; Kelly & Strupp, 1992). Research has also shown a correlation between similarity and trust; specifically, clients perceive therapists with a similar attitude as more empathic, trustworthy and respectful (Simon et al., 1970). When the therapist and the client come from different ethnic backgrounds, the client may be acutely aware of the differences in the worldview and culture with the therapists (Sue et al., 1991). These differences can lead to a lack of trust and understanding (Simon et al., 1970), which are critical components of establishing an effective TR.

Another way to understand the connection between cultural and racial differences and the TR is through the perspective of transference and countertransference (Holmes, 1992). It has

been argued that racial differences between therapists and clients can significantly influence the formation of the working alliance and the dynamic development of transference and countertransference (Comas-Díaz & Jacobsen, 1991). Gelso and Mohr (2001) believe when a client interacts with a therapist from a different racial or cultural background, the client may develop negative cultural transference toward the therapist, a phenomenon in which the client projects distorted beliefs and attitudes about the therapist's racial or cultural group onto the therapist under the impact of their prior experiences and perceptions. For example, when a client has been a victim of racial discrimination, social bias, or unjust systems, they may unconsciously view the therapist as an oppressor, resulting in the reenactment of negative cultural transference, such as anger or fear, rooted in their past experiences (Fuertes et al., 2015). However, Curry (1964) argues that in cross-cultural psychotherapy, clients may project distorted beliefs and attitudes related to the therapist's race or cultural group even before the initial meeting, a concept he terms "pre-transference." If these issues are not addressed, it will be difficult for clients to establish a genuine TR and develop real transference in psychotherapy (Brauner, 2000).

3.3 Potential Barriers to Establishing Effective Cross-Cultural Therapeutic

Relationships with Asian Clients

Based on theories of why cultural and racial differences may influence the TR, some multicultural scholars (e.g., Atkinson, 1983; Sue, 1988) have investigated how cultural differences specifically affect the TRs between White therapists and Asian American clients. As a point of clarification, most cross-cultural psychotherapy studies were conducted in the US. The term "Asian Americans" in these studies is used to describe people of East Asian or Southeast Asian descent, whereas in the UK, the term "Asians" generally refers to people of South Asian ancestry. In the study samples referred to as Asian Americans, most were

Chinese and their descendants, but a small number of Japanese and Filipinos were also included (Sue et al., 1994). The rationale for those multicultural researchers grouping these populations together was based on the need to achieve sufficient sample sizes required for statistical analysis and on the assumption that the cultures of these Asian countries were collectivistic in nature and shared many commonalities (Uba, 1994).

At this stage, exploring these pervasive cultural barriers to the TR between the White therapists and Asian American clients' dyad may help to understand the potential interactional dynamics between Chinese clients and White therapists.

3.3.1 Different Conceptualisations of the Mental Health Problems

Cultural differences in the conceptualisation of mental health issues can significantly impact the formation of the TR (Cardemil & Battle, 2003). In many Asian cultures, the mind and body are typically viewed as inseparable (Yee & Au, 1997). Furthermore, due to a pervasive cultural stigma surrounding the acknowledgement of mental health issues and a cultural discouragement of expressing strong emotions (Ng, 1997), Asian Americans often tend to somatise mental health problems, manifesting psychological distress through physical symptoms (Sue & Morishima, 1982). In contrast, Western biomedicine is grounded in the mind-body dualism, which treats the mind and body as distinct entities (Mehta, 2011). The fundamental divergence in the conceptualisation of mental health issues may result in Asian American clients rejecting explanations provided for the cause of their illness, leading mental health practitioners to mistakenly perceive them as lacking insight, cognitive capacity, or even as exhibiting psychopathology (Tsui & Schultz, 1985).

3.3.2 Different Communication Styles

A second way TR might be interfered with relates to cultural differences in communication styles (Sue, 1990). There are predominantly two main differences in communication style.

According to Sue (1990), there are significantly different standards for how much private information can be shared outside an individual's home with nonfamily members. Asian Americans generally uphold the values of collectivism and emphasise the self-construction of interdependence (Yee, 1992). Within such cultural contexts, the concept of privacy often extends beyond the individual to include immediate and even extended family members. Therefore, if a client discloses family problems to their therapist, it can be seen as an invasion of the privacy of other family members and will disgrace the whole family, which may lead to the client's feeling of guilt (Leong & Lau, 2001). A White therapist raised in a culture that emphasises individualism may fail to understand an Asian American client's struggle to talk about family conflicts and may mistakenly interpret the client as inarticulate.

In addition, the two cultures also interpret nonverbal information differently (Sue & Sue, 1990). Chua and Gudykunst (1987) argued that in Western culture, semantic meaning is believed to be conveyed by a specific word itself and that the word does not vary regardless of a change in the situation. This type of communication is called low-context communication, in which the meaning of information is least dependent on the environment. The difference is that Asian Americans tend to use a high-context communication style relying on non-verbal information, such as contextual cues and body language, to understand the speaker's meaning (Nishimura et al., 2008). High-context communication is a form of subtle and complex interpersonal communication. Living in a collectivist social culture and often having very complex interpersonal relationships, Asian Americans prefer high-context

communication because it is considered more conducive to maintaining interpersonal relationships and avoiding the disruption of socially acceptable behaviour patterns (Leong & Lau, 2001).

A client's choice of what to communicate and how to communicate during psychotherapy has specific clinical implications (Qureshi & Collazos, 2011). If these communication styles are misinterpreted in psychotherapy, the development of the bonding elements in the TR can be impeded (Saizman, 1995).

3.3.3 Different Concepts of Self

Cultural differences in self-concept between the therapists and clients also affect the TR (Sue & Sue, 1990). Asian cultures emphasise collectivism, consider the family the core of society, and value harmonious interpersonal relationships, social responsibilities and interdependence rather than independence (Shea et al., 2010). Thus, the concept of self is embedded in relation to others in the social context (Ng & James, 2013). Western norms, however, prioritise separation and clear boundaries in relationships, individuality, and autonomy (Harkness et al., 2008). Cultural differences in self-concept may also lead to uncertainty or divergence in treatment goals (Lee, 2011). A typical example is that the therapist may want to help the client set boundaries with a difficult parent, but the client may not tolerate establishing a boundary with the parent because it puts him or her in conflict with his or her social obligation to respect the parent as an elder (Sue, 1988). The treatment goal is an essential part of the work alliance, and if there are differences in treatment goals, the quality of the TR will be affected (Thompson et al., 2007).

3.3.4 Critique of the Literature of Potential Challenges of Working with Asian Clients

While this literature provides some insight into understanding how cultural and racial differences may affect establishing effective TRs between White therapists and Asian American clients, it holds some limitations.

Firstly, this understanding of the effects of cultural differences on the TR is primarily based on the perspectives of therapists who have clinical experience with Asian American clients (e.g., Tsui & Schultz, 1985; Kim et al., 2012) or the assumptions of the multicultural researchers (e.g., Sue & Sue, 1990; Sue, 1988). There are insufficient empirical investigations to explore clients' subjective experiences and perceptions of race and culture in cross-cultural psychotherapy. It is highly critical to understand the client's experience of cross-cultural TR and the potential impact of cultural differences on the TR because studies have shown that the client's evaluation of the TR is most closely related to the therapeutic outcome (Norcross, 2002).

Secondly, merely considering cross-cultural differences as variables that may influence the TR is an overly idealistic view that may not fit in real-world psychotherapy (Saizman, 1995). Assessing these variables out of context is a reductionistic way, as the race or ethnicity of a client does not exist in a vacuum (Speight & Vera, 1997). In reality, even two individuals from the same ethnicity can be very different. As mentioned earlier, a study by Furnham and Li (1993) found that FGCI's face more significant acculturative challenges and report a higher prevalence of mental health issues compared to second-generation Chinese immigrants. Thus, immigrants from different generations may arguably have different perceptions of mental health and preferences for counselling styles due to their distinct life experiences.

3.4 Generational Differences Among Clients

More recently, multicultural experts have turned their attention to within-group differences among clients in psychotherapy. For example, Leong and Lee (2006) stress the importance of acculturation as a constant variable that enables therapists to understand the differences within Asian American clients. Acculturation can be defined as the extent to which individuals identify with the White-dominated culture and integrate it into their lives (Berry, 2005). Current acculturation theory postulates a bilinear dimensional model comprised of two continuums: a) one's adherence to their own indigenous culture and b) one's acculturation to the dominant culture (Berry, 1990). On this basis, some scholars have conceptualised acculturation construct from different dimensions (Kim et al., 2001). In particular, cultural values (such as attitudes toward social dynamics and cultural customs) and behaviours (such as spoken language preferences and use of colloquial vocabulary) are considered to be two critical dimensions of acculturation (Szapocznik et al., 1978). In addition, Kim and Abreu (2001) believe that values and behaviours present different change processes, with the former occurring at a much slower rate than the latter. Studies (e.g., Huang & Lamb, 2015; Kim et al., 1999) have shown that FGCI in the host country are still strongly affiliated with Chinese cultural values, and this affiliation does not change regardless of the length of time they have lived abroad, although assimilation may take place in their behaviours after they move to the host country.

Based on these theories, it is believed that immigration status is another important indicator of client difference (Leong & Lee, 2006). Research shows that first-generation Asian immigrants tend to maintain stronger ties to traditional Asian cultural values than later generations (Berry, 1997; Kim et al., 1999). This affiliation to their indigenous culture makes them less likely to seek mental health services (Tracey et al., 1986) and poses additional

challenges for these services to meet their needs effectively (Fung & Wong, 2007). Language barriers can arguably further exacerbate these challenges for first-generation Asian immigrants, creating more significant obstacles than those faced by their second-generation counterparts. Specifically, verbal communication is essential in psychotherapy, and limited language proficiency can heighten the risk of misunderstandings, often leading professionals to mistakenly perceive clients as uncooperative or negative (Sue & Sue, 2016). Furthermore, the restricted emotional vocabulary in many non-English languages (Moore, 1999) can make it particularly challenging for first-generation immigrant clients who are not native English speakers to articulate their feelings in English during psychotherapy (Qi & Kring, 2021). This difficulty in self-expression can intensify their anxiety and shame in engaging in mental health services, thereby reinforcing barriers to effective treatment (Shen, 2021).

An empirical study by Abe-Kim et al. (2007) examined intergenerational differences in the use of mental health services among 2,095 Asian Americans nationwide. The results showed that first-generation Asian Americans (2.2%) were significantly less likely to utilise mental health services than second-generation Asian Americans (6.2%), and they were much less likely to perceive mental health services as helpful compared to their second-generation counterparts (51.5% versus 72.6%). Notably, the study also found that among all Asian groups, Chinese Americans reported the lowest levels of satisfaction with mental health services. Therefore, these findings underscore the importance of considering cultural and generational differences when therapists conceptualise client issues and develop treatment strategies and goals (Atkinson et al., 1990).

3.5 Cultural Competence

Research indicates that a therapist's cultural competence (also referred to as cultural sensitivity, multicultural competence or cultural responsiveness) is crucial for establishing effective TRs with clients of colour. This competence significantly contributes to the variations in satisfaction among ethnic minority clients beyond evaluations of a therapist's general competence (Constantine, 2002). As a result, there has been a longstanding advocacy for providing culturally "sensitive" or "competent" services to members of minority groups (Sue et al., 2009).

Although multicultural scholars continue to face challenges in operationalising cultural competence and its components (Sue et al., 2009), the relevant literature has identified three widely accepted dimensions (Sue & McDavis, 1992). A culturally competent therapist should not only have some foundational knowledge of their clients' cultures but also engage in continuous self-reflection on their own beliefs, attitudes, and potential biases, and how these may play a role in the way they engage with clients. This ongoing self-awareness is crucial in preventing cultural encapsulation, a concept defined by Wrenn (1962), where a therapist becomes constrained by their own cultural assumptions and fails to recognise or address the cultural differences of their clients.

The development of specific skills, interventions, and strategies is another critical aspect of cultural competence (Sue & Zane, 1987). Sue (1998) highlights that an important skill is to have the flexibility of balancing generalising and individualising in accordance with the client's cultural background and personal experiences. This means that therapists must be able to identify when group characteristics or cultural values are pertinent to a client's issues and, at the same time, see the individuality of the client to prevent the risk of stereotyping.

Despite the recognised importance of cultural competence in cross-cultural therapy, there is a lack of empirical evidence supporting the effectiveness of culturally sensitive therapeutic interventions (Jim & Pistrang, 2007).

3.6 Research Investigating the Cross-Cultural Therapeutic Relationships with Ethnic Minority Clients

There are a large number of empirical studies in the cross-cultural therapy literature that explore the TR according to the client's preference for the characteristics of the therapists (Vera et al., 1999), of which quantitative analysis occupies the majority. In the following section, both quantitative and qualitative studies that may offer insights into understanding the experiences of Chinese immigrant clients in cross-cultural psychotherapy will be reviewed.

3.6.1 Quantitative Research

A group of scholars conducted a series of single-session counselling studies with Asian college students and European-American counsellors to explore Asian American clients' preferences for the characteristics of counsellors in cross-cultural counselling. For example, Kim et al. (2002) discovered that Asian American clients reported strong working alliances when their counsellors provided a direct solution to the problem they mentioned in the counselling. Later, Kim et al. (2003) investigated the impact of therapist self-disclosure and discovered that clients also perceived stronger working alliances when therapists shared their own past strategies for dealing with similar issues. Another study by Kim et al. (2005) found that the clients who matched the counsellors' worldview perceived stronger work alliances than those who did not. While these studies provided some advice to White counsellors on how to work with Asian clients, they were methodologically deficient. Since this series of

single-session counselling studies employed similar research designs, they shared common methodological limitations. Therefore, only one of these studies will be discussed in detail as a representative case to examine these limitations.

To study the role of counsellors' self-exposure in cross-cultural counselling, Kim et al. (2003) recruited 62 American college students from China, Japan, and South Korea as volunteers in return for academic credits. In the study, they were told they would have a 50-minute counselling session with a European American counsellor about personal issues. Of the 62 students, half were assigned to the counsellor who disclosed personal information and the other half to the counsellor who refrained from self-exposure. Two researchers observed their interaction through a one-way mirror. After the session, participants were asked to complete questionnaires to provide feedback on the counselling. The results indicated that Asian American clients perceived stronger working alliances when their counsellors self-disclosed the strategies they had used in the past to solve various problems reported by clients. The study held several limitations. Firstly, the volunteers recruited in the study were all well-educated college students who tended to be more culturally aware. Using these individuals in the study limited the generalizability of the results to other groups. Secondly, this study used the design of single-session counselling, which bears little resemblance to the actual counselling dynamic without the constraints of experimental parameters. For example, in this experiment, the volunteer client may participate in the counselling experiment for academic credit, while in real life, most people seek psychological counselling with different motivations. In addition, counsellors in this study were required to use self-exposure techniques deliberately, which is not identical to the real counselling scenario, where counsellors can flexibly use intervention techniques according to the problems presented by the client. These facts limit the generalizability of the findings in a real counselling setting.

Third, observers were used in the study, which can be disruptive to both the client and the counsellors. Fourth, according to Despland et al. (2001), setting up a stable working alliance takes at least three counselling sessions. Therefore, results from using one counselling session may not truly reflect the effects of counsellors' use of self-exposure on the working alliance formation in actual counselling.

3.6.2 Qualitative Research

Pope-Davis et al. (2001) pointed out the need to study clients in actual multicultural psychotherapy sessions to explore the client's subjective experience of racial and cultural issues in psychotherapy and how these differences may impact the TR. Sue (1999) also called for using a wider range of methodological approaches, including qualitative and ethnographic methods, to study multicultural psychotherapy. However, upon reviewing the existing literature, I found a paucity of qualitative research specifically exploring the experiences of ethnic minority clients in cross-cultural psychotherapy. In the following, I will review several key studies on this topic.

Chang and Berk (2009) were pioneers in examining the cross-cultural therapy experiences of ethnic minority clients through a phenomenological/consensual research approach, offering valuable insights into the experiences of minorities in therapy. They recruited sixteen minority clients (including Black, Latino, and Asian individuals) who had undergone cross-cultural psychotherapy with White therapists in the US. Using a paired design, the authors compared the experiences of eight clients who reported satisfaction with treatment with those of eight clients who reported dissatisfaction. The researchers found that most clients reported racial differences created barriers to TR formation. However, satisfied clients felt that their therapist's ability to listen well, empathise and repair relationship rupture, which the authors

defined as generic counselling skills, could overcome any difficulties caused by racial differences. Notably, a small percentage of satisfied clients reported that working with White counsellors had positive effects on the TR, such as being more comfortable talking about sensitive topics such as sexual orientation. On the other hand, unsatisfied clients were more likely than satisfied clients to emphasise the negative impact of racial differences on TRs and cite the therapist's cultural insensitivity as the main reason for TR failure. Finally, the author emphasises the importance of multicultural and generic counselling competence in cross-cultural psychotherapy.

While this study provides some new understandings of the influence of racial differences on the TR, a vital consideration is the heterogeneity of the sample in this study. Thirty-seven per cent of the participants were first-generation immigrants, while the rest were American-born, suggesting that the participants' degree of acculturation varied. The design of comparing the experience of the satisfied and unsatisfied customers was to investigate how racial differences may play a role in establishing the TR. However, as the variable of acculturation was not considered, the credibility of results drawn from such comparisons is questionable. Furthermore, since the study aimed to identify common processes between all ethnic minority clients and White therapists, the specific dynamics in the Chinese clients-White therapists' dyad based on the racial/cultural differences between the two groups were unable to be examined. In addition, this research has been conducted in a North American context. Considering the differences in the socio-political environment and the composition of the UK and the US multicultural society, it will be hard to apply the study's results to Chinese immigrants in the UK.

Gurpinar-Morgan et al.'s (2014) research is one of the few UK-based studies on the cross-cultural psychotherapy experiences of ethnic minority clients. The researchers employed IPA to explore how Black and minority ethnic adolescents perceive the impact of race on TRs and its relevance to their current challenges. The five participants who received mental health services in the northwest of England were recruited. The findings have shown that for clients who believe that race affects their psychosocial status, the cultural sensitivity of their therapist is particularly important. In addition, most participants mentioned that counsellors taking the initiative to discuss similarities and differences between themselves and clients would help strengthen the TR.

However, there are some limitations to the study. First, they used adolescents as clients, and the findings cannot be generalised to the adult population. Second, since the participants in the study were UK-born adolescents, a sample of non-UK-born people may have different views that are not reflected in the responses of this sample. Furthermore, similar to Chang and Berk's (2009) study, participants in this study were from different ethnic backgrounds, which resulted in a high heterogeneity of the study sample. Some researchers argued that grouping ethnic minority groups from diverse cultural backgrounds together in studies can interfere with a full and accurate understanding of how people of different ethnicities receive cross-cultural psychotherapy and that such findings do not allow therapists to accurately capture the specific needs of clients of various ethnicities (Yoshida, 2013). Therefore, Sue et al. (2012) suggested that minority subgroups be studied as different research groups to ensure that the samples are sufficiently homogenous in terms of cultural factors.

Jim and Pistrang (2007) addressed these concerns by conducting a study focused exclusively on Chinese immigrant clients in the UK. Employing IPA, the researchers explored the

experiences of eight Chinese participants —six of whom were first-generation, one second-generation, and one third-generation—who received psychotherapy in the UK. Three participants worked with Chinese therapists, while the remainder worked with non-Chinese therapists. The study’s primary aim was to understand how cultural factors, particularly those rooted in Chinese cultural values, influence the TR and the clients’ perceptions of psychotherapy. The findings revealed that cultural sensitivity is crucial for Chinese clients, especially when understanding the cultural context of their issues. The study identified four key themes: “cultural encapsulation,” where clients felt misunderstood due to therapists’ lack of cultural knowledge; “cultural formulation,” where therapists’ cultural competence helped clients make sense of their issues; “cultural liberation,” where non-Chinese therapists allowed clients to express themselves more freely; and “culture is not important,” where some clients felt that the therapist’s cultural background did not significantly impact their experience as long as they could communicate effectively.

While the study provides valuable insights into the role of culture in the process of Chinese immigrant clients’ experience of therapy in the UK, there are some limitations to consider. First, the study did not address the generational differences among participants. The existing literature (e.g., Kim et al., 1999) indicates that first-generation and second-generation Chinese immigrants may face distinct challenges in cross-cultural psychotherapy. Therefore, including clients from different generational immigrant backgrounds can lead to an oversimplified analysis that fails to capture the full complexity of cultural or language factors in the TR. Additionally, this study sought to explore the role of culture in the therapeutic experiences of Chinese immigrant clients, rather than specifically examining the dynamics between Chinese immigrant clients and British therapists. This focus is reflected in the researchers’ choice to include both clients working with Chinese therapists and those

working with non-Chinese therapists in their sample, without specifying the cultural backgrounds of the non-Chinese therapists. This leads to how FGCI's experience cross-cultural TRs with White British therapists remaining unknown.

3.7 Summary of the Review and Proposal of a Research Question

As one of the fastest-growing immigrant groups in the UK (Latham & Wu, 2013), research has shown that FGCI's are vulnerable to mental health problems due to migration and acculturation difficulties (Furnham & Li, 1993). At the same time, however, they are under-represented in mental health services (GOV.UK, 2020) and tend to disengage prematurely in therapy (Pedersen et al., 2002).

Through the literature, it is found that the cultural differences between therapists and clients and the potential challenges that these differences pose to the TR may cause poor treatment outcomes among Chinese immigrant clients in White-dominated societies (Chin, 1998; Sue & Sue, 2012). Establishing a strong TR in cross-cultural therapy is particularly challenging with first-generation immigrant clients. Their deep connection to their indigenous culture (Leong & Lee, 2006) and potential language barriers (Sue & Sue, 2016) can contribute to significant challenges in communication and understanding with White therapists. These challenges are arguably more pronounced for first-generation immigrants compared to those of the second generation.

Although some empirical quantitative studies (e.g., Kim et al., 2002; 2003; 2005) by researchers who specialise in Asian American clients have provided some insights into how to establish effective TRs with Asian American clients, their conclusions are of limited applicability because the participants in these studies had no experience of real-life

psychotherapy without the constraints of experimental parameters. Additionally, the qualitative studies (e.g., Chang & Berk, 2009; Gurpinar-Morgan et al., 2014) that have explored clients' experience in actual intercultural TRs have mainly focused on the experience of second-generation immigrants from diverse ethnic backgrounds, while the experience of first-generation immigrants who are likely to have a lower level of cultural assimilation (Leong & Lee, 2006) has been neglected. It is argued that grouping ethnic minority groups from diverse cultural backgrounds together in studies can interfere with a full and accurate understanding of how people of different ethnicities receive cross-cultural psychotherapy and that such findings do not allow therapists to accurately capture the specific needs of clients of various ethnicities (Yoshida, 2013). Jim and Pistrang's (2007) study serves as one of the few studies that focus on Chinese immigrants, but their research aims to explore the role of culture in the therapeutic experiences of Chinese immigrant clients rather than exploring the TR between Chinese immigrant clients and British therapists. Therefore, there is a gap in the literature where the FGCI clients' experiences of cross-cultural TR remain unknown. Based on this, the study aims at investigating:

How do first-generation Chinese immigrant clients experience the cross-cultural therapeutic relationship with White British therapists in the UK?

In addition to filling in the gap in the literature, this study serves two main objectives. Firstly, it aims to explore the perspectives of FGCI on cultural and racial differences and their potential impact on cross-cultural TR. Because the literature suggests that establishing a TR with first-generation immigrants can be more challenging (Leong & Lee, 2006), these perspectives from the clients are of great significance. They can give the therapists a deeper

insight into FGCI clients' actual evaluation of the TR and inform them how to better comprehend and address these differences in psychotherapy.

Secondly, the study seeks to identify the key factors contributing to a successful TR between White British therapists and FGCI clients from the clients' perspectives. This will enable therapists to understand the needs of this group and provide them with more culturally sensitive psychotherapy services. It also has the potential to improve the experience and group-wide reputation of psychotherapy services among FGCI clients in the UK, which may, in turn, encourage this group to seek more psychological help.

3.8 Relevance to Counselling Psychology

As mentioned before, due to cultural and racial differences, White therapists may encounter some challenges in establishing effective TRs with Chinese immigrant clients, especially with FGCI clients, who are likely to have a lower level of cultural assimilation (Leong & Lee, 2006). Therefore, exploring how FGCI clients may experience the cross-cultural TR with White British therapists is highly relevant to CoP and potentially contributes to CoP.

Since cross-cultural psychotherapy was proposed in 1969, the vast majority of cross-cultural studies have been conducted in the US (Rosenfield, 2017). Newland and Patel (2004) argued that cross-cultural research in the UK is woefully inadequate. Eleftheriadou (2010) also believed more research is needed from counselling psychologists to understand how culture and ethnicity may influence clinical practice. This study aims to explore the experience of the FGCI clients in cross-cultural psychotherapy based on the philosophy and epistemology of CoP to value clients' subjective experience, feelings and interpretation (BPS, 2010) and, therefore, to contribute to enriching cross-cultural research in the UK. At the same time, Chinese people are currently under-represented in the psychotherapy literature in the UK, and

their need for counselling services remains unknown (Yin, 2016). This study will try to give them a voice, which is also in line with one of the disciplines of CoP of giving under-represented groups a voice (Douglas et al., 2016)

In addition, considering that the theory, research and practice of CoP highly emphasise the centrality of TRs (BPS, 2005), this exploration of the FGCI client's experience of cross-cultural TR has fundamental clinical significance for counselling psychologists. Based on the experiences of FGCI clients, this research attempts to understand their perspectives on how cultural and racial differences impact the TR and what is needed to establish an effective TR for White British therapists working with this group. Results from this study may give counselling psychologists and other practitioners some insights into working with this group effectively. This is also in line with one of the disciplines of CoP, that as scientist-practitioners, counselling psychologists have a professional responsibility to provide safe and effective services supported by empirical research (Moran, 2011).

4. Research Methodology

In the methodology section, the rationale for choosing a qualitative research approach and the Interpretative Phenomenological Analysis (IPA) method will be discussed. This is followed by an overview of participant recruitment, the steps involved in analysis, and relevant ethical considerations.

4.1 Rationale for a Qualitative Study

A qualitative approach was considered to be more appropriate than a quantitative one for this research for several reasons. Firstly, most existing cross-cultural psychotherapy studies in the literature (e.g. Kim et al., 2005) have used quantitative methods, which are based on a

positivist epistemological stance to discover ethnic minority clients' preferences for therapists' characteristics through standardised measures. However, such quantitative approaches may not be appropriate to answer the questions of this study, which at its core aims at investigating the nuances and complexities of the subjective experiences of FGCI clients in cross-cultural TRs. In contrast, a qualitative approach which facilitates a more in-depth and holistic understanding of the individual's experiences and the subjective meanings they may attach to them (Maxwell, 2008) is more consistent with the aim of this study. This is particularly crucial given the limited research on FGCI's experiences of cross-cultural TRs in literature. Second, the choice of qualitative research aligns with one of the primary principles of CoP, which seeks to understand individuals' internal phenomenological reality through their subjective experiences and feelings (BPS, 2010). Therefore, a qualitative approach would be well-suited for examining how FGCI clients experience cross-cultural TRs, as well as how they perceive the influence of cultural differences on the TR. The knowledge gained from this study would help inform the practices of counselling psychologists and other professionals to better support this group.

It is suggested that researchers adopt methods that are closely related to their own ontological and epistemological stance (Finlay, 2006). Therefore, my decision to adopt a qualitative approach also reflects my ontological and epistemological stance, which will be outlined next.

4.2 Ontological and Epistemological Position

Epistemology concerns the study of knowledge, while ontology addresses the nature of existence (Orlikowski & Baroudi, 1991). A researcher's epistemology and ontology can, therefore, guide their methodological decisions in research, influencing how data is collected,

analysed, and interpreted (Hesse-Biber & Leavy, 2010). Additionally, these philosophical stances often reflect the researcher's personal worldview and beliefs about how reality should be understood and perceived (Etherington, 2004).

From an ontological perspective, realism and relativism are at opposite ends of a continuum. Realism acknowledges the existence of a reality that is entirely independent of the human mind (Ponterotto, 2005), while relativism sees reality as a socially constructed product of the human mind (Fletcher, 1996). Similarly, epistemology can be seen as a continuum, ranging from positivism at one end to social constructivism at the other (Braun & Clarke, 2013). According to positivist epistemology, only "facts" derived from empirical research can constitute genuine knowledge, and it assumes the researcher is separate from and has no influence on the results of the research (Willig, 2013). Social constructivists, on the other hand, argue that humans understand the world based on the experiences they have had, which are unique to their culture and time-specific (Crotty, 1998). Therefore, according to a social constructivist, humans' experience of reality is constructed through interactions with other people on both a micro-level, such as conversations and narratives, as well as a macro-level, such as culture and society (Olssen, 1996).

Critical realism merges these perspectives by adopting a realist ontology while embracing a relativist epistemology. In one sense, critical realism takes a realist view when it comes to ontology, as it believes there is a mind-independent, changing and structured reality (Finlay, 2006). Nevertheless, critical realism adopts a relativist epistemology in that it recognises knowledge as a social product that is related to the human subjective factors which impact its construction (Bhaskar, 1975). Therefore, critical realism maintains that reality can be understood partially and probabilistically, rather than absolutely or solely. It recognises that

all events and experiences have some underlying reality to them but are also subject to social construction and interpretation (Groff, 2004).

Therefore, critical realism can best represent the ontological and epistemological stance of this study, as it acknowledges that the cultural and racial differences between the FGCI clients and their White British therapists exist out there independently of the researcher but also allows that clients' own interpretations of their own experiences differ according to their own social and culturally constructed perceptions. Moreover, the critical realism perspective closely aligns with the foundational principles of CoP's practice and philosophy. Counselling psychologists adopt a humanistic framework, with their core values highlighting the significance of an individual's rich and complex subjective experiences, as well as the social and relational contexts in shaping meaning (Strawbridge, 2016).

4.3 Rationale for Using IPA

Corresponding with my epistemological stance, IPA (Smith, 1996) was chosen to explore FGCI clients' experiences of cross-cultural TRs. IPA integrates principles from phenomenology, hermeneutics, and idiography to offer a deep examination of participants' lived experiences (Smith et al., 2009). Several reasons make IPA the most suitable method for this study.

Firstly, the phenomenological stance of IPA attempts to explore individuals' unique subjective experiences in detail, and it focuses on individuals' personal perceptions of a particular phenomenon or event rather than trying to produce objective descriptions (Giorgi & Giorgi, 2003). This feature of IPA lends itself well to the purpose of this study, which is to investigate the subjective experiences of FGCI clients in the cross-cultural TR and their

perspectives on how racial and cultural differences may impact the TR with their White British therapists.

Secondly, one of the theoretical underpinnings of IPA is hermeneutics, involving a dual process in which the researchers attempt to make sense of how the participants make sense of their personal experiences (Spinelli, 1989). This process goes beyond merely describing observations; it requires researchers to play an active role in shaping their access to the participants' experiences and how, through interpretation, they construct an understanding of the participants' subjective reality (Pietkiewicz & Smith, 2012). This means that as a researcher, I needed to interpret how FGCI clients make sense of their experiences in a cross-cultural therapeutic setting, considering not only the surface-level events but also the deeper meanings of these experiences. As such, the interpretative depth of IPA's hermeneutic approach enables a nuanced understanding of FGCI clients' subjective experiences in cross-cultural therapy. At the same time, I was aware in this study that I would view the participants' experiences not only through my role as a trainee counselling psychologist, but also through the lens of a FGCI who had experienced cross-cultural TRs myself. Therefore, the various aspects of the researcher's identity may introduce an additional agenda and framework involving multiple-stage hermeneutic operations. To fulfil the role of a reflective practitioner and researcher in CoP, it is exceedingly critical that the researcher carefully consider the biases and assumptions that are potentially introduced throughout the data collection process as a result of their own subjective experiences (Hanley et al., 2013). The potential biases and assumptions I might have held throughout the research process will be discussed further in the Reflexivity Statement Part Two.

In addition, the idiographic aspect of IPA focuses on an in-depth analysis of the specific lived experiences of an individual in one particular context (Lyons & Coyle, 2007). This enables this study to explore how FGCI clients experience the potentially nuanced cultural differences in cross-cultural TRs on a profound and detailed level. Taking all these factors into consideration, IPA was believed to be the most appropriate method for this study.

4.4 Consideration of Other Qualitative Methods

Grounded theory (GT; Glaser & Strauss, 1967) and Discourse Analysis (DA; Brown et al., 1983) were initially considered as potential alternative methods for this study. However, they were ultimately not selected for the following reasons.

GT is a commonly used approach for studying lived experience (Willig, 2013). Despite this, GT was deemed unsuitable for this study based on its focus. Unlike IPA, which centres on understanding individuals' personal experiences, GT aims to develop a theoretical explanation or model of a phenomenon (Payne, 2007). GT's theory-building approach does not align with the goals of this research, which is to investigate the lived experiences of FGCI clients in cross-cultural TRs with White British therapists. The focus here is on gaining a deeper understanding of their personal experiences rather than constructing a theoretical framework. Therefore, the theoretical underpinnings of IPA align more closely with the objectives of this research, making IPA a more appropriate methodology than GT.

DA was also considered for this study but was not chosen for the following reasons. DA analyses the relationship between discourse and social context (Trappes-Lomax, 2004). It provides insights into how meaning is constructed through different types of language,

primarily focusing on group dynamics and social processes (Potter, 2012). In contrast, IPA focuses more on understanding how individuals make sense of their personal experiences (Smith et al., 2022). Although language is important in IPA as well, it is viewed as a means through which individuals convey their inner worlds, with the primary focus on how people reveal their personal experiences and the subjective meanings behind those experiences, which is different from DA's focus on constructing social meaning through language (Biggerstaff & Thompson, 2008). IPA seeks to understand participants' internal perspectives on their experiences, rather than focusing on the language used to construct those experiences. Given that this study aims to investigate the subjective experiences of FGCI clients and their internal perspectives on cross-cultural TR, IPA was considered more appropriate than DA.

4.5 Reflexivity on Epistemology and Ontology

Willig (2008) highlights the importance of understanding how qualitative researchers interpret the world around them. Reflecting on epistemological and ontological positions allows researchers to assess how these perspectives influence their research choices, including the methods they employ (Willig, 2001). In the following, I will explain how I developed my current epistemological and ontological stance.

Before moving to the UK for my postgraduate studies, my entire education took place in China. During my secondary education, I studied the natural sciences, which placed a strong emphasis on a strong positivist approach, prioritising experiments and statistical analysis. At that time, I was taught to believe that many problems had only one "correct answer".

However, my university experiences gradually challenged this worldview. A significant turning point came when I encountered a group of American professors who, much to my

surprise, greatly enjoyed sunbathing. This was my first direct encounter with cultural differences; in my culture, people generally avoid the sun in pursuit of fair skin, while in Western cultures, sunbathing is seen as desirable. As I began studying psychological counselling, I became increasingly aware that even when people experience similar traumatic events, their responses and interpretations can be remarkably different. This realisation gradually shifted my epistemological stance from positivism towards a more interpretative approach, and I started to value critical realism more. After I came to the UK to pursue a doctorate in CoP and as I was exposed to more clients and colleagues from diverse cultural backgrounds, I felt even more strongly that the stance of critical realism is very much in line with the way I see the world.

At the same time, I recognised the importance of selecting research methods based on their suitability for addressing the research question rather than my personal preference. I ultimately chose IPA as my research method because it not only aligns with my epistemological and ontological stance but also provides the most appropriate framework for addressing my research questions and filling gaps in the existing literature.

4.6 Participants

To better understand participants' overall perception of their lived experiences, IPA utilises a purposeful, homogeneous and relatively small sample (Smith & Eatough, 2007). A professional doctoral study is generally recommended to use 6 to 8 cases (Smith et al., 2009). Accordingly, the current study recruited six FGCI clients who had experienced one-on-one psychotherapy with White British therapists (see Table 1 for participants' demographics).

In contrast to previous studies (e.g., Jim & Pistrang, 2007) that have included Chinese immigrants from the first to third generation, this research aimed to ensure the sample was more homogenous by exclusively recruiting participants who self-identified as FGCI. These participants had lived in the UK for varying lengths of time, ranging from one to nine years. Studies (e.g., Huang & Lamb, 2015; Kim et al., 1999) have shown that FGCI in the host country are still strongly affiliated with Chinese culture, and this affiliation does not change regardless of the length of time they have lived abroad.

The participants' ages ranged from 23 to 38, which is in accordance with the National Institute for Health and Care Excellence guidelines, which define individuals within this age bracket as adults (NICE, 2011). Furthermore, evidence shows that at least three therapy sessions are needed to establish a stable TR, which remains consistent in subsequent sessions (Despland et al., 2001). For this reason, the study required that all participants had attended at least three psychotherapy or counselling sessions, regardless of the psychotherapeutic approach, with a White British therapist, counsellor, or psychologist.

In addition, to ensure accurate recall of treatment experiences, participants were asked to be still in psychotherapy at the time of the interview or to have completed treatment in the 12 months prior to the interview. The inclusion of participants who were still in therapy was carefully considered in light of potential ethical implications. Given that this study examines the experiences of FGCI clients with White British therapists, it is essential to explore the TR from the client's perspective. Including individuals still in therapy allowed for the capture of their real-time experiences and the subtle nuances of the TR, likely contributing to a more comprehensive understanding of cross-cultural psychotherapy. As mentioned earlier, previous studies (e.g., Jim & Pistrang, 2007) on Chinese immigrant clients' use of mental

health services have frequently combined different generations due to recruitment challenges. As such, including individuals currently undergoing treatment may have helped mitigate recruitment difficulties and enhanced the homogeneity of the sample. To address the potential ethical implications of discussing their TRs while still in therapy, this study ensured that participants were fully informed about its objectives and their right to participate or withdraw from the study. Additionally, they were made aware of the mental health support resources available to them should they experience any distress. A detailed account of these ethical safeguards is provided in the 4.9 Ethical Considerations section.

Moreover, this study only included participants who were willing to be interviewed in English. This decision was made considering IPA's emphasis on understanding experience through language and meaning-making (Smith, 1996). Conducting the interviews in English rather than Chinese avoided the potential complexity that translation could introduce to data analysis. Furthermore, all participants had previous experiences of engaging in psychotherapy in English with British therapists in the UK, which in itself demonstrated their sufficient proficiency in English to participate in the interviews. However, I recognised that conducting interviews in a non-native language might limit the richness of participants' expression. During the interviews, some participants might have struggled to find accurate English words to convey some cultural concepts. In such cases, they were encouraged to use Chinese words or phrases and then explain their meaning in English to clarify what the concept meant to them. This process did not involve me interpreting the meaning of the Chinese words they used, as I believe that could introduce bias on my part.

Table 1. Summary of the participants' demographics

Pseudonym	Gender	Age	Occupation	Years stayed in the UK	Sessions attended	Therapy completed	Setting	Therapist's approach	Therapist's gender
Lee	Male	23	Master Graduate	4	11	Ongoing	Private practice	Psycho-dynamic	Male
Lily	Female	29	PhD Student	5	40+	Ongoing	Private practice	Integrative	Female
Wong	Female	27	Employed	9	8	Four months	NHS	Cognitive Behavioural Therapy (CBT)	Male
Yan	Female	38	Employed	1	30+	Ongoing	Private practice	Integrative	Female
Mei	Female	24	Master Student	1	6	One month	University	CBT	Female
Tao	Female	28	Part-time student/ Part-time employed	5	30+	Two months	Private practice	Psycho-dynamic	Female

4.7 Procedure

4.7.1 Recruitment

To effectively recruit eligible participants, I advertised on social media platforms, such as Weibo, WeChat, and Xiaohongshu. Additionally, considering that international students have the dual status of immigrants and students, I also distributed flyers on the campus of London Metropolitan University. Meanwhile, I contacted some Chinese community mental health charities, and they responded that they would post my recruitment advertisements on their websites. In the end, all six participants were recruited through social media platforms. This might be related to the ongoing COVID-19 pandemic at the time, when many people were working and studying from home, leading to a possible decrease in the number of Chinese students on campus compared to the past.

Before deciding to use social media for participant recruitment, I gave it careful consideration. Chinese immigrant participants have always been a difficult group to reach

(Yin, 2016), and as an insider researcher, I had the advantage of knowing and accessing the social media platforms that Chinese participants are more active on, such as Weibo and Xiaohongshu. However, I also noticed the risks associated with recruiting participants through social media. For example, using a personal account to post recruitment information could blur the boundaries between the researcher's professional role and private life. To avoid these issues, I specifically created a professional account on social media to ensure that I maintain high standards of professionalism throughout the research process. Additionally, I assured participants that their personal information would be kept confidential. The methods for obtaining informed consent and allowing withdrawal from the study were the same as those used in traditional recruitment approaches.

4.7.2 Data Collection

Semi-structured interviews are the recommended data collection method in IPA research (Smith et al., 1999) as they allow for an in-depth understanding of lived experiences related to a specific phenomenon. Additionally, using open-ended questions in these interviews is encouraged as it enables participants to guide the conversation toward topics that matter most to them (Smith & Osborn, 2008). Therefore, to gather the data I needed, I used semi-structured interviews featuring open-ended questions, with each interview lasting between 1 hr to 1 hr 30 mins. During the interviews, when necessary, I also provided appropriate prompts to help participants better understand the questions and guide them to further elaborate on their responses (Smith et al., 2022). Although I initially planned to conduct face-to-face interviews, due to the ongoing COVID-19 pandemic during the recruitment phase, and the fact that eligible participants were spread across different cities in the UK, many participants preferred to be interviewed via video. Therefore, video interviews were

conducted via Microsoft Teams. Conducting interviews via video had received approval from the ethics committee.

It is recommended to observe participants' non-verbal cues during interviews as a way to assess how the process or particular questions may be influencing them (Smith & Osborn, 2008). However, I found that in practice, fully capturing participants' body language during video interviews was challenging, even when the camera was in use. To minimise the impact, I encouraged participants to choose an environment where they felt both comfortable and secure. Additionally, I emphasised that they had the option to pause the interview at any point should they experience any discomfort, and that we could discuss their concerns as needed.

4.7.3 Materials

Several materials were used in this study to ensure the smooth progress of the research. The first was a recruitment poster (see Appendix A), which was used to recruit participants. Secondly, the Participant Information Sheet (see Appendix B) was sent to interested individuals via email, and those confirming their interest were subsequently invited to complete the Patient Health Questionnaire (PHQ-9; Spitzer et al., 1999) and the Generalised Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006; see Appendix C). Participants who were deemed eligible were then invited to sign an informed consent form (see Appendix D). Additionally, they completed a demographic questionnaire (see Appendix E) to provide essential background details before the formal interview. During the interview, an interview schedule (see Appendix F) was followed to elicit participants' views based on their experiences. After the interview was completed, participants were given a debriefing form (see Appendix G). At all times, a Distress Protocol (see Appendix H) was in place to manage

and address any emotional discomfort participants might experience during the research process.

4.8 Data Analysis

According to the guidelines of Smith et al. (2022), the IPA analysis process began after I transcribed the recordings of each participant into verbatim data. Each interview was transcribed following the guidelines established by Jefferson (2004) for transcription (see Appendix I). The process of analysing the transcripts followed several stages. First, I immersed myself in the data by reading the transcripts multiple times, numbering each line of text, and leaving large margins for comments. As I read, I noted my initial impressions and observations in the right margins to capture both the participants' words and my interpretations (see Appendix J). I continuously referred back to the original audio recordings to ensure accuracy.

In the second stage, I developed experiential statements (see Appendix K) by reviewing and interpreting the initial notes (Smith & Eatough, 2006). I used the left margin to write these experiential statements, which represented key ideas and insights related to the participants' experiences. During this stage, I ensured that the connection between my notes and the transcript was maintained, and I used a reflective journal to monitor my assumptions and personal biases, allowing for a more unbiased analysis (Kaskzet, 2012).

In the third stage, I examined the connections between experiential statements and grouped them into clusters based on similarities. I envisioned a "magnet" pulling related themes together. During this process, I frequently went back and forth between the verbatim data and the initial comments on the experiential statements to ensure that the integrity of the verbatim

data was preserved. After labelling the identified clusters with titles, I generated a summary table of all the Personal Experiential Themes (PETs) with corresponding quotations for each participant (see Appendix L). Given the idiographic focus of the IPA, I approached the analysis of each subsequent transcript with awareness, ensuring the previous analysis did not interfere (Lyons & Coyle, 2007).

Finally, by looking for connections and patterns across all the summary tables of PETs, I constructed a final table of Group Experiential Themes (GETs) for all participants (see Appendix M). The selection of the PETs was based not only on their prevalence in the data but also on factors such as the richness of specific paragraphs highlighting the themes and how these themes helped elucidate other aspects of the participants' narratives (Smith et al., 2022). During this process, I revisited the original text and linked the developed themes with participants' descriptions as needed, making adjustments and rearrangements of themes when necessary. Extreme care was taken in constructing the final table of GETs, including sharing it with my supervisor to verify the consistency of the themes.

4.9 Ethical Considerations

This research was carried out in my attempts to maintain an ethical attitude consistent with the BPS Code of Ethics and Conduct (2009). Ethical approval was gained from the LMU Research Ethics Committee before the recruitment started (see Appendix N).

4.9.1 Informed Consent

Initial talks were held with interested individuals to provide information about the research and the protocols of the interviews, during which they were invited to ask questions and talk about their concerns. Subsequently, the Participant Information Sheet was sent to the

interested individuals via email after the initial talk, and those confirming their interest were invited to complete the PHQ-9 and the GAD-7 online. Participants who were eligible were invited to attend the interview. Prior to each interview, I thoroughly briefed the critical information again. Participants' autonomy was of utmost importance in the interview; therefore, I informed the participants that they could decide the amount of information they wanted to disclose.

Consent forms were obtained before the interview commenced, and a signed copy was retained by the participant and me. All the participants were assured they could withdraw anytime within four weeks after the interview. However, since it would be difficult for me to separate individual data from the whole interpretative analysis after the data analysis starts, participants were informed that they could not withdraw from the study four weeks post-interview.

4.9.2 Confidentiality

In the Consent Form, details about the usage and storage of audio recordings and personal information were clearly explained. If there is a need to publish the results of the study, consent will be obtained in a separate form. To ensure the anonymity of each participant, I deleted or changed all of their identifiable information in accordance with the BPS, Code of Ethics and Conduct (2009). The audio recordings and other forms of digital data were stored securely within a password-protected laptop in my flat. Paper copies of all the materials used in this study, which include interview notes and transcripts of all the participants, as well as consent forms, were locked and will be shredded once no longer needed. After completing this study, all data would be retained for five years for publication purposes, after which they would be processed according to the Data Protection Act (1998).

In addition, each participant was informed about the confidentiality limits. In the Consent Form, participants were notified that confidentiality could be breached if there was a high risk of suicide, potential harm to others, or if serious criminal or terrorist activities were disclosed. I requested explicit consent for this, and only those who signed the Consent Form, agreeing to these conditions, were allowed to participate in the study.

4.9.3 Monitoring Distress

It was anticipated that the topic in this study could be sensitive and personal for the participants. Therefore, one risk for them was that discussing it might trigger some difficult feelings. In order to safeguard participants from any possible distress, the following measures were taken in accordance with both the Code of Ethics and Conduct of the HCPC (2006) and the BPS Code of Ethics and Conduct (2009).

Firstly, the PHQ-9 and the GAD-7 were used to investigate the well-being of the potential participants. Those with suicidal thoughts, depressive disorder, or generalised anxiety disorder were not included in the study, as some of the topics that were discussed could have caused distress. A score of 10 was often recommended as the cut-off point for both the PHQ-9 (Manea et al., 2012) and GAD-7 (Johnson et al., 2019), and those who scored above the cut-off point of 10 for either questionnaire were excluded. In addition, those who scored higher than 0 points in the Q9 part (on suicidality) of the PHQ-9 were considered at risk for suicide and were excluded. A total of seven individuals responded to the call for participants. One was excluded after scoring 12 on the PHQ-9 (with a score of 0 on the Q9), exceeding the cut-off threshold. This individual was notified by email that they would not be invited to participate in the study for their own protection. They were also advised that if they had any

questions or concerns about their psychological well-being, they should seek advice and support from their GP or a number of other mental health support services. Additionally, contact details for these services were provided to offer further resources for professional assistance.

Additionally, participants' psychological and emotional states were monitored and responded to throughout the interview. Meanwhile, as a trainee counselling psychologist, I developed expertise in working with individuals experiencing mental health difficulties. This allowed me to encourage the participants to talk deeply about their experiences whilst ensuring their safety. Meanwhile, the LMU Distress Protocol was employed to provide further protection, which guided me in recognising signs of distress and taking appropriate actions.

4.9.4 Debriefing

The post-interview debriefing provided useful websites and organisations for participants who might have needed further help. The contact details of the investigator and the research supervisor were provided at the end of the consent form, considering some participants might have had questions that required further discussion and assistance.

4.10 Validity and Trustworthiness

This study followed Yardley's guidelines (2000, 2008) to ensure research quality, focusing on four essential principles. To maintain sensitivity to the context, I conducted a thorough literature review on cross-cultural therapy, with a specific focus on the experiences of FGCI clients, which helped guide the research questions. Meanwhile, to create a comfortable environment for participants to freely share their personal experiences, video interviews were conducted with the participants in their own homes. This setting facilitated open discussion

on potentially sensitive topics. To further ensure a supportive environment, I assured participants that I would keep their responses confidential. During the interviews, I also paid close attention to their body language to ensure they felt comfortable addressing the questions posed.

Commitment and rigour were demonstrated in several aspects. Prior to conducting the analysis, I received research training through my doctoral studies in CoP, which included theoretical lectures and also practical workshops where I practised IPA data analysis with peers, receiving feedback from both peers and lecturers. Additionally, I attended an IPA data analysis workshop offered to PhD and doctoral students by London Metropolitan University. I also thoroughly studied Smith et al.'s (2022) newest book on IPA Theory, Method and Research.

During the analysis stage, I strictly adhered to the IPA guidelines as Smith et al. (2022) set out. At the beginning stage of the analysis, I shared anonymised, annotated transcripts with peers who also used IPA in their research, which helped ensure the validity of the analysis and provided alternative perspectives on the experiential statements. In the second phase, I shared the PET tables and summaries for each case with my supervisor, after which I analysed patterns across all cases. Once the analysis was complete, the final table of GETs was sent to my supervisor for review and refinement under academic supervision. After starting work with a second supervisor, I also submitted the final table of GETs for their secondary review, further ensuring the validity of the data analysis. To further enhance the validity of the study, I incorporated Smith et al.'s (1996) recommendation to invite participants to review the study's findings. Upon request, I invited participants to review

summaries of the results and the final GET table by email. Half of them responded and expressed satisfaction with the summaries of the findings.

As Yardley (2000) notes, transparency and coherence are essential for validating qualitative research. In this study, transparency was ensured by providing a clear description of all research procedures. I maintained a reflexive journal throughout the research process, documenting how my own cultural background as a FGCI would impact the way I conducted the study (this is discussed in detail in the Reflexivity Statement). This reflexive approach allowed me to acknowledge and remain aware of any personal biases that could influence data interpretation. It also reflected the interpretative activity central to IPA (Shinebourne, 2011). Additionally, I followed Yin's recommendations (1989) for ensuring methodological transparency by maintaining a comprehensive audit trail from the study's initial stages through to the final report. For example, Appendix J contains the annotated transcript of a participant (Lee), Appendix K provides experiential statements from Lee's transcript, and Appendix L includes a Table of PETs for Lee.

The last principle of Yardley's guidelines relates to the study's impact and significance. This research offers valuable insights into the cross-cultural TRs experienced by FGCI clients, and its findings have practical implications for therapists working with Chinese immigrant clients (and this will be discussed in detail in the Discussion).

5 Analysis

Three GETs emerged from analysing the participants' experiences of cross-cultural TR with White British therapists. The first GET, Pre-Cross-Cultural Psychotherapy Challenges, describes the difficulties faced by FGCI before seeking therapy, including predicaments

related to employment and education, the stigma and silence surrounding mental health issues within the Chinese community, as well as their preconceptions of receiving psychotherapy in the UK. The second GET, Cross-Cultural Therapy Experiences, explores participants' experiences during therapy, particularly the emotional barriers faced in the initial stages, language-related challenges, and the mixed impact of cultural differences. The third GET, The Role of the Therapist, reflects how participants perceive their therapists' personal attributes, cultural sensitivity, and therapeutic approaches. The details of these GETs, PETs, and relevant participant quotes are summarised in Table 2.

Table 2: Summary of Group experiential themes (GETS) and Personal experiential themes (PETS) with relevant quotes

GETS	PETS	Relevant quotes/extracts
Pre-Cross-Cultural therapy Challenges	Predicaments of FGCI	<i>"I feel that my anxiety at that time was mainly about employment and further education [...] And if I want to first secure a work visa to stay here, this is extremely, extremely difficult."</i> Lee, Line 102-114
	Stigma and Silence in the Chinese Community	<i>"There are also some stereotypes or stigmas around people looking for mental health help that you need mental health help because you are weak."</i> Tao, Line 169-173
	Preconceptions of Approaching Psychotherapy in the UK	<i>"... part of the reason why I didn't want to go to the therapists at the very beginning, was because I feel like they couldn't understand me completely because we're from different cultures..."</i> Lily, Line 449-453
Cross-Cultural Therapy Experiences	Navigating Emotional Barriers during the Initial Phases	<i>"I felt I was a burden to my therapist because I still didn't recognise it was a mental health problem...As a minority, I felt we could shut down quite quickly if we sensed the therapist was not interested or judging us."</i> Wong, Line 289-291
	Therapy in English: Hindrance or Catalyst?	<i>"So that's why I feel so comfortable doing therapy in English because I learned everything of expression emotions in English because I don't know how to do that in Chinese."</i> Yan, Line 915-917
	Challenges of Cultural Differences	<i>"I felt a bit tired as it took quite a bit of effort to explain some cultural phenomena and current policies to her. I wondered whether she could really understand them as a foreigner."</i> Mei, Line 683-685
	Benefits of Cultural Differences	<i>"I wasn't afraid of my therapist's judgement when I talked to her, because she didn't know Chinese culture that well. I guess that's really important in therapy."</i> Lily, Line 1410-1413
The Role of the Therapist	Personal Attributes	<i>"She spoke in a very gentle manner, her tone was slow, soft and steady. She would always look into my eyes when she was listening...She gave me a very warm feeling. It felt like</i>

		<i>as soon as I entered the room and saw her, there was an abstract hug there. Mei, Line 532-538</i>
	Cultural Sensitivity	<i>“Simply showing me that she experienced other cultures didn’t mean she could understand me. I felt she was downplaying the cultural differences.” Tao, Line 442-448</i>
	Therapeutic Approaches	<i>“I don’t know if that’s my therapist approach or not. The way that she never answers my questions, the way how she raises questions just make me think more about myself, so I could get to know myself better.” Lily, Line 692-697</i>

5.1 GET 1: Pre-Cross-Cultural Psychotherapy Challenges

This GET reflects the challenges experienced by participants before they received psychotherapy. This includes some of the difficulties they encountered as FGCI in the UK, their cultural perspectives on mental health issues and how these views influenced their decision to pursue psychotherapy, as well as their preconceptions of undergoing psychotherapy in the UK.

5.1.1 PET: Predicaments as First-Generation Chinese Immigrants

All participants described the various challenges they faced while living or studying in the UK and the subsequent mental strains they endured. They cited that these unique challenges were direct or indirect triggers for their initial pursuit of psychotherapy. The following quotations highlight some of these difficulties:

I feel that my anxiety was mainly about employment and further education. I worked so hard to complete my Master’s, but the policies for immigration here are incredibly strict, especially for some jobs that I really want to pursue; they generally don’t grant a visa, and this made me feel stuck. If I want to secure a work visa to stay here, it’s extremely, extremely difficult. (Lee; 102-114)

Lee articulated the challenges he encountered trying to stay in the UK after completing his Master's degree. He emphasised he “worked so hard” to complete his education, which seems to contrast with the external obstacles he encountered subsequently. This discrepancy appears to indicate a significant gap between the effort he invested and the actual outcomes regarding employment prospects and potential rewards. It also could highlight his perception of the unfairness of the immigration system's restrictions on Chinese international students. The term “stuck” that Lee used may suggest his feelings of helplessness and being out of control. Additionally, Lee's repetition of “extremely” could be an emphasis on the intensity of the challenges he faced in extending his stay in the UK. Similarly, Yan spoke of the struggles in her own experience:

I needed, let's say, half a million Chinese money to get the visa [...] For the British, going to any country to study is like having fun. But for the Chinese, going to any country to study or work, Jesus! How hard is that?! It's not just you have to make academic achievements, but also learn English [...] I actually studied philosophy at first in college. I changed my major later on because I knew it was extremely hard for me to get a job. My friend who also studied philosophy together felt like I was a traitor. (Yan; 321-329; 451-453)

Yan's comments on the costs associated with obtaining a visa seem to highlight the significant economic challenge she faced concerning immigration. Beyond academic requirements, she also brought attention to the language adjustment hurdle, likely emphasising it as a significant yet potentially often ignored struggle for many Chinese students. While Lee spoke of job search challenges, Yan's narrative may reflect the personal and relational sacrifices she made for improved employment opportunities. Their stories

appear to reveal the pervasive pressures that FGCIIs might confront in their efforts to remain in the UK.

Moreover, by contrasting the ease with which British citizens study abroad with the numerous obstacles faced by Chinese students, Yan seems to stress the inequalities between the two and the sense of unfairness these may cause. Where Lee's narratives may convey helplessness, Yan's appears to be tinged with irritation and frustration toward the stringent immigration policies affecting Chinese immigrants, seemingly encapsulated by her exasperated outcry, "Jesus! How hard is that?!" Similar to other participants, Mei discussed her challenges, focusing on her academic stress:

Last October I had two deadlines coming, and they were just for drafts, but I was really worried about my academic life and how I could write the assignments. I was really stressed. So, I contacted the school's counselling department [...] I worried I couldn't graduate. I have used so much money from my parents, and I would feel guilty if I couldn't graduate. When I came here, everyone said that 'all I need to do is graduate'. It seems for most Chinese or international students, it's a task you must do.
(Mei;14-22;57-64)

Mei articulated her feelings using highly emotive terms, including "really stressed" and "really worried," which seem to convey the depth of her struggles with academic stress vividly. Her concerns, even for the drafts, may suggest a profound fear of criticism or failure. Mei's admission of guilt over the financial burden on her parents appears to show her sense of responsibility and the stress she may feel to fulfil their expectations. Additionally, when Mei mentioned that "everyone" had told her she must graduate, it may suggest that academic

success holds more than personal significance; it's a collective ambition imbued with parental and communal hopes, thereby potentially increasing the weight of expectation on her. By noting that many Chinese international students might share such pressures, Mei seems to indicate that this is not just her individual experience, but a reality faced by a broader Chinese international student community.

Beyond the overt challenges related to employment or education, the emotional and social challenges can take a toll on FGCIIs, which is illustrated by Tao's narrative:

It was very hard to form cross-cultural friendships with locals. It was quite rare to get someone to listen to you and try to figure out what you meant and why it was important to you. I think my classmates or colleagues haven't provided that, probably because they're not your therapist (laugh) (...) I had experiences with the majority here about discrimination in general. It might not necessarily be discrimination, but definitely neglect, like cultural insensitivity. (Tao; 408-422)

Tao's discussions on the challenges of forging cross-cultural friendships seem to hint at feelings of isolation, loneliness, and perhaps a sense of being an outsider. The rarity Tao mentioned, of finding someone who genuinely listens and comprehends, may highlight her need for connection and validation—going beyond just being heard to a desire for true understanding and value. Her light-hearted mention of others not being her therapist, punctuated by laughter, is telling. On the surface, this might appear as a casual acknowledgement of the limitations of others. However, it also seems Tao might be downplaying her own expectations, possibly hinting at past disappointments. She appears to employ humour to mask a deeper pain derived from unmet needs and expectations.

Furthermore, Tao's differentiation between "discrimination" and "neglect" may indicate that her insights into the challenges she experienced as a FGCI are not just casual remarks but stem from her experiences and refined understanding.

5.1.2 PET: Stigmas and Silence in Chinese Community

This PET delves into the attitudes towards mental health issues in Chinese culture and their potential impact on participants seeking psychotherapy. Participants commonly reflected that within the context of Chinese culture, there is often a neglect of mental health issues and a sense of shame associated with seeking mental health support. Tao pointed out the neglect for mental health issues in her culture:

It's not a thing in my culture. It's not even a thing. People really don't pay attention to mental health issues. Growing up, I don't remember anything about mental health issues or mental health aid during anytime I was in school. So, it's never existed?! [...] There are also some stereotypes or stigmas around people looking for mental health help that you need mental health help because you are weak. (Tao; 164-173)

Tao referred to the neglect of mental health issues within Chinese culture as "it is not a thing." She continually repeated this as if striving to demonstrate that it is not merely a casual observation, but a deeply ingrained reality. With references to "anything" and "anytime," Tao seems to further underscore the profound lack of attention to mental health issues she experienced during her school years. There is a sense of shock in Tao's rhetorical question, "It's never existed?!" which may reflect her disbelief or an awakening to the critical yet overlooked importance of mental health in her personal and cultural history. Tao also addressed the stigma of seeking mental health help, likely implying that such stigmas in her

community may inhibit individuals from pursuing mental health support out of fear of being seen as vulnerable or inadequate.

Wong shared a perspective echoing Tao's viewpoint. While Tao focused on how her schools overlooked the issue, Wong used her own family as an example:

My mum had three different diagnoses in three different hospitals, but she thought the doctors were wrong. She was extremely stubborn [...]. Still, in my family, depression is classified as 'you enjoy your life too much and start to create problems for yourself'. By no means she's an outlier in my culture. [When I started to feel depressed], I still had that thought that I was creating problems for myself. I said to myself what happened to my mom wouldn't happen to me, and I would do better than going to a doctor. I was also ashamed that this happened to me. (Wong; 119-125)

Wong highlighted that her mother was diagnosed with depression in several hospitals, a fact that starkly contrasts with her mother's denial. This seems to emphasise a profound sense of shame felt within her family regarding mental health. By pointing out that her mother's behaviour isn't an "outlier," Wong may be suggesting that these beliefs and actions aren't isolated cases but are ingrained in the broader cultural backdrop.

Notably, Wong used "extremely" to describe her mother's stubbornness, which may imply that she is somewhat disheartened by her mother's attitude towards mental health. However, when facing her own depressive episodes, Wong perceived it as self-inflicted trouble and refrained from seeking professional assistance. This attitude seems to reflect the influence of her family's perspectives, suggesting that Wong may have internalised the shame regarding

the pursuit of mental health care. By mentioning that she “also” felt ashamed of her own mental health struggles, Wong seems to express a sense of helplessness in being unable to escape this cycle of shame.

Lee, like the previous participants, went on to outline the societal pressures and potential consequences one might face when deciding to seek mental health assistance:

For me and the social stigma, seeing a therapist is being weak and unpredictable. There’s the fear of being abnormal, like depression or anxiety is in the category of abnormality. Especially in Chinese culture, if I was exposed, like the information was leaked in my friend circle, I guess they would secretly discuss it, “You know what?! That guy went to see a therapist. What’s wrong with him?” This kind of gossip will potentially damage friendships. (Lee;387-393)

Lee emphasised that individuals in Chinese society are typically expected to manage their emotions independently. There’s a clear delineation in Lee’s words between “normal” and “abnormal,” suggesting that mental health issues are not seen as a natural or expected part of the human experience in his cultural context. Moreover, he believed those who seek therapy are often perceived as emotionally weak, revealing the extent of stigma and misconceptions about mental health treatments in his community.

Lee also expressed deep concerns about how his therapy could potentially alter the dynamics of his friendships. This reveals the depth of the stigma, which is not just about self-perception, but also about tangible consequences for personal relationships. The word “leak” vividly captures his profound worries, even fear, of his therapy being discovered by others.

He described in detail how others might gossip about him, hinting that he's repeatedly imagined such scenarios, further demonstrating his internal anxieties and concerns about societal judgments.

Yan spoke of her observations on the prevalent emotional repression within Chinese culture:

I think culturally Chinese people don't really talk about feelings. They feel like if you have feelings then you are very weak, or that is something that only belongs to women (laugh). I feel like Chinese culture actually are based on laws of rules and obedience. That's a part of Confucius culture. (Yan;342-351)

Yan argued that "Chinese people don't really talk about feelings," and she seems to suggest that this might stem from a broader cultural perspective where showing emotions is seen as a sign of weakness, even equated to femininity – a reflection of a patriarchal view where emotions are gendered. Notably, Yan's laughter in this context might indicate her discomfort or irony regarding this cultural norm. Her use of the term "they" appears to further signify that she holds a different stance on this view. By pointing out that the foundational pillars of Chinese culture are rules and obedience, Yan seems to suggest that this emotional repression might be linked to the very foundation of Chinese culture.

5.1.3 PET: Preconceptions of Approaching Psychotherapy in the UK

All participants shared their preexisting beliefs, expectations, and concerns surrounding the process of seeking psychotherapy within the UK context. The subsequent excerpts illustrate this sentiment:

I honestly didn't know what to expect for the first time because it was not like going to a GP, they prescribe you medicine, blood tests, and maybe some investigation. I just didn't know how the British professionals would help me, and what type of service I would get or even whether they could help me or not. I just didn't know! I honestly had no expectations. (Wong; 70-77)

Wong's narrative seems to capture a sense of uncertainty and unfamiliarity regarding her initial experience of seeking mental health support in the National Health Service (NHS). She contrasted the experience with the more straightforward and predictable process of visiting a general practitioner (GP), a comparison that seemingly highlights her apprehension about her lack of clarity about what to expect from psychotherapy. Wong's repeated use of the phrase "I just didn't know" seems to further indicate a sense of unease and scepticism about the process and effectiveness of the treatment. This sentiment may stem from a lack of understanding of mental health services or could be due to cultural views she previously mentioned in PET 5.1.2 that traditionally do not prioritise psychological support. Moreover, Wong's reference to "British professionals" could imply a concern about cross-cultural communication; she may ponder whether British therapists can fully comprehend and meet her needs. Her declaration, "I had no expectations," seems to potentially reveal her emotional fragility when stepping into the unknown, hinting that she might be trying to avoid setting her hopes too high to prevent disappointments.

Similarly, Mei also shared that she had low expectations for the cross-cultural psychotherapy she would receive from her university:

I didn't have much expectation about how the therapist here could help me (laugh), probably because I was in a deep depression and my thoughts were really negative at that time. I didn't have much hope, but my idea was at least not to give up, and to try if this path could work. I just told myself it might help. But actually, I didn't believe it, because I had therapy before and I knew my problems couldn't be solved in a short period [...] Before I started the therapy, I also worried a little bit about the language barrier, like what if I couldn't express myself clearly. I worried about that. (Mei;290-300;1069-1072)

Mei expressed modest expectations for working with a therapist from “here”, which seems to reveal her scepticism towards the effectiveness of receiving psychotherapy through her university. Her laughter here, possibly, serves as a mask for the discomfort of admitting her distrust so openly. Mei later acknowledged that she “didn't have much hope,” seemingly further highlighting her doubts and pessimism about the benefits of receiving therapy in the UK. Upon deciding to “try if this path could work,” she noted that she did not believe, based on previous experience, that there would be a quick solution to her problem, which might illustrate her internal conflict between hope and scepticism before seeking help. This ambivalence likely serves both as a guard against further disappointment and a pragmatic recalibration of her expectations.

In addition, Mei's anxiety over language barriers seems to add another layer of resistance she might face when considering therapy. Her concerns seem to go beyond just understanding the language itself, which may reveal her sense of deeper fear of not being genuinely heard and understood. This fear might amplify her already existing emotional loneliness. Lily's

statement offers more insight into the multifaceted concerns faced by FGCIIs when seeking therapy in the UK:

Part of the reason why I had not gone to therapy earlier was I worried British therapists couldn't understand me fully, because we're from different cultures, of course (laugh). I worried that when I described something, they might not know that much. Unlike talking to a therapist who could speak my mother language, it would just be harder to describe things to them. (Lily; 408-418)

Lily expressed her initial reluctance to pursue therapy due to concerns about not being fully understood by British therapists, seemingly hinting at an underlying anxiety about engaging in therapy. This apprehension, alongside her comments elsewhere in her transcript about feeling almost desperate before seeking therapy, appears to reveal the complex emotional struggle Lily experienced in deciding to seek treatment in a cross-cultural context. She seems to be caught between a critical need for assistance and the fear of miscommunication. Moreover, her laughter here seems to serve as a cover for the embarrassment of voicing a concern that seems blatantly evident, even carrying a nuance of self-mockery as she pondered the likelihood of being thoroughly understood by a British therapist.

By drawing a comparison to therapy in her native language, Lily seems to imply a desire to be seen and understood within her full cultural and personal context by the therapist.

Communicating in her mother tongue might symbolise a deeper, intangible bond to her roots, values and life experiences. In contrast, sharing her struggles with a British therapist who might not be familiar with her language and potential cultural background could arguably make her feel that the therapist might not be able to provide the depth of understanding she

desires. Therefore, Lily's hesitation to approach may be rooted not just in a fear of misinterpretation but also in the concern over the potential loss of meaning and emotion in translation.

5.2 GET 2: Cross-Cultural Psychotherapy Experiences

This GET involves participants' actual experiences within the cross-cultural TR, focusing on how cultural differences were perceived in the therapeutic process. It also reflects the emotional barriers participants faced and the diverse experience of expressing themselves in English in therapy.

5.2.1 PET: Navigating Emotional Barriers During the Initial Phases

This PET reflects that participants experienced a range of complex and difficult emotions in the early stages of cross-cultural therapy. These internal struggles with an emotional basis may have posed certain obstacles to the progress of therapy. Some of the emotional struggles are highlighted in the following quotations:

I felt embarrassed in therapy at the beginning. I still carried the baggage of how seeking mental health help was stigmatised in my culture. But embarrassed feelings also related to just disclosing personal stuff to a stranger, especially a foreign person, like not one of my family or one of my culture. (Tao;213-217)

The word "embarrassed" seems to reflect Tao's initial feelings of unease and even shame when beginning therapy. Tao acknowledged this discomfort stems from the stigma associated with seeking mental health support in her culture. This corresponds to her earlier mention in PET 5.1.2 that in her culture, such help might be considered unnecessary, or a sign of

weakness. The word “baggage” seems to capture well the feeling of heaviness that the stigma has brought to her. Moreover, Tao’s embarrassment may also hint at a fear of not being understood or accepted in cross-cultural communication. While opening up to strangers about one’s personal struggles is daunting in itself, Tao’s specific mention of “a foreign person” as opposed to “one of my culture” seems to indicate her concerns about the level of understanding and acceptance she could receive from a therapist of a different culture, not just on a personal level but also on a broader cultural level.

Similarly, Wong’s account of her early therapy sessions with a British therapist seems to highlight her emotional barriers:

I felt I was a burden to my therapist because I still didn’t recognise it was a mental health problem. I still felt guilty for taking other’s time (sigh)... I couldn’t open up in the first couple of sessions. I had to test the water first, to give a little bit and then to see what was coming out of it. As a minority, I felt we could shut down quite quickly if we sensed the therapist was not interested or judging us. (Wong;289-300)

Wong’s realisation that she “didn’t recognise it was a mental health problem” appears to mirror her earlier admissions in PET 5.1.2 about her unwillingness to accept her depression due to the cultural and familial shame associated with mental illness. This ingrained sense of shame may prevent Wong from seeing her need for mental health support, which in turn could contribute to her feelings of being a “burden” and experiencing “guilt” for taking up the therapist’s time. Moreover, Wong’s sigh here and repeated use of the word “still” appears to carry a sense of disappointment in herself for her lack of awareness regarding her mental health.

Her hesitation to “open up” and her inclination to “test the water” may reflect her fears of potential judgment or being misunderstood, seemingly indicating a hesitancy to fully trust or feel secure within the therapeutic setting. Additionally, Wong’s attention to her status as a “minority” may suggest she navigates therapy not just as a client, but also as someone who feels like an “outsider,” which might intensify her worries about being judged or not being understood properly. This seems to echo Tao’s concern over cultural misunderstandings.

Likewise, Lily conveyed the emotional obstacles in establishing a trusting relationship with her British therapist:

I think Chinese can be quite defensive generally due to a lack of knowledge about mental health issues...and I do have trust issues with other people myself. So, I struggled to build a trusting relationship with my therapist at the beginning. The fact that my therapist comes from another culture probably made it more difficult. She couldn't do much without me trusting her as I couldn't tell her my true feelings and was always hiding something. (Lily; 223-232)

The term “struggled” seems to precisely capture the emotional hurdles Lily faced in establishing trust with her therapist during the early stages of therapy. Lily’s reflection on whether these difficulties with trust stem from a broader defensive stance she observed in her community or her personal experiences seems to suggest that she was aware of the significant challenges she had in building trust within the TR. Moreover, Lily mentioned that the therapist was from another country, which seems to add another layer of difficulty in establishing trust, suggesting that cross-cultural dynamics may complicate the TR. Her

recognition of her defensiveness and issues with trust may hint at her underlying vulnerability or fears of being completely open.

Lily's acknowledgement that "she couldn't do much without me trusting her" may indicate her conscious understanding of the pivotal role of trust in therapy. Nevertheless, her admission that she "was always hiding something" possibly betrays a profound inner struggle: her desire to expose her genuine frailties in therapy battles with her fear of becoming utterly vulnerable.

Mei, too, shared her feelings of distrust at the beginning of working with a British therapist:

Because this was my first time having therapy in the UK, I felt a bit lost as I didn't know what to talk about or where to start at first. My therapist told me later that she felt I didn't seem to trust her much at the beginning. I think it might be because I was not too willing to rely on the strength of others to step out. It's like we have a walking stick to climb a mountain, but we just won't use it, we insist on climbing up on our own. (Mei;454-465)

Although Mei mentioned earlier that she had experienced therapy before, she admitted to feeling "lost" during her initial therapy sessions in the UK. This feeling might stem from a completely new therapeutic environment and a therapist of a different culture, which potentially makes her past experiences seem less applicable.

Mei then articulated her hesitation to fully "trust" by likening it to a reluctance to use a walking stick. Her reference to the walking stick, likely a metaphor for external support,

seems to indicate that she may be aware of the potential benefits of therapy, but her insistence on “climbing up on our own” could reveal her preference for self-reliance over seeking external help. This likely demonstrates Mei’s inner conflict between acknowledging the need for help in a difficult journey and her deeply rooted belief in self-reliance, which seems to resonate with the shared theme of resistance to the therapeutic process expressed by other participants. Furthermore, the use of “we” in her analogy seems to suggest that this value of self-reliance and independence might be potentially reflective of a broader cultural inclination in the Chinese community.

5.2.2 PET: Therapy in English: Hindrance or Catalyst?

This PET explores participants’ experiences of receiving therapy in English with a British therapist, as well as the feelings that emerged during this process. Mei elaborated on the struggle with language that she faced during therapy:

Sometimes, I would get stuck even on a very simple word, or there were moments when I couldn’t find a certain word to express my feelings, then I became anxious and embarrassed, and I needed to stop to think. (Mei;1102-1107)

Mei discussed how even simple words can become stumbling blocks, seemingly indicating the additional challenges that language barriers present in therapy; as a client, she is tasked with not only navigating her emotional world but also translating it into a language that isn’t her first. The anxiety Mei felt during moments of linguistic deficiency seems to highlight her vulnerability, particularly in therapy where clear expression of feelings is critical; ineffective communication can arguably exacerbate her feelings of helplessness and frustration. Echoing Mei’s previously mentioned concerns about expressing herself in English before starting

therapy in PET 5.1.3, the embarrassment she referred to also appears to reflect a self-perceived inadequacy, as well as a concern about how her therapist might view her language difficulties. The moments where she has to “stop to think” may reflect not only Mei’s need to find the right words but also the internal struggle and interruptions she faces while attempting to explore and articulate her emotions.

In contrast, Wong’s account illuminates how language barriers might manifest in therapy from a different perspective:

I felt quite lucky that language was not a problem for me [...] A lot of my childhood trauma happened at that time when I could only speak Chinese. When I was going into those memories, I had to think really hard about what happened. Also, because of the language barrier, I had to go through the memories again and again, trying to say I didn’t miss any details, which was quite traumatic. (Wong; 779-781; 1176-1186)

Wong’s assertion that “language was not a problem” seems to suggest she felt adept at using English in therapy, which differs markedly from Mei’s experience. She expressed a sense of fortune for not facing language difficulties, seemingly reflecting her belief that language barriers can often trouble FGCI clients in cross-cultural therapy. Yet Wong seems to encounter similar challenges as Mei in processing past traumas. Her mention of having to “think really hard” may hint at the strenuous effort required to delve into painful memories and the emotional strain involved. Despite her English fluency, the necessity to revisit these memories repeatedly to articulate them in a non-native language may arguably intensify her exhaustion and frustration. The term “traumatic” seems to further emphasise the distress of this process, a stark contrast to her initial sense of advantage. This discrepancy emphasises

the added complexity that language considerations can introduce to therapy for individuals navigating cross-cultural environments.

Tao introduced a different perspective on the emotional burden that comes with communicating in a non-native language during therapy:

I felt I had to make more effort to make this communication in therapy effective because, obviously, my therapist couldn't speak Chinese. It also made me feel why I was always accommodating others, constantly making all the effort to explain myself in a language that is not my mother language, and why no one coming from another direction came closer to me. (Tao;927-935)

Tao's mention of having to "make more effort" sheds light on the extra labour she may feel compelled to put forth to articulate her thoughts in English during therapy. Her statement "obviously my therapist couldn't speak Chinese," might suggest her awareness that it is impractical to expect her therapist to understand her native language, an "obvious" reality that may intensify the fatigue from the one-sided effort and accommodation in the TR. This exertion prompts Tao to reflect on a recurring theme in her life, where she has always felt the burden of making "all the effort" to bridge language and cultural gaps. Such continuous effort could be particularly draining in a therapeutic context, where one expects to be met with understanding and support. Tao's rhetorical question, "Why [does] no one [come] from another direction come closer to me?" appears to encapsulate a deeper sense of loneliness within her therapeutic experience and beyond, as well as a longing for mutual effort and understanding in her interactions with others.

Unlike the previous three participants, Yan portrayed a different experience of expressing emotions in a non-native language during therapy:

Asking how you feel, talking about emotions, processing emotions, and describing them all felt so weird in Chinese. When I was growing up, I didn't have the vocabulary. That is why I felt so comfortable doing this in English; I learned everything in English, and I actually don't know how to do that in Chinese. (Yan; 915-922)

Yan's description of her experience with emotional discourse in Chinese as "weird" seems to suggest a disconnect with her mother tongue in expressing feelings, mirroring her earlier reference to an emotional suppression within Chinese cultural norms in PET 5.1.2. Her admission about the absence of an intricate emotional vocabulary in Chinese from her formative years carries a hint of melancholy or disappointment, possibly stemming from a sense of loss and estrangement from her cultural roots due to this linguistic gap. In stark contrast, Yan speaks of a sense of ease with English in therapeutic settings. Phrases like "felt so comfortable" and "I learned everything in English" appear to indicate that Yan experiences a sense of liberation and discovery by using English in therapy, providing her with the necessary tools to navigate her emotional landscape, a capacity she perceives as lacking in her native tongue.

5.2.3 PET: Challenges of Cultural Differences

This PET discusses participants' experiences of the multifaceted barriers and challenges that cultural differences pose in psychotherapy with their British therapists. The following extract captures this:

One difficulty was about explaining the university degree. I spent quite a bit of time getting my therapist to understand things rooted in Chinese culture, like how you were told from a very young age that you needed to go to top universities to be successful and how everybody would respect you straightaway by hearing you were from the top universities. But with all these explanations, I had this feeling that he didn't quite get it (laugh). (Lee;475-484)

Lee described the challenge of conveying to his therapist the deep cultural significance of attending prestigious universities in China, a task he referred to as “one difficulty.” This reflects the struggle to bridge the cultural gap with someone from a different cultural background, to make them understand the societal esteem and personal worth attributed to such educational achievements within Chinese society. Lee’s mention of “spent quite a bit of time” and “all these explanations” suggests he invested considerable effort in trying to communicate this cultural concept, with possibly an underlying hope that the therapist would grasp it and its associated emotional weight. Yet, his remark “he didn’t quite get it” suggests a gap between Lee’s intended message and the therapist’s understanding, which could result in feelings of being misunderstood or disconnected within the therapeutic context. Lee’s laughter at the end may be a means to mask the disappointment of not achieving a deep level of understanding with his therapist.

Mei’s discussion seems to echo this sentiment of exhaustion when elaborating on cultural norms and current policies:

I felt a bit tired as it took quite a bit of effort to explain some cultural phenomena and current policies to her. I wondered whether she could really understand them as a foreigner. Even if she could understand what I was saying literally, she might not fully empathise. For example, when I told her about my relationship with my Dad, I felt she might not understand why I felt guilty or why I was still so obedient to my dad, and the concept of Xiao [filial piety], like loyalty to the family, in Chinese culture.

(Mei; 683-695)

Mei referred to her therapist as a “foreigner,” seemingly emphasising the large cultural divide between them. By differentiating between literal and empathetic understanding, Mei seems to hint at her expectation for the therapist to comprehend the deep cultural meanings behind the issues she discusses. Mei continues to talk about her relationship with her father and the ensuing emotions, echoing her earlier reason for seeking therapy, which was related to her own feelings of guilt, seemingly highlighting the significance of these issues for her.

Mentioning “she might not understand,” Mei seems to acknowledge that concepts such as “loyalty” and “Xiao (filial piety)” in Chinese culture may not be easily translated or hold the same significance in another cultural context. This could lead to a feeling of isolation, as if her emotional experiences are being diminished or misinterpreted. Mei candidly admitted that conveying these concepts requires “quite a bit of effort”. The term “tired” not only reiterates the physical or mental fatigue she may be feeling but also may imply an emotional burden associated with the challenging task of bridging this cultural gap.

Lily spoke about the challenges posed by the differences in non-verbal communication:

I felt there was an invisible wall. I can see if a Chinese believes me or not by their body language, but I could never tell with my British therapist. When she said something nice, I didn't know if she really meant it or just being polite. I always felt she was shrouded in a veil. I got insecure if I didn't know others' real intentions. It took me eight months to have a comfortable relationship with her, but maybe with a Chinese therapist, it just needs three months. (Lily;984-994)

Lily described a metaphorical “invisible wall,” which seems to imply an intangible yet perceptible divide in culture and communication between her and her therapist. In her narrative, there seems to be an ease and clarity with Chinese when it comes to non-verbal communication, contrasting with the alienation and ambiguity she experiences with a British therapist. This stark contrast seems to suggest the challenges of understanding one another in a cross-cultural TR due to differences in non-verbal communication.

Furthermore, Lily talked about how British politeness norms leave her unsure of the therapist's true thoughts and feelings. She referred to the therapist as being “shrouded in a veil,” a metaphor for her struggle to understand the therapist's true motives, a situation that both frustrates and unsettles her. Lily's specific timeline—the establishment of a relationship with a Chinese therapist takes three months, in contrast to eight months with a British therapist—quantifies the challenges she may feel in a cross-cultural TR. It also suggests that Lily believes overcoming cultural barriers and building trust with a British therapist requires additional emotional labour and time.

Yan reflected on the poignant disparity in cultural and societal positioning between her and her therapist:

I felt like, it was funny in a way, there was no way that my therapist could just slightly imagine an immigrant's pain, no way! She never experienced this because she was born with this privilege, the British passport lottery. How would she possibly understand?! I had to do so much to just be able to sit in the same room with her. There's a big difference between me and a random White British girl seeing her. The price we pay is just so different. (Yan;1158-1168)

Yan described the therapist's native British citizenship as a "privilege," akin to winning the "British passport lottery," contrasting sharply with her own "immigrant" status. This shows Yan's acute awareness of the differences in social privilege and the cultural gap between herself and her British therapist. By emphasising that her therapist cannot "just slightly imagine an immigrant's pain, no way!" Yan appears to underscore the intrinsic difficulty in conveying the immigrant experience to a therapist lacking similar life experiences, along with a profound sense of loneliness and defeat.

Yan earlier discussed the financial challenges and difficulties she faced as an immigrant living in the UK in PET 5.1.1, which seems to resonate with her current reference to "the price we pay," emphasising the effort and sacrifices she, as an immigrant, has made to "just be able to sit in the same room with her therapist." She believes that "a random White British girl" would not have to endure these costs. The statement "it was funny in a way" seems to suggest that Yan finds it almost ironic or even absurd to expect the therapist to understand these issues. Yan's use of "no way" repeatedly seems to indicate her doubts that her therapist, or any White British person, could fully comprehend the pain of immigrants, implying a significant disconnect in the TR caused by these cultural and social privilege differences.

5.2.4 PET: Benefits of Cultural Differences

Participants mentioned the potential benefits of cross-cultural therapy, which are facilitated by the cultural differences they have experienced with their British therapists. Lily's experience highlights the perceived benefits of engaging with a British therapist who is unfamiliar with her cultural background:

I wasn't afraid of my therapist's judgement when I talked to her because she didn't know Chinese culture that well. I guess that's really important in therapy; you'll feel free to talk about anything if you're not afraid of being judged. Sometimes, I needed to explain things more thoroughly to make her understand. It actually made me find things that I hadn't noticed previously! I could get to know myself more. (Lily; 1410-1421)

There seems to be a sense of liberation in Lily's words when she mentioned that her therapist's unfamiliarity with Chinese culture alleviated her fear of judgment. Lily went on to express "that's really important," which appears to indicate her appreciation for the non-judgmental attitude within therapy, considering it crucial for enabling clients to freely discuss personal issues. Intriguingly, Lily shifts from using "I" to "you" here, which might suggest her intent to normalise her experiences as something anyone could encounter. I wonder whether this shift may also serve to mitigate any unease she might feel discussing these matters with me, someone who understands Chinese culture and thus could have preconceived notions. When speaking about the self-discovery she gained while bridging cultural differences, her tone seems to carry an element of surprise, perhaps signalling that this benefit is unexpected.

Similarly, Lee talked about the benefits of the therapist's unfamiliarity with Chinese culture:

It is reasonable to assume that Chinese therapists hold some social stigma norms.

While the British therapist physically couldn't access the presumptions, that made me feel secure [...] I felt more powerful when I introduced some new knowledge about my culture. I felt I wasn't merely a client. I could take a little bit of control of that, instead of the therapist being the one who knows it all. I couldn't do this with Chinese therapists. (Lee; 389-393; 503-509)

The British therapist's inability to "physically access the presumptions" is Lee's metaphorical way of saying the therapist is removed from the cultural norms and prejudices that would be ingrained in a Chinese therapist. There seems to be a sense of comfort and relief in Lee's expression that the cultural distance of his British therapist makes him "feel secure." This sense of security seems to be particularly important for Lee, considering his previous expression in PET 5.1.2 of the stigmatisation of mental health issues in his cultural community. In addition, Lee sees himself not "merely as a client" but as an active contributor to therapy by sharing cultural knowledge with his British therapist, a dynamic that grants him a sense of control and agency. This contrasts with Lily's experience of achieving self-knowledge through addressing cultural differences. His statement, "I couldn't do this with Chinese therapists," seems to further underscore his need for empowerment within the TR. For Mei, she used a concrete example to illustrate how cultural differences have been beneficial:

When I told my therapist, I was afraid I couldn't graduate, she said graduation is just a choice, not what you have to do. These words were like "boom" and had quite a deep impact on me. It seems that many Chinese people may not even realise that graduation is not a must. This is quite interesting and a positive part brought by our different cultural backgrounds. (Mei; 1340-1348)

Mei appears to experience a defining moment when her therapist reframes the concept of graduation from an obligation to a choice, confronting an ingrained belief among the Chinese community that "graduation is a must." Mei's depiction of her therapist's statement as creating a "boom" effect vividly captures the profound and immediate shift in her viewpoint. By referring to "many Chinese people may not even realise that," Mei seems to emphasise the significance and value of being able to see her situation differently from the stereotypical perspective of her community due to her therapist's impact. Using terms like "interesting" and "positive" Mei seems to convey her appreciation for the way cross-cultural therapy has broadened her perspective and reduced the weight of the cultural expectations deeply rooted within her.

5.3 GET 3: The Role of the Therapists

The GET discusses the participants' experiences regarding the role of the therapists and what they bring into the TR. This includes participants' perceptions of therapists' personal attributes, cultural competencies and therapeutic approaches.

5.3.1 PET: Personal Attributes

All participants talked about their perceptions of the therapist's attributes and their potential impact. Some participants seemed to appreciate certain attributes that the therapist

demonstrated in the TR, while others expressed frustration with the therapist's perceived lack of these attributes. Yan described it this way:

One thing I really liked about my therapist is that she was very open; she didn't have that kind of typical and stupid prejudgment. She listened to my perspective carefully and made no judgment. Sometimes I felt like, 'Wow, it was very impressive that she could understand a lot of things I told her, more than I expected.' (Yan;458-469)

Using “really liked,” Yan appears to express her profound appreciation for her therapist's welcoming and open attitude. Her description of prejudgment as “typical and stupid” likely reflects her antipathy towards such biases, a sentiment that may stem from apprehensions about being stereotyped. In this context, the therapist's unbiased openness appears to be particularly meaningful for her. In addition, Yan's emphasis on her therapist's attentive listening seems to suggest she sensed a conscious and active engagement by the therapist in her narrative. With the phrase “very impressive,” Yan seems to convey a sense of satisfaction and even admiration for the therapist's profound understanding and empathic connection with her experiences.

Mei also shared her positive feelings about some qualities displayed by her therapist:

She spoke in a very gentle manner, her tone was slow, soft and steady. She would always look into my eyes when she was listening...She gave me a very warm feeling. It felt like as soon as I entered the room and saw her, there was an abstract hug there. The first time we met, she invited me to sit on the small couch, telling me I could lean

back and relax. She also said that if I felt insecure, I could hold a pillow. It made me feel comfortable and at ease. (Mei; 532-544)

The description of “an abstract hug” poetically captures Mei’s feelings of warmth and acceptance within her TR. The gentle tone her therapist consistently uses may suggest the therapist’s intentional effort to communicate in a way that is easy to follow, soothing, and non-threatening. Mei’s observation that her therapist “would always look into my eyes” appears to speak to the therapist’s attentiveness and willingness to establish a personal connection, which might also make Mei feel seen. Furthermore, the therapist’s thoughtful gesture of offering a pillow may reflect her sensitivity to Mei’s potential vulnerability as a client, thus reinforcing a supportive and nurturing atmosphere. Mei’s reference to feeling “comfortable and at ease” seems to suggest that she may feel a sense of security and containment in the therapeutic environment created by her therapist.

In stark contrast, Wong seems to perceive the therapist as lacking the qualities of warmth and empathy:

I didn’t feel connected at all since the beginning. He just... (sigh) lacked emotions, lacked understanding and lacked empathy. I felt like he couldn’t be bothered; he was like, ‘I’m here, I can talk to someone for 50 minutes that I get paid, then I back off.’ I felt he probably didn’t suffer from mental health issues as a practitioner. He just sounded like it was so easy to learn all the techniques. He didn’t understand as a patient, knowing the techniques and being able to apply them to your daily life, especially in a crisis, is extremely difficult. (Wong; 442-454)

Wong repeatedly mentioned the word “lacked,” which appears to not only signal her dissatisfaction and frustration with her therapist but also indicate her desire for the therapist to demonstrate qualities she perceives as missing, namely “emotions, understanding, and empathy.” Her sigh seems to convey a profound sense of disappointment, echoing her feelings of being misunderstood and overlooked in therapy. She characterised the therapist’s attitude as “couldn’t be bothered,” which may reflect her perception of the therapist as indifferent and utilitarian, with the therapeutic process seeming more like a routine than a caring, personalised intervention.

Additionally, Wong’s description of employing psychological techniques in crises as “extremely difficult” sharply contrasts with what she perceives as her therapist’s dismissive view that “it was so easy.” This disparity appears to suggest Wong’s view of her therapist as deficient in genuine empathy and understanding regarding the complexities of her struggles “as a patient.” Meanwhile, it’s not difficult to infer that when Wong feels her emotions are disregarded or misunderstood, it may arguably confirm her previously mentioned distrust in PET 5.2.1 “as a minority” during the initial therapy sessions. This validated distrust likely exacerbates her sense of insecurity, contributing to a heightened sense of isolation and helplessness throughout her therapy experience.

5.3.2 PET: Cultural Sensitivity

This PET discusses participants’ understanding of the varying abilities of their therapists in handling cultural differences and their potential impact. The following narrative captures this:

She asked me many questions about my cultural background. I had to explain all the cultural stuff to her. What’s the point if half the time I paid for was used for

explaining everything (laugh)? It was not that therapeutic [...] She tried to persuade me that she understood me by saying she probably wasn't raised here. It wasn't the same. If you have a client from another culture, at least you have to learn basic knowledge about their culture and history, and check and ask all the time. Simply showing me that she experienced other cultures didn't mean she could understand me. I felt she was downplaying the cultural differences. (Tao;434-448)

The statement “I had to explain all the cultural stuff” seems to indicate Tao’s exhaustion from repeatedly attempting to minimise the cultural divide with her therapist. This sentiment aligns with Tao’s previous feelings of a one-sided effort to bridge language and cultural gaps in broader interpersonal relationships mentioned earlier in PET 5.2.2. Tao’s expression, “What’s the point?” seems to reflect her strong frustration at having to use her paid therapy time to fill these gaps in understanding. Her laughter here, while seemingly light-hearted, may be an attempt to downplay the irritation she may have felt in the situation. However, the comment “it wasn’t that therapeutic” distinctly conveys her dissatisfaction and the sense that the sessions did not meet her needs, leaving her deeply disappointed.

Her statement, “It’s not the same,” appears to indicate that the therapist’s attempt to connect by referencing her own experiences with other cultures was ineffective. She then mentioned that genuine cross-cultural understanding requires someone to “learn so many things, and check and ask all the time” about another’s cultural background, which potentially indicates her specific expectations of the British therapist and hints at a gap between what she expects and what is offered. Tao’s mentioning of “downplaying cultural differences” may further communicate her dissatisfaction and disappointment with the perceived therapist’s

oversimplification of cultural understanding. It might lead to her feelings of being undervalued and overlooked in therapy, resulting in frustration and a sense of ineffectiveness.

While Wong detailed an encounter where cultural differences are seemingly ignored:

Because I speak fluent English, he might not have even realised the cultural differences. When I told him that I feel extremely stressed when my parents influence my life too much or demand too much from me and that I need to address this stress, he asked, 'Why do they have so many opinions about your life?' I know it's a valid question to ask if you're talking to a friend having no idea about your culture, but I don't feel it's a valid question from a therapist. Then he suggested that I shouldn't care too much about my parents' opinions. I didn't find this helpful at all, and I felt he didn't understand what I was saying at all. It happened a few times. In the end, I just felt very shut down by him. (Wong; 605-619).

Wong's use of "even" seems to subtly convey her surprise or disappointment that the therapist might have overlooked such a fundamental issue as cultural differences. Upon sharing the profound influence her parents had on her life, the therapist raised the question, "Why do they have so many opinions about your life?" a question possibly aimed at fostering introspection. Wong appears to interpret this as a reflection of the therapist's inadequate grasp of the role of family within her cultural framework. Her mentioning that "it's a valid question to ask if you're talking to a friend having no idea about your culture" likely further emphasises this interpretation. Moreover, Wong makes a clear distinction between her expectations of a therapist versus those of a friend in social settings, potentially signalling her wish for the therapist to exhibit greater cultural sensitivity and understanding in his practice.

The phrase “not...helpful at all” seems to reflect Wong’s deep frustration and even a sense of being offended, with the therapist’s advice of “not caring too much about [her] parents’ opinions”. In Chinese culture, parents’ opinions play a crucial role in a person’s sense of identity (Kim et al., 2001). Therefore, although the therapist’s advice may have been well-intentioned, Wong might have felt it almost impossible for her to do so. It may also have led to Wong feeling that the complexity and importance of her family relationships had been underestimated. The expression “felt very shut down” appears to further indicate that Wong felt extremely disappointed by her therapist’s lack of cultural understanding.

Yan’s account offers a positive deviation from the previous participants’ experiences:

I was lucky that I met a therapist who shared some similar experiences. I only found out later that her partner is Japanese, and she spent many years in South Africa. She actually knows other cultures and stuff like racism and cultural conflicts. I’m really scared of that kind of therapist who only stays in one place, with no diversity. (...) She probably didn’t understand some cultural customs, but that was okay. But she always tried to focus on understanding my feelings in those situations. She didn’t let culture become a barrier to her understanding me, which she did very well.

(Yan;1679-1683;1700-1706)

The word “lucky” seems to reflect Yan’s appreciation for her therapist, whose personal and relational experiences have equipped her with an understanding of diverse cultures. Yan also mentioned a fear of therapists who do not share this breadth of cultural engagement, which seems to imply a worry of being misunderstood due to the other’s lack of diverse cultural

exposure. This also seems to suggest Yan's relief that her therapist was open-minded. Such a narrative seems to subtly emphasise the importance Yan placed on therapists having cultural sensitivity and awareness.

The phrase "she did very well" likely captures Yan's sentiment of being truly seen and understood by her therapist. It also acknowledges the therapist's proactive efforts to bridge cultural divides. Combined with Yan's mention that it is "okay" for the therapist to not fully understand some cultural customs, it seems to indicate that she values the therapist's willingness to engage with and attempt to understand her feelings in her cultural context more than just impeccable cultural knowledge.

Lee's narrative presents a therapist who adopts a more balanced engagement when dealing with cultural differences:

I guess I could be the first few Chinese clients he had, but he didn't really show any particular consideration about that. It sounds bad, as I know it's almost like a protocol here to ask your cultural or sexual orientation differences. But I actually liked that he just treated me like a normal client. He didn't ask about extra things, like 'How does your culture see this?'. If he did ask, then I would say that's raising a problem here...but when I did mention anything related to my culture, he would pay attention to it and discuss it with me. (Lee; 976-987)

Lee noticed that the therapist did not emphasise his cultural background, diverging from the norm he's familiar with. Lee's reference to this divergence seems to indicate his appreciation or even gratitude for the therapist's unconventional engagement. By mentioning his

preference for being treated “like a normal client,” Lee likely suggests he does not want his therapy centred on his cultural identity or to be treated differently due to it. His comments about the therapist not probing into “extra things” and his statement “that’s raising a problem here” reflect his concerns that overemphasis on his cultural background could lead to a reductive understanding of his personal journey and potentially lead to a sense of alienation.

However, Lee also notes that when he brings up cultural matters, the therapist will listen attentively and engage in discussion, which may indicate that when cultural identity is indeed relevant, it is properly considered and respected. Lee’s account seems to highlight his therapist’s balanced engagement when dealing with cultural differences, which seems to provide Lee with emotional satisfaction and reflect the therapist’s adept handling of cultural sensitivity with flexibility and professionalism.

5.3.3 PET: Therapeutic Approaches

All participants discussed the various therapeutic approaches that their British therapists used and their perceived value. Lily illustrated a therapeutic approach focused on self-discovery:

The way she never answered my questions directly and the way she raised questions ... just made me think more about myself, so I could get to know myself better, such as what triggered my depression, and things that were deeply rooted in my personality. Once I knew myself better, I just felt like certain mental issues were no longer issues anymore. (Lily;692-700)

Lily mentioned that her therapist “never answered my questions directly,” which seems to not only reflect a strategy designed to encourage self-reflection but also subtly hints at Lily’s past

tendency to look for solutions outside herself. Discussing how her therapist “made me think more about myself,” Lily likely suggests that this thoughtful approach has prompted her transition from seeking external answers to cultivating internal understanding, enhancing her autonomy and empowerment. By mentioning understanding “what triggered my depression” and “things that were deeply rooted in my personality,” Lily may suggest that the result of the therapist’s method is profound self-knowledge rather than just addressing surface symptoms.

There is a sense of liberation when Lily acknowledges that “mental issues were no longer issues,” which seems to indicate a fundamental shift in her mental health perspective due to her therapist’s approach. Such a breakthrough would be significant for any client, but it may be particularly salient for Lily, as she not only just makes a cognitive change but also breaks free from the deep-rooted cultural stigmatisation of mental issues that she had mentioned elsewhere in her transcript.

Yan echoed the sentiment of valuing the depth of her therapist’s approach:

She would always help me analyse my feelings or dig something deeper. For example, she would help you think, ‘Why are you feeling like this?’. Also, she would not only teach you how to do ABC—I think that’s the problem I had with my previous therapist—but also she really made you understand why this happened. That skill was extremely impressive. (Yan;621-632)

Yan’s use of terms like “analyse” and “dig something deeper” seems to indicate that the therapist provides a deep and meaningful way of exploring emotions. This might be particularly significant for Yan, given her earlier mention of the lack of emotional expression

and exploration in her cultural upbringing. When Yan reflects on being asked, “Why are you feeling like this?” it seems to suggest that her therapist’s approach is geared towards encouraging self-examination, leading Yan to explore beyond her initial emotional responses to understand the underlying causes of her emotions. In comparing her current therapist to the previous one, Yan seems to highlight a transition from a surface-level to a more comprehensive therapeutic approach, one that not only provides her with problem-solving tools but also aids in understanding the roots of her issues. This approach could contribute to Yan’s sense of empowerment. Her use of the term “extremely impressive” further expresses Yan’s approval and appreciation for the therapist’s approach.

In contrast, Mei talked about how her therapist seems to take a very different approach than Yan’s:

She kept providing me with practical solutions. I doubted how effective it was. I knew these solutions she suggested might be the right thing to do, but I couldn’t do them. She probably knew this too, but she didn’t consider what I should do if I couldn’t do these. Maybe I wasn’t looking for a solution. Maybe I hoped she could have helped me track the source of my emotions, recognise them and express them because I had difficulties in them. (Mei;1235-1246)

The sentence “I doubted how effective it was” seems to reveal Mei’s scepticism towards the therapist’s emphasis on practical solutions. Meanwhile, it also seems to express Mei’s sense of disappointment; the repeated provision of solutions might make her feel that her problems are being overly simplified. The statement “I knew these solutions ... might be the right thing to do, but I couldn’t do them” might expose Mei’s inner conflict and also hint at a possible

mismatch between the therapist's advice and her ability or willingness to follow through. Mei mentioned that the therapist might be aware of this discrepancy but hasn't adjusted her approach accordingly, which potentially suggests that Mei feels she isn't receiving adequate support and understanding.

Additionally, this might indicate Mei believes the therapist's method is too one-sided, leaving her without alternative strategies. The phrase "track the source of my emotions" signifies Mei's desire for a deeper therapeutic approach to help her understand her emotional experiences. Considering Mei's previous mention of battling severe anxiety and guilt in PET 5.1.1, it seems she is seeking guidance to uncover and understand the origins of these profound and distressing emotions, hoping for a therapeutic intervention that goes beyond surface-level solutions to address the deeper underpinnings of her emotional turmoil.

Similar to Mei, Wong expressed dissatisfaction with the solution-focused therapeutic approach taken by her British therapist:

My British therapist tried to teach me some techniques and solutions; as if I practised them, then my problems would go away. It didn't work. I only realised that my childhood experience was a contributing factor to my anxiety with the help of my current Chinese therapist. It was relieving. My British never helped me see that.
(Wong: 461-472)

The sentence "as if I practised them, then my problems would go away" seems to carry a sarcastic tone, indicating Wong's perception that the therapist's optimism about the efficacy of focusing on practising the "techniques" in resolving her issues is somewhat naïve. This

also appears to suggest that Wong views the therapist's grasp of her challenges as overly reductive. By contrasting the methods of her British therapist with her current Chinese therapist, Wong seems to subtly criticise the limitations of the British therapist's approach. Wong's statement, "It was relieving," suggests she found a sense of liberation in recognising the roots of her anxiety. Given Wong's earlier mention in PET 5.1.2 of the extreme stigmatisation of mental health in her culture and family, this insight seems particularly relevant and could help alleviate her shame about mental health struggles. "He never helped me see that" further indicates Wong's disappointment that the British therapist's methods do not help achieve these therapeutic results.

6 Discussion

This section will examine the study's findings in relation to the existing literature and explore their implications for theory, research, clinical practice and clinical training. Subsequently, the findings will be critically evaluated, and suggestions for future research will be provided.

6.1 Review of the Current Findings in Relation to the Existing Literature

6.1.1 Pre-Cross-Cultural Psychotherapy Challenges

All participants reported their challenges while living or studying in the UK and the resulting psychological stress. These descriptions are consistent with existing literature (e.g., Furnham & Li, 1993; Huang & Spurgeon, 2006), which suggests that FGCI's experience significant acculturative stress when adapting to a new cultural environment. Typical acculturative stressors identified in the literature surrounding mental health struggles of Chinese immigrants in the UK (e.g., Furnham & Li, 1993; Huang & Spurgeon, 2006; Magnusdottir & Thornicroft, 2022), such as occupational pressures, academic demands, and a lack of social interactions, are evident in participants' accounts.

In addition, the economic burden of coming to the UK, mentioned by some participants as one of the difficulties they faced, may provide some new understanding of the acculturative challenges faced by the FGCI in the UK. Research shows that immigrants coming to the UK, whether for work or study, have to bear high visa fees and renewal costs, which, combined with the stress and anxiety of the application process, has a wide-ranging negative effect on immigrants' quality of life (Brindle, 2024). This is reflected in Yan's description of how part of her stress came from the extremely high financial cost of living in the UK as an immigrant. As for Mei, an international student, she and her family not only had to pay the cost of her visa but also high tuition fees. Although Mei did not have to bear the financial burden herself, she had to take on the psychological pressure of having her parents cover the cost for her to study in the UK. For her, she could only succeed in her studies; otherwise, she would feel incredibly guilty. Although Lee and Yan talked less about the financial pressure and more about the disappointment of not being able to find a suitable and enjoyable job, it can be argued that given the high financial costs they had to pay to live in the UK, the sense of disappointment was even more acute when their life and work in the UK failed to live up to their expectations.

All participants indicated that they needed help with their mental health, yet they were reluctant to seek help. This ambivalence is consistent with the existing literature (e.g., GOV.UK, 2020; Li et al., 1999), which shows that Chinese immigrants in the UK underutilise mental health services, even when they clearly need such support. Moreover, participants highlighted that stigmas surrounding mental health in their culture were a significant barrier to seeking support. This finding is in line with research by Li et al. (1999)

and Shen (2021), who found that cultural factors have a significant impact on how Chinese perceive their mental health and access support.

The development of these attitudes on mental health can be traced back to the influence of Taoist philosophy in Chinese culture, which often encourages individuals to hide their emotions and adopt a stance of self-reliance (Yip, 2004). As a result, this cultural influence leads many Chinese people to instinctively hide their emotional struggles, fearing that seeking psychological help may be perceived as a lack of self-control and a sign of weakness (Busiol, 2016). This idea is clear to see in the narratives of Tao and Lee. In addition, Lee also mentioned that when a person in his community suffers from depression or anxiety, then that person is prone to be treated as “abnormal” by his community. This view is consistent with Li et al.’s (2014) study, which demonstrates that the Chinese community has very negative perceptions of mental health issues, believing that mental illness is the result of character flaws, moral failures, or punishment for inappropriate behaviour. These perceptions can contribute to the social stigma of mental illness (Ngai et al., 2014). This stigmatisation of mental health problems is reflected in the accounts of all the participants.

In addition to stigma on a cultural level, participants also discussed their pre-existing beliefs and concerns about receiving psychotherapy in the UK, which might have delayed their decision to seek help. They expressed their low expectations of having psychotherapy in the UK and also implicitly talked about their scepticism and pessimism about its effectiveness. These attitudes are consistent with Shen’s (2021) research, which found that Chinese international students in the UK are generally sceptical about the efficacy of psychotherapy.

Furthermore, participants highlighted other concerns that may have contributed to their hesitation in seeking help. For example, Lily was concerned that British therapists might not be able to understand some cultural nuances, a key factor that deterred her from pursuing psychotherapy earlier. Similarly, Wong seemed to doubt whether a British professional would truly understand and address her needs. These thoughts and feelings, which seem to be triggered by the therapist's cultural background before any direct interaction with the therapist, align with Curry's (1964) concept of pre-transference in cross-cultural TR. Mei's narrative revealed additional scepticism about receiving counselling from her university, partly due to her anxiety about expressing herself clearly in English during sessions. This is consistent with the literature, which frequently cites language barriers as a significant factor preventing many FGCIIs from seeking mental health services in the UK (e.g., Li et al., 1999; Shen, 2021).

6.1.2 Cross-Cultural Psychotherapy Experiences

A novel finding of this study was that all participants reported experiencing a range of complex and difficult emotions during the early stages of psychotherapy. These emotions included shame, guilt, embarrassment, and mistrust. It was evident that participants were burdened by the stigma attached to mental health problems and the emphasis on self-reliance within their culture in the therapeutic process. Psychotherapy, however, is a process that encourages clients to be open and honest in addressing, recognising, and reflecting on challenging life issues (Kolden et al., 2018). This process requires participants to maintain a level of openness to the therapist, while this seems to clash with their cultural values. This conflict makes opening up to their therapists a challenging and, at times, painful experience for the participants. This observation is consistent with Leong et al.'s (1995) argument that Chinese cultural values often clash with those that underpin Western

psychotherapy. The participants' accounts of the complex emotions resulting from this conflict seem to add some valuable qualitative perspectives on this subject to the current literature.

Moreover, participants seemed to indicate that the therapist's cultural and racial background could be another significant factor contributing to their negative emotions. Participants' perception of the therapist as being from a different culture and the negative associations with this, align with the concept of cultural transference as outlined in Gelso and Mohr's (2001) research. Comas-Díaz and Jacobsen (1991) explain that cultural transference in cross-cultural TRs typically manifests as mistrust, suspicion, and potential hostility. This seems to be illustrated in the experiences of Wong, Lily and Tao. For example, Tao stressed that the therapist being a "foreign person, not one of [her] family or [her] culture" made it more awkward and challenging for her to open up in psychotherapy. Similarly, Wong emphasised an increased fear of scrutiny from her therapist because of her status as a "minority."

The feelings associated with having therapy in a non-native language with a White British therapist were identified as another key PET. Some participants reported feelings of anxiety and embarrassment due to difficulties in articulating their thoughts and finding the right words to express their emotions in English during therapy. This is consistent with the existing literature (e.g., Moore et al., 1999; Qi & Kring, 2021), which shows that FGCI clients may find it challenging to express themselves in therapy due to limited English language proficiency and lack of the necessary emotional vocabulary in their native language.

Further to the existing literature, my study seems to offer new perspectives on how using a non-native language in psychotherapy can obstruct the therapeutic process. For Wong and

Tao, expressing themselves in a second language presented challenges in unexpected ways despite their fluency in English. Wong mentioned that she needed to repeatedly revisit some traumatic memories from her childhood (a time when she did not yet speak English) to accurately express them, which in turn exacerbated her sense of distress. Tao, who was just as fluent in English, felt she needed to put extra effort into communicating because her therapist did not speak Chinese. This additional effort reminded Tao of her constant pandering to others in adapting to British cultural norms. This seems to have triggered a negative cultural transference in the therapy, in which she perceived herself to be unilaterally “accommodating” her British therapist, which made her feel frustrated and tired.

In contrast to these narratives, some participants preferred having psychotherapy in English to Chinese. In therapy, Yan felt better equipped to express her emotions using her non-native English compared to her native Chinese because it provided her with the necessary vocabulary to express her emotions in the way she desired. This is consistent with Jim and Pistrang’s (2007) view that for some Chinese immigrant clients, having therapy in English can free them from restrictive cultural norms and allow them to enjoy greater freedom of expression.

In addition to the challenges posed by language barriers, all participants discussed the cultural differences they perceived with their therapists as the therapy progressed, and the challenges these differences posed to the TR. This is consistent with perspectives presented in Festinger’s Social Comparison Theory (1954), Heider’s Equilibrium Theory (1958), and Bourne’s Theory of Attraction (1971). These theories propose that when a therapist and client belong to different racial or ethnic backgrounds, the client may become particularly conscious of the disparities in worldview and culture between themselves and the therapist

(Sue et al., 1991). Such differences may, in turn, lead to the client's distrust of the therapists (Simon et al., 1970).

Consistent with the literature on barriers for White therapists to establish effective cross-cultural TR with Asian clients (e.g., Atkinson, 1983; Sue, 1988), my study has found that differences in values and communication styles between Eastern and Western cultures can create barriers between therapists and their clients. Sue and Sue (1988) suggest that the cultural differences between White therapists and Asian clients regarding their self-concepts are thought to impede communication between them, and this is reflected in Mei's narratives. Mei believed that her therapist might not be able to understand her filial piety to her family. Filial piety, in Chinese culture, emphasises a child's loyalty to their parents and represents a self-concept embedded in relation to their family (Schwartz et al., 2010). It is reasonable for Mei to conceive that her therapist, with a Western cultural background that highlights the clear boundaries in relationships and individuality (Harkness et al., 2008), may struggle to understand her on this point.

Lee provided a different example of how differences in cultural values may challenge cross-cultural TRs, which adds to the literature on this topic. In his narrative, Lee highlighted the significance of educational success in gaining respect from both society and family, and the difficulties he faced in conveying this to his therapist. The emphasis on academic achievement in Lee's culture is rooted in Confucianism. Confucius believed that the ultimate goal of education was to train scholars for officialdom (Wang, 2006). Therefore, education has long been viewed as closely linked to utilitarianism, with the primary goal of achieving great economic and social status (Lee, 1996). In addition, learning has also been seen as a moral obligation, where diligent study is seen as a duty to one's family (Watkins & Biggs,

2001). These perspectives contrast sharply with the Western educational philosophy, which emphasises autonomy and self-actualisation (Yu et al., 2018). This fundamental difference seems to be the root cause of Lee's belief that his therapist cannot understand the importance of education and its added value.

Furthermore, Lily described the challenges she encountered in understanding her therapist caused by the differences in nonverbal communication. This supports the view in the literature on high-context and low-context communication (e.g., Sue & Sue, 1990; Chua & Gudykunst, 1987; Nishimura et al., 2008) that differences in communication styles can present significant barriers to an understanding between White therapists and ethnic minority clients. Meanwhile, Yan believed that the differences in social privilege between her and the therapist hindered the therapist's understanding of her experiences. This is in line with the literature (e.g., Cardemil & Battle, 2003; Pinderhughes, 1989) on power and privilege in cross-cultural therapy, which suggests that the privilege disparity between therapists and clients can negatively impact the TR.

It is worth noting that many participants discussed these differences with their therapists with strong emotions. For instance, Lily found it difficult to interpret her therapist's non-verbal cues, which made it hard for her to trust the therapist and caused her to feel very insecure about the therapist's intentions. Yan felt that her therapist was inherently privileged, and she believed that there was "no way" for her therapist to understand the frustrations and pain she experienced as an immigrant. As mentioned earlier, Tao felt deeply frustrated from having to use English in therapy to "accommodate" the British therapist. These intense emotional responses, which seem to be evoked by the British therapists' cultural background or the cultural differences observed by these participants, further confirm the phenomenon of

cultural transference in literature and also align with Aggarwal's (2011) view that perceived differences in cross-cultural TR can become a primary source of cultural transference and countertransference. All the participants mentioned their awareness of the cultural differences between themselves and their therapists, but the intensity of their internal feelings these perceived differences triggered seemed to be fairly different. This also supports Leary's (1995) view that race and culture not only have an external reality but also a psychological dimension that influences clients' unconscious and conscious thoughts toward their therapists and the cross-cultural TR.

Interestingly, beyond the challenges posed by cultural differences, four participants also mentioned some benefits that these differences brought to the TR. For example, some participants indicated that cultural differences instead allowed them to explore some of their emotions and thoughts more freely, as they felt relieved from the concern that their therapists hold the stigmatisation of mental health issues common in their culture. This is consistent with existing literature (e.g., Chang & Berk, 2009; Jim & Pistrang, 2007). In addition, Mei described how having a therapist from a different culture provided her with new perspectives on understanding some of her struggles. This is in line with Cheng and Lo's (1991) study. Although their research focuses on the TR between ethnic minority therapists and White clients, Cheng and Lo argue that when therapists are sufficiently familiar with their client's culture, the fact that the therapist is from another culture can instead help the client to see new coping choices and enhance their adaptive skills.

Participants' perceived benefits of cultural differences appear to be related to their negative feelings about their own culture. According to Comas-Diaz and Jackson (1991), clients with strong negative feelings about their cultural background may have conflicts within their

cultural identity. When working with a therapist of the same ethnicity, they are more likely to develop intraethnic transference, projecting these negative emotions onto the therapist who shares their ethnic background. Such clients may prefer therapists from different cultural backgrounds to avoid internal conflict and the negative self-perceptions that might be projected onto an ethnically similar therapist. This dynamic is evident in the narratives of Lee and Mei. Lee suggested that the reason he felt more secure working with a British therapist was due to his belief that Chinese therapists also held socially stigmatised norms. Similarly, Mei particularly valued her therapist's different perspective, as she believed her community was confined to the stereotype of "graduation is a must," as she was herself.

6.1.3 The Role of the Therapists

Most participants expressed appreciation when their therapists exhibited attributes such as being non-judgmental, empathetic, attentive, actively listening, and warm. In contrast, one participant also described the negative impact felt when these core qualities were absent. This finding echoes the idea in the literature on facilitative factors in the TR (e.g., Carl Rogers, 1957; Castonguay & Beutler, 2006) that these qualities of therapists are universally valuable in building a strong TR regardless of cultural background.

Therapists' sensitivity in addressing potential cultural differences with their clients and its perceived impact on the TR emerged as another important PET. Consistent with the existing literature on cross-cultural TR (e.g., Chang & Berk, 2009; Gurpinar-Morgan et al.'s, 2014; Jim & Pistrang, 2007), some participants praised their therapists for their cultural sensitivity. For example, Yan expressed gratitude for working with a therapist who could understand her feelings in certain cultural contexts, which she thought was more important than possessing the knowledge itself. This is consistent with the findings of Jim and Pistrang's (2007) study,

which highlights that while cultural knowledge is important, it is equally crucial for the therapist to have the ability to comprehend the Chinese clients' specific distress and dilemmas within the framework of their cultural values.

La Roche and Maxie (2003) further emphasised that therapists' exposure to diverse cultures is vital when working with ethnic minority clients. This cultural sensitivity can be developed through travel to different countries or actively engaging with ethnically diverse neighbourhoods and communities. Yan's experience reflects this perspective. She mentioned that she benefited from working with a therapist who had experiences with diverse cultures, both personally and professionally. She also candidly admitted her fear of working with a therapist who lacked such diverse experiences.

In contrast, some participants reported feeling frustrated, resulting from their therapists' lack of knowledge about Chinese culture and their insensitivity to the cultural differences with their clients. This is consistent with studies by Constantine (2007) and Chang and Berk (2009), which show the adverse effects of therapists' cultural insensitivity on the therapeutic experiences of clients of colour. In Tao's case, she felt let down by her therapist's overreliance on her to provide information about her cultural background and attempts to downplay their cultural differences. This approach fell significantly short of Tao's expectations for a therapist. This aligns with the emphasis in the literature that one of the foundational elements of cultural competence is that therapists possess a good knowledge of their client's cultural backgrounds (Sue, 1998) and demonstrates how a failure to do so can lead to misunderstandings and a sense of being minimised. Moreover, the way Tao's therapist interacts with her is consistent with Wrenn's (1962) concept of "cultural encapsulation", where the therapist operates within a narrow, culturally limited perspective.

Similarly, Wong's account further illustrates the negative impact of "cultural encapsulation" in therapy. Wong believed her therapist did not even recognise the cultural differences between them, and she felt misunderstood and judged by her therapist's culturally insensitive advice. Misunderstandings between therapists and clients are common and somewhat unavoidable (Bachelor & Horvath, 1999). However, if these misunderstandings are serious or happen repeatedly, they can disrupt the TR and create a deadlock in therapy (Safran et al., 1990). Both Tao and Wong reported that their therapists' repeated lack of cultural sensitivity ultimately led to a profound sense of disappointment and even a rupture in the TR.

Some multicultural psychotherapy scholars (e.g., Fuertes et al., 2002; Li et al., 2007; Sue & Sundberg, 1996) suggest that therapists adopt a more proactive approach by openly discussing cultural and ethnic issues with their clients to explore how these issues might influence the therapeutic process. This is particularly important in the early stages of psychotherapy. If Tao and Wong's therapists had adopted the approach advocated in the literature, friction and even ruptures in their TRs might have been avoided. Firstly, engaging in an open discussion might have enabled the therapists to more effectively address the negative cultural transference, such as mistrust and scepticism, which Tao and Wong might have experienced early in their therapy. As Grier (1967) notes, when managed and interpreted correctly, this pre-transference and cultural transference can act as catalysts for uncovering and addressing deeply ingrained neurotic attitudes in clients. If these transference reactions remain unresolved, they can continue to disrupt the TR (Comas-Díaz & Jacobsen, 1991). The success of this process, however, largely depends on the therapist's ability to effectively manage their own cultural countertransference (Jacobsen, 1988).

Secondly, when Tao and Wong felt that their therapists did not sufficiently understand their cultural background or were insensitive to cultural differences, open dialogue would allow them to express their dissatisfaction and voice their expectations of their therapists. This opportunity can be particularly crucial for Chinese clients, who may find it challenging to express their dissatisfaction in therapy due to the cultural value of other-centredness (Quek & Storm, 2012). This, coupled with the power imbalance between majority-group therapists and minority-group clients (Chang & Berk, 2009), makes it even harder for Chinese clients to articulate their dissatisfaction. Tao, for instance, expected her therapist to actively check in and confirm her feelings throughout the sessions. Such engagement seems to be particularly important to Tao and Wong.

However, Sue (1998) argues that a culturally competent therapist needs to strike a delicate balance in practice—knowing when to generalise and when to personalise. Having such an open conversation about culture is not appropriate for every client. This is particularly evident in Lee’s narrative. Lee mentioned that he preferred to be treated “like any other client” in therapy, without overemphasising cultural differences, yet with sensitivity when cultural issues were relevant.

All participants discussed the different therapeutic approaches employed by their therapists and the perceived value of each approach. Notably, those who engaged in psychodynamic and integrative therapies expressed appreciation for the depth of exploration these approaches provided. They valued the opportunity to engage in those analytical and explorative discussions that helped them gain a deeper understanding of their emotions and underlying issues. This observation aligns with Yin’s (2016) research, which suggests that Chinese who access psychological support wish to address deep-rooted issues. Yin suggests that this

preference may be shaped by Confucian values that emphasise lifelong learning and self-improvement.

My study offers a valuable perspective on why Chinese immigrants may favour more in-depth treatment approaches. Participants' desire to comprehend the root causes of their emotional difficulties appears to be connected to their wish to mitigate the stigma associated with their mental health struggles. Some participants reported that their therapists were successful in helping them identify the underlying causes of the emotions troubling them, leading to a reduction in feelings of shame surrounding their mental struggles. This aspect seemed particularly significant for the Chinese clients, given their cultural background and the stigma commonly present within their families and social circles.

Conversely, participants who underwent CBT highlighted its limitations when their therapist only focused on providing practical solutions without addressing deeper emotional issues. For instance, both Wong and Mei observed that the therapeutic process was insufficient if the therapist provided solutions without incorporating emotional exploration and some introspective work. This finding contrasts with the existing literature (e.g., Kim et al., 2002; Kuo et al., 2011; Ng & James, 2013; Wei & Heppner, 2005), which often claims that Chinese clients generally prefer a directive, solution-oriented approach.

Several factors may contribute to this discrepancy. First, empirical research on effective therapeutic approaches for Chinese clients remains limited. Among the few existing studies (e.g., Kuo et al., 2011; Wei & Heppner, 2005), most have focused on non-immigrant Chinese participants working with Chinese therapists. As a result, these studies primarily reflect the preferences of non-immigrant Chinese clients within a monocultural therapeutic context,

rather than those of Chinese immigrants in cross-cultural therapy settings. In contrast, Ng and James (2013) conducted a study specifically exploring therapy expectations among overseas Chinese clients. However, their research also centred on Chinese immigrant clients working with Chinese therapists, and most participants reported highly positive therapy experiences. Therefore, the findings from their study may also not be fully applicable to clients engaged in cross-cultural TRs, particularly for those with mixed or ambivalent experiences in therapy. Additionally, some participants in my study expressed concerns that Chinese therapists, or individuals within the Chinese community, might share cultural biases or reinforce societal stigma around mental health struggles. As such, they feared being judged by a Chinese therapist when discussing sensitive topics, which made it easier for them to open up about their emotional struggles with British therapists. This may help explain why previous studies have found that Chinese clients in therapy with Chinese therapists tend to prefer directive, solution-focused approaches rather than those offering deeper emotional exploration.

Moreover, some studies examining Chinese immigrant clients' expectations in cross-cultural TRs have methodological limitations. For example, Kim et al. (2002) conducted a study investigating Asian American college students' experiences of having one counselling session with a European American counsellor about career uncertainty. The study found that these students reported strong working alliances with counsellors who offered immediate problem-solving solutions rather than those who focused on gaining insight through exploration. However, as the primary concerns of participants in Kim et al.'s study were career-related issues, they might inherently prefer more directive and problem-solving-oriented therapeutic approaches. As such, the result of this study may not accurately reflect client preferences in broader therapeutic contexts where deeper emotional and introspective exploration might be more relevant or beneficial.

6.2 Evaluation and Suggestions for Future Research

A key strength of this study is the use of IPA, which provides a detailed exploration of how FGCI clients experience cross-cultural TRs with White British therapists. Consistent with IPA's idiographic commitment (Smith et al., 2009), this study offers valuable insights into how this underrepresented group in UK psychotherapy literature understands the influence of cultural differences on TRs and expresses their specific needs for psychological treatment. This aligns with the guiding principle in CoP of giving a voice to marginalised groups (Douglas et al., 2016) and recognises the central role that awareness of cultural issues plays in the core values of CoP (Martin, 2010).

Another major strength of this study lies in its focus on a homogenous sample by recruiting only FGCI clients who had psychotherapy with a White British therapist, allowing for an in-depth investigation of their unique experiences related to the challenges posed by cultural differences and language barriers in cross-cultural psychotherapy. Historically, the stigma associated with seeking mental health treatment within the Chinese community has made it difficult for researchers to recruit homogenous samples from this population. For instance, many cross-cultural studies in the US (e.g., Chang & Berk, 2009.; Kim et al., 2002) group different Asian or minority populations together, while the few studies specifically on Chinese immigrants (e.g., Jim & Pistrang, 2007) often include participants from different generations, potentially masking the distinct experiences of FGCI clients. In this study, by addressing participants' concerns, providing clear information about confidentiality, and highlighting the importance and benefits of the research, I successfully recruited a highly homogenous sample of FGCI clients.

By conducting an in-depth analysis of such a homogenous group, the study provides some new insights into understanding FGCI clients' distinct experiences in a cross-cultural TR with White British therapists. Specifically, this study not only confirms the language barriers mentioned in the literature (e.g., Moore et al., 1999; Qi & Kring, 2021) but also uncovers more complex challenges posed by engaging in psychotherapy in a non-native language. Furthermore, participants in this study also emphasised the limitations of psychotherapy approaches that focus only on providing practical solutions. This finding contrasts with the cross-cultural therapy studies in the literature (e.g., Kim et al., 2002; Ng & James, 2013), which generally suggest that clients from collectivist cultures tend to prefer directive, solution-oriented approaches. Many of the assumptions in the literature about the needs of Chinese immigrant clients appear outdated (Yin, 2016). Meanwhile, some other relevant studies have not fully explored Chinese immigrant clients' perspectives in real-life therapeutic settings, leading to an incomplete understanding of their needs. This may also explain the higher dropout rates among Chinese immigrant clients in psychotherapy. Therefore, the new insights from this study may provide therapists with a deeper understanding of the needs of FGCI clients, particularly in cross-cultural contexts.

Given the limited research on FGCI clients' experiences of cross-cultural therapy, further studies are needed to understand their expectations of therapeutic approaches and the challenges they may face when engaging in cross-cultural therapy. It would be interesting to conduct a larger-scale study involving participants from different age groups and educational backgrounds to explore whether the findings from this research apply to a broader range of FGCI clients.

However, the study is not without limitations, and these limitations need to be considered when interpreting these findings. Firstly, it is important to acknowledge that participants may not have been fully aware of their own cultural transference towards their British therapists. As Jim and Pistrang (2007) suggest in their research, not only therapists but also clients may experience a form of “cultural encapsulation”, which can make it difficult for them to recognise the underlying assumptions they hold about cross-cultural interactions. This could have led to an underestimation of the participants’ own contributions to the results they reported, while attributing a disproportionate emphasis to therapist-related factors in explaining negative results. Additionally, the study’s exclusive reliance on participants’ retrospective self-reports means that the findings likely represent participants’ internal representations of their cross-cultural therapy experiences, which may have been subject to recall biases. Nevertheless, following the phenomenological approach (Giorgi, 1997), I considered participants’ subjective accounts to be valid data for understanding their lived experiences, acknowledging that any filtering of memory or expression is part of how they internally perceive and represent those experiences.

Moreover, the findings of this study must be interpreted in light of the specific characteristics of the participants. The sample was self-selected and generally well-educated. They were interviewed in English, which might also have represented they have good enough English skills and are acculturated enough. Their willingness to participate may have also indicated a greater psychological awareness and a reduced stigma towards mental health issues.

Additionally, their experience working with a British therapist might have meant they were more open-minded to cross-cultural therapy. As such, the results may reflect a bias towards Chinese immigrants who are more educated, acculturated, and receptive to cross-cultural psychotherapy. Given that previous studies (e.g., Li et al., 1999; Shen, 2021)) have shown

that the language barrier remains a significant obstacle preventing Chinese immigrants in the UK from accessing mental health services, future research could focus on immigrants with limited English proficiency to better understand their specific needs and expectations of psychotherapy.

Another limitation is that several variables within the participants could have impacted their experiences of cross-cultural psychotherapy. In this study, the overwhelming majority of participants were female, with only one male respondent. The absence of male participants could be attributed to the lower proportion of Chinese men seeking mental health treatment compared to women, likely due to traditional concepts of masculinity (Yang, 2017).

Additionally, Chinese men may feel more reluctant to discuss mental health issues than women. This reluctance, combined with my position as a female researcher, may have further discouraged male participants from exploring their mental health concerns. It is possible that some men would have felt more comfortable discussing such sensitive and personal matters with a male researcher, perceiving that men may better understand each other's experiences and pressures. These factors likely contributed to the underrepresentation of male perspectives in the study. As my study included only one male participant, it may not fully capture the male experience, thus limiting the generalisability of the findings. As research indicated that mental health issues were more stigmatised among Chinese men (Yang, 2017), they may arguably face different challenges in seeking mental health support, and their expectations of such support may differ from those of Chinese women. Therefore, future research may benefit from investigating the experience of male FGCI clients in cross-cultural psychotherapy, as this may generate new findings.

Additionally, most participants worked with therapists of the same gender. Only one participant had experience working with a therapist of a different gender. As a result, this study offers limited data on the experiences of FGCI clients who worked with therapists of the opposite gender. In cross-cultural therapy, gender matching or mismatch may further complicate the dynamics between the client and therapist, with clients whose gender does not match that of their therapist potentially facing additional complexities that could influence their therapeutic experience. Future research should seek to include a more diverse range of gender combinations between therapists and clients, such as Chinese female clients with British male therapists. This would provide valuable insights into how gender differences between White British therapists and Chinese immigrant clients affect the therapeutic process.

Another variable among participants is the diversity of treatment settings where they received treatment. Participants received therapy through university services, the NHS, and private clinics. Each setting may offer varying degrees of accessibility, duration, and intensity of treatment, thereby influencing clients' experiences. Additionally, given that participants mentioned significant financial pressures while living in the UK, their expectations of paid versus free therapy services may differ. It may be interesting for future research to explore how the setting influences clients' experiences of cross-cultural therapy.

Finally, this study offers only a limited "snapshot" of participants' experiences in cross-cultural psychotherapy, without capturing the more subtle changes in their views on TRs that may have occurred over the course of multiple sessions. While participants discussed the

importance of therapists' personal qualities, cultural competence, and therapeutic approaches in cross-cultural therapy, this study may not have adequately assessed the relative importance of these factors to clients.

6.3 Implications for Clinical Practice and Training

6.3.1 Implications for Counselling Psychology Practice

This study provides valuable insights into how FGCI clients experience cross-cultural TR with a White British therapist. Such insights can provide some guidance to counselling psychologists and other professionals when they work with FGCI clients in the future.

One consideration the therapists need to pay attention to is the significant acculturative stress experienced by FGCIs. These challenges not only affect the mental health of FGCIs but also complicate their therapeutic experiences. Given that clients' experiences of interacting with their therapist's racial or cultural group may shape their perceptions of the therapist (Gelso & Mohr, 2001), it is essential for therapists to understand the multiple stressors FGCI clients face during their adaptation process. This understanding may help therapists better grasp the potential roots of their negative cultural transference in therapy, which could lead to improved management of the transference reactions in future sessions. Meanwhile, recognising these pressures may also enable therapists to gain a clearer understanding of the FGCI client's real-life context, facilitating a greater understanding of and empathy for their experiences.

This study also highlights that FGCI clients experience complex internal conflicts and negative emotions during the initial stages of therapy. One of the consequences of these internal struggles is that FGCI clients find it very challenging to open up to their therapist. Therefore, it is crucial for therapists to recognise these internal struggles early in the

therapeutic process, as this awareness can enhance their ability to empathise with the distinct challenges FGCI clients face in therapy. Participants in this study particularly valued qualities such as empathy, attentiveness, non-judgmental attitudes, active listening, and warmth in their therapists. This suggests that therapists should exhibit these qualities from the outset of therapy to foster a safe and trusting environment, which may, in turn, make FGCI clients feel more secure and comfortable to open up.

Additionally, this study identifies that FGCI clients may face obstacles in therapy due to the need to express themselves in a non-native language. These findings emphasise the importance of therapists exercising patience and giving clients enough time to express themselves. Moreover, therapists could consider asking clients about their experience of having therapy in English, which might help clients articulate how communicating in a non-native language affects them. This, in turn, would allow therapists to address the emotions that may be activated due to having to communicate in a foreign language during therapy.

Another key finding is that differences in values and communication styles between Eastern and Western cultures can create additional challenges for FGCI clients and their White British therapists to understand each other. This finding highlights the need for therapists to acknowledge these differences and make efforts to minimise potential misunderstandings by familiarising themselves with relevant topics through reading or training. This is particularly important as participants in this study expressed an expectation that therapists should take the initiative to familiarise themselves with basic aspects of Chinese culture. Such cultural

knowledge can enhance the therapist's ability to connect with Chinese clients and better comprehend their feelings in certain cultural contexts.

However, having cultural knowledge alone is not sufficient to overcome the challenges mentioned above. This study found that different clients seem to have varying expectations regarding therapists' cultural competence. This suggests that therapists need to deal with cultural issues with sensitivity and flexibility. According to the literature (e.g., Li et al., 2007; Sue & Sundberg, 1996), an essential aspect of working with ethnic minority clients is to have open conversations about their expectations for therapy, especially concerning cultural and racial issues, in the early stages of psychotherapy. Such discussions can help therapists assess when to address issues such as cultural transference. For clients who expect their therapist to pay attention to their cultural background, the therapist can address negative cultural transference earlier, such as distrust or suspicion toward the therapist. For clients who express that cultural issues are not important, the therapists may focus on building a strong therapeutic alliance first and only attempt to address cultural transference issues when they sense the clients are ready to explore them. Additionally, it is also essential for therapists to create a space where clients feel secure to offer feedback and share any concerns about the therapy process (Chang & Berk, 2009). This is particularly crucial for FGCI clients, as they might feel uncomfortable expressing concerns or dissatisfaction during psychotherapy, and they often prefer therapists to take the initiative in checking how they feel throughout the process.

This study also found that FGCI clients may favour psychodynamic and integrative therapies, as these approaches can help them gain a deeper understanding of their emotions and underlying issues. This preference may stem from a desire to reduce the stigma surrounding their mental health challenges. Counselling psychologists, with their humanistic

underpinnings and emphasis on understanding individuals' experiences within their distinct developmental and cultural backgrounds, are particularly suited to address these issues (Jones Nielsen & Nicholas, 2016).

6.3.2 Implications for Counselling Psychology Training

Given the central role of awareness of cultural issues in CoP (Martin, 2010), some of this study's findings may provide insights into counselling and psychotherapy training, particularly counselling psychology training.

Participants mentioned their expectations of therapists in terms of cultural knowledge, cultural awareness, and skills, which aligns with three elements of cultural competence brought up by Sue et al. (1992). Training institutions could use Sue et al.'s (1992) cultural competence framework to help practitioners develop cultural competence, particularly in the area of cultural awareness. Sue et al. (1992) believe that cultural awareness requires therapists to continuously reflect on their own beliefs, attitudes, and potential biases and understand how these factors play a role in their interactions with clients. Cultivating this awareness can help therapists identify their potential cultural countertransferences when working with FGCI clients. Comas-Díaz & Jacobsen (1991) suggested that cultural countertransference, such as denying cultural differences, overemphasising cultural factors, or feeling guilt, pity, or hostility when working with ethnic minority groups, may hinder therapists from exploring and addressing cultural and racial issues with their clients.

Furthermore, this study found that FGCI clients expect therapists to have more multicultural working experience. Therefore, training organisations could make teaching modules and workshops more interactive and provide trainees with more opportunities for diverse populations. For example, institutions that train counselling psychologists could consider

offering trainees more work placements to interact with ethnically diverse communities, alongside increased supervision in cross-cultural therapy. Such practical experience would help therapists move beyond theoretical knowledge and develop genuine cultural sensitivity. The study also indicates that, despite the challenges cultural differences bring, they may have a positive impact on the TR. Therefore, providing better services does not necessarily require matching FGCI clients with therapists from the same racial or cultural background; rather, the key lies in enhancing therapists' cultural competence. In fact, as long as therapists approach cultural differences with sensitivity and openness, cross-cultural therapy can offer FGCI clients unique opportunities to gain new perspectives and help them break free from the constraints of some of their cultural norms.

7 Reflexive Statement Part Two

At the beginning of this thesis, I reflected on the potential biases I might have had during the literature review process. In this reflective statement, I will focus on my reflections during the interviews, data analysis, and interpretations of the research findings. Reflection plays a crucial role in qualitative research, as it helps researchers continuously examine and monitor their own feelings throughout the research process, while also making these feelings transparent, thereby enhancing the transparency of the research (Orlipp, 2008).

Throughout the research, I consistently reflected on my assumptions and beliefs about the research topic, such as the impact of cultural differences on the TR, the influence of Chinese culture on FGCI's engagement with psychotherapy, and the unique challenges faced by FGCI groups in this context. I realised that if left unchecked, these presumptions I had could potentially interfere with the way I conducted the research. To minimise their influence, I

kept a reflective journal at different stages of the research to record my thoughts and insights, ensuring that I remained aware of these potential biases. Additionally, I engaged in supervision, personal therapy, and discussions with colleagues to further ensure that I could “bracket” my personal views, emotions, and understandings (Smith et al., 2022).

During the initial stages of the interviews, I was curious about how my shared cultural background with my participants would make them view my role as an insider researcher. I believe that being an insider researcher might have both advantages and disadvantages for the research. On the one hand, my Chinese identity helped me recruit enough participants quickly and facilitated smooth communication with them prior to the interviews. Additionally, as an immigrant who has experienced therapy with White British therapists, I could easily understand the cultural issues and difficulties in communication that the participants mentioned; this is another advantage of being an insider researcher. As Smith et al. (2009) pointed out, IPA has a strong tradition of adopting an insider researcher approach, as one of its core principles is to encourage understanding from the perspective of those experiencing the phenomenon.

However, I also became aware of the challenges that come with being an insider. For instance, during the first interview, the participant discussed the severe stigmatisation of mental health issues in his cultural and familial background, which caused him considerable distress. He also expressed concerns that Chinese therapists might hold similar cultural biases. Every time he mentioned this, I could sense his pain. After the interview, I reflected on what it meant for the participant to share a cultural background with me as the researcher—did it make him worry that I might judge him through the lens of Chinese culture? If the researcher had been White, would he have been more open in discussing the

uncomfortable aspects of Chinese culture? To further explore this, I sought advice from my supervisor. My supervisor asked how I felt when hearing the participant's concerns, and I admitted that I was somewhat surprised, as I had not anticipated the depth of his struggles with these cultural biases. Upon reflection, I also realised that my response—saying, “This is completely understandable; I understand your pain”—might have stemmed from an unconscious need to reassure the participant that I would not judge him. My supervisor helped me recognise that this over-empathy might have been a form of compensation, an effort to align myself with the participant and dispel any doubts about my objectivity. However, this response may have inadvertently made it harder for him to explore these issues freely.

Based on this feedback, I adjusted my approach in subsequent interviews. I maintained empathy but adopted a more neutral stance, allowing participants the freedom to express themselves without feeling overly reassured or aligned with my personal views. This shift helped create a freer environment for participants to express their thoughts and emotions.

In addition, I also realised that my personal experiences of working with White therapists could impact the way I interpret the participants' words. For instance, during an interview with one participant, she shared that after discussing her parents' overly controlling behaviour, her therapist asked, “Why do your parents have so many opinions about your life?” This question left the participant feeling that the therapist didn't understand her cultural context. I immediately resonated with her and agreed with her perspective as I had personal experiences with White therapists who lacked cultural awareness, which partly motivated my decision to undertake this research. Yet, when I later reviewed this part of the interview analysis with my supervisor, he offered a different interpretation, suggesting the therapist

may have been encouraging the participant to consider her situation from another point of view. This feedback showed me how my past experiences might have introduced biases in my data analysis. From that moment, I became more mindful of my potential biases during subsequent analyses. I also sought input from peers experienced in IPA research, and their feedback, alongside my supervisors, helped me take a more balanced and objective approach to understanding participants' experiences.

This research feels like a child I have personally nurtured, and I have been filled with hope that it will provide meaningful support for the Chinese immigrant community. However, I also realised that this strong desire to succeed created considerable pressure throughout the research process. For example, during the initial stages of the interviews, I was concerned that the data might only lead to superficial conclusions or fail to generate significant findings. This anxiety may have influenced my interpretation of participants' responses, leading to over-analysis or drawing conclusions that were too abstract. During the data analysis, feedback from my supervisor and peers helped me focus on understanding the participants' experiences from their perspectives. Yet, I was fully aware that my personal interpretations and viewpoints inevitably shaped the analysis to some degree. As IPA acknowledges, interpretation is an unavoidable and legitimate part of the analytical process (Heidegger, 1962).

At the same time, this research has given me a deeper understanding of the challenges and opportunities present in cross-cultural TRs. For instance, one participant shared how discussing childhood trauma in a non-native language intensified the emotional pain. This made me realise that the challenges faced by FGCI clients are far more complex than I had previously imagined. These valuable insights not only enriched my research but have also

had a profound impact on my practice as a therapist. They have made me more empathetic, as I now truly understand that each client who walks into the therapy room may have had to overcome significant obstacles just to be there.

8 Concluding Words

This study revealed several key challenges faced by FGCI clients in establishing cross-cultural TRs with their White British therapists. One of the challenges is the potential conflicts between the cultural values of FGCI clients and the principles of psychotherapy. These conflicts, combined with the cultural transference of mistrust or scepticism that FGCI clients may have toward their White British therapists, make it difficult for them to open up in the early stages of therapy. Additionally, differences between Eastern and Western cultures in communication styles and value systems, privilege imbalances, as well as transference reactions resulting from these perceived differences add another layer of complexity to the cross-cultural TRs between FGCI clients and their White British therapists. Furthermore, FGCI clients' need to use a non-native language to express themselves can also present even more challenges for them in the therapeutic process.

However, the study also found that despite the challenges posed, cultural differences can also offer certain benefits. Some participants reported that these differences provided them with new experiences and perspectives, allowing them to be more open in discussing certain cultural topics. At the same time, the results emphasise that therapists need not only cultural sensitivity but also certain personal attributes to establish a genuine and supportive TR with FGCI clients, such as attentiveness and empathy. The study also highlights that helping FGCI

clients explore the root causes of their emotional difficulties, rather than merely solving practical problems, is particularly important when working with them.

These findings may provide some new understandings of the experiences of FGCI clients in a cross-cultural TR with their white British therapist and their perceptions of how cultural differences between them may impact their TR. Given the limited empirical research on this group, I hope this study can offer valuable guidance to counselling psychologists and other practitioners, enabling them to better understand the therapeutic needs of FGCI clients. Additionally, I hope these findings will also contribute to improving training in cultural competence for practitioners, allowing them to work more effectively with FGCI clients.

9 References

- Abe-Kim, J., Takeuchi, D. T., Hong, S., Zane, N., Sue, S., Spencer, M. S., Appel, H., Nicdao, E., & Alegría, M. (2007). Use of mental health-related services among immigrant and US-born Asian Americans: results from the National Latino and Asian American Study. *American journal of public health, 97*(1), 91–98. <https://doi.org/10.2105/AJPH.2006.098541>
- Aggarwal, N. K. (2011). Intersubjectivity, Transference, and the Cultural Third. *Contemporary Psychoanalysis, 47*(2), 204–223. <https://doi.org/10.1080/00107530.2011.10746451>
- Allen-Meares, P., & Burman, S. (1999). Cross-cultural therapeutic relationships: Entering the world of African Americans. *Journal of Social Work Practice, 13*(1), 49–57. <https://doi.org/10.1080/026505399103502>
- Arthur, D., Chan, H. K., Fung, W. Y., Wong, K. Y., & Yeung, K. W. (1999). Therapeutic communication strategies used by Hong Kong mental health nurses with their Chinese clients. *Journal of psychiatric and mental health nursing, 6*(1), 29–36. <https://doi.org/10.1046/j.1365-2850.1999.00180.x>
- Atkinson, D. R. (1983). Ethnic Similarity in Counseling Psychology: A Review of Research. *The Counseling Psychologist, 11*(3), 79-92. <https://doi.org/10.1177/0011000083113009>
- Atkinson, D. R., Whiteley, S., & Gim, R. H. (1990). Asian-American acculturation and preferences for help providers. *Journal of College Student Development, 31*(2), 155–161.
- Bachelor, A., & Horvath, A. (1999). The therapeutic relationship. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 133–178). American Psychological Association. <https://doi.org/10.1037/11132-004>
- Berry, J. W. (1990). Acculturation and adaptation: A general framework. In W. H. Holtzman & T. H. Bornemann (Eds.), *Mental health of immigrants and refugees* (pp. 90–102). Hogg Foundation for Mental Health.

- Berry, J. W. (2005). Acculturation: Living successfully in two cultures. *International Journal of Intercultural Relations*, 29(6), 697-712. <https://doi.org/10.1016/j.ijintrel.2005.07.013>
- Berry, J.W. (2006). Acculturative Stress. In Wong, P.T.P., Wong, L.C.J. (Eds.) *Handbook of Multicultural Perspectives on Stress and Coping. International and Cultural Psychology* (pp. 287-298). Springer. https://doi.org/10.1007/0-387-26238-5_12
- Berry, J. W., Kim, U., Minde, T., & Mok, D. (1987). Comparative Studies of Acculturative Stress. *International Migration Review*, 21(3), 491-511. <https://doi.org/10.1177/019791838702100303>
- Bhaskar, R. (1975). Forms of realism. *Philosophica*, 15.
- Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: for reflection and debate. *Journal of Epidemiology & Community Health*, 58(6), 441-445. <https://doi.org/10.1136/jech.2003.013466>
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, 16(3), 252–260. <https://doi.org/10.1037/h0085885>
- Bos, A. E. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, 35(1), 1–9. <https://doi.org/10.1080/01973533.2012.746147>
- Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage Publications.
- Brauner, R. (2000). Embracing difference: Addressing race, culture and sexuality. In C. Neal & D. Davies (Eds.), *Issues in therapy with lesbian, gay, bisexual and transgender clients* (pp. 7–21). Open University Press.

- Brindle, B. (2024, April 5). *Q&A: Immigration fees in the UK*. The Migration Observatory.
<https://migrationobservatory.ox.ac.uk/resources/commentaries/qa-immigration-fees-in-the-uk/>
- British Psychological Society. (2005). *Division of Counselling Psychology Professional Practice Guidelines*. <https://doi.org/10.53841/bpsrep.2005.rep75>
- British Psychological Society (2009). *Code of ethics and conduct*.
<http://www.bps.org.uk/system/files/documents/code-of-ethics-and-conduct.pdf>
- British Psychological Society (2010). *What is Counselling Psychology?*
- British Psychological Society (2021). *Code of Human Research Ethics*.
<https://doi.org/10.53841/bpsrep.2021.inf180>
- Brown, G., & Yule, G. (1983). *Discourse analysis*. Cambridge University Press.
- Brown, J., & Brown, J. (2006). *China, Japan, Korea: Culture and Customs*. BookSurge, LLC.
- Brubaker, R. (2004). *Ethnicity without Groups*. Harvard University Press.
<https://doi.org/10.4159/9780674258143>
- Busiol, D. (2016). Help-seeking behaviour and attitudes towards counselling: a qualitative study among Hong Kong Chinese university students. *British Journal of Guidance and Counselling*, 44(4), 382-401. <https://doi.org/10.1080/03069885.2015.1057475>
- Byrne, D. (1971). *The Attraction Paradigm*. Academic Press.
- Cardemil, E. V., & Battle, C. L. (2003). Guess who's coming to therapy? Getting comfortable with conversations about race and ethnicity in psychotherapy. *Professional Psychology: Research and Practice*, 34(3), 278–286. <https://doi.org/10.1037/0735-7028.34.3.278>
- Carter, R. T., & Qureshi, A. (1995). A typology of philosophical assumptions in multicultural counseling and training. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 239–262). Sage Publications.

- Castonguay, L. G., & Beutler, L. E. (2006). Principles of therapeutic change: a task force on participants, relationships, and techniques factors. *Journal of clinical psychology, 62*(6), 631–638. <https://doi.org/10.1002/jclp.20256>
- Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*(4), 521–536. <https://doi.org/10.1037/a0016905>
- Cheng, L. Y., & Lo, H. T. (1991). On the advantages of cross-culture psychotherapy: the minority therapist/mainstream patient dyad. *Psychiatry, 54*(4), 386–396. <https://doi.org/10.1080/00332747.1991.11024567>
- Chua, E. G., & Gudykunst, W. B. (1987). Conflict resolution styles in low- and high-context cultures. *Communication Research Reports, 4*(1), 32–37.
- Clark, K., & Drinkwater, S. (2006). Changing patterns of ethnic minority self-employment in Britain: Evidence from census microdata. *IZA Discussion Papers, No. 2495*, Institute for the Study of Labor (IZA), Bonn. <https://nbn-resolving.de/urn:nbn:de:101:1-20080509198>
- Clarkson, P. (2003). *The Therapeutic Relationship* (2nd ed.). John Wiley & Sons.
- Close, C., Kouvonon, A., Bosqui, T., Patel, K., O'Reilly, D., & Donnelly, M. (2016). The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews. *Globalization and health, 12*(1), 47. <https://doi.org/10.1186/s12992-016-0187-3>
- Comas-Díaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*(3), 392–402. <https://doi.org/10.1037/h0079267>
- Condon, J. W., & Crano, W. D. (1988). Inferred evaluation and the relation between attitude similarity and interpersonal attraction. *Journal of Personality and Social Psychology, 54*(5), 789–797. <https://doi.org/10.1037/0022-3514.54.5.789>

- Constantine, M. G. (2007). Racial microaggressions against African American clients in cross-racial counseling relationships. *Journal of Counseling Psychology, 54*(1), 1–16.
<https://doi.org/10.1037/0022-0167.54.1.1>
- Crotty, M. (1998). *The Foundations of Social Research: Meaning and Perspective in the Research Process*. Sage Publications.
- Curry, A. E. (1964). The Negro Worker and the White Client: A Commentary on the Treatment Relationship. *Social Casework, 45*(3), 131-136.
<https://doi.org/10.1177/104438946404500301>
- Data Protection Act (1998).
- Department of Health and Social Care. (1999, September 10). *National service framework: mental health*. <https://www.gov.uk/government/publications/quality-standards-for-mental-health-services>
- Desbarats, J. (1986). Ethnic differences in Adaptation: Sino-Vietnamese Refugees in the United States. *International Migration Review, 20*(2), 405-427.
<https://doi.org/10.1177/019791838602000215>
- Despland, J. N., de Roten, Y., Despars, J., Stigler, M., & Perry, J. C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The Journal of psychotherapy practice and research, 10*(3), 155–164.
- Douglas, B. (2016). Conceptualising in client work. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *The Handbook of Counselling Psychology* (4th ed., pp 151-168). Sage Publications. <https://doi.org/10.4135/9781529714968>
- Eleftheriadou, Z. (2010). Cross-cultural Counselling Psychology. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of Counselling Psychology* (3rd ed., pp 195-212). Sage Publications.

- Etherington, K. (2004) *Becoming a reflexive researcher: Using our selves in research*. Jessica Kingsley Publishers.
- Fan, Y. (2000). A classification of Chinese culture. *Cross Cultural Management: An International Journal*, 7(2), 3-10. <https://doi.org/10.1108/13527600010797057>
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7(2), 117–140. <https://doi.org/10.1177/001872675400700202>
- Finlay, L. (2006). Mapping methodology. In L. Finlay and C. Ballinger (Eds.), *Qualitative research for allied health professionals: Challenging choices*. John Wiley & Sons.
- Fischer, A. R., Jome, L. M., & Atkinson, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist*, 26(4), 525–588. <https://doi.org/10.1177/0011000098264001>
- Fletcher, G. J. (1996). Realism versus relativism in psychology. *The American journal of psychology*, 409-429.
- Foster, R. P. (1999). An intersubjective approach to cross-cultural clinical work. *Smith College Studies in Social Work*, 69(2), 269–291. <https://doi.org/10.1080/00377319909517555>
- Foyle, M. F., Beer, M. D. & Watson, J. P. (1998). Expatriate mental health. *Acta Psychiatrica Scandinavica*, 97(4), 278-283. <https://doi.org/10.1111/j.1600-0447.1998.tb10000.x>
- Franklin, A. J., Carter, R. T., & Grace, C. (1993). An integrative approach to psychotherapy with Black/African Americans: The relevance of race and culture. In G. Stricker & J. R. Gold (Eds.), *Comprehensive handbook of psychotherapy integration* (pp. 465–479). Plenum Press. https://doi.org/10.1007/978-1-4757-9782-4_32
- Freud, S. (1913). On the beginning of treatment: Further recommendations on the technique of Psycho-Analysis. In J. Strachey (Ed.), *Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, pp. 122-144). Hogarth Press.

- Freud, S. (1958). The dynamics of transference. In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, pp. 97–108). Hogarth Press.
- Fuertes, J. N., Brady-Amoon, P., Thind, N., & Chang, T. (2015). The therapy relationship in multicultural psychotherapy. *Psychother Bull*, *50*, 41-5.
- Fuertes, J. N., Mueller, L. N., Chauhan, R. V., Walker, J. A., & Ladany, N. (2002). An investigation of European American therapists' approach to counseling African American clients. *The Counseling Psychologist*, *30*(5), 763–788. <https://doi.org/10.1177/0011000002305007>
- Fung, K., & Wong, Y. L. (2007). Factors influencing attitudes towards seeking professional help among East and Southeast Asian immigrant and refugee women. *The International journal of social psychiatry*, *53*(3), 216–231. <https://doi.org/10.1177/0020764006074541>
- Furnham, A., & Li, Y. H. (1993). The psychological adjustment of the Chinese community in Britain. A study of two generations. *The British journal of psychiatry : the journal of mental science*, *162*(1), 109–113. <https://doi.org/10.1192/bjp.162.1.109>
- Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change*. American Psychological Association. <https://doi.org/10.1037/12349-000>
- Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist*, *13*(2), 155–243. <https://doi.org/10.1177/0011000085132001>
- Gelso, C. J., & Mohr, J. J. (2001). The working alliance and the transference/countertransference relationship: Their manifestation with racial/ethnic and sexual orientation minority clients and therapists. *Applied & Preventive Psychology*, *10*(1), 51–68. [https://doi.org/10.1016/S0962-1849\(05\)80032-0](https://doi.org/10.1016/S0962-1849(05)80032-0)
- Giorgi, A. (1997). The Theory, Practice, and Evaluation of the Phenomenological Method as a Qualitative Research Procedure. *Journal of Phenomenological Psychology*, *28*(2), 235-260. <https://doi.org/10.1163/156916297X00103>

- Giorgi, A., & Giorgi, B. (2003). Phenomenology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 25–50). Sage Publications.
- Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: Strategies for qualitative research. Aldine De Gruyter.
- GOV.UK. (2020). *Chinese ethnic group: facts and figures*. <https://www.ethnicity-facts-figures.service.gov.uk/summaries/chinese-ethnic-group>
- Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, 34(2), 155–179.
- Grier W. H. (1967). When the therapist is Negro: some effects on the treatment process. *The American journal of psychiatry*, 123(12), 1587–1592.
<https://doi.org/10.1176/ajp.123.12.1587>
- Groff, R. (2004). *Critical realism, post-positivism and the possibility of knowledge*. Routledge.
- Gurpinar-Morgan, A., Murray, C., & Beck, A. (2014). Ethnicity and the therapeutic relationship: Views of young people accessing cognitive behavioural therapy. *Mental Health, Religion & Culture*, 17(7), 714–725. <https://doi.org/10.1080/13674676.2014.903388>
- Hanley, T., Cutts, L., Gordon, R. & Scott, A. (2013). A research informed approach to counselling psychology. In G. Davey (Ed.), *Applied Psychology*. BPS Wiley Blackwell.
- Harkness, S., Super, C. M., & Tijen, N. V. (2000). Individualism and the “Western mind” reconsidered: American and Dutch parents' ethnotheories of the child. *New directions for Child and Adolescent Development*, 2000(87), 23-39.
<https://doi.org/10.1002/cd.23220008704>
- Harrison, D. K. (1975). Race as a counselor-client variable in counseling and psychotherapy: A review of the research. *The Counseling Psychologist*, 5(1), 124–133.
<https://doi.org/10.1177/001100007500500130>

- Health and Care Professions Council. (2023). Diversity data: practitioner psychologists – July 2023. <https://www.hcpc-uk.org/resources/data/2023/diversity-data-practitioner-psychologists-2023/>
- Health and Care Professions Council (HCPC). (2016). *Standards of proficiency for practitioner psychologists*. <https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/>
- Heidegger, M. (1962). *Being and Time*. Blackwell Publishing.
- Heider, F. (1958). *The psychology of interpersonal relations*. John Wiley & Sons. <https://doi.org/10.1037/10628-000>
- Helms, J. E. (2007). Some better practices for measuring racial and ethnic identity constructs. *Journal of Counseling Psychology*, 54(3), 235–246. <https://doi.org/10.1037/0022-0167.54.3.235>
- Hesse-Biber, S. N., & Leavy, P. (2010). *The practice of qualitative research*. Sage Publications.
- Higher Education Statistics Agency. (2020, January 29). *Higher Education Student Statistics: UK, 2018/19 - Where students come from and go to study*. <https://www.hesa.ac.uk/news/16-01-2020/sb255-higher-education-student-statistics/location>
- Holmes D. E. (1992). Race and transference in psychoanalysis and psychotherapy. *The International journal of psycho-analysis*, 73 (Pt 1), 1–11.
- Horvath, A. O. (2000). The therapeutic relationship: From transference to alliance. *Journal of Clinical Psychology*, 56(2), 163–173. [https://doi.org/10.1002/\(SICI\)1097-4679\(200002\)56:2<163::AID-JCLP3>3.0.CO;2-D](https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<163::AID-JCLP3>3.0.CO;2-D)
- Horvath, A. O., & Greenberg, L. S. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529–556). Guilford Press.
- Howard C. (2006). *Youth Counselling and Family Therapy Project – an evaluation report*. Chinese Mental Health Association & Islington Chinese Community Association.

- Huang, C.-Y., & Lamb, M. E. (2015). Acculturation and Parenting in First-Generation Chinese Immigrants in the United Kingdom. *Journal of Cross-Cultural Psychology, 46*(1), 150-167. <https://doi.org/10.1177/0022022114555763>
- Huang, S. L., & Spurgeon, A. (2006). The mental health of Chinese immigrants in Birmingham, UK. *Ethnicity & health, 11*(4), 365–387. <https://doi.org/10.1080/13557850600824161>
- Ip, V., Chan, F., Chan, J. Y., Lee, J. K., Sung, C., & H Wilson, E. (2016). Factors influencing Chinese college students' preferences for mental health professionals. *Journal of mental health, 25*(2), 142–147. <https://doi.org/10.3109/09638237.2015.1057328>
- Jacobsen, F. M. (1988). Ethnocultural assessment. In L. Comas-Díaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health* (pp. 135–147). John Wiley & Sons.
- Jim, J., & Pistrang, N. (2007). Culture and the therapeutic relationship: Perspectives from Chinese clients. *Psychotherapy Research, 17*(4), 461–473. <https://doi.org/10.1080/10503300600812775>
- Johnson, S. U., Ulvenes, P. G., Øktedalen, T., & Hoffart, A. (2019). Psychometric properties of the general anxiety disorder 7-item (GAD-7) scale in a heterogeneous psychiatric sample. *Frontiers in Psychology, 10*, Article 1713. <https://doi.org/10.3389/fpsyg.2019.01713>
- Jones Nielsen, J. D., & Nicholas, H. (2016). Counselling psychology in the United Kingdom. *Counselling Psychology Quarterly, 29*(2), 206–215. <https://doi.org/10.1080/09515070.2015.1127210>
- Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review, 27*(2), 64–73. <https://doi.org/10.53841/bpscpr.2012.27.2.64>
- Kelly, T. A., & Strupp, H. H. (1992). Patient and therapist values in psychotherapy: perceived changes, assimilation, similarity, and outcome. *Journal of consulting and clinical psychology, 60*(1), 34–40. <https://doi.org/10.1037//0022-006x.60.1.34>

- Kim, B. S. K., & Abreu, J. M. (2001). Acculturation measurement: Theory, current instruments, and future directions. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed., pp. 394–424). Sage Publications.
- Kim, B. S. K., Atkinson, D. R., & Umemoto, D. (2001). Asian cultural values and the counseling process: Current knowledge and directions for future research. *The Counseling Psychologist*, 29(4), 570–603. <https://doi.org/10.1177/0011000001294006>
- Kim, B. S. K., Atkinson, D. R., & Yang, P. H. (1999). The Asian Values Scale: Development, factor analysis, validation, and reliability. *Journal of Counseling Psychology*, 46(3), 342–352. <https://doi.org/10.1037/0022-0167.46.3.342>
- Kim, B. S. K., Hill, C. E., Gelso, C. J., Goates, M. K., Asay, P. A., & Harbin, J. M. (2003). Counselor self-disclosure, East Asian American client adherence to Asian cultural values, and counseling process. *Journal of Counseling Psychology*, 50(3), 324–332. <https://doi.org/10.1037/0022-0167.50.3.324>
- Kim, B. S. K., Li, L. C., & Liang, T. H. (2002). Effects of Asian American client adherence to Asian cultural values, session goal, and counselor emphasis of client expression on career counseling process. *Journal of Counseling Psychology*, 49(3), 342–354. <https://doi.org/10.1037/0022-0167.49.3.342>
- Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of Client Expectation for Counseling Success, Client-Counselor Worldview Match, and Client Adherence to Asian and European American Cultural Values on Counseling Process With Asian Americans. *Journal of Counseling Psychology*, 52(1), 67–76. <https://doi.org/10.1037/0022-0167.52.1.67>
- Kim, L. (2015). *Psychotherapy with Asian clients: An exploratory study of the perspectives of East Asian clinicians* (Publication No. 10005003) [Doctoral dissertation, Rutgers The State University of New Jersey, Graduate School of Applied and Professional Psychology]. ProQuest Dissertations & Theses Global.

- Kolden, G. G., Wang, C.-C., Austin, S. B., Chang, Y., & Klein, M. H. (2018). Congruence/genuineness: A meta-analysis. *Psychotherapy, 55*(4), 424–433.
<https://doi.org/10.1037/pst0000162>
- Kozuki, Y., & Kennedy, M. G. (2004). Cultural Incommensurability in Psychodynamic Psychotherapy in Western and Japanese Traditions. *Journal of Nursing Scholarship, 36*(1), 30–38. <https://doi.org/10.1111/j.1547-5069.2004.04008.x>
- Kuo, B. C. H., Hsu, W. S., & Lai, N. H. (2011). Indigenous crisis counseling in Taiwan: An exploratory qualitative case study of an expert therapist. *International Journal for the Advancement of Counselling, 33*(1), 1–21. <https://doi.org/10.1007/s10447-010-9108-y>
- La Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice, 34*(2), 180–186.
<https://doi.org/10.1037/0735-7028.34.2.180>
- Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357–361. <https://doi.org/10.1037/0033-3204.38.4.357>
- Latham, K., & Wu, B. (2013). *Chinese immigration into the EU: New trends, dynamics and implications*. Europe China Research and Advice Network.
- Lee, E. (2011). Clinical significance of cross-cultural competencies (CCC) in social work practice. *Journal of Social Work Practice, 25*(2), 185–203.
<https://doi.org/10.1080/02650533.2011.573654>
- Lee, W. M., & Mixson, R. J. (1995). Asian and Caucasian client perceptions of the effectiveness of counseling. *Journal of Multicultural Counseling and Development, 23*(1), 48–56.
<https://doi.org/10.1002/j.2161-1912.1995.tb00266.x>

- Lee, W. O. (1996). The cultural context for Chinese learners: Conceptions of learning in the Confucian tradition. In D. Watkins & J. Biggs (Eds.), *The Chinese learner: Cultural, psychological and contextual influences* (pp. 25-41). Comparative Education Research Centre; Australian Council for Educational Research.
- Leong, F. T., & Lau, A. S. (2001). Barriers to providing effective mental health services to Asian Americans. *Mental health services research*, 3(4), 201–214.
<https://doi.org/10.1023/a:1013177014788>
- Leong, F. T., & Lee, S.-H. (2006). A cultural accommodation model for cross-cultural psychotherapy: Illustrated with the case of Asian Americans. *Psychotherapy: Theory, Research, Practice, Training*, 43(4), 410–423. <https://doi.org/10.1037/0033-3204.43.4.410>
- Leong, F. T. L., Wagner, N. S., & Tata, S. P. (1995). Racial and ethnic variations in help-seeking attitudes. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of Multicultural Counseling* (pp. 415–438). Sage Publications.
- Leary, K. (1995). " Interpreting in the dark": Race and ethnicity in psychoanalytic psychotherapy. *Psychoanalytic Psychology*, 12(1), 127.
- Li, L. C., Kim, B. S. K., & O'Brien, K. M. (2007). An analogue study of the effects of Asian cultural values and counselor multicultural competence on counseling process. *Psychotherapy: Theory, Research, Practice, Training*, 44(1), 90–95. <https://doi.org/10.1037/0033-3204.44.1.90>
- Li, P. L., Logan, S., Yee, L., & Ng, S. (1999). Barriers to meeting the mental health needs of the Chinese community. *Journal of public health medicine*, 21(1), 74–80.
<https://doi.org/10.1093/pubmed/21.1.74>
- Li, S., Hatzidimitriadou, E., & Psinos, M. (2014). "Tangled wires in the head": Older migrant Chinese's perception of mental illness in Britain. *Journal of Aging Studies*, 30, 73–86.
<https://doi.org/10.1016/j.jaging.2014.04.001>

- Lyons, E., & Coyle, A. (Eds.). (2007). *Analysing qualitative data in psychology*. Sage Publications.
<https://doi.org/10.4135/9781446207536>
- Magnusdottir, E., & Thornicroft, G. (2022). Mental health of Chinese international students: Narrative review of experiences in the UK [version 1; peer review: 2 approved with reservations]. *NIHR Open Research*, 2(52). <https://doi.org/10.3310/nihropenres.13268.1>
- Mahler, M. S. (1972). On the first three subphases of the separation-individuation process. *The International Journal of Psychoanalysis*, 53(3), 333–338.
- Manea, L., Gilbody, S., & McMillan, D. (2012). Optimal cut-off score for diagnosing depression with the Patient Health Questionnaire (PHQ-9): a meta-analysis. *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne*, 184(3), E191–E196.
<https://doi.org/10.1503/cmaj.110829>
- Marks, G., & Miller, N. (1987). Ten years of research on the false-consensus effect: An empirical and theoretical review. *Psychological Bulletin*, 102(1), 72–90. <https://doi.org/10.1037/0033-2909.102.1.72>
- Martin, P. (2010). Training and professional development. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 547-568). Sage Publications.
- Maxwell, J. A. (2008). Designing a qualitative study. In L. Bickman, & D. J. Rog (Eds.), *The SAGE handbook of applied social research methods* (pp. 214-253). Sage Publications.
<https://www.doi.org/10.4135/9781483348858>
- Mehta N. (2011). Mind-body Dualism: A critique from a Health Perspective. *Mens sana monographs*, 9(1), 202–209. <https://doi.org/10.4103/0973-1229.77436>
- Milton, M. (Ed.). (2010). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*. John Wiley & Sons.
- Minority Rights Group. (2022, September). *Chinese in the United Kingdom*.
<https://minorityrights.org/minorities/chinese-7/>

- Montoya, R. M., Horton, R. S., & Kirchner, J. (2008). Is actual similarity necessary for attraction? A meta-analysis of actual and perceived similarity. *Journal of Social and Personal Relationships*, 25(6), 889–922. <https://doi.org/10.1177/0265407508096700>
- Moran, P. (2011). Bridging the gap between research and practice in counselling and psychotherapy training: Learning from trainees. *Counselling & Psychotherapy Research*, 11(3), 171–178. <https://doi.org/10.1080/14733145.2010.509510>
- National Institute for Health and Care Excellence. (2011). *Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence* (NICE Guideline CG115). www.nice.org.uk/guidance/cg115
- Newland, J., & Patel, N. (2004). Professional and ethical practice in multicultural and multiethnic society. In Tribe, R., & Morrissey, J. (Eds.). (2004). *Handbook of Professional and Ethical Practice for Psychologists, Counsellors and Psychotherapists* (1st ed., p. 233). Routledge. <https://doi.org/10.4324/9780203323625>
- Ng C. H. (1997). The stigma of mental illness in Asian cultures. *The Australian and New Zealand journal of psychiatry*, 31(3), 382–390. <https://doi.org/10.3109/00048679709073848>
- Ng, C. T. C., & James, S. (2013). "Directive approach" for Chinese clients receiving psychotherapy: Is that really a priority? *Frontiers in Psychology*, 4, Article 49. <https://doi.org/10.3389/fpsyg.2013.00049>
- NHS Digital. (2024, August 16). Use of NHS mental health, learning disability and autism services. GOV.UK. <https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-using-nhs-funded-mental-health-and-learning-disability-services/latest/>
- Nishimura, S., Nevgi, A., & Tella, S. (2008). Communication style and cultural features in high/low context communication cultures: a case study of Finland, Japan and India. In A. Kallioniemi (Ed.), *Uudistuva ja kehittyvä ainedidaktiikka: Ainedidaktinen symposiumi 8.2.2008*

Helsingissä. Osa 2 (pp. 783-796). (Tutkimuksia / Helsingin soveltavan kasvatustieteen laitos; No. 299). Helsingin yliopisto.

Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Oxford University Press.

Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 113–141). American Psychological Association. <https://doi.org/10.1037/12075-004>

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, 48(1), 4–8. <https://doi.org/10.1037/a0022180>

Olsen, M. (1996). Radical constructivism and its failings: Anti-realism and individualism. *British Journal of Educational Studies*, 44(3), 275–295. <https://doi.org/10.1080/00071005.1996.9974075>

Office for National Statistics. (2011). *Migration statistics quarterly report: November 2011*. The National Archives. Retrieved September 09, 2024, from <https://webarchive.nationalarchives.gov.uk/ukgwa/20150506100916/http://www.ons.gov.uk/ons/rel/migration1/migration-statistics-quarterly-report/november-2011/msqr.html>

Office of the Surgeon General (US), Center for Mental Health Services (US), & National Institute of Mental Health (US). (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Substance Abuse and Mental Health Services Administration (US).

Orlikowski, W. J., & Baroudi, J. (1991). Studying Information Technology in Organisations: Research Approaches and Assumptions. *Information Systems Research*, 2(1), 1-28. <https://doi.org/10.1287/isre.2.1.1>

Ortlipp, M. (2008). Keeping and Using Reflective Journals in the Qualitative Research Process. *The Qualitative Report*, 13(4), 695-705. <https://doi.org/10.46743/2160-3715/2008.1579>

- Payne, S. (2007). Grounded theory. In E. Lyons, & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 65-86). Sage Publications. <https://doi.org/10.4135/9781446207536>
- Pedersen, P. B., Draguns, J. G., Lonner, W. J., & Trimble, J. E. (Eds.). (1996). *Counseling across cultures* (4th ed.). Sage Publications.
- Pietkiewicz, I. & Smith, J.A. (2012) Praktyczny przewodnik interpretacyjnej analizy fenomenologicznej w badaniach jakościowych w psychologii. *Czasopismo Psychologiczne*, 18(2), 361-369.
- Pinderhughes, E. (1989). *Understanding race, ethnicity, and power: The key to efficacy in clinical practice*. Free Press.
- Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126–136. <https://doi.org/10.1037/0022-0167.52.2.126>
- Pope-Davis, D. B., Liu, W. M., Toporek, R. L., & Brittan-Powell, C. S. (2001). What's missing from multicultural competency research: review, introspection, and recommendations. *Cultural diversity & ethnic minority psychology*, 7(2), 121–138. <https://doi.org/10.1037/1099-9809.7.2.121>
- Potter, J. (2012). Discourse analysis and discursive psychology. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 119–138). American Psychological Association. <https://doi.org/10.1037/13620-008>
- Pui-Ling, L., & Logan, S. (1999). *The mental health needs of Chinese people in England: A report of a national survey*. Chinese National Healthy Living Centre.

- Quek, K. M. T., & Storm, C. L. (2012). Chinese values in supervisory discourse: Implications for culturally sensitive practices. *Contemporary Family Therapy*, 34, 44-56.
<https://doi.org/10.1007/s10591-011-9172-4>
- Qureshi, A. (2005). Dialogical Relationship and Cultural Imagination: A Hermeneutic Approach to Intercultural Psychotherapy. *American Journal of Psychotherapy*, 59(2), 119–135.
- Qureshi, A., & Collazos, F. (2011). The intercultural and interracial therapeutic relationship: challenges and recommendations. *International review of psychiatry*. 23(1), 10–19.
<https://doi.org/10.3109/09540261.2010.544643>
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21(2), 95–103. <https://doi.org/10.1037/h0045357>
- Rohner, R. P. (1984). Toward a conception of culture for cross-cultural psychology. *Journal of Cross-Cultural Psychology*, 15(2), 111–138. <https://doi.org/10.1177/0022002184015002002>
- Rosenfield, L. (2017). Unraveling Cultural Countertransference: The Experience of Caucasian Therapists Working with Asian-American Adults. *Psychoanalytic Social Work*, 27(1), 61–82.
<https://doi.org/10.1080/15228878.2020.1712660>
- Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research, Practice, Training*, 27(2), 154–165. <https://doi.org/10.1037/0033-3204.27.2.154>
- Salzman, M. (1995). Attributional discrepancies and bias in cross-cultural interactions. *Journal of Multicultural Counseling and Development*, 23(3), 181–193. <https://doi.org/10.1002/j.2161-1912.1995.tb00273.x>
- Schaefer, R. T. (2008). *Encyclopedia of race, ethnicity, and society* (Vol. 1). Sage Publications.

- Schneider, J. (2016). *First/second generation immigrants* (NESET II ad hoc question no. 4/2016).
 Institute for Migration Research and Intercultural Studies (IMIS), University of Osnabrück.
https://nesetweb.eu/wp-content/uploads/2019/06/NESET2_AHQ4.pdf
- Schön, D. A. (1987). *Educating the reflective practitioner: Toward a new design for teaching and learning in the professions*. Jossey-Bass.
- Schwartz, S. J., Weisskirch, R. S., Hurley, E. A., Zamboanga, B. L., Park, I. J. K., Kim, S. Y., Umaña-Taylor, A., Castillo, L. G., Brown, E., & Greene, A. D. (2010). Communalism, familism, and filial piety: are they birds of a collectivist feather?. *Cultural diversity & ethnic minority psychology, 16*(4), 548–560. <https://doi.org/10.1037/a0021370>
- Shea, M., Yang, L. H., & Leong, F. T. (2010). Loss, Psychosis, and Chronic Suicidality in a Korean American Immigrant Man: Integration of Cultural Formulation Model and Multicultural Case Conceptualization. *Asian American journal of psychology, 1*(3), 212–223.
<https://doi.org/10.1037/a0020951>
- Shen, M. 2021. *An interpretative phenomenological analysis of the experiences of Chinese international students seeking mental health support at UK universities* [DCPsych thesis, Middlesex University / Metanoia Institute Psychology]. Middlesex University Research Repository. <https://repository.mdx.ac.uk/item/8q250>
- Shinebourne, P. (2011). The theoretical underpinnings of Interpretative Phenomenological Analysis (IPA). *Existential Analysis: Journal of the Society for Existential Analysis, 22*(1).
<https://link.gale.com/apps/doc/A288874145/LitRC?u=anon~d81be39e&sid=googleScholar&xid=81e4da4d>
- Simons, H. W., Berkowitz, N. N., & Moyer, R. J. (1970). Similarity, credibility, and attitude change: A review and a theory. *Psychological Bulletin, 73*(1), 1–16. <https://doi.org/10.1037/h0028429>
- Smaje, C., & Grand, J. L. (1997). Ethnicity, equity and the use of health services in the British NHS. *Social science & medicine, 45*(3), 485–496. [https://doi.org/10.1016/s0277-9536\(96\)00380-2](https://doi.org/10.1016/s0277-9536(96)00380-2)

- Smith, J. A. (1996). Qualitative methodology: analysing participants' perspectives. *Current Opinion in Psychiatry*, 9(6), 417-421.
- Smith J. A., & Eatough, V. (2006). Interpretative phenomenological analysis. In G. Breakwell, C. Fife-Schaw, S. Hammond & J. A. Smith (Eds.), *Research Methods in Psychology* (3rd ed., pp.11-20). Sage Publications.
- Smith, J. A., & Eatough, V. (2007). Interpretative phenomenological analysis. In E. Lyons & A. Coyle (Eds.), *Analysing qualitative data in psychology* (pp. 35–50). Sage Publications.
<https://doi.org/10.4135/9781446207536.d10>
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage Publications.
- Smith, J. A., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis: Theory, Method and Research* (2nd ed.). Sage Publications.
- Smith, J. A., Jarman, M. and Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray, & K. Chamberlain (Eds.), *Qualitative Health Psychology: Theories and Methods* (pp. 218-240). Sage Publications. <http://dx.doi.org/10.4135/9781446217870.n14>
- Smith, J. A., & Osborn, M. (2004) Interpretative phenomenological analysis. In G. M. Breakwell (Ed.) *Doing Social Psychology Research* (pp. 229-254). Blackwell Publishing.
- Speight, S. L., & Vera, E. M. (1997). Similarity and difference in multicultural counseling: Considering the attraction and repulsion hypotheses. *The Counseling Psychologist*, 25(2), 280–298. <https://doi.org/10.1177/0011000097252009>
- Spinelli, E. (1989). *The interpreted world: An introduction to phenomenological psychology*. Sage Publications.
- Spitzer, R. L., Kroenke, K., & Williams, J. B. W. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *JAMA*, 282(18), 1737–1744.
<https://doi.org/10.1001/jama.282.18.1737>

- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). Generalized Anxiety Disorder 7 (GAD-7) [Measurement instrument]. APA PsycTests. <https://doi.org/10.1037/t02591-000>
- Stillman, S., McKenzie, D., & Gibson, J. (2009). Migration and mental health: Evidence from a natural experiment. *Journal of health economics*, 28(3), 677–687. <https://doi.org/10.1016/j.jhealeco.2009.02.007>
- Strauss, D. A. (1986). The myth of colorblindness. *The Supreme Court Review*, 1986, 99-134. <https://doi.org/10.1086/scr.1986.3109520>
- Strawbridge, S. (2016). Science, craft and professional values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.). *The Handbook of Counselling Psychology* (4th ed., pp. 20–38). Sage Publications.
- Sue, D., & Sundberg, N. D. (1996). Research and research hypotheses about effectiveness in intercultural counseling. In P. B. Pedersen, J. G. Draguns, W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (4th ed., pp. 323–352). Sage Publications.
- Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development*, 70(4), 477–486. <https://doi.org/10.1002/j.1556-6676.1992.tb01642.x>
- Sue, D. W., & Sue, D. (1990). *Counseling the culturally different: Theory and practice* (2nd ed.). John Wiley & Sons.
- Sue S. (1988). Psychotherapeutic services for ethnic minorities. Two decades of research findings. *The American psychologist*, 43(4), 301–308. <https://doi.org/10.1037//0003-066x.43.4.301>
- Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist*, 53(4), 440–448. <https://doi.org/10.1037/0003-066X.53.4.440>
- Sue S. (1999). Science, ethnicity, and bias: where have we gone wrong?. *The American psychologist*, 54(12), 1070–1077. <https://doi.org/10.1037/0003-066x.54.12.1070>

- Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533–540. <https://doi.org/10.1037//0022-006x.59.4.533>
- Sue, S., & Lam, A. G. (2002). Cultural and demographic diversity. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 401–421). Oxford University Press.
- Sue, S., & Morishima, J. K. (1982). *The mental health of Asian Americans: Contemporary issues in identifying and treating mental problems*. Jossey-Bass.
- Sue, S., Nakamura, C. Y., Chung, R. C.-Y., & Yee-Bradbury, C. (1994). Mental health research on Asian Americans. *Journal of Community Psychology, 22*(2), 61–67. [https://doi.org/10.1002/1520-6629\(199404\)22:2<61::AID-JCOP2290220203>3.0.CO;2-T](https://doi.org/10.1002/1520-6629(199404)22:2<61::AID-JCOP2290220203>3.0.CO;2-T)
- Sue, S., Yan Cheng, J. K., Saad, C. S., & Chu, J. P. (2012). Asian American mental health: a call to action. *The American psychologist, 67*(7), 532–544. <https://doi.org/10.1037/a0028900>
- Szapocznik, J., Scopetta, M. A., Kurtines, W., & Aranalde, M. D. (1978). Theory and measurement of acculturation. *Revista Interamericana de Psicología, 12*(2), 113–130.
- Tang, N. M., & Gardner, J. (1999). Race, culture, and psychotherapy: transference to minority therapists. *The Psychoanalytic quarterly, 68*(1), 1–20. <https://doi.org/10.1002/j.2167-4086.1999.tb00634.x>
- Thompson, S. J., Bender, K., Lantry, J., & Flynn, P. M. (2007). Treatment Engagement: Building Therapeutic Alliance in Home-Based Treatment with Adolescents and their Families. *Contemporary family therapy, 29*(1-2), 39–55. <https://doi.org/10.1007/s10591-007-9030-6>
- Tracey, T. J., Leong, F. T., & Glidden, C. (1986). Help seeking and problem perception among Asian Americans. *Journal of Counseling Psychology, 33*(3), 331–336. <https://doi.org/10.1037//0022-0167.33.3.331>

- Trappes-Lomax, H. (2004). Discourse analysis. *The handbook of applied linguistics*, 133-164.
- Uba, L. (1994). *Asian Americans : personality patterns, identity, and mental health*. Guilford Press.
- Vera, E. M., Speight, S. L., Mildner, C., & Carlson, H. (1999). Clients' perceptions and evaluations of similarities to and differences from their counselors. *Journal of Counseling Psychology*, 46(2), 277–283. <https://doi.org/10.1037/0022-0167.46.2.277>
- Wang, T. (2006). Understanding Chinese Culture and Learning. In P. Jeffery (Ed.), *AARE Conference 2006 Papers* (pp. 1-14). (AARE conference proceeding). Australian Association for Research in Education.
<https://webarchive.nla.gov.au/awa/20070228130000/http://pandora.nla.gov.au/pan/24691/20070301-0000/www.aare.edu.au/06pap/wan06122.pdf>
- Watkins, D. A., & Biggs, J. B. (2001). The Paradox of the Chinese Learner and Beyond. In D. A. Watkins & J. B. Biggs (Eds.), *Teaching the Chinese learner: Psychological and pedagogical perspectives* (pp. 3-23). Comparative Education Research Centre; Australian Council for Educational Research.
- Wei, M., & Heppner, P. P. (2005). Counselor and client predictors of the initial working alliance: A replication and extension to Taiwanese client-counselor dyads. *The Counseling Psychologist*, 33(1), 51–71. <https://doi.org/10.1177/0011000004268636>
- Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: findings from community studies. *American journal of public health*, 93(2), 200–208.
<https://doi.org/10.2105/ajph.93.2.200>
- Williams, R. (2008). *Culture*. Routledge.
- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Open University Press.
- Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Open University Press.

- Willig, C. (2008). A phenomenological investigation of the experience of taking part in 'extreme sports'. *Journal of health psychology, 13*(5), 690–702.
<https://doi.org/10.1177/1359105307082459>
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). McGraw-Hill Education.
- Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review, 32*(4), 444–449.
- Yang, J. (2017). *Mental health in China: change, tradition, and therapeutic governance*. John Wiley & Sons.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215–228.
<https://doi.org/10.1080/08870440008400302>
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed. pp. 235-251). Sage Publications.
- Yee, L., & Au, S. (Eds.). (1997). *Chinese mental health issues in Britain: Perspectives from the Chinese mental health association*. The Mental Health Foundation.
- Yin, R. K. (1989). *Case study research: Design and methods*. Sage Publications.
- Yin, Y. (2016). *Cultural perspectives of mental health beliefs and treatment expectations within the Chinese immigrant community*. [Unpublished Doctoral thesis, City, University of London].
 City Research Online. <https://openaccess.city.ac.uk/id/eprint/16160/>
- Yip K. S. (2004). Taoism and its impact on mental health of the Chinese communities. *The International journal of social psychiatry, 50*(1), 25–42.
<https://doi.org/10.1177/0020764004038758>
- Yoshida, A. R. (2013). *The perspectives of Asian therapists on the impacts of race and ethnicity with Asian clients and non-Asian clients of color*. [Masters thesis, Smith College, Northampton, MA]. Smith ScholarWorks. <https://scholarworks.smith.edu/theses/951>

Yu, S., Chen, B., Levesque-Bristol, C., & Vansteenkiste, M. (2018). Chinese education examined via the lens of self-determination. *Educational Psychology Review*, 30, 177-214.

Zetzel, E. R. (1956). Current concepts of transference. *The International journal of psycho-analysis*, 37(4-5), 369–376.

Zhan, H. J., & Montgomery, R. J. V. (2003). Gender And Elder Care In China: The Influence of Filial Piety and Structural Constraints. *Gender & Society*, 17(2), 209-229.

<https://doi.org/10.1177/0891243202250734>

10 Appendices
Appendix A: Recruitment Poster

ATTENTION: CHINESE COMMUNITY MEMBERS
(中国小伙伴们注意了)

**HAVE YOU EVER HAD PSYCHOTHERAPY
EXPERIENCES WITH A WHITE BRITISH THERAPIST?
IF YES, PLEASE READ ON...**

If you are:

- ✓ a first-generation Chinese immigrant (non-UK born)
- ✓ aged 18-65
- ✓ have had at least 3 psychotherapy/ counselling sessions with a White British psychotherapist/ psychological counsellor/ psychologist in the past 12 months
- ✓ Feel comfortable to be interviewed in English

If you meet the above criteria, you will be invited to attend a doctoral research study to explore *how first-generation Chinese immigrant clients experience cross-cultural therapeutic relationships with white British therapists*.

Your participation matters!

Studies have shown that Chinese immigrants in the UK rarely seek psychological counselling even if they have psychological needs. Once they do seek counselling services, they tend to drop out from the counselling. Your participation may help to find out **how to better understand the needs of Chinese immigrants and provide them with more culturally sensitive counselling services**. This study will involve a one-hour conversation with me in English at a time and location convenient to you, and you would be asked to share your therapy experiences.

If you are interested in participating or would like more information about this study, please contact Ms Feng (Email: xif0025@my.londonmet.ac.uk.) for more information about this study.

THANK YOU!
(谢谢)

Appendix B: Participant Information Sheet

To whom it may concern,

I am a trainee counselling psychologist at London Metropolitan University. I am currently conducting research to explore how first-generation Chinese immigrant clients experience cross-cultural therapeutic relationships with white British therapists.

Studies have shown that Chinese immigrants in the UK rarely seek psychological counselling even if they have psychological needs. Once they do seek counselling services, they tend to drop out from the counselling. Little is known about how first-generation Chinese experience intercultural therapeutic relationships in the UK. I hope that this study can provide British therapists with some insights to better understand the needs of Chinese immigrants and provide them with more culturally sensitive counselling services.

I am writing this letter hoping that you will be interested in helping me in this endeavour and sharing your experience of cross-cultural therapeutic relationships by participating in an interview. The interview will last approximately one hour and will be audio-recorded and strictly confidential. The interview will be held at a mutually convenient place in a secure and private location. Your interview data will be used in my doctoral-level counselling psychology project. Only the researcher will have access to the recorded data.

Participation is entirely voluntary. If you choose to participate, you are free to withdraw without question up to four weeks post-interview. All data, including recordings, will be safely stored and will be destroyed at the completion of the project or may be kept for a period of five years in case the research will be published and will be destroyed after this period. All the data will be processed in accordance with the Data Protection Act (1998).

Before you decide to attend an interview, you must understand that sensitive topics will be discussed in the interview and may trigger some difficult feelings. Therefore, please take your time to decide if you want to participate. You will have the opportunity to discuss any feelings evoked at length post-interview with the researcher and be given information on sources of support if you would like this.

Thank you so much for your time, if you have any further queries, please do not hesitate to contact the researcher by phone: 0739XXXX or email: xif0025@my.londonmet.ac.uk , or contact the research supervisor Dr Raffaello Antonino1 by Tel: 0207 133 XXXX or Email: r.antonino1@londonmet.ac.uk.

I look forward to hopefully hearing from you soon.

Yours Sincerely,

[Xia Feng]

Appendix C: Patient Health Questionnaire-9 & Generalised Anxiety Disorder-7

PATIENT NAME: _____

DATE: _____

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
		PHQ9 total score:			

Q6 CORE10	I made plans to end my life in the last 2 weeks	NO	YES
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GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
		GAD7 total score:			

The PHQ-9 and the GAD-7 were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute, 1999. For research information, contact Dr. Spitzer at rls8@columbia.edu.

Appendix D: Consent Form

Title of research:

An Exploration of How First-Generation Chinese Immigrant Clients May Experience the Cross-Cultural Therapeutic Relationship with White British Therapists in the UK

Description of procedure: In this research you will be asked a number of questions regarding your experience of the Cross-Cultural Therapeutic Relationship within a voice recorded interview.

- I have read the participant information sheet and I understand the nature and described purpose of the research and the procedures to be used.
- I understand that my participation is voluntary, and I can decline to answer any question and request a pause or an end to the interview at any time.
- I understand I am free to withdraw from this study at any time up to four weeks post-interview without question.
- I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g., address, friend's names) will be changed prior to transcription.
- I understand that all the information that I reveal will be kept confidential. However, there are limits to confidentiality; confidentiality will be breached in the event of high suicidal risk (intent, plans, method, failure to agree to a safe plan), risk of harm to others (abuse, bodily harm), and disclosure of serious criminal/terrorist activity by contacting statutory services.
- I understand that I may find this interview upsetting and that it may evoke a number of difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings at length post interview with the researcher. The researcher will also give information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given to me via the debriefing form.
- I understand that the researcher will use quotations from my interview in the writing-up and the publication of the study.
- I understand that the data I supply will be securely stored and will be destroyed at the completion of the project or may be kept for a period of five years in case the research will be published and will be destroyed after this period. I also understand that only the researcher will have access to the recorded data.

Signature of participant:.....

Print name:.....

Date:

Signature of researcher:.....

Print name:.....

Date:

Appendix E: Demographic Details Form

Age:

Gender:

Place of birth:

Religion:

Marital status²:

Current employment:

Education qualification:

How long have you lived in the UK:

Model of Therapy:

Length of Therapy:

Dates between which therapy was completed:

Therapist's gender:

² Demographic information, including religion and marital status, was collected to explore whether these factors played a role in shaping participants' cross-cultural therapeutic experiences. While these aspects were not explicitly mentioned by participants in the interviews, their inclusion was part of an exploratory approach to ensure a comprehensive understanding of potential influences on their experiences. The absence of discussion on these topics may indicate that they were not central to participants' experiences in this particular study.

Appendix F: Interview Schedule

Asking the listed prompts will depend on the answers given; these are potential prompts and may be altered or not asked if already answered elsewhere.

Preliminaries

What made you want to work with a White British therapist? Where did you find your therapist?

The Cross-cultural Therapeutic Relationship

Can you tell me about your experience of the cross-cultural therapeutic relationship with your White British therapist?

Prompt: How would you describe the relationship with your white British therapist? How is working with a white British therapist like? Tell me how you feel about your therapist.

What positive and negative experiences have you had of building a cross-cultural therapeutic relationship with a White British therapist?

Prompt: When did you feel most satisfied in therapy? What makes the experience positive? Can you tell me when you felt least satisfied in therapy? What makes the experience negative?

Based on your experience, what contributes to a successful cross-cultural therapeutic relationship between your therapist and you?

Prompt: What do you think is a successful therapeutic relationship? Can you tell me what may hinder building a successful cross-cultural therapeutic relationship?

Cultural/ racial differences

Do the cultural/ racial differences between your therapist and you impact the therapeutic relationship? If they do, in what way? How does your therapist deal with the differences?

Prompt: Is Chinese culture important in your life? Are there any noticeable cultural differences you noticed in your therapy? How do the racial differences between the therapist and you influence the therapeutic relationship?

Ending

Is there anything else about understanding the cross-cultural therapeutic relationship that you would like to add, that has not been covered?

Appendix G: Debriefing Form

Thank you for taking part in this research study. This is part of a Doctoral project that the researcher is conducting.

If you are interested in the results of the study, or if you have any questions about this study, or if you wish to withdraw, please contact the researcher on the following email addresses: xif0025@my.londonmet.ac.uk.

Emails will be checked regularly.

Please remember that if you wish to withdraw your data from this study it should be done by up to four weeks post-interview as it may not be possible at a later stage.

Equally, if you have any questions or concerns you are more than welcome to address them now.

If you have any complaints regarding any aspect of the way you have been treated during the course of the study please contact my research supervisor Dr Raffaello Antonino1 by Tel: 0207 133 xxx or Email: r.antonino1@londonmet.ac.uk

If participation has raised any concerns or issues that you wish to discuss further, a number of agencies can provide advice and support.

- Samaritans. To talk about anything that is upsetting you, you can contact [Samaritans](https://www.samaritans.org) 24 hours a day, 365 days a year. You can call 116 123 (free from any phone), email jo@samaritans.org or [visit some branches in person](#).
- SANEline. If you're experiencing a mental health problem or supporting someone else, you can call [SANEline](https://www.sane.org.uk) on 0300 304 7000 (4.30pm–10.30pm every day).
- The Mix. If you're under 25, you can call The Mix on 0808 808 4994 (Sunday-Friday 2pm–11pm), request support by email [using this form on The Mix website](#) or [use their crisis text messenger service](#).

In an emergency, always call the police on 999.

(Note: This document is adapted from the learning materials of London Metropolitan University)

Appendix H: Distress Protocol

Protocol to follow if participants become distressed during participation:

This program is designed to address the possibility that some participants may become distressed and/or anxious during their participation in this study. This study is about how first-generation Chinese immigrants may experience intercultural therapeutic relationships with white British therapists. Although participants may not necessarily belong to the clinical population, they may experience psychological stress due to the nature of the topics discussed in the interview.

The researcher, a trainee in counselling psychologist at London Metropolitan University, has extensive experience in managing stressful situations as a result of her clinical training in counselling psychology. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. No extreme disaster is expected, or that the relevant action will become necessary.

Mild distress:

Signs to look out for:

Tearfulness
Voice becomes choked with emotion/ difficulty speaking
Participant becomes distracted/ restless

Action to take:

Ask participant if they are happy to continue
Offer them time to pause and compose themselves
Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

Uncontrolled crying/ wailing, inability to talk coherently
Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

The researcher will intervene to terminate the interview/experiment.
The debrief will begin immediately
Relaxation techniques will be suggested to regulate breathing/ reduce agitation
The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover from PTSD
If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

Severe agitation and possible verbal or physical aggression
In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

Maintain safety of participant and researcher

If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.

If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.

If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

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Appendix I: Transcription Guidelines

Interviews were transcribed following the guidelines established by Jefferson (2004) for transcription.

Symbol	Explanation
()	Unclear talk
(())	Non-verbal behaviour
...	Significant pause
-	Unfinished word
[]	Explanatory material added by the researcher
[...]	Material omitted
<u>Underline</u>	Speaker emphasis
CAPITAL	Section of speech noticeably louder
(Inaudible)	Difficult to understand.

British therapist's political bias	301 stereotypes about Chinese, especially in the 302 political sense (laugh). Because he was	This validates my earlier assumption that he might initially idealized the situation(maybe)his British therapist as having no preconceived notions. However, as the counselling progressed, he realized the therapist had some preconceived ideas about China, especially regarding politics. // The participant laughed here, with a hint of <u>mockery</u> ? Did he think the therapist's political views are wrong? Or does he think the therapist fits the stereotype of Westerners criticizing the Chinese government?
Feeling uncomfortable with the therapist's political bias	303 basically trying to, not to convince me, but I 304 could see that he has some political views on 305 that, like how the Chinese government should 306 react and all those things. I wasn't feeling very 307 comfortable about that. But I will say that	
Limited impact by therapist's political bias	308 there's not even close to the influence of social 309 stigmas, like how you should get to a good 310 university, and how you should have a good 311 life in Chinese culture. Those are the things he 312 doesn't have. So, I don't really mind about the 313 political thing. It's not relevant to my problem 314 anyways.	
	315 316 R: Can you tell me a little bit more about that? 317 You know, because this relates to what I'm 318 going to ask you next. How did you actually 319 experience your cross-cultural therapeutic 320 relationship with your therapist? 321	
The importance of the therapist's immediate reactions to the client	322 P: My therapeutic relationship, I will say 323 nearly 100% of the quality of my therapy 324 relationship is relying on the intimate and 325 immediate reactions in the therapy room 326 instead of outside of it. So maybe he could, if 327 he was reacting to my emotions, my my 328 little gestures, or the way I was talking, that 329 that helped to build the therapeutic 330 relationship, instead of him immediately 331 getting what I meant by some Chinese 332 background knowledge. That is not that 333 important. Well, I thought it could be 334 important. I thought it could get me some 335 difficulties. But I guess when I can explain it in 336 one sentence or two, then it's no problem at all.	Compared to understanding the participant through their cultural background, it is more important for the therapist to understand their immediate reactions in the therapy room. //The use of "100%" is interesting, as if the participant is emphasizing that understanding his culture is not important at all. Is this emphasis due to previous painful experiences of cultural prejudice from his Chinese peers/therapist? // The participant says that understanding his cultural background is not that important, which is somewhat contradictory to what he mentioned earlier, meaning that understanding their culture still holds some significance. // emphasizing that he can explain some Chinese phenomena to his British therapist in just a sentence or two, and the therapist can understand, so cultural differences don't seem to be a problem. Is the implication here that if he had to spend more time explaining, or if the therapist still didn't understand after the explanation, it might affect the counseling relationship? // This has a similar meaning to the previous paragraph (line64).
The potential problems of cultural stereotypes	337 I did try to explain a lot of phenomena in 338 Chinese society, like how, how a student is 339 determined, based on their scores on their final 340 exam in high school, and how this step-by-step 341 system works, and how everybody is rushing to 342 marriage before 30 years old, so I could 343 explain them quite simply to him, and he could 344 totally understand them. It was the political 345 thing that he has his own views on, but that 346 again is not about my personal problems. He 347 just briefly mentioned it and I do not think that 348 will hinder our therapeutic relationship.	
Cultural differences cause fewer difficulties than expected.		

Appendix K: Experiential Statements of A Participant (Lee)

Seeking further treatment in the UK

Seeking self-exploration

Need an excuse to enter therapy

The true motivation for entering therapy

Personal growth from therapy

Anxiety of job searching

Defensive attitude before therapy

Clearer goals before UK therapy

Expectations to manage anxiety in UK therapy

Early experiences as core issues

Needing an excuse to avoid shame

Delayed treatment due to trust concerns

UK therapy ethics provide a sense of security

Emotional independence as a barrier to therapy

Discussing mental health seen as abnormal

Fear of friends discovering therapy participation

Therapy implying emotional instability

Father's strong bias against psychology

Misunderstanding from family

Stigma around mental health

Sensitivity of mental health issues

Lacking attention to mental health

Lack of trust in Chinese therapists due to inexperience

UK therapists create a sense of safety by not judging

First impressions of UK therapists

Feel less judged due to Cultural differences

Cultural differences enabling open expression

A sense of safety created by cultural differences

The political bias of the UK therapist

Feeling uncomfortable with the therapist's political bias

Limited impact by therapist's political bias

The importance of the therapist's immediate reactions

Problems of Cultural stereotypes

Cultural differences cause fewer difficulties than expected

Physical distance as a safety

Biases unrelated to personal issues

Brief explanations of cultural differences

Different views on culture

Misunderstandings leading to disappointment

The importance of understanding early experiences

Cultural phenomena taking longer to understand

Cultural misunderstandings and bias

Advantages of explaining cultural aspects

Discomfort in explaining culture

Challenges of translation

Discussions around events in China

No language barriers discussing things in the UK

Less descriptive and emotional vocabulary in Chinese

Pros and cons of expressing in English during therapy

Extra time of discussing Chinese events

UK Therapist's patience

UK Therapist's open attitude

Loss of emotion and context in translation

Re-examine cultural terms by translation

Benefits of explaining specific terms

Problems with explaining unimportant terms

No overlapping social circles with UK therapist

Geographic and cultural distance with UK therapist

UK therapist without cultural bias

New perspectives of the UK therapist

Focuses on individual understanding

UK therapist's Lack of cultural knowledge

Extra time explaining phenomena

Language barriers when explain things in the past

Misunderstandings caused by cultural or relational issues

The lack of expected response from therapist

Cultural differences being a shield

Misunderstandings due to cultural differences

Negative transference

Cultural differences being a scapegoat for misunderstandings

The value of explanations of cultural differences

Good and bad experiences of interactions with British

Impacts of interactions with other white people

Racial homogeneity in China

Race being not important

Importance of being treated like other clients

Acknowledging cultural blind spots honestly

Issues of overemphasising cultural factors

Following the client's lead for cultural exploration

Problems of oversimplifying personal history

Problems of emphasising cultural differences

Power imbalance in cross-cultural therapy

The privilege of the UK therapist

Importance of racial issues and their impact

Appendix L: A Table of PETs for A Participant

A participant's (Lee's) list of PETs, **experiential statements** and corresponding page and line numbers

Pre-cross-cultural psychotherapy challenges

Reasons of seeking psychotherapy in the UK [1:6-11; 29-37; 2: 59-66; 99-114; 3: 126-138]

Obstacles from Chinese culture to seeking psychotherapy [3: 157-164; 4: 205-215; 217-222; 232-240; 279-293]

Obstacles from family and friends [4: 173-178; 223-231; 5:258-269; 272-277]

Concerns before entering psychotherapy in the UK [6: 320-327; 7:334-342]

Benefits of cultural differences

Feeling more empowered [9: 503-509;

A sense of security 7:369-378; 391-395; 12:630-635

New perspectives 11:592-597; 600-605; 12:654-657; 671-675]

The individuality is valued 13:693-699]

Challenges of cultural differences

Misunderstandings and bias [7: 399-409; 8:401-404; 9:445-462

Challenges of explaining certain cultural phenomena [9:485-493]

Cultural differences mask real problems in the TR [14: 748-756; 777-793; 15:800-808]

Potential challenges of having therapy in English

Challenges of translating things that happened in China [10: 530-542; 11:572-579; 585-594]

Extra Time to translate things [9: 480-485; 14 728-734]

Benefits of having therapy in English

More vocabulary for expressing emotions [10:550-554; 558-560]

Discussing things that happened in the UK is easier in English [11:554-550]

Racial issues

The impact of Interaction with White British people on the TR [17: 910-921; 18:932-942]

The privilege of the British therapist [20:1073-1077; 1079-1084]

The role of the therapist

The first impression of the therapist [7: 354-368]

Therapist's qualities: [8:421-429; 19:1031-1038]

Culture sensitivity [18:974-983; 21:1109-1115]

Therapist's approach [3: 132-143]

Appendix M: A Table of GETs Across Cases

GET 1: Pre- Cross-Cultural Psychotherapy Challenges	Line reference
PET 1: Predicaments of FGCI	
Lee: I feel that my anxiety at that time was mainly about employment and further education [...] And if I want to first secure a work visa to stay here, this is extremely, extremely difficult.	102-114
Yan: I needed, let's say, half a million Chinese money to get the visa [...] For the British, going to any country to study is like having fun. But for the Chinese, going to any country to study or work, Jesus! How hard is that?! It's not just you have to make academic achievements, but also learn English [...] I actually studied philosophy at first in college. I changed my major later on because I knew it was extremely hard for me to get a job. My friend who also studied philosophy together felt like I was a traitor.	321-329; 451-453
Mei: Last October I had two deadlines coming, and they were just for drafts, but I was really worried about my academic life and how I could write the assignments. I was really stressed. So, I contacted the school's counselling department [...] I worried I couldn't graduate. I have used so much money from my parents, and I would feel guilty if I couldn't graduate. When I came here, everyone said that "all I need to do is graduate". It seems for most Chinese or international students, it's a task you must do.	14-22;57-64 408-422
Tao: It was very hard to form cross-cultural friendships with locals. It was quite rare to get someone to listen to you and try to figure out what you meant and why it was important to you. I think my classmates or colleagues haven't provided that, probably because they're not your therapist (laugh) (...) I had experiences with the majority here about discrimination in general. It might not necessarily be discrimination, but definitely neglect, like cultural insensitivity.	
Wong: As a minority in this country, we definitely experienced things like (sigh) racism, or subtle or unconscious racism.	1282-1284
PET 2: Stigma and Silence in the Chinese Community	
Tao: It's not a thing in my culture. It's not even a thing. People really don't pay attention to mental health issues. Growing up, I don't remember anything about mental health issues or mental health aid during anytime I was in school. So, it's never existed?! [...] There are also some stereotypes or stigmas around people looking for mental health help that you need mental health help because you are weak.	164-173

- Wong: My mum had three different diagnoses in three different hospitals, but she thought the doctors were wrong. She was extremely stubborn [...] Still in my family depression is classified as “you enjoy your life too much and start to create problems for yourself”. By no means she’s an outlier in my culture. [when I started to feel depressed], I still had that thought that I was creating problems for myself. I said to myself, what happened to my mom wouldn’t happen to me and I would do better than going to a doctor. I was also ashamed that this happened to me. 119-125
- Lee: For me and the social stigma, seeing a therapist is being weak and unpredictable. There’s the fear of being abnormal, like depression or anxiety is in the category of abnormality. Especially in Chinese culture, if I was exposed, like the information was leaked in my friend circle, I guess they would secretly discuss it, “You know what?! That guy went to see a therapist. What’s wrong with him?” This kind of gossip will potentially damage friendships. 387-393
- Yan: I think culturally Chinese people don’t really talk about feelings. They feel like if you have feelings then you are very weak, or that is something that only belongs to women (laugh). I feel like Chinese culture actually are based on laws of rules and obedience. That’s a part of Confucius culture. 342-351
- Lily: I feel like the majority of Chinese people don't even know that they're suffering from mental health problems. We are used to hiding our mental issues from other people, due to some concerns that you want to find a job in the future or something like that. Because your employers will have concerns about your mental health, “Can you handle this problem?” “Can you do this job?”, then you lose the chance. So that's why I don't really want to go for professional help. I don't know if there'll be a record or not. So that's something I'm trying to avoid. 321-339
- PET 3: Preconceptions to Cross-Cultural Psychotherapy**
- Lily: part of the reason why I didn’t want to go to the therapists at the very beginning, was because I feel like they couldn’t understand me completely because we’re from different cultures...” 449-453
- Wong: I honestly didn’t know what to expect for the first time because it was not like going to a GP, they prescribe you medicine, blood tests, and maybe some investigation. I just didn’t know how the British professionals would help me and what type of service I would get or even whether they could help me or not, I just didn’t know! I honestly had no expectations. 70-77
- Mei: I didn’t have much expectation about how the therapist here could help me (laugh), probably because I was in a deep depression and my thoughts were really negative at that time. I didn’t have much hope, but my idea was at least not to give up, and to try if this path could work. I just told myself it might help. But actually, I didn’t believe it, because I had therapy before and I knew my problems couldn’t be solved in a short period [...] Also, before I started the therapy, I also worried a little bit 290-300;1069-1072

about the language barrier, like what if I couldn't express myself clearly. I worried about that.

Yan: I didn't have like, so much expectation... I didn't have a goal because like, before I actually met my therapist... I didn't really have a specific goal because I didn't realize how bad my situation was...maybe I didn't want to feel disappointed as well. 65-71

Tao: I knew I had a lot of things I want to talk about, like things before I moved to UK, and after I moved to UK, like, loads of things, I wanted to have someone to talk to, but at the same time, probably I wasn't sure how the therapist could help me. Because it was the first time to have a therapist, so I probably wasn't sure. 42-48

GET 2: Cross-Cultural Psychotherapy Experiences

PET 1: Navigating Emotional Barriers During the Initial Phases

Tao: I felt embarrassed in therapy at the beginning. I still carried the baggage of how seeking mental health help was stigmatised in my culture. But embarrassed feeling also related to just disclosing personal stuff to a stranger, especially a foreign person, like not one of my family or one of my culture. 213-217

Wong: I felt I was a burden to my therapist because I still didn't recognise it was a mental health problem. I still felt guilty for taking other's time (sigh)... I couldn't open up in the first couple of sessions. I had to test the water first, to give a little bit and then to see what was coming out of it. As a minority, I felt we could shut down quite quickly if we sensed the therapist was not interested or judging us. 289-300

Lily: I think Chinese can be quite defensive generally due to a lack of knowledge about mental health issues...and I do have trust issues with other people myself. So I struggled to build a trusting relationship with my therapist at the beginning. She couldn't do much without me trusting her as I couldn't tell her my true feelings and was always hiding something. 223-232

Mei: Because this was my first time having therapy in the UK, I felt a bit lost as I didn't know what to talk about or where to start at first. My therapist told me later that she felt I didn't seem to trust her much at the beginning. I think it might be because I was not too willing to rely on the strength of others to step out. It's like we have a walking stick to climb a mountain, but we just won't use it, we insist on climbing up on our own. 454-465

PET 2: Therapy in English: Hindrance or Catalyst?

Mei: Sometimes I would get stuck even on a very simple word, or there were moments when I couldn't find a certain word to express my feelings, then I became anxious and embarrassed and I needed to stop to think. 1102-1107

Yan: Asking how you feel, talking about emotions, processing emotions, and describing them all felt so weird in Chinese. When I was growing up, I didn't have the vocabulary. That is why I felt so comfortable doing this in English; I learned everything in English, and I actually don't know how to do that in Chinese. 915-922

Wong: I felt quite lucky that language was not a problem for me [...] A lot of my childhood trauma happened at that time when I could only speak Chinese. When I was going into those memories, I had to think really hard about what happened and also because of the language barrier, I had to go through the memories again and again trying to say I didn't miss any details, which was quite traumatic. 779-781;1176-1186

Tao: I felt I had to make more effort to make this communication in therapy effective because obviously my therapist couldn't speak Chinese. It also made me feel why I was always accommodating others, constantly making all the effort to explain myself in a language that is not my mother language, and why no one coming from another direction came closer to me. 927-935

Lee: But regarding the things happening here, or the experience every week, or every day I have here, then I had no problem at all because I experienced them in English culture. Like I was having this XXX University training in English, so whatever I encountered in that, I could just say it in English as it was in the original words. Maybe it is even easier for me to express things that happened here in English (...) But another thing that I think sometimes this translation, this reinterpretation definitely could lead to some loss of meanings. Like, if I say the university entrance examination, that does not sound like GaoKao (the Chinese of the university entrance examination), So Gaokao means a whole lot of things. And that single word represents a whole world of definitions, references on values, and how that is important to everybody. 539-550;581-591

PET 3: Challenges of Cultural Differences

Lee: One difficulty was about explaining the university degree. I spent quite a bit time getting my therapist to understand things rooted in Chinese culture, like how you were told from a very young age that you needed to go to top universities to be successful, and how everybody would respect you straightaway by hearing you were from the top universities. But with all these explanations, I had this feeling that he didn't quite get it (laugh). 475-484

Mei; I felt a bit tired as it took quite a bit of effort to explain some cultural phenomena and current policies to her. I wondered whether she could really understand them as a foreigner. Even if she could understand what I was saying literally, she might not fully empathise. For example, when I told her about my relationship with my Dad, I felt she might not understand why I felt guilty or why I was still so obedient to my dad, the concept of Xiao [filial piety], like loyalty to the family, in Chinese culture. 683-695

Lily: I felt there was an invisible wall. I can see if a Chinese believes me or not by their body language, but I could never tell with my British therapist. When she said something nice, I didn't know if she really meant it or just being polite. I always felt she was shrouded in a veil. I got insecure if I didn't know others' real intentions. It took me eight months to have a comfortable relationship with her, but maybe with a Chinese therapist, it just needs three months. 984-994

Yan: I felt like, it was funny in a way, there was no way that my therapist could just slightly imagine an immigrant's pain, no way! She never experienced this because she was born with this privilege, the British passport lottery. How would she possibly understand?! I had to do so much to just be able to sit in the same room with her. There's a big difference between me and a random White British girl seeing her. The price we pay is just so different. 1158-1168

Tao: It was almost like a cultural exchange at the beginning. I had to explain all the cultural stuff to my therapist...like the one-child policy and the gender issues, like how my mother's generations was different from my grandparents generation...It was tiring to explain all these things. 244-257

PET 4 : Benefits of Cultural Differences

Lily: I wasn't afraid of my therapist's judgement when I talked to her, because she didn't know Chinese culture that well. I guess that's really important in therapy, you'll feel free to talk about anything if you're not afraid of being judged. Sometimes I needed to explain things more thoroughly to make her understand. It actually made me find things that I hadn't noticed previously! I could get to know myself more. 1410-1421

Lee: It is reasonable to assume that Chinese therapists hold some social stigma norms. While the British therapist physically couldn't access the presumptions, that made me feel secure [...] I felt more powerful when I introduced some new knowledge about my culture. I felt I wasn't merely a client. I could take a little bit of control of that, instead of the therapist being the one who knows it all. I couldn't do this with Chinese therapists. 389-393; 503-509

Mei: When I told my therapist, I was afraid I couldn't graduate, she said graduation is just a choice, not what you have to do. These words were like "boom" and had quite a deep impact on me. It seems that many Chinese people may not even realise that graduation is not a must. This is quite interesting and a positive part brought by our different cultural backgrounds. 1340-1348

Yan: I think actually, this was also actually a little bit good to work with British therapists. Like, because I kind of like I got like, you know, traumatized by a lot of like bullshits in Chinese cultural, you know, that kind of thing. But then like, I don't need to get traumatized again to work with a Chinese therapist. Or at least I felt like I can get like a fresh perspective from how they actually treat people or like a patient in general or clients in general. 858-867

GET 3: The Role of the Therapists

5.3.1 PET: Personal Attributes

Yan: One thing I really liked about my therapist is that she was very open; she didn't have that kind of typical and stupid prejudgment. She listened to my perspective carefully and made no judgment. Sometimes I felt like, 'Wow, it was very impressive that she could understand a lot of things I told her, more than I expected. 458-469

Mei: She spoke in a very gentle manner, her tone was slow, soft and steady. She would always look into my eyes when she was listening...She gave me a very warm feeling. It felt like as soon as I entered the room and saw her, there was an abstract hug there. The first time we met, she invited me to sit on the small couch, telling me I could lean back and relax. She also said that if I felt insecure, I could hold a pillow. It made me feel comfortable and at ease. 532-544

Wong: I didn't feel connected at all since the beginning. He just... (sigh) lacked emotions, lacked understanding and lacked empathy. I felt like he couldn't be bothered; he was like, "I'm here, I can talk to someone for 50 minutes that I get paid, then I back off." I felt he probably didn't suffer from mental health issues as a practitioner. He just sounded like it was so easy to learn all the techniques. He didn't understand as a patient, knowing the techniques and being able to apply them to your daily life, especially in a crisis, is extremely difficult. 442-454

Lee: He was very polite and he would invite me in by greeting me saying "how's your day" when he saw me. He showed me the way to the therapy room. Basically, the first session was me talking, but I felt he was listening to me very carefully. That was nice. 421-429

5.3.2 PET: Cultural Sensitivity

Tao: She asked me many questions about my cultural background. I had to explain all the cultural stuff to her. What's the point if half the time I paid for was used for explaining everything (laugh)? It was not that therapeutic...She tried to persuade me that she understood me by saying she probably wasn't raised here. It wasn't the same. If you have a client from another culture, at least you have to learn basic knowledge about their culture and history, and check and ask all the time. Simply showing me that she experienced other cultures didn't mean she could understand me. I felt she was downplaying the cultural differences. 434-448

Wong: Because I speak fluent English, he might not have even realised the cultural differences. When I told him that I feel extremely stressed when my parents influence my life too much or demand too much from me and that I need to address this stress, he asked, "Why do they opinion so much about your life?" I know it's a valid question to ask if you're talking to a friend having no idea about your culture, but I don't feel it's a valid question from a therapist. Then he suggested that I shouldn't care too much about my parents' opinions. I didn't find this helpful at all, and I felt he didn't understand what I was saying at all. It happened a few times. At the end I just felt very shut down by him. 605-619

Yan: I was lucky that I met a therapist who shared some similar experiences. I only found out later that her partner is Japanese, and she spent many years in South Africa. She actually knows other cultures and stuff like racism and cultural conflicts. I'm really scared of that kind of therapist who only stays in one place, no diversity (...) She probably didn't understand some cultural customs, that was okay. But she always tried to focus on understanding my feelings in those situations. She didn't let culture become a barrier to her understanding me, which she did very well. 1679-1683;1700-1706

Lee: I guess I could be the first few Chinese clients he had, but he didn't really show any particular consideration about that. It sounds bad as I know it's almost like a protocol here to ask your cultural or sexual orientation differences. But I actually liked that he just treated me like a normal client. He didn't ask about extra things, like "How does your culture see this?". If he did ask, then I would say that's raising a problem here...but when I did mention anything related to my culture, he would pay attention to it and discuss it with me. 976-987

Mei: She probably noticed that I felt embarrassed when I said something wrong in English and she would give me enough to think what I want to say next. I mean, if she didn't give me extra time, I would feel very uncomfortable in the relationship. 1100-1106

PET 3: Therapeutic Approaches

Lily: The way she never answered my questions directly and the way she raised questions... just made me think more about myself, so I could get to know myself better, such as what triggered my depression, and things that were deeply rooted in my personality. Once I know myself better, I just felt like certain mental issues were no longer issues anymore. 692-700

Lee: while I was working with the British therapist, he helped me discover that there was this initial drive for me, to explore, to try to get answers to my questions... There's something behind all of those. He helped me to see all the problems that bothered me or what caused all the anxiety for me was probably linked to my early years experience, what I had in my middle school, in high school. My therapist helped me a lot to realise these very deep issues. 132-143

Yan: She would always help me analyse my feelings or dig something deeper. For example, she would help you think, "Why are you feeling like this?". Also, she would not only teach you how to do ABC—I think that's the problem I had with my previous therapist—but also she really made you understand why this happened. That skill was extremely impressive. 621-632

Mei: I doubted how effective it was. I knew these solutions she suggested might be the right thing to do, but I couldn't do them. She probably knew this too, but she didn't consider what I should do if I couldn't do these. Maybe I wasn't looking for a solution. Maybe I hoped she could have helped me track the source of my emotions, recognise them and express them because I had difficulties in them. 1235-1246

Wong: My therapist tried to teach me some techniques and solutions; as if I practised them, then my problems would go away. It didn't work. I only realised that my childhood experience was a contributing factor to my anxiety with the help of my current Chinese therapist. It was relieving. He never helped me see that. 461-472

Appendix N: London Metropolitan University Ethical Approval



Angela Loulopoulou <A.Loulopoulou@londonmet.ac.uk>
 To Xia Feng
 March 21, 2022

Dear Xia,

Please be informed that the Psychology reviewer and the Chair of Ethics for the School of Social Sciences and Professions have fully approved your ethics application form for your doctoral research. Please find it attached.

Keep this email and the ethics application form with the approvals by Dr Satti and Professor Chandler as evidence of ethical approval and to append to your submitted thesis in due course.

Kind Regards,
 Angela

Dr Angela Ioanna Loulopoulou PhD; AFBPsS; FHEA (she/her) | HCPC Registered Practitioner Psychologist; EMDR Therapist
 Principal Lecturer in Counselling Psychology; Programme Director of the Professional Doctorate in Counselling Psychology; Deputy Head of Psychology for PG Psychology courses
 Lead for Collaborative Partnerships with Psychology | Chair of Subject Standards Board for PG Psychology | Chair of Ethics Review Committee for PG Psychology | Member of the Global Diversities and Inequalities research centre | School of Social Sciences and Professions

	Name	Signature	Date
Student : XIA FENG	Xia Feng		10/11/2021
Supervisor	Dr Raffaell Antonino		08/12/2021

PSYCHOLOGY: REVIEW

Reviewer

Enter X in correspondence with one and only one of the following statements:

C Clear without amendment. X

	Name	Signature	Date
Referee	Dr Faisal Satti		25.02.22

Final judge (if one was appointed)

Enter X in correspondence with one and only one of the following statements:

C Clear without amendment. X

	Name	Signature	Date
Final judge	Prof Chris Chandler		10.03.2022

Appendix O: Journal Article

Abstract

As one of the fastest-growing immigrant groups in the UK (Latham & Wu, 2013), research has shown that first-generation Chinese immigrants (FGCIs) are vulnerable to mental health problems due to migration and acculturation difficulties (Furnham & Li, 1993). However, they are under-represented in mental health services (GOV.UK, 2020) and tend to disengage prematurely when they seek psychotherapy services (Pedersen et al., 2002). This research employed Interpretative Phenomenological Analysis (IPA). Semi-structured interviews were conducted with six participants to explore their subjective experiences of the cross-cultural TRs with White British therapists. Three Group Experiential Themes emerged from the analysis of participants' accounts: a) Pre-Cross-Cultural Psychotherapy Challenges, b) Cross-Cultural Therapy Experiences (which include the emotional barriers, language-related challenges, and the mixed impact of cultural differences during therapy), c) The Role of the Therapist. This article explores the second theme, "Cross-Cultural Therapy Experiences" as the researchers consider it to provide the most significant implications for both clinical practice and research. The Group Experiential Themes "Cross-Cultural Therapy Experiences" explore the emotional barriers of FGCI clients in therapy, language-related challenges, and the mixed impact of cultural differences during therapy. The study revealed that FGCI clients face significant challenges in cross-cultural TRs with White British therapists. It highlights the importance of therapists possessing both cultural sensitivity and key personal qualities to foster trust and connection with FGCI clients.

Introduction

In the last decades, China has become the top country of origin for new immigrants coming to the UK (Latham & Wu, 2013). During the 2018/2019 academic year, 136,520 Chinese students studied in the UK, making up the largest cohort of international students (HESA, 2020). In addition to Chinese students, the number of Chinese investors and skilled migrants to the UK has increased dramatically (Latham & Wu, 2013). The rapid growth of new immigrants largely explains why the vast majority of Chinese in the UK are first-generation immigrants, comprising 68.7 per cent of the population, while second-generation immigrants represent 23.7 per cent (GOV.UK, 2020).

Migration is considered a stressful event (Stillman et al., 2009). Immigrants entering a new country often encounter persistent and multifaceted challenges linked to migration and acculturation, known as acculturative stress (Berry et al., 1987). This stress has been extensively recognised as potentially detrimental to the mental health of immigrants (Williams et al., 2003). FGCI in the UK are at a higher risk of mental illness, as indicated by research (e.g., Close et al., 2016; Furnham & Li, 1993). A quantitative study by Furnham and Li (1993) found that FGCI face more significant acculturative challenges and report a higher prevalence of mental health issues compared to second-generation Chinese immigrants.

However, statistics show that among all ethnic groups in the UK, Chinese adults are the least likely to use mental health services, with only about 1,500 out of every 100,000 Chinese individuals seeking such support (GOV.UK, 2020). Additionally, further evidence suggests that even when Chinese immigrants begin to seek psychotherapy, they often prematurely disengage from treatment (Pedersen et al., 2002; Pui-Ling & Logan, 1999; Yee & Au, 1997).

It is argued that the high drop-out rate among Chinese immigrant clients may result directly from the therapists' unfamiliarity with Chinese culture (Yin, 2016). Cultural

differences between therapists and clients have long been recognised as a potentially vital variable influencing TRs (Qureshi & Collazos, 2011). One way to understand how cultural differences may impact the TR comes from the field of social psychology. Based on Festinger's Social Comparison Theory (1954) and Heider's Balance Theory (1958), Byrne (1971) put forward the attraction paradigm, which argues that people tend to interact with others with similar views. Byrne believes that interacting with like-minded people confirms their ideas and reinforces the logic and consistency of their worldview. However, interacting with people with different perspectives may undermine the logic and coherence of how people view the world, which can lead to anxiety, confusion and even rejection.

Another way to understand the connection between cultural and racial differences and the TR is through the perspective of transference and countertransference (Holmes, 1992). Gelso and Mohr (2001) believe when a client interacts with a therapist from a different racial or cultural background, the client may develop negative cultural transference toward the therapist, a phenomenon in which the client projects distorted beliefs and attitudes about the therapist's racial or cultural group onto the therapist under the impact of their prior experiences and perceptions. However, Curry (1964) argues that in cross-cultural psychotherapy, clients may project distorted beliefs and attitudes related to the therapist's race or cultural group even before the initial meeting, a concept he terms "pre-transference".

Based on theories of why cultural and racial differences may influence the TR, some multicultural scholars (e.g., Atkinson, 1983; Sue, 1988) have investigated how cultural differences specifically affect the TRs between White therapists and Asian American clients. Cultural differences in the conceptualisation of mental health issues can significantly impact the formation of the TR (Cardemil & Battle, 2003). In many Asian cultures, the mind and body are seen as inseparable, while Western medicine treats them as distinct. This difference

can lead Asian American clients to reject mental health explanations, causing therapists to misinterpret them as lacking insight or having psychopathology.

In addition to differences in conceptualisation, communication styles also impact the TR. Asian Americans, valuing collectivism, may view discussing family issues as a breach of family privacy, which may lead to feelings of guilt. A therapist from an individualistic culture may misunderstand this reluctance, perceiving it as inarticulateness. Furthermore, Asian Americans tend to use high-context communication, relying on non-verbal cues, while Western culture favors low-context communication focused on explicit verbal content. Misinterpretation of these styles can hinder the TR and its bonding elements.

Cultural differences in self-concept will also affect the TR (Sue & Sue, 1990). Asian cultures emphasize collectivism, family, and interdependence, where the self is defined in relation to others (Shea et al., 2010; Ng & James, 2013). In contrast, Western norms prioritize individuality and autonomy (Harkness et al., 2008). These differences can cause divergence in treatment goals, such as when a therapist encourages setting boundaries with a parent, which may conflict with the client's cultural obligation to respect elders (Sue, 1988). Disagreement on treatment goals impacts the TR's quality (Thompson et al., 2007).

While the literature offers insights into cultural and racial differences in therapeutic relationships (TR), it has limitations. Most findings are based on therapist perspectives (e.g., Tsui & Schultz, 1985; Kim et al., 2012) and lack empirical studies exploring clients' experiences. Client evaluations of the TR are crucial to therapeutic outcomes (Norcross, 2002). Merely considering cultural differences in TR as variables is reductionistic (Saizman, 1995) since clients' race and ethnicity don't exist in isolation (Speight & Vera, 1997).

Recently, attention has turned to within-group differences among Asian American clients. Acculturation, defined as identifying with the dominant White culture (Berry, 2005), plays a key role in understanding these differences (Leong & Lee, 2006). First-generation

immigrants tend to maintain stronger cultural ties and face more challenges accessing mental health services than later generations (Berry, 1997; Fung & Wong, 2007). Language barriers also add to these difficulties (Sue & Sue, 2016), with limited English proficiency hindering communication (Qi & Kring, 2021) and increasing anxiety (Shen, 2022). Studies show that first-generation Asian Americans are less likely to seek mental health services and find them less helpful than second-generation individuals (Abe-Kim et al., 2007).

A group of scholars conducted a series of single-session counselling studies with Asian college students and European-American counsellors to explore Asian American clients' preferences for the characteristics of counsellors in cross-cultural counselling. For example, Kim et al. (2002) discovered that Asian American clients reported strong working alliances when their counsellors provided a direct solution to the problem they mentioned in the counselling. Another study by Kim et al. (2005) found that the clients who matched the counsellors' worldview perceived stronger work alliances than those who did not. While this series of studies provided some advice to White counsellors on how to work with Asian clients, their conclusions are of limited applicability because the participants in these studies had no experience of real-life psychotherapy without the constraints of experimental parameters. Besides, the qualitative studies (e.g., Chang & Berk, 2009; Gurpinar-Morgan et al., 2014) that have explored clients' experience in actual intercultural TRs have mainly focused on the experience of second-generation immigrants from diverse ethnic backgrounds, while the experience of first-generation immigrants who are likely to have a lower level of cultural assimilation (Leong & Lee, 2006) has been neglected. Meanwhile, another problem these qualitative studies have is that their participants are from diverse cultural backgrounds, which can interfere with a full and accurate understanding of how people of different ethnicities receive cross-cultural psychotherapy and that such findings do not allow therapists to accurately capture the specific needs of clients of various ethnicities (Yoshida, 2013). Jim

and Pistrang's (2007) study serves as one of the few studies that focus on Chinese immigrants, but their research aims to explore the role of culture in the therapeutic experiences of Chinese immigrant clients rather than exploring the TR between Chinese immigrant clients and British therapists. Therefore, there is a gap in the literature where the FGCI clients' experiences of cross-cultural TR remain unknown. Based on this, the study aims to investigate how first-generation Chinese immigrant clients experience the cross-cultural therapeutic relationship with White British therapists in the UK.

Methodology

Reflexivity on Epistemology and Ontology

Reflection plays a crucial role in qualitative research, as it helps researchers continuously monitor their own feelings throughout the research process, while also making these feelings transparent, thereby enhancing the transparency of the research (Ortlipp, 2008). This study was conducted as part of the requirements for a Professional Doctorate in Counselling Psychology at London Metropolitan University, and this article is prepared for publication. As a trainee counselling psychologist but also as a FGCI who had experienced cross-cultural TRs with White therapists, I was aware that my role of being an "insider" researcher could impact his decisions at various stages of the research process. To minimise this influence, I kept a reflective journal at different stages of the research to record my thoughts and insights. Additionally, I engaged in supervision, personal therapy, and discussions with colleagues to further ensure that I could "bracket" my personal views, emotions, and understandings (Smith et al., 2009). Yet, I was fully aware that my personal interpretations and viewpoints inevitably shaped the analysis to some degree. As IPA acknowledges, interpretation is an unavoidable and legitimate part of the analytical process (Heidegger, 1962).

Design

Interpretative Phenomenological Analysis (IPA) was chosen to explore FGCI clients' experiences of cross-cultural TR for several reasons. Firstly, the phenomenological stance of IPA attempts to explore individuals' unique subjective experiences in detail. (Giorgi & Giorgi, 2003). This feature of IPA lends itself well to the purpose of this study. Secondly, one of the theoretical underpinnings of IPA is hermeneutics, involving a dual process in which the researchers attempt to make sense of how the participants make sense of their personal experiences (Spinelli, 1989). In addition, the idiographic aspect of IPA focuses on an in-depth analysis of the specific lived experiences of an individual in one particular context (Lyons & Coyle, 2007)). This enables this study to explore how first-generation Chinese immigrant clients experience the potentially nuanced cultural differences in the intercultural TR from a profound and detailed level.

Participants and Recruitment

IPA utilises a purposeful, homogeneous and relatively small sample (Eatough & Smith, 2006). Accordingly, the current study recruited six FGCI clients who had experienced one-on-one psychotherapy with White British therapists (see Table 1 for participants' demographics). I advertised on social media platforms and distributed flyers on the campus of London Metropolitan University to recruit eligible participants. In the end, all six participants were recruited through social media platforms. The participants' ages ranged from 23 to 38. Evidence shows that at least three therapy sessions are needed to establish a stable TR, which remains consistent in subsequent sessions (Despland et al., 2001). Therefore, the study required that all participants had attended at least three psychotherapy sessions, regardless of the psychotherapeutic approach, with a White British therapist. In addition, to ensure accurate recall of treatment experiences, participants were asked to be still

in psychotherapy at the time of the interview or to have completed treatment in the 12 months prior to the interview.

Table 1. Summary of the participants' demographics

Pseudonym	Gender	Age	Occupation	Years stayed in the UK	Sessions attended	Therapy completed	Setting	Therapist's approach	Therapist's gender
Lee	Male	23	Master Graduate	4	11	Ongoing	Private practice	Psycho-dynamic	Male
Lily	Female	29	PhD Student	5	40+	Ongoing	Private practice	Integrative	Female
Wong	Female	27	Employed	9	8	Four months	NHS	Cognitive Behavioural Therapy (CBT)	Male
Yan	Female	38	Employed	1	30+	Ongoing	Private practice	Integrative	Female
Mei	Female	24	Master Student	1	6	One month	University	CBT	Female
Tao	Female	28	Part-time student/ Part-time employed	5	30+	Two months	Private practice	Psycho-dynamic	Female

Procedure

Semi-structured interviews are the recommended data collection method in IPA research (Smith et al., 1999) as they allow for an in-depth understanding of lived experiences related to a specific phenomenon. Additionally, using open-ended questions in semi-structured interviews is encouraged as it enables participants to guide the conversation toward topics that matter most to them. (Smith & Osborn, 2008). Therefore, I utilised semi-structured interviews with open-ended questions to collect data, with each interview lasting between one to one and a half hours. Although I initially planned to conduct face-to-face interviews, due to the ongoing COVID-19 pandemic during the recruitment phase, and the fact that eligible participants were spread across different cities in the UK, many participants

preferred to be interviewed via video. Conducting interviews via video had also been approved by the ethics committee.

Data Analysis

According to the guidelines of Smith et al. (2022), the IPA analysis process began after I transcribed the recordings of each participant into verbatim data. The process of analysing the transcripts followed several stages. First, I immersed myself in the data by reading the transcripts multiple times, numbering each line of text, and leaving large margins for comments. As I read, I noted my initial impressions and observations in the right margins, including descriptive, linguistic, and conceptual comments, to capture both the participants' words and my interpretations (see Appendix J). I continuously referred back to the original audio recordings to ensure accuracy.

In the second stage, I developed experiential statements by reviewing and interpreting the initial notes (Smith & Eatough, 2006). I used the left margin to write these experiential statements, which represented key ideas and insights related to the participants' experiences. During this stage, I ensured that the connection between my notes and the transcript was maintained, and I used a reflective journal to monitor my assumptions and personal biases, allowing for a more unbiased analysis (Kaskzet, 2012).

In the third stage, I examined the connections between experiential statements and grouped them into clusters based on similarities. I envisioned a “magnet” pulling related themes together. During this process, I frequently went back and forth between the verbatim data and the initial comments on the experiential statements to ensure that the integrity of the verbatim data was preserved. After labelling the identified clusters with titles, I generated a summary table of all the Personal Experiential Themes (PETs) with corresponding quotations for each participant (see Appendix L). Given the idiographic focus of the IPA, I approached

the analysis of each subsequent transcript with awareness, ensuring the previous analysis did not interfere (Lyons & Coyle, 2007).

Finally, by looking for connections and patterns across all the summary tables of PETs, I constructed a final table of Group Experiential Themes (GETs) for all participants (see Appendix M). The selection of the PETs was based not only on their prevalence in the data but also on factors such as the richness of specific paragraphs highlighting the themes and how these themes helped elucidate other aspects of the participants' accounts (Smith et al., 2009). During this process, I revisited the original text and linked the developed themes with participants' descriptions as needed, making adjustments and rearrangements of themes when necessary. Extreme care was taken in constructing the final table of GETs, including sharing it with my supervisor to verify the consistency of the themes.

Ethical considerations

This research was carried out with the researcher's attempts to maintain an ethical attitude consistent with the BPS Code of Ethics and Conduct (2009). Ethical approval was gained from the LMU Research Ethics Committee before the study started.

Participants who were eligible were invited to attend the interview. Prior to each interview, the researcher thoroughly briefed the critical information again. Participants' autonomy was of utmost importance in the interview; therefore, the researcher informed the participants that they could decide the amount of information they wanted to disclose.

Consent forms were obtained before the interview commenced, and a signed copy was retained by the researcher and the participant. All the participants were assured they could withdraw anytime within four weeks after the interview. However, since it would be difficult for the researcher to separate individual data from the whole interpretative analysis

after the data analysis starts, participants were informed that they could not withdraw from the study four weeks post-interview.

Results

Following the six semi-structured interviews, the IPA analysis identified three main themes, namely, “Pre-psychotherapy challenges”, “Cross-cultural therapy experiences”, and “The role of the therapist”. This paper focuses on “Cross-cultural therapy experiences” as the researcher believes this offers the strongest implications for clinical practice and research. This superordinate theme involves participants’ actual experiences within the cross-cultural TR, focusing on how cultural differences were perceived in the therapeutic process. It also reflects the emotional barriers participants faced and the diverse experience of expressing themselves in English in therapy. These can be broken down into four sub-themes: “Navigating Emotional Barriers during the Initial Phases”, “Therapy in English: Hindrance or Catalyst?”, “Challenges of Cultural Differences”, “Benefits of Cultural Differences”. All participant names are pseudonyms to ensure confidentiality and anonymity at all times.

Cross-Cultural Therapy Experiences	Navigating Emotional Barriers during the Initial Phases	<i>“When the first time talking to a therapist [...] I feel I’m a burden because I feel I have problems and other people don’t.” Wong, 345-349</i>
	Therapy in English: Hindrance or Catalyst?	<i>“So that’s why I feel so comfortable doing therapy in English because I learned everything of expression emotions in English because I don’t know how to do that in Chinese.” Yan, 915-917</i>
	Challenges of Cultural Differences	<i>“I felt a bit tired as it took quite a bit of effort to explain some cultural phenomena and current policies to her. I wondered whether she could really understand them as a foreigner.” Mei, 1340-1344</i>
	Benefits of Cultural Differences	<i>“I wasn’t afraid of my therapist’s judgement when I talked to her, because she didn’t know Chinese culture that well. I guess that’s really important in therapy.” Lily, 1410-1413</i>

Navigating Emotional barriers during the Initial phases

All participants shared that they experienced a range of complex and difficult emotions in the early stages of cross-cultural therapy. Some of the emotional struggles are highlighted in the following quotations:

I felt embarrassed in therapy at the beginning. I still carried the baggage of how seeking mental health help was stigmatised in my culture. But embarrassed feeling also related to just disclosing personal stuff to a stranger, especially a foreign person, like not one of my family or one of my culture. (Tao;213-217)

Tao acknowledged her discomfort stems from the stigma associated with seeking mental health support in her culture. The word “baggage” seems to capture well the feeling of heaviness that the stigma has brought to her. Moreover, Tao’s embarrassment may also hint at a fear of not being understood or accepted in cross-cultural communication. While opening up to strangers about one’s personal struggles is daunting in itself, Tao’s specific mention of “a foreign person” as opposed to “one of my culture” seems to indicate her concerns about the level of understanding and acceptance she could receive from a therapist of a different culture. Similarly, Wong’s account of her early therapy sessions with a British therapist seems to highlight her emotional barriers:

I felt I was a burden because I still didn’t recognise it was a mental health problem... I couldn’t open up in the first couple of sessions. I had to test the water first, to give a little bit and then to see what was coming out of it. As a minority, I felt we could shut down quite quickly if we sensed the therapist was judging us. (Wong;289-300)

Wong’s hesitation to “open up” and her inclination to “test the waters” may reflect her fears of potential judgment or being misunderstood, seemingly indicating a hesitancy to

fully trust or feel secure within the therapeutic setting. Additionally, Wong's attention to her status as a minority may suggest she navigates therapy not just as a client, but also as someone who feels like an "outsider", which might intensify her worries about being judged or not being understood properly. Mei, too, shared her feelings of distrust at the beginning of working with a British therapist:

My therapist told me later that she felt I didn't seem to trust her much at the beginning. I think it might be because I was not too willing to rely on the strength of others to step out. It's like we have a walking stick to climb a mountain, but we just won't use it, we insist on climbing up on our own. (Mei;454-465)

Mei then articulated her hesitation to fully "trust" by likening it to a reluctance to use a walking stick. Her reference to the walking stick, likely a metaphor for external support, seems to indicate that she may be aware of the potential benefits of therapy, but her insistence on "climbing up on our own" could reveal her preference for self-reliance over seeking external help. This likely demonstrates Mei's inner conflict between acknowledging the need for help in a difficult journey and her deeply rooted belief in self-reliance.

Therapy in English: Hindrance or Catalyst?

All participants shared their experiences with undergoing therapy in English with a British therapist, as well as the feelings that emerged during this process. Mei elaborated on the struggle with language that she faced during therapy:

Sometimes I would get stuck even on a very simple word, or there were moments when I couldn't find a certain word to express my feelings, then I became anxious and embarrassed and I needed to stop to think. (Mei;1102-1107)

Mei discussed how even simple words can become stumbling blocks, seemingly indicating the additional challenges that language barriers present in therapy. The anxiety Mei feels during moments of linguistic deficiency seems to highlight her vulnerability, particularly in therapy where clear expression of feelings is critical—ineffective communication can arguably exacerbate her feelings of helplessness and frustration. The embarrassment she referred to also appears to reflect a self-perceived inadequacy.

In contrast, Wong’s account illuminates how language barriers might manifest in therapy from a different perspective:

I felt quite lucky that language was not a problem for me [...] A lot of my childhood trauma happened at that time when I could only speak Chinese. When I was going into those memories, I had to think really hard about what happened and also because of the language barrier, I had to go through the memories again and again trying to say I didn't miss any details, which was quite traumatic. (Wong;779-781;1176-1186)

Wong mentioned that having to “think really hard” may hint at the strenuous effort required to delve into painful memories and the emotional strain involved. Despite her English fluency, the necessity to revisit these memories repeatedly to articulate them in a non-native language may arguably intensify her exhaustion and frustration. The term “traumatic” seems to further emphasise the distress of this process, a stark contrast to her initial sense of advantage. This discrepancy underscores the added complexity that language considerations can introduce to therapy for individuals navigating cross-cultural environments.

Tao introduced a different perspective to the emotional burden that comes with communicating in a non-native language during therapy:

I felt I had to make more effort to make this communication in therapy effective ... It also made me feel why I was always accommodating others, constantly making all the effort to explain myself in a language that is not my mother language, and why no one coming from another direction came closer to me. (Tao;927-935)

Tao's mention of having to "make more effort" sheds light on the extra labour she feels compelled to put forth to articulate her thoughts in English during therapy. This exertion prompts Tao to reflect on a recurring theme in her life, where she has always felt the burden of making "all the effort" to bridge language and cultural gaps. Such continuous effort could be particularly draining in a therapeutic context, where one expects to be met with understanding and support. Tao's rhetorical question "why no one coming from another direction came closer to me?" appears to encapsulate a deeper sense of loneliness within her therapeutic experience and beyond, as well as a longing for mutual effort and understanding in her interactions with others.

In contrast, Yan talked about her positive experiences of expressing emotions in a non-native language during therapy:

I felt so comfortable talking about emotions in English; I learned everything in English, and I actually don't know how to do that in Chinese. (Yan; 915-922)

Yan spoke of a sense of ease with English in therapeutic settings. Phrases like "felt so comfortable" and "I learned everything in English" appear to indicate that Yan experiences a sense of liberation and discovery by using English in therapy, providing her with the

necessary tools to navigate her emotional landscape—a capacity she perceives as lacking in her native tongue.

Challenges of Cultural Differences

This sub-theme explores participants' experiences of the multifaceted barriers and challenges that cultural differences pose in psychotherapy with their British therapist. The following extract captures this:

I felt a bit tired as it took quite a bit of effort to explain some cultural phenomena and current policies to her. I wondered whether she could really understand them as a foreigner. Even if she could understand what I was saying literally, she might not fully empathise. For example, when I told her about my relationship with my Dad, I felt she might not understand why I felt guilty or why I was still so obedient to my dad, the concept of Xiao [filial piety], like loyalty to the family, in Chinese culture. (Mei; 683-695)

Mei referred to her therapist as a “foreigner” seemingly emphasising the large cultural divide between them. By differentiating between literal and empathetic understanding, Mei seems to hint at her expectation for the therapist to comprehend the deep cultural meanings behind the issues she discusses. Mentioning “she might not understand,” Mei seems to acknowledge that the concepts such as “obedience” “loyalty” and “Xiao (filial piety)” in Chinese culture may not be easily translated or hold the same significance in another cultural context. This could lead to a feeling of isolation, as if her emotional experiences are being diminished or misinterpreted.

Lily spoke about the challenges posed by the differences in non-verbal communication:

I felt there was an invisible wall. I can see if a Chinese believes me or not by their body language, but I could never tell with my British therapist...I always felt she was shrouded in a veil. I got insecure if I didn't know others' real intentions. It took me eight months to have a comfortable relationship with her, but maybe with a Chinese therapist, it just needs three months. (Lily;984-994)

Lily described a metaphorical “invisible wall”, which seems to imply an intangible yet perceptible divide in culture and communication between her and her therapist. In her narrative, there’s an ease and clarity with Chinese when it comes to non-verbal communication, contrasting with the alienation and ambiguity she experiences with a British therapist.

Furthermore, Lily referred to the therapist as being “shrouded in a veil”, a metaphor for her struggle to understand the therapist’s true motives, a situation that both frustrates and unsettles her. Lily’s specific timeline—the establishment of a relationship with a Chinese therapist taking three months, in contrast to eight months with a British therapist—quantifies the challenges she feels in a cross-cultural TR. It also suggests that Lily believes overcoming cultural barriers and building trust with a British therapist requires additional emotional labour and time.

Yan reflected on the poignant disparity in cultural and societal positioning between her and her therapist:

There was no way that my therapist could just slightly imagine an immigrant's pain, no way! She never experienced this because she was born with this privilege, the British passport lottery. How would she possibly understand?! I had to do so much to just be able to sit in the same room with her. (Yan;1158-1168)

Yan described the therapist's native British citizenship as a "privilege," akin to winning the "British passport lottery," contrasting sharply with her own "immigrant" status. This shows Yan's acute awareness of the cultural and socio-economic gap between herself and her British therapist. By emphasising "she cannot slightly imagine the pain of an immigrant," Yan appears to underscore the intrinsic difficulty in conveying the immigrant experience to a therapist lacking similar life experiences, along with a profound sense of loneliness and defeat.

Benefits of Cultural Differences

Participants mentioned the potential benefits of cross-cultural psychotherapy, which are facilitated by the cultural differences they have experienced with their British therapist. Lily's experience highlights the perceived benefits of engaging with a British therapist who is unfamiliar with her cultural background:

I wasn't afraid of my therapist's judgement when I talked to her, because she didn't know Chinese culture that well. I guess that's really important in therapy, you'll feel free to talk about anything if you're not afraid of being judged. Sometimes I needed to explain things more thoroughly to make her understand. It actually made me find things that I hadn't noticed previously! I could get to know myself more. (Lily; 1410-1421)

There seems to be a sense of liberation when Lily mentioned that her therapist's unfamiliarity with Chinese culture alleviates her fear of judgment. Lily went on to express "that's really important", which appears to indicate her appreciation for the non-judgmental attitude within therapy, considering it crucial for enabling clients to freely discuss personal

issues. Intriguingly, Lily shifts from using “I” to “you “ here, which might suggest her intent to normalise her experiences as something anyone could encounter. I wonder whether this shift may also serve to mitigate any unease she might feel discussing these matters with the researcher, who is someone that understands Chinese culture and thus could have preconceived notions. When speaking about the self-discovery she has gained while bridging cultural differences, her tone seems to carry an element of surprise, perhaps signalling that this benefit is unexpected.

Similarly, Lee talked about the benefits of the therapist’s unfamiliarity with Chinese culture:

It is reasonable to assume that Chinese therapists hold some social stigma norms. While the British therapist physically couldn’t access the presumptions, that made me feel secure [...] I felt more powerful when I introduced some new knowledge about my culture. I felt I wasn’t merely a client. I could take a little bit of control of that, instead of the therapist being the one who knows it all. I couldn’t do this with Chinese therapists. (Lee; 389-393; 503-509)

The British therapist’s inability to “physically access the presumptions” is Lee’s metaphorical way of saying the therapist is removed from the cultural norms and prejudices that would be ingrained in a Chinese therapist. There seems to be a sense of comfort and relief in Lee’s expression that the cultural distance of his British therapist makes him “feel secure”. In addition, Lee sees himself not “merely as a client” but as an active contributor to therapy by sharing cultural knowledge with his British therapist, a dynamic that grants him a sense of control and agency. This contrasts with Lily’s experience of achieving self-knowledge through addressing cultural differences. His statement “I couldn’t do this with

Chinese therapists” seems to further underscore his need for empowerment within the TR. Considering Lee’s previous expressions of helplessness as an immigrant job-seeker in the UK, I am led to wonder if this newfound sense of control in therapy acts as a compensatory mechanism for him.

For Mei, she used a concrete example to illustrate how cultural differences have been beneficial:

When I told my therapist, I was afraid I couldn’t graduate, she said graduation is just a choice, not what you have to do. These words were like “boom” and had quite a deep impact on me. It seems that many Chinese people may not even realise that graduation is not a must. This is quite interesting and a positive part brought by our different cultural backgrounds. (Mei; 1340-1348)

Mei appears to experience a defining moment when her therapist reframes the concept of graduation from an obligation to a choice, confronting an ingrained belief among the Chinese community that “graduation is a must.” Mei’s depiction of her therapist’s statement as creating a “boom” effect vividly captures the profound and immediate shift in her viewpoint. By referring to “many Chinese people may not even realise that”, Mei seems to emphasise the significance and value of being able to see her situation differently from the stereotypical perspective of her community due to her therapist’s impact. Using terms like “interesting” and “positive” Mei seems to convey her appreciation for the way cross-cultural therapy has broadened her perspective and reduced the weight of the cultural expectations deeply rooted within her.

Discussion

A novel finding of this study was that all participants reported experiencing a range of complex and difficult emotions during the early stages of psychotherapy. It was evident that participants were burdened by the stigma attached to mental health problems and the emphasis on self-reliance within their culture in the therapeutic process. Psychotherapy, however, is a process that encourages clients to be open and honest in addressing, recognising, and reflecting on challenging life issues (Kolden et al., 2018). This process requires participants to maintain a level of openness to the therapist, while this clashes with their cultural values. This conflict makes opening up to their therapists a challenging and, at times, painful experience for the participants. This observation is consistent with Leong et al.'s (1995) argument that Chinese cultural values often clash with those that underpin Western psychotherapy.

Moreover, participants indicated that the therapist's cultural background appeared to be a significant factor contributing to their negative emotions. The participants' reflections on the perceived cultural differences with their therapists during the early stages of treatment, as well as their negative associations with these differences, align with the concept of cultural transference as outlined in Gelso and Mohr's (2001) research. Comas-Díaz and Jacobsen (1991) explain that cultural transference in cross-cultural relationships typically manifests as mistrust, suspicion, and potential hostility. This is clearly illustrated in Wong and Tao's experiences.

The feelings associated with having therapy in a non-native language with a White British therapist were identified as another theme. Some participants reported feelings of anxiety and embarrassment due to difficulties in articulating their thoughts and finding the right words to express their emotions in English during therapy. This is consistent with the existing literature (e.g., Moore et al., 1999; Qi & Kring, 2021), which shows that FGCI clients

may find it challenging to express themselves in therapy due to limited English language proficiency and lack of the necessary emotional vocabulary in their native language.

Further to the existing literature, my study seems to offer new perspectives on how using a non-native language in psychotherapy can obstruct the therapeutic process. For some participants, expressing themselves in a second language presented challenges in unexpected ways despite their fluency in English. For example, Wong mentioned that she needed to repeatedly revisit some traumatic memories from her childhood (a time when she did not yet speak English) to accurately express them, which in turn exacerbated her sense of distress.

In contrast to these narratives, some participants preferred having psychotherapy in English to Chinese. This is consistent with Jim and Pistrang's (2007) view that for some people, therapy in English can free them from binding cultural norms and allow them to enjoy greater freedom of expression.

In addition to the challenges posed by language barriers, all participants discussed the cultural differences they perceived with their therapists as the therapy progressed, and the challenges these differences posed to the TR. This is consistent with Bourne's Theory of Attraction (1971). Meanwhile, consistent with the literature on barriers for White therapists to establish effective cross-cultural TR with Asian clients (e.g., Atkinson, 1983; Sue, 1988), my study has found that differences in values and communication styles between Eastern and Western cultures can create barriers between therapists and their clients.

Beyond differences in values and communication styles, differences in power and privilege with the therapist were also identified as contributing to the therapist's difficulties in understanding the participants. For instance, Yan felt that the privilege her therapist was born into prevented her from fully understanding the depth of Yan's frustration and pain as an immigrant. This is in line with the literature (e.g., Cardemil & Battle, 2003; Pinderhughes,

1989) on power and privilege in cross-cultural therapy, which suggests that the privilege disparity between therapists and clients can negatively impact the TR.

Interestingly, beyond the challenges posed by cultural differences, four participants also mentioned some benefits that these differences brought to the TR. This is consistent with existing literature (e.g., Chang & Berk, 2009; Jim & Pistrang, 2007). For example, Mei described how having a therapist from a different culture provided her with new perspectives on understanding some of her struggles. This is in line with Cheng and Lo's (1991) study. Although their research focuses on the TR between ethnic minority therapists and White clients, Cheng and Lo argue that when therapists are sufficiently familiar with their client's culture, the fact that the therapist is from another culture can instead help the client to see new coping choices and enhance their adaptive skills.

Participants' perceived benefits of cultural differences appear to be related to their negative feelings about their own culture. According to Comas-Diaz and Jackson (1991), clients with strong negative feelings about their cultural background may have conflicts within their cultural identity. When working with a therapist of the same ethnicity, they are more likely to develop intraethnic transference, projecting these negative emotions onto the therapist who shares their ethnic background. Such clients may prefer therapists from different cultural backgrounds to avoid internal conflict and the negative self-perceptions that might be projected onto an ethnically similar therapist. This dynamic is evident in the narratives of Lee and Mei. Lee suggested that the reason he felt more secure working with a British therapist was due to his belief that Chinese therapists also held socially stigmatised norms. Similarly, Mei particularly valued her therapist's different perspective, as she believed her community was confined to the stereotype of "graduation is a must", as she was herself.

Implications for clinical practice

This study provides valuable insights into how FGCI clients experience cross-cultural TR with a White British therapist. Such insights can provide some guidance to counselling psychologists and other professionals when they work with FGCI clients in the future.

One consideration is that FGCI clients experience complex internal conflicts and negative emotions during the initial stages of therapy. One of the consequences of these internal struggles is that FGCI clients find it very challenging to open up to their therapist. Therefore, it is crucial for therapists to recognise these internal struggles early in the therapeutic process, as this awareness can enhance their ability to empathise with the distinct challenges FGCI clients face in therapy.

Additionally, this study identifies that FGCI clients may face obstacles in therapy due to the need to express themselves in a non-native language. These findings emphasise the importance of therapists exercising patience and giving clients enough time to express themselves. Moreover, therapists could consider asking clients about their experience of having therapy in English, which might help clients articulate how communicating in a non-native language affects them. This, in turn, would allow therapists to address the emotions that may be activated due to having to communicate in a foreign language during therapy.

Another key finding is that differences in values and communication styles between Eastern and Western cultures can create additional challenges for FGCI clients and their White British therapists to understand each other. This finding highlights the need for therapists to acknowledge these differences and make efforts to minimise potential misunderstandings by familiarising themselves with relevant topics through reading or training. This is particularly important as participants in this study expressed an expectation that therapists should take the initiative to familiarise themselves with basic aspects of

Chinese culture. Such cultural knowledge can enhance the therapist's ability to connect with Chinese clients and better comprehend their feelings in certain cultural contexts.

However, having cultural knowledge alone is not sufficient to overcome the challenges mentioned above. This study found that different clients seem to have varying expectations regarding therapists' cultural competence. This suggests that therapists need to deal with cultural issues with sensitivity and flexibility. According to the literature (e.g., Li et al., 2007; Sue & Sundberg, 1996), an essential aspect of working with ethnic minority clients is to have open conversations about their expectations for therapy, especially concerning cultural and racial issues, in the early stages of psychotherapy. Such discussions can help therapists assess when to address issues such as cultural transference. For clients who expect their therapist to pay attention to their cultural background, the therapist can address negative cultural transference earlier, such as distrust or suspicion toward the therapist. For clients who express that cultural issues are not important, the therapists may focus on building a strong therapeutic alliance first and only attempt to address cultural transference issues when they sense the clients are ready to explore them. Additionally, it is also essential for therapists to create a space where clients feel secure to offer feedback and share any concerns about the therapy process (Chang & Berk, 2009). This is particularly crucial for FGCI clients, as they might feel uncomfortable expressing concerns or dissatisfaction during psychotherapy, and they often prefer therapists to take the initiative in checking how they feel throughout the process.

Limitations and Further Research

Firstly, it is important to acknowledge that participants may not have been fully aware of their own cultural transference towards their British therapists. As Jim and Pistrang (2007) suggest in their research, not only therapists but also clients may experience a form of "cultural encapsulation", which can make it difficult for them to recognise the underlying

assumptions they hold about cross-cultural interactions. This could have led to an underestimation of the participants' own contributions to the results they reported, while attributing a disproportionate emphasis to therapist-related factors in explaining negative results. Additionally, the study's exclusive reliance on participants' retrospective self-reports means that the findings likely represent participants' internal representations of their cross-cultural therapy experiences, which may have been subject to recall biases. Nevertheless, following the phenomenological approach (Giorgi, 1997), I considered participants' subjective accounts to be valid data for understanding their lived experiences, acknowledging that any filtering of memory or expression is part of how they internally perceive and represent those experiences.

Moreover, the findings of this study must be interpreted in light of the specific characteristics of the participants. The sample was self-selected and generally well-educated. They were interviewed in English, which might also have represented they have good enough English skills and are acculturated enough. Their willingness to participate may have also indicated a greater psychological awareness and a reduced stigma towards mental health issues. Additionally, their experience working with a British therapist might have meant they were more open-minded to cross-cultural therapy. As such, the results may reflect a bias towards Chinese immigrants who are more educated, acculturated, and receptive to cross-cultural psychotherapy.

Another limitation is that several variables within the participants could have impacted their experiences of cross-cultural psychotherapy. In this study, the overwhelming majority of participants were female, with only one male respondent. Therefore, it may not fully capture the male experience, thus limiting the generalisability of the findings. As research has indicated that mental health issues are more stigmatised among Chinese men (Yang, 2017), they may arguably face different challenges in seeking mental health support,

and their expectations of such support may differ from those of Chinese women. Therefore, future research may benefit from investigating the experience of male FGCI clients in cross-cultural psychotherapy, as this may generate new findings.

Additionally, most participants worked with therapists of the same gender. Only one participant experienced working with a therapist of a different gender. As a result, this study offers limited data on the experiences of FGCI clients who worked with therapists of the opposite gender. In cross-cultural therapy, gender matching or mismatch may further complicate power dynamics between the client and therapist, with clients whose gender does not match that of their therapist potentially facing additional complexities that could influence their therapeutic experience. Future research should also seek to include a more diverse range of gender combinations between therapists and clients, such as Chinese female clients with British male therapists.

Finally, this study offers only a limited “snapshot” of participants’ experiences in cross-cultural psychotherapy, without capturing the more subtle changes in their views on therapeutic relationships that may have occurred over the course of multiple sessions. While participants discussed the importance of therapists’ personal qualities, cultural competence, and therapeutic approaches in cross-cultural therapy, this study may not have adequately assessed the relative importance of these factors to clients.

References

(References are included in the thesis Reference List)