

**Perspectives of second-generation Pakistani Muslim therapists utilising CBT with  
ethnically similar clients:  
An Interpretative Phenomenological Analysis.**

By

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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:** The aim of the proposed research is to explore the experiences of second-generation Pakistani Muslim (SGPM hereafter) therapists practicing Cognitive Behavioural Therapy (CBT) with ethnically similar clients, that is, Pakistani Muslim (PM) clients. This exploration will be made against the backdrop of relevant literature and current arguments. Studies have highlighted the significance of religion and culture for SGPMs and the need to produce culturally sensitive interventions for this group. The key findings from the quantitative and qualitative studies have highlighted a gap in knowledge between Islam and culture and the delivery of CBT in relation to the professional and/or cultural identity of the therapist.

**Design/Method:** Verbatim accounts of six semi-structured interviews were analysed using Interpretive Phenomenological Analysis (IPA). Participants were SGPM therapists aged between 28 and 46 who had worked with ethnically similar clients in the UK.

**Findings:** Three superordinate themes were generated: 'Intra-cultural influences', which refers to factors such as relatability and trust, language, gender and communal anxieties – all of which reflect the salience of collectivism in Pakistani culture; 'Professional Compass', which refers to impartiality in sessions and a consideration of religious factors; and finally, 'Negotiating CBT Boundaries', which refers to therapist and client frustrations and limitations and a need for integration.

**Conclusions:** Participants' accounts highlighted that they seemed able to work with their PM clients allowing for an open and honest space in which to traverse cultural and religious terrain. Given the saturation of PM society by both religion and culture, participants - using their personal understanding - sensitively created an effective therapeutic dialogue. This was generated by weaving together CBT parameters and cultural/religious influences. This involved working towards congruency by achieving both an integrative approach and developing a comprehensive outlook, accepting the therapist- and the client-melded worldview.

This study implies further questions; in whether there are gendered elements and whether matching the culture of therapists and clients should be extended to other minority groups in order to enhance both therapeutic dialogue and outcomes.

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## **Acknowledgments**

Firstly, I would like to thank my parents for instilling within me the desire to seek and be curious about the world around me. I thank my sister Qamer and dearest friend David profusely for being the voices of reason during this arduous journey. I thank my cousin Mohsin for keeping me grounded and encouraging me to look ahead.

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## **Reflexivity**

The first section of this review will explore literature relevant to Pakistani Muslims (PM) in the UK related to culture, religions, language and acculturation. This will be followed by an outline of research related to the psychological wellbeing of PMs in the UK followed by literature related to which methods of therapy are currently being employed with SGPMs both in the UK and overseas, particularly in light of modality and the concept of ethnic matching. These will be explored from the therapists' perspectives as well as a narrower focus on research reported about cultural and professional identity.

This will be followed by a discussion on Methodology and the rationale for adopting a qualitative research methodology including ethical considerations and the analytical process. The Analysis section will draw from all six accounts of participants inclusive of analytical and reflexive processes, followed by a Discussion of the unique findings extracted as well as convergences and divergences with literature. It is hoped that the reader will consider their experience as traversing a map with the researcher. A Reflexive statement will be introduced first.

### **Reflexive Statement Part 1**

I am a 33-year-old female, born and raised in the U.K., of parents who migrated from Kashmir to the U.K. in 1969. This reflexive statement offers my personal position as a pretext to the exploration of the perspectives of Second-Generation Pakistani Muslim (SGPM) therapists working intra-culturally with CBT.

I was raised in a Muslim household wherein Islamic and cultural teachings conflatedly indented everyday practices such as praying, avoiding alcohol and obedience to elders, which have resultantly governed much of my adult life. Upon becoming a trainee Counselling Psychologist, I questioned a lot of what culture and religion had taught me. Having dissociated the two, I have felt more affiliation with the latter than the former due to its universal applicability, whereas culture is far too bound by geography or traditions that I lack a proximity to.

In discussions with my (non-ethnically similar) peers or other practitioners who were interested in my experiences, they would often be unable to tell the difference between cultural traditions and

religious teachings. Having had experienced religion and culture as overlapping modes of conduct for most of my life, the concept of religion and culture as binary entities began to tickle my curiosity. In my journey to redefine these parameters, I had to look at my life in London, and my mother's - as a first-generation immigrant to the UK - both PMs but coloured by culture and religion to varying degrees. For my mother's generation, religion and culture had a comfortable coexistence, without much question or critique, whereas my worldview had the added vantage point of British culture through which I began to critically assess religion and culture as disparate constructs. For example, the conduct of a woman is defined differently through Islam, South Asian culture and British culture so it became easy to see the nuances. These experiences made me wonder how culture and religion are experienced in the therapy room and how these values interact and manifest, particularly in light of CBT as the main psychological intervention (NICE, 2009).

I am aware that the researcher's inevitable entrenchment in the research process increases the likelihood of certain characteristics to become muddled with subjectivity. The concept of reflexivity entails neutrality (Ritchie et al., 2013) and an awareness that biases may arise. I witnessed a tendency to select literature which would affirm a preferred outcome; such as evidence to suggest that culture and religion are indeed important topics to differentiate in therapy and the staunch belief that all PMs would want to explore this. In an attempt to bracket my assumptions towards this research topic, I undertook a reflexive journal throughout in order to adopt an objective stance (Smith, Flowers & Osborn, 2009) as well as speaking with my peers and colleagues to promote transparency (Larkin & Thompson, 2012).

My first experience of working with an ethnically and religiously similar client gave rise to issues related to parameters and crossing boundaries that, according to literature, is allied with intra-cultural therapy experiences (Toledano, 1996). I had a tendency to self-disclose in instances where I thought this may facilitate the therapeutic relationship. Upon reflection, this was more to do with the sharing of similar identities and the need to not disappoint having appointed myself a cultural expert. On reflection, I realise I had taken on a responsibility that ignored the boundaries that form the crux of ethical therapy in a professional context (BPS, 2009; 2010) and thus the therapist-client role became tangled. This need to please may stem from my experiences growing up watching my mother negate herself in favour of pleasing others. As respecting one's elders' forms part of my cultural background, I carried this

through my adult life. Age and generation therefore are embedded in my experience of cultural assertions and beliefs, which is why I may have desired to explore generation as a factor for my current topic. In the initial stages of my research, I found myself inadvertently selecting literature pertinent to second generation Muslims. Had this remained the case, it could have impacted the process by affirming pre-existing beliefs and negating literature on first generation experiences, thus validating my own personal need to perhaps feel assurance in choosing the “correct” area to research. Seeking counsel from my supervisor and peers, I noticed this and began to widen my scope to incorporate broader reading into first generation experiences.

Reflexivity and personal therapy have helped me to maintain a reflexive outlook in a conscious effort to situate the clients’ experiences in an empathic, inquisitive and tentative manner.

## Chapter 1. Introduction

Throughout this review, the term ‘South Asian’ denotes individuals from Pakistan, India and Bangladesh; ‘first generation’ refers to individuals born overseas and have since migrated to the UK; ‘second generation’ refers to individuals born in the UK to first generation parents; ‘therapist’ is used in place of Counselling Psychologist despite this research being primarily devised from a Counselling Psychologist angle. This is so that all other allied professionals can be included in this study. Terms such as ‘therapist-client matching’; ‘sameness’; ‘matching’; ‘ethnic similarity’ are used interchangeably to express the plethora of ways in which matching has been understood and outlined in the literature. The term ‘matching’ describes the process through which the client is allocated a therapist based on commonalities such as ethnicity, religion, language, gender or sexual orientation. Given the scope of the present study, the focus will be on ethnicity and religion.

Pakistan’s population is at about 220 million (Worldometer, 2020) with the majority of Pakistanis being Muslim. The two official languages of Pakistan are Urdu and English, and the four major ethnic groups are Punjabi (55%), Pathan (12%), Sindhi (18%) and Baluchi (3%). Since acquiring sovereignty in 1947, Pakistan has experienced significant political, social and economic disturbance since the 1960’s resulting in waves of migration to the UK. Tabassum, Macaskill and Ahmad (2000) reported high levels of psychological distress for immigrant Pakistanis to the UK, such as social isolation, language barriers and alienation. Statistics have shown an increase in the number of PMs in the U.K. from 747,285 in 2001 to 1,175,983 in 2011 (ONS, 2011). This is relevant as it suggests a potential relationship between the socio-cultural history of Pakistanis in the U.K. and some of the current issues with psychological wellbeing in this community today.

Indigenous healing traditions are practiced by Pakistanis all over the world (Rathod et al., 2013). Faith and religious healers are prolifically used for psychological and relationship problems (Farooqi, 2006) for reasons related to affordability, family pressure, community beliefs and proximity (Shaikh & Hatcher, 2005a). This indicates that religion and spirituality have a prominent role in the concept of healing for Pakistanis. It is known that faith healers in the community are usually a first port-of-call when issues arise (Naeem et al., 2015).

To achieve a consensus on the definition of culture is nearly impossible (Segall, 1984) but can be considered socially-driven, whereby ways of living, beliefs and attitudes are generated and passed down generationally (Craig et al., 2012; Rohner 1984). Ethnicity is reported to have a relatively similar meaning to culture and can stem from one's nationality, where one was born, as well as a common history shared through heritage (Craig et al., 2012). For SGPMs, the pressure becomes greater in trying to preserve Pakistani culture whilst also assimilating Western norms, values and expectations (Hutchison et al., 2015). This has been reflected in studies whereby affiliation to one's own culture has been deemed compromised in order to fit into the dominant host culture (Dhillon & Ubhi, 2003; Jacobson, 1997). For example, Furnham and Sheikh (1993) reported higher stress and depression in second generation immigrants of South Asian descent, living in the UK, than in first generation immigrants. It was noted that one of the difficult challenges was the pressures associated with conformity to one's origin culture while attempting to assimilate into a Western way of life.

These studies suggest a considerable difference between first and second -generation experiences. This can be explained by Breakwell's (2015) Identity Process Theory (ITP) that states a strong sense of self, underpinning psychological well-being, is dictated by distinctiveness, self-esteem and consistency. It is possible then, that when a social structure goes against an individual's sense of identity, this might create a response that triggers threat. For many SGPMs the struggle to navigate the multiplicity of cultures inflecting their lives becomes pertinent in therapy (Naeem et al., 2011).

Zaidi et al. (2016) researched the experiences of South Asian youth and emphasised the difference in parental role in the Eastern collectivist cultures versus Western individualism. Due to the strong presence of kinship ties in South Asian culture, the family structure takes precedence over any other relationship. Decisions are almost always discussed collectively and judged in terms of its effect on the wider group (Ayyub, 2000). In this sense, individuals are not considered independent of the larger family unit and traditions are maintained via cultural and social institutions to preserve "izzat" (honour) (Wardak, 2000). Gender socialisation is integral to the PM culture, particularly for immigrant families outside of Pakistan. Children, especially girls, are socialised according to the patriarchal cultural and religious diktats that are embedded as unbending do's and don'ts within the society (Dwyer, 2000). This is relevant to the current study as it provides a backdrop against which the ethnic similarity manifests.

Laungani (2005) supports Zaidi et al. (2016) and states that PMs collectivist culture is associated with the collective membership to the Muslim community (Ummah) stressing a “we” approach to responsibility, emphasising the rights of a community before the individual.

### **1.1 Psychological Wellbeing of Pakistani Muslims in the UK**

Literature pertaining to PMs in mental health services in the UK is limited, particularly from the perspective of the PM therapist. However, a number of studies have explored the experiences of South Asians. It has been stated that UK mental health services are not suitably addressing the cultural and religious needs of the South Asian community (Bowl, 2007; Netto, Gaag & Thanki, 2006). Considering the South Asian Muslim population continues to grow, particularly those belonging to a Pakistani heritage, the challenges of providing culturally suitable psychological therapies is ever more important. Bowl (2007) reported that one of the reasons South Asian communities underutilise therapy is due to a fear of being discriminated against or stigmatised by mental health therapists. For fear of inviting cultural shame (Leong, Kim & Gupta, 2011), South Asians postpone seeking treatment for mental health issues until it becomes severe (Sue, Cheng, Saad, & Chu, 2012).

Tabassum, Macaskill and Ahmad (2000) qualitatively studied the mental health issues and needs of first- and second-generation participants in Pakistani families in the UK. Language, stigma, cultural and religious practises were highlighted as barriers to seeking professional help. Notably, the voices of therapists were absent from Bowl’s (2007) research and there was limited discussion on how the modality may have impacted the outcomes. Future research may be able to provide insight into the views of SGPM therapists practicing CBT, particularly as Counselling Psychology values and seeks to address the needs of all individuals (Strawbridge & Woolfe, 2010).

So far, we have learned that there is limited research on PM therapists, particularly on how religion and ethnicity may impact the therapeutic process and concepts surrounding the “same” and the “other” (Sue, 1998). This area poses a gap in the knowledge and warrants attention as more minority therapists enter the field.

## **1.2 Culture, Islam and Therapy**

The Muslim population in Britain is ethnically diverse with three quarters of Muslims arriving from South Asia and are predominantly Pakistani (43%), compared to Bangladeshi (6%), and Indian (8%), (ONS, 2011). Islam is a monotheistic faith whereby its followers (Muslims) worship God ('Allah' in Arabic) as the creator of the universe and believe that the Quran is the word of God (Haque & Kamil, 2012). Researchers have found a direct link between the emotional well-being of Muslims and Islamic beliefs (Ali, Liu & Humedian, 2004). Religious beliefs play a prominent role in providing psychological treatment (Weatherhead & Daiches, 2010). For the majority of Pakistanis, Islam offers societal boundaries; parenting styles; education; relationship conduct and mental health treatment (Datillio & Bahadur, 2005) and so is viewed as a comprehensive manual facilitating every facet of life.

## **1.3 Gender, Culture, Islam and Therapy**

Although gender is not a primary focus at this stage, it is anticipated to be of interest at analysis stage and so some literature on gender and culture would be worthwhile.

Research shows that generational and gender differences exist where second generation South Asian female clients perceive counselling with more optimistic attitudes compared with first generation South Asian males (Panganamala, 1998; Goodwin & Cramer, 1998). Negative attitudes are considered to be derived from the expectation and worry of feeling shamed, marginalised, unaccepted and understood poorly in therapy (e.g., Newham Innerscity Multifund and Newham Asian Women's Project, 1998; Bhugra & Hicks, 2004). As a result, many South Asians hold onto alternative coping methods such as through family, friends, and religion (Hussain and Cochrane, 2003). This research contributes to comprehending the fears, expectations and needs of the community at large.

A recent study carried out by Soorkia et al. (2011), using quantitative methods, identified gender differences when exploring attitudes towards help-seeking. Female participants held more positive beliefs towards psychological help as compared with males. This was also predicted by the relationship between help-seeking and adherence to one's cultural set of values, suggesting that the more therapy was considered a process committed to incorporating the client's cultural values, the more positive the attitudes held. This has been supported by authors who have discussed the importance of cultural

competence in therapy (Patterson, 1996; Sue, 1988; Betancourt & Lopez, 1993). Soorkia et al. (2011) also reported this to be the case for all Indians and Pakistanis (and other South Asian clients), illustrating homogeneity between communities.

Hamid et al. (2009) identified that matching clients to therapists based on gender, for the South Asian community, may be conducive to encouraging more positive experiences and attitudes towards therapy. This is because gender-matching may reduce concerns around being judged or misunderstood. Moreover, stigma in relation to men seeking psychological help is prolific in the community. However, practitioners are cautioned to be mindful of making assumptions and over identifying which would require reflection, as is the case with matching on any other basis (Hamid et al., 2009). Furthermore, in-group differences exist within the broader South Asian community and so these must be considered when working with clients (Betancourt and Lopez, 1993). Additionally, generational differences may colour the experiences of therapy for clients of this background; cultural values differ in accordance with acculturative factors (e.g. relationship with family, elders, the community; beliefs about education, etc).

The study nonetheless puts forward important implications in the way of inviting cultural values into the therapy process and potentially bridging the gap between what mental health services represent and the wider community (Ibrahim, 1985; Sue, 1988).

Literature exploring gender and matching in therapy have found that female service users experience a higher level of understanding and satisfaction when engaging in therapy with a female therapist. This is not however the case for male clients (Flaherty & Adams, 1998). Pattee and Farber (2008) investigated gender roles with just over 200 patients by exploring their experiences of self-disclosure in therapy. They found that female clients seen by female therapists experienced more distress in disclosure than male clients with female therapists. In addition, therapists who were seen as flexible in identifying specific gender roles attained greater levels of openness with clients compared with those who were recognised as having more traditional gender roles. Blow et al. (2008) held the notion that gender-matching has no impact on the therapeutic process or outcome as supported by Sterling et al. (1998) and Okiishi et al. (2006). A greater need to investigate gender matching is required due to inconsistencies in research. In contrast to ethnic matching, distinctive views are found when considering matching based on gender. It has been reported that gender has no implication or impact on the therapeutic process (Blow et

al., 2008; Okiishi et al., 2006; Vociscano et al., 2004). Literature suggests that the impact of gender may be significant when in place with another level of matching, such as ethnicity.

Tarabi (2016), in his research on Pakistani Muslim Men and the experience of CBT, discussed gender related expressions of distress as being profoundly different between men and women in Pakistani culture. Muslim families are generally patriarchal (Al Hashimi, 2005) with the woman generally being responsible for child-rearing. Moreover, women are discouraged from interacting with men outside the family without supervision and any breach of family honour in relation to men (kissing, hugging, sexual behaviour) is taken seriously. El-Islam (2008) discussed Arabic women in certain cultures not being permitted to talk about their emotions in the presence of strangers, including mental health practitioners.

Tarabi's (2006) study revealed the views that Pakistani Muslim men hold in relation to cultural responsibilities and masculinity which are passed on almost hereditarily. Therapy is thus a manifestation of battling two different personalities – the values of their host culture and that of those of their ethnic background. How women and men interact and how they engage in the therapeutic space is markedly influenced by gender roles in Muslim dominated communities (Ahmed and Amer, 2012). The restricted interactions between men and women, enforced by readings of Islamic rule can be a barrier that limits access to therapy. In addition, Call and Shafer (2018), and Dwairy (2006) reported that men's mental health issues are considered more understandable, by way of stress at work or home, whereas women with mental health problems are considered "crazy" or "mad". Further, men are able to attend therapy more discreetly whereas women would find it more difficult to seek help due to needing permission from their partners. It is interesting that elsewhere in literature, in relation to BAME community groups and communication emotional distress, that clients tend to somatise their symptoms – a socially and culturally recognised behaviour in BAME communities.

In sum, the role of gender and culture in therapy is of significance, particularly when working alongside adherence to religion and acculturation. Given that the views of PM therapists are also absent from scholarly research, this review will focus on the experiences of SGPM therapists and the use of CBT, considering this is the treatment of choice (NICE, 2009) in the National Health Service (NHS). The next section will explore culture, Islam and modality in order to understand how different modalities seek

to explore issues of an Islamic or cultural nature with an emphasis on the effectiveness of CBT and its particular congruence with culture and Islam.

## **Chapter 2. Culture, Religion and Therapeutic Modality**

### **2.1 Therapy with Pakistani Muslim Clients - Mainstream Modalities**

According to Moodley, Rai and Alladin (2010), modern psychology emerged as a scientific discipline and devoted itself to encompassing the values of empiricism and objectivity. Theories such as psychoanalysis, humanistic psychology and cognitive psychology were utilised by practitioners, including Muslim psychologists, worldwide and assumed to be universal (Abdullah, 2002). Haque (1998) argued that since modern psychology assumes human behaviour to be observable and therefore measurable, it neglects the spiritual aspect of individuals which Islam upholds. These concerns therefore raise questions regarding which type of therapies are consistent and compatible with cultural worldviews of Muslims (Shah, 2005).

However, it would be naïve and reductionist to assume that all approaches offer secular solutions only, nor is it appropriate to assume that modern psychology has not made any contribution to Muslim mental health (Lines, 2006). However, a huge disparity remains as to how a particular modality is experienced. For this reason, we require an understanding of how religion and culture are experienced from the perspective of the PM therapist. Additionally, it would be worthwhile exploring the intra-cultural dynamics between the ethnically and religiously similar therapist and client within the CBT dynamic (Naeem, 2011) to appreciate the nuances within ethnic homogeneity.

In order to understand how to address the needs of PM individuals, it is vital to understand the three main modalities used across the UK Psychodynamic, Humanistic and CBT in relation to culture or Islam (Norcross, 2005).

### **2.2 Psychodynamic Approach**

Some scholars have postulated that psychodynamic therapy is beneficial for ethnic minority groups, particularly immigrants, considering the multiple layers of cultural identity and acculturation effects (Tummala-Nara, 2011). Moreover, interpersonal relationships and valuing cultural history underpin Pakistani culture, and are also key facets of psychodynamic therapy. Psychodynamic therapy sensitively addresses the complexity of cultural expectations that are often prevalent in profound

intrapsychic conflicts and crucial in understanding the individual (Roland, 1996). Not only is there a hesitance in needing external help but also a scepticism in general about the psychotherapy process, considering the lack of a similar process in the South Asian world until recently (McGoldrick et al., 2005; Tummala-Nara, 2013).

In the context of Pakistani culture, it is unsurprising that the therapist is viewed as a “helper” or “guide” and in this sense, the depth, transparency and longevity of psychodynamic therapy may be at odds with what can be seen as a prescriptive culture. It warrants repetition that for many PMs there is a cultural context that needs to be respected and worked with, which, contrary to popular belief, psychodynamic is capable of.

The psychodynamic approach also acknowledges the interdependent nature of the PM’s relationships and the importance of the family role (Jayakar, 1994). Though psychodynamic therapy lends itself to a holistic view of the PM culture, there is still a lag in applying therapy from a culturally sensitive perspective.

### **2.3 Humanistic Approach**

Rather than perceiving the therapeutic modalities as vastly distinct and separate, it is perhaps more conducive to view them as complementary offshoots of a whole. Humanistic psychotherapy focuses on fully realising the human potential, self-actualisation and becoming an active agent in shaping one’s environment (Raskin, Rogers & Witty, 2014). One could argue that these qualities are in line with cultural competency. Interestingly, ethnic minority therapists have been drawn to humanistic psychology (Jenkins, 2001) suggesting a symbiosis between the particular practitioner and the practice.

While this approach might transcend issues related to culture and religion in favour of a more rational approach, it can still be very respectful and one of the most enabling models that can work with difference and diversity. Muslim clients, particularly South Asians, expect direct advice from an expert when in therapy (Dwairy, 2006). An exploratory and indirective therapy may therefore be met with scepticism from PM clients. For this reason, there is growing belief that psychodynamic and humanistic approaches may not be suitable for the majority of PM clients (Ahmed & Amer, 2012; Haque, 2004) and are more likely to benefit from action focused approaches such as CBT (Elliot et al., 2004).

## **2.4 CBT**

CBT has been recognised to meet the Positive Practice guidelines (Stiles et al., 2008) developed for ethnic minority clients, rendering it culturally competent. However, CBT has been referred to as a “Universalist Service” (Levinson & Rodebaugh, 2012), based on the premise that problems can be understood using a standard framework of ideas (Falicov, 1995). The origin of CBT stems from randomised controlled trials primarily on non-minority, Caucasian middle-class participants (Miranda et al., 2005). Thus, this would have been deemed the dominant social group and their values (individualism) may have been considered the barometer on which CBT would be applied (Hays & Iwamasa, 2006). Therefore, as Smith (2008) argues, variables such as ethnicity, race, religion and class may not have been given consideration.

However, the inclusive approach taken in CBT makes it co-function with an Islamic framework, as it takes into account cultural and religious nuances when practiced correctly (Carter & Rashidi, 2004). This has proven difficult to locate in literature as research tends to concentrate on the clients’ perspective or those who are secular working with this population. The limited literature that has explored CBT as experienced by Muslim Psychologists has tended to investigate Muslims from a broad perspective rather than focusing specifically on a particular culture (Beshai et al., 2013; Mir et al., 2015; Waller et al., 2010).

While it would have been interesting to explore additional modalities, CBT is the most commonly used model in the NHS (NICE, 2009) and most effective psychological intervention for a variety of presentations (Linehan, 1993; Wells & Leahy, 1998). It is worth noting however that this does not exclude other therapies in their capacity to be congruent with PM’s. The next section will explore studies related to the use of CBT when practiced with Pakistani clients.

## **2.5 CBT with Muslims**

This section will look at studies that explore the effectiveness of CBT practiced with cultures different to the dominant Caucasian model on which CBT was founded. Although it is recognised that CBT cannot be adapted for all cultures or religions (Rathod et al., 2013), certain studies have looked at the concept of adapting CBT to work with minority clients. Cultural adaptation refers to the modification of

therapy in order to meet the individual and collective needs of patients, taking into account religious and cultural factors.

A large portion of published literature has focused on the adaptability of CBT to individuals from Judaeo-Christian backgrounds (Pecheur & Edwards, 1984) with a few who have explored the usefulness of CBT with Muslims, predominantly more in the USA than in the UK (Mahr et al., 2015; Naeem et al., 2015; Rathod et al., 2013; Razali, Aminah & Khan, 2002). This section of the review therefore explores literature on the effectiveness of CBT for Muslim clients and then narrow this down to CBT for SGPM clients with some discussion around therapist perspectives.

It has been noted that Islam and CBT can complement one another as they share common features such as the focus on education, rational discussion and forward thinking (Hodge & Nadir, 2008). The Islamic faith advocates for reflection (“dhikr”) and setting goals as a means to encourage behaviour change, which seems to be in line with the philosophical underpinnings of CBT as it reflects the notion of reason and rationality (Carter & Rashidi, 2004) and the individual being responsible for how they direct their existence.

However, there can be a divergence between Islam and CBT, considering Islam, and many faiths that hinge on the concept of an afterlife, tends toward an eschatological trope in which death and final destiny are promoted as a promise for the believer as a reminder of this life’s temporariness. Against this spiritualising, the Muslim mindset may have already compartmentalised their issues as a given or a ‘test’ that may not necessarily be resolved in this life. The very semantics reinforce this acceptance, given that ‘Islam’ means ‘submission to the will of God’ and so for a therapist to traverse this submission through CBT may require a level of critical thinking with the PM client. Equally, Islam’s eschatological reasoning can be utilised in CBT by addressing the promise of an afterlife as a salve for the present issues being faced (Sabry & Vohra, 2013).

## **2.6 CBT with Pakistani Muslims**

A smaller number of studies have explored the suitability of CBT for PMs. Naeem and colleagues used thematic analysis to look at therapist-experiences of providing CBT in Pakistan (Naeem, Gobi, Ayub & Kingdon, 2010). All therapists in the study agreed that CBT was not fit for use with clients

in Pakistan who espouse mainly a collectivist cultural outlook. Although modifications were said to be necessary, it was unclear as to how therapists experienced CBT with their clients or how they modified their approach. The interviewed therapists held qualifications that were not formally accredited and were only trained in Rational Emotive Behaviour Therapy (REBT); since this has similarities with CBT, the authors decided to proceed with the interviews. Yet the plausibility of this study remains under question given that the participants were all recruited from one city and state hospital which may have compromised generalisability – particularly in Pakistan where socio-political factors differ greatly according to the different provinces.

Naeem, Waheed, Gobbi, Ayub and Kingdon (2011) conducted another study one year later in Pakistan. Culturally-adapted CBT refers to addressing treatment challenges with ethnic minorities and refugee groups and includes adaptations of core CBT techniques (Hinton et al., 2011).

Naeem and colleagues showed culturally-adapted CBT to be effective with reducing symptoms of anxiety and depression. However, as with their previous study in 2010, no information was provided as to the therapists' experiences and practise of modifying CBT.

Most importantly, Naeem and colleagues highlighted a key issue to consider when working with PMs in the West:

*'A Pakistani therapist working with Pakistanis is more likely to be aware of the cultural and religious factors and can easily adjust therapy compared with a therapist from a non-Pakistani background, who might not be aware of the patients' culture and religion'* (Naeem et al., 2015. p.5).

This statement foregrounds the importance of ethnic matching between therapist and client, which will be explored in depth with this review. Reporting on the mental health situation in Pakistan, Irfan et al. (2017) suggested that cultural adaptation of CBT is not merely a matter of translating from a therapy manual but rather involves various facets of therapy. The 'Triple A' principle was thus formed and referred to: Awareness of cultural issues; engagement during Assessment; Adjustments in techniques. These entail cultural, linguistic and family related issues, all of which are believed to play a crucial role in helping therapists and clients understand one another and in the delivery of effective therapy.

Considering Padesky and Greenberger's (1995) stance that dysfunctional beliefs and cognitive errors may fluctuate from culture to culture, research into Pakistani people has highlighted that beliefs related to dependency on other people, pleasing people, submitting to demands of loved ones and sacrifice in the name of honour and integrity for the family's sake, are commonplace beliefs in the PM community. As a result, Irfan et al. (2017) encourage an exploration of the systemic nature of the individual's context to assess the cultural context of these beliefs. Interestingly, they suggested utilising the Asian model of spiritual healing (stories and images) rather than applying CBT mechanically to presented physical symptoms. Since healing systems in Pakistan are underpinned in spiritual, psycho-social and biological traditions (including Greek, Chinese, Bhuddist, Indian and Muslim traditions), it is advised that these are used alongside CBT and other Western modalities in order to help clients achieve spiritual needs.

The next section will look at studies exploring CBT with PMs in the UK and further highlight the concept of modifications to CBT with this group.

## **2.7 CBT with Pakistani Muslims in the UK**

Rathod, Kingdon, Phiri and Gobbi (2010) took an ethnographic approach to studying the experiences of (predominantly white) CBT therapists in the UK. As with Naeem et al.'s (2011) study, interviews explored the positive and negative experiences of using CBT with Black, Asian and Minority Ethnic (BAME) clients and whether or not the CBT manual was used. Although South Asian Muslim participants were studied, it constituted of Bangladeshis and Pakistanis. As we know, cultural diversity exists amongst Muslims, so a uniform exploration of Pakistanis, or any other Muslim culture for that matter, may have shed light on some of the intracultural differences.

Interestingly, the non-Muslim therapists believed that CBT does not need to be changed to suit BAME groups and that this modality was the "same for everyone". In the same study, religion was also avoided as the non-Muslim therapists thought they had limited knowledge. Whereas had the SGPM therapist's perspective been at the helm of such a study, inevitably they would possess the cultural knowledge required to facilitate a successful outcome.

Rathod et al.'s (2010) study recognises that modifying CBT is necessary but we know little about the therapists' motives in doing so. As a follow up, Rathod et al. (2012) conducted a randomized control

trial (RCT) assessing the feasibility of modifying CBT for psychosis. They compared treatment as usual (TAU; pharmacotherapy and psychiatric reviews) with a culturally adapted CBT for psychosis and found that adopting a different CBT for each cultural group is not feasible, despite positive outcomes. The authors noted that a qualitative approach may delve into the experiences of therapists when delivering CBT in a modified way which may play a role in successful therapeutic outcomes. For instance, in Naeem et al.'s (2010) qualitative study, tweaking therapy may have been based on the cultural or religious identity of the PM therapists and their knowledge of the two which may make adapting therapy easier with culturally-similar clients. Only CBT therapists were interviewed whose training may be different from that of other therapists. Therapists from broader training backgrounds may be more in tune with the need to adapt or integrate therapies which may be even truer for the SGPM therapist practicing CBT, thus possibly making them better positioned to be culturally sensitive.

To varying degrees, all of these studies have highlighted the necessity to modify CBT for ethnic minorities, namely PMs. The outcomes from these studies have formed a framework which is currently being used in Morocco, China and the Middle East and have proven successful; though to date, nothing has been established for similar utilisation in the UK (Naeem et al., 2015). These studies also illustrate that it would be presumptuous to believe that individuals from any given culture are identical, therefore, flexibility and cultural adaptation is required. Additionally, the guidance appears to be geared towards CBT therapists, neglecting the vast array of Applied Psychologists and practitioners who practice CBT and who may be able to contribute a more reflexive outlook on diversity (Strawbridge & Woolfe, 2010).

By focusing more on the therapist's perspective, it will allow an understanding of the points of contact/detachment between CBT and the values of a PM therapist. To summarise, UK-based PM therapists have used CBT in a modified way, perhaps to match their own values and beliefs. These studies suggest that it could be beneficial for therapeutic outcomes but do not highlight how therapists experience this, which makes it worthwhile to look at what happens to the PM therapist practicing CBT.

## **Chapter 3. Ethnic Matching**

### **3.1 Therapist-client matching based on ethnicity**

Since the mid 1970's, there has been an upsurge in literature on the role of ethnicity and culture in psychotherapy. Farsimadan et al. (2003, 2007, 2011) reached a conclusion that most ethnic minorities prefer an ethnically similar therapist over an ethnically dissimilar therapist. However, she further suggested that the results might also be confounded by significant within-group variability (level of acculturation, cultural mistrust, cultural commitment, presenting problem). Prior to this, there have been some interesting archival studies which imply ethnic non-matching has an unfavourable effect on outcome and increases the rate of early client dropout (Beutler et al., 1994; Flaskerud, 1991; Sue, 1977; Sue, 1998; Sue et al., 1991). For instance, Flaskerud's (1991) study explored a large number of records of Asian American clients in Los Angeles' mental health facilities between 1983 and 1988; it was discovered that ethnically matched dyads had both lower dropout rates and clients attended more sessions. A myriad of suggestions have been put forward as to why this might have been. For instance, Patterson (1978) suggested language barriers or barriers to empathic understanding. Sue (1977; 1987) suggested that this might be a function of the therapists' inability to respond to the varying expectations/needs of ethnic minority clients. Karlsson (2005) however has criticised the aforementioned studies on the grounds that they do not entail any measure of process or effect of demographic factors.

There are also a limited number of studies drawing data from clients and therapists examining ethnic similarity, working alliance and therapeutic outcome, but which render inconclusive findings (Ricker et al., 1999; Erdur et al., 2000). This is presumably due to samples constituting American younger college students who are presumably more acculturated, culturally conscious, of higher socio-economic status than the rest of the population and who have partaken in very minimal sessions. Therefore, these findings may underestimate the strength of intra-cultural preferences as well as inter-cultural negative perceptions in other parts of the population both inside and outside of the U.S. Moreover, data from the therapist's perspective seems to be ignored which the present study hopes to illuminate.

Farsmaddin (2005) attempted to address some of these problems by exploring the effects of ethnic matching on both process and outcome in a large sample of therapeutic dyads from a client population in the UK. Their sample comprised of Indian, Pakistani, Bangladeshi, Black and Middle Eastern clients. It was found that ethnic matching was the single predictor of working alliance, therapeutic outcome as well as perceived therapist credibility. Moreover, it was discovered that the process mediates the relationship between matching and outcome.

This study is of particular interest as it only included therapists from ethnic minorities, which was posed as a criticism by some but highlights some of the inter-cultural differences. However, the study focuses on a range of cultural backgrounds whereby it could be argued that clients from different cultures may face different kinds of difficulties with therapists. Furthermore, the sample consisted of clients only and so the voices of therapists working in ethnically similar dyads are not accounted for.

In 2011, Farsimaddin and Khan reviewed the research in relation to ethnic matching between therapist and client on therapy process and outcome, with a particular critical focus on reviews and meta-analyses (including Karlsson's, 2005). In looking at archival studies – which benefit from higher ecological validity – found that when accompanied by linguistic matching, ethnic matching significantly improves and increases duration and therapy uptake and reduces premature drop-out. For example, Flaskerud (1986) examined case records of 300 Asian-American, African American, Mexican and White clients in 4 community mental health facilities. Ethnic and linguistic matching were found to increase retention and significantly reduce drop-out rates. Flaskerud and Liu (1990) later examined files from 1,746 Asian American clients and found that both ethnic and linguistic matching increased attendance. In another study on Asian American women, Fujino et al. (1994) discovered that both gender and ethnic matching were significantly associated with reduced dropout rates and increased treatment retention.

In one of the very scarcely available randomised control trials available, Matthews et al. (2002) studied the effect of ethnic matching among around 6,000 inpatients by assigning Asian-Americans, African-Americans and Hispanics to three psychiatric inpatient units which are ethnically focused. For Asian-Americans and Hispanics, matching was associated with a significant increase in accepting residential or outpatient treatment referrals and a lower likelihood of referrals for locked facilities.

Regarding ethnic and linguistic matching, archival studies have shed light on improved outcomes for some groups. Sue et al. (1991) discovered that ethnic matching (except for African Americans) led to longer treatment and lower dropout but for Asian- and Mexican-Americans who were non-native speakers of English, ethnic matching had a significant effect to a clinically relevant degree. Granted, most archival studies were conducted in the U.S, however, in Australia, ethnic matching has also proved to be significant. Ziguras et al. (2003) examined ethnic matching in clients (Greek, Italians, Vietnamese, Macedonians) from a non-English speaking background with bilingual clinicians and found longer and more frequent contact with care teams and fewer contacts with crisis teams. Linguistically matched clients also benefited from fewer hospital admissions than even Australian-born clients.

Similar results of ethnic matching for minorities are also reported in studies of young people. Yeh et al (1994) examined up to 5,000 young Caucasian-, Mexican-, Asian- and African American clients and found that while ethnic matching did not significantly impact children, it predicted dropout and duration to a significant degree in adolescents.

It appears that samples constituting Caucasian-Americans and African-Americans do not benefit from ethnic matching perhaps due to belonging to the same mainstream cultural and linguistic group less than other minority groups. This could be the case for ethnic groups in the UK but there is limited literature to support this. However, to firmly conclude that ethnic matching is clinically irrelevant for African and Caucasian-Americans would be hasty. Shin et al. (2005) and Gamst et al. (2000) argue that results for African-Americans were perhaps affected by greater psychological and social problems as compared to other minorities, as well as there being a paucity of African-American therapists in mental health services. Matching may be more conducive for African-American clients who espouse their racial identity and reject White American values. It is therefore perhaps noteworthy to control for racial identity status when studying preference for ethnic matching (Gamst et al., 2000).

In regard to the U.K, in 2007, Farsimadin examined the effects of ethnic matching on therapy outcome, working alliance and perceived therapist credibility over time in 100 ethnic minority clients based in London. Clients were South Asian, Black African and Caribbean, and Middle Eastern. Clients in matched dyads conveyed a preference for matching, particularly between 6 and 12 sessions, suggesting

that the quality of process was determined early on in therapy. Outcome and process were significantly better in matched dyads than unmatched with marked effect sizes.

A number of qualitative studies have contributed to a detailed understanding of the role of ethnic matching in therapy. When enclosed within the wider picture sketched by quantitative data, qualitative data can yield a richness which can be useful for practitioners. Chang and Berk (2009) took a qualitative approach to compare the experiences of satisfied and dissatisfied clients from Latino, Asian and mixed-race ethnic minorities in the city of New York, U.S who saw a Caucasian-American therapist. Differences were centred around expectations, emotional connectedness, therapy ending and interest in the therapeutic relationship. Interestingly, clients who were satisfied did not cite issues with therapist cultural competence, but this was prominent for clients who were dissatisfied. Satisfied clients expressed the significance of therapeutic skills over ethnic differences but did report alienation from their own ethnic group, pigeonholing ethnic differences away from therapy and some identification with the therapist. Chang and Berk (2009) conclude that despite core therapy processes being 'universal', "...the dynamics of racial/ethnic mismatches introduce unique challenges to the therapy relationship that may require attention and flexible adaptation of basic therapy skills" (p.532). To this end, the current study hopes to explore some of this uniqueness and to understand why/how this flexible adaptation takes place from the therapist's perspective.

Farsimadin (2002) used IPA with twelve matched clients from several ethnic minorities in London (Indian, Pakistani, West Indian, Nigerian, Iranian, Lebanese, Iraqi). Participants reported positive experiences of therapy in relation to sharing the same ethnicity, same-gender experiences and therapist maturity. For South Asian participants in particular, relationship and family issues determined their choice of an ethnically matched therapist. Khan (2005) used the same methodology to study the experiences of south Asian clients in London who ended early in treatment with a white psychodynamic therapist. Identified themes included: portraying a socially desirable self, wrestling with one's culture of origin, secrecy and trust, expectations, therapist empathy and transference/projections. Participants reported that problems arising from these themes led to a withholding of information for fear of judgement. All participants relayed that ethnic background became more prominent when their problems were related to culture. These studies are of particular interest because of their focus on IPA to explore the experiences of

ethnic minorities in London, particularly the latter (Khan, 2005) focusing on South Asians clients. The current study hopes to use the same methodology to shed light on further nuances such as the intra-cultural aspect of the Pakistani Muslim experience in therapy.

To summarise, ethnic similarity can have important clinical implications as ethnic dissimilarity is often accompanied by reduced duration and increased dropout prematurely. When working with ethnic minority client, some authors (e.g., Karlsson, 1995) state that it is not solely ethnic matching that may be problematic and rather target factors such as acculturation level, language, affiliation to one's culture, education, therapist's cultural competence and so on. However, these factors can be considered constituents of ethnicity, rather than independent of it. Were ethnicity to be stripped of cultural, linguistic, religious, etc differences, there would be a scarcity in what is left over besides physical markers of identity (body, facial features, skin, etc) that alone, cannot influence therapy. One may argue that when identified, these differences can be attended do in mismatched and matched dyads. However, qualitative data suggest that when basic conditions such as emotional connectedness, acceptance, empathy, clarity of communication and overall, a positive therapy process is met, ethnic differences do not affect therapy as they don't interfere with these conditions. It remains unclear however, whether this follows the therapist's and/or the client's cultural competence.

Farsimadin and Khan (2011) mark out a couple of interrelated processes that can deem therapy with ethnically different clients problematic. Firstly, clients may seek an ethnically similar or dissimilar therapist with a positive or negative assumption regarding being understood. This assumption may become fulfilled insofar as the client is open (or not) and trusting. Further, it is thought that people naturally give importance to aspects of reality that fit their assumptions/worldview, so in therapy, negative (not entirely conscious) stereotypes about the ethnic background of the other may automatically hinder the ensuing of a positive process. Lastly, due to the differences in how affective information is exchanged and not necessarily because of cultural differences, therapists and clients may fail to understand each other. Cultures can differ in how they deal with similar affects (when they should manifest, ascribing meaning to them, etc). These differences are always being affected by one's cultural milieu throughout development. Such cultural idiosyncrasies can also operate below immediate consciousness and so misunderstandings may develop. This can further be influenced by factors such as intra-cultural differences, the therapeutic

setting and modality used. Since it is recognized that differences occur intra-culturally, this has yet to be explored both clinically and experientially. This research therefore aims to take this into account from the perspective of a specific ethnic and religious group in the UK.

To this end, the next section will look at culture, Islam and CBT when practiced with clients from a similar background.

### **3.2 Culture, Islam and CBT when Practiced with Clients from a Similar Background**

Previous studies have shown an overlap between CBT and PMs such as cultural modifications to CBT, therapist identity and the values inherent in CBT. These seem to suggest that the values of a modality and those of the therapist are somehow involved in why cultural modifications are needed which will now be explored.

In areas where there is a high concentration of South Asian communities in the UK, services have adopted a ‘therapist-client matching’ approach allowing people from South Asian backgrounds to obtain therapy from a therapist who shares the same culture, religion and language (Farsimadin, 2007; Fernando, 2005). This process has assisted South Asians to consider that they are being understood and given the space to self-disclose (Fernando, 2005). Whilst this approach aims to bridge the gap between the mental health services and the needs of South Asians in the UK, a number of risks also arise, including: over-identification; therapist self-disclosure; fear of bringing shame onto the family (Hussain & Cochrane, 2003); difficulty in maintaining boundaries (Eleftheriadou, 2003).

Research into clients’ experiences of ethnic matching however has been manifold. Morrison (1977) suggested that ethnic minority therapists generate a trusting space given the shared background experiences, further supported by Farsimadin et al. (2007) who argued that the ‘sameness’ improved outcome measures of treatment. A recent study on non-matching client-therapist dyads (Asian clients and white therapists) showed that clients did fear they will be misunderstood due to the lack of shared background and did not talk in-depth about their experiences during sessions (Chang & Yoon, 2011). However, it was also found that clients’ concerns could be ameliorated providing the therapist was

compassionate and engaging. Furthermore, some expressed a preference for non-matching therapists to avoid some of the disadvantages such as overidentification.

Mir et al. (2015) conducted a qualitative study on the adaptation of CBT with Muslims in the UK, which entailed discussion on patient-therapist matching. Key findings suggested that religion was often conflated with culture, indicating a need for knowledge of the two disparately. Participants believed that matching brought about more understanding, however, for both Muslim and non-Muslim therapists, there was anxiety around when to discuss religion and the impact on their professional role. Though this disconnect was not explored further, it highlights the nuances that exist in culture and religion that a quantitative study like Cabral and Smith's meta-analytic review (2011) may not have been able to capture. In either case, knowing about this may help us to understand what it is about a therapist's ethnic identity that helps or hinders the therapeutic outcome.

Related to this, if the therapist conceptualises the client's problems in a way that contradicts that client's beliefs (Frank & Frank, 1993), the therapist's credibility may diminish. This highlights that the therapist and client can sometimes be using different criteria of success to judge the effectiveness of therapy (Murase & Johnson, 1974).

Widening the scope of exploration, Chan and Quinn (2009) reported that adolescent patients did not show a preference for an ethnically-matched therapist, regardless of their background and rather stated that they preferred an ethnically-dissimilar therapist due to a fear of speaking to someone from the same community. This is echoed by Netto et al. (2006) who reported that Asian British clients did not want to see an ethnically similar therapist due to the fear of being judged and not accepted. There is a general consensus that to avoid cultural stereotyping and making assumptions, therapists who work with ethnically-similar clients should be cognizant of their own internalised structure and comprehension of morals, identity and self-beliefs (Ho, 1995).

There is minimal literature exploring therapist-client religious matching but some that pertains to a client-perceived need for religious commonality. Hussain and Cochrane (2002) found that South Asian women with depression believed it was important to have a therapist of the same religion who could help frame their presenting problems in a spiritual and cultural context.

These studies have yielded a need to understand the relationship between religion and culture; the therapist's understanding of their own religion and culture; how the identification of culture and religion in training and clinical practice informs intervention with religiously-inclined clients (Constantine et al., 2000; Walker et al., 2004; Wolf & Stevens, 2001).

Although it has been recommended that a greater level of cultural competency is required during training, irrespective of ethnicity, there is still a dearth in literature regarding the experiences of therapists who match ethnically and religiously with their clients. The present research study aims to contribute to the lessening of this gap.

### **3.3 Challenges of Ethnic Matching**

Ertl et al. (2019) illustrate the impossibility in perfectly matching therapists and clients on every given facet of identity, given the multifaceted nature of identities. Yet even when matching occurs, on any broad religio-cultural level, challenges emerge as a direct result of matching.

In extension to the work of Sue and Zane (1987), Maki (1999) described overidentification as a "felt bond with another person who is seen as an extension of oneself because of a common experience" (p. 141). This is in addition to self-disclosure and the assumptions that are made. As a result, "taking for granted" shared cultural themes are cited as some of the main counter-transference issues that arise in the therapeutic relationship. Maki (1990) explored the experiences of Japanese American and white practitioners and found a high intensity of identification with the sharing of "common ethnic experiences and perspectives that are rooted in a group's particular historical experience...and modified by generational status" (p.68). This meant that the Japanese American practitioners also invested a great deal in Japanese American clients and often spent more time with this group out of interest. Although this study was primarily focused on Japanese Americans, it is nonetheless valuable in understanding the concepts of shared culture, ethnic matching and over identification issues.

Sue (1998) postulated that therapists must be aware when to generalise regarding culture and when to customise the role of cultural values that might be relevant to the client's presentation; thus, avoiding perpetuating stereotypes. This "cultural encapsulation" (Wrenn, 1962) occurs when the therapist unintentionally loses sight of how their own culture can influence their responses to and interpretations of

the client's presentation and narrative, thus going against cultural competence.

A review of the literature thus establishes that using religion in therapy supports clients who have a strong preference for exploring spirituality in session. There is no direct promotion of religious matching but an idea that religion and spirituality are crucial in a therapeutic relationship (Worthington & Berry, 2001). While some may have preferences to be matched (Ripley et al. 2001; Hussain and Cochrane 2002), an emphasis on religious backgrounds as part of training is made. Moreover, when religion and culture are matched together, this is seen as significant to tap into unique elements of the client's world. It would therefore be interesting to explore this angle from the perspective of SGPM therapists using CBT and how their cultural and/or professional identity, alongside the values inherent in CBT, may impact how they perceive their "same" clients.

Reddy (2019) conducted a phenomenological approach via semi-structured interviews with eight South Asian therapists working in South Asian women's organisations in New York. Reddy (2019) spoke of the social and cultural norms that authorise violence in family relationships and the view of the South Asian participants who believed that with a collective voice, this can be tackled. Interestingly, Reddy illustrates the uniqueness of the therapist's positions as also being activists. It seems therefore that for the participants in this study, working with ethnically similar clients went beyond the therapeutic realm and into one of social justice and reform. Central to these efforts was cultural responsiveness and congruency and a need to accommodate South Asian clients who were unfamiliar with Western styles of therapy. Since this study focused on South Asian therapists' experiences in an organisation for South Asian women, it would be interesting to understand how ethnic sameness is experienced in non-homogenous organisations with a focus on PMs as a subsection of the broader South Asian demographic.

The next section will explore studies that go beyond ethnic background and look at the concept of cultural, religious and professional identity of the therapist as potential factors which hinder or improve therapeutic relationships and outcomes.

### **3.4 Identity – Negotiating World Views**

Previous research suggests that PM therapists adapt CBT for similar clients with successful outcomes, but we know less well why these adaptations work. We can assume that the therapists saw the

disparity between CBT and the client with regards to family, community, society etc., which the therapist recognised as relevant to the client. It seems the concept of cultural or religious identity appeared important in this sense, which requires further explication.

Baker and Wang (2004) carried out a grounded theory study looking at Christian clinical psychologists in the UK, and the impact of their beliefs on their clinical work. Results showed that the identities of being Christian and a psychologist oscillated depending on context and was seen as a multi-faceted relationship. Rather than being viewed as difficult, it was this malleable sense of personal identity that was seen as a natural outcome of the confluence between two significant and perhaps “competing roles” (Baker & Wang, 2004, p. 134).

Waller and Gilbody (2009) conclude that CBT therapists, regardless of cultural background, do not fully adhere to the CBT approach due to lack of practice of the model and performance anxiety which causes CBT therapists to abandon its complete acceptance. Waller’s research emphasises that a crucial problem in protocol-driven CBT is that it may not be properly employed by CBT therapists who are experienced (Brosan et al., 2008). This is supported by Naeem et al. (2010) who suggest that CBT therapists working with South Asian clients addressed their concerns by doing what they regarded was suitable rather than following protocol. This raises questions as to the relationship between CBT and the clinicians’ own values and beliefs which will be looked at in the next section.

### **3.5 Professional vs. Cultural Identity**

Some of the studies previously explored highlighted a conflict with Muslim and non-Muslim therapists with regards to the role of religion and culture in therapy. One can assume that there is perhaps a separate but overlapping professional identity at play which may mediate the decision-making to incorporate religion.

Chreim, Williams and Hinings (2007) refer to professional identity as ‘an individual’s self-definition as a member of a profession’ (p. 14). In a field that is predominantly seen as ‘white’ (Patel, 1998), ethnic minority therapists may experience a disparity between their ethnic and professional self, questioning how one conceptualises a particular modality as being congruent with their cultural identity or faith (Goodbody & Burns, 2011).

It has been noted that ethnic minority professionals often undermine the resources that they can competently bring into the therapy room, particularly with a similar “other” (Bell et al., 2003). Nolte (2007) suggested that second generation family therapists who had come to Britain experienced a sense of connection to clients from similar backgrounds as they could understand the clients’ frame of reference – politically, historically and socially. Research shows that BAME professionals who maintain a cultural identity as part of their professional practice led to increased competence in the therapy room (Patel, 1998). However, BAME trainees who are often positioned as cultural experts have experienced resistance, especially as this sometimes conflicts with their subjective beliefs of incompetence (Rajan & Shaw, 2008) leading to fears of being useful only with BAME clients (Burman, Gowrisunkur & Sangha, 1998). If cultural awareness training became mandatory for both BAME and their white counterparts, then the issue of pigeon-holing may reduce as it would be expected that all practitioners begin from a stance of “not knowing” (Toledano, 1996). This would have a tendency to lessen biases or stereotypes that may manifest in a therapeutic encounter.

So far, this section has highlighted that a therapist’s identity, both professional and cultural could be potential factors affecting the therapeutic relationship and potentially the outcome. The next section aims to bring together a summary of the review so far and the gaps highlighted.

## Chapter 4. Summary of Review

The Muslim population in the UK continues to rise (ONS, 2011) and is primarily constituted of PMs. Due to political and social issues, this group has experienced social isolation, alienation and discrimination (Bowl, 2007). SGPMs in particular are caught between two opposing cultures (Hutchison et al., 2015) that may lack expressiveness in therapy (Naeem et al., 2012). Differences in cultural attitudes and religious teachings are under-explored, so conflating culture and religion is often the case in published literature (Mir et al., 2015; Naeem et al., 2012; Rathod et al., 2010).

A review of different modalities has shown that CBT is the most effective with Muslim clients, particularly PMs as such interventions are more problem-focused and direct (Beck, 2011), enhancing the client's ability to make changes using suggested coping strategies that have been adapted (Dwairy, 2006).

Accepting that CBT aligns with Islam, we also know about some of the drawbacks related to CBT that highlight areas that can be incongruent for PMs - namely the difference between the individualistic values inherent in CBT and PMs collectivist values. From the studies conducted on PMs and CBT, it is recognised that while CBT cannot be modified for all cultures and religions, some adaptation has occurred in order to suit PM clients' needs (Naeem et al., 2010). Both qualitative (Naeem et al., 2010, 2011) and quantitative (Rathod et al., 2012) studies on the use of CBT on PMs have been conducted and while these have been explored in both Pakistan and the West, some of the key findings overlap. Therapists' perspectives are minimal and the majority of accounts tend to be from the clients' perspective which is why the present research focuses on documenting therapists' accounts. Acculturation is underscored across many of the studies as a cultural variable that impacts the decision for therapists to modify CBT, particularly with second generation clients.

A therapist's own identity, values and belief system may play a role in influencing the therapeutic process, relationship and outcome and this could shed light on some of their motives for tweaking CBT. A deeper exploration in this area from a practitioner's perspective may help future trainees, applied psychologists and therapists, enhance therapeutic outcomes and engage in more discussion around effective practice.

On the topic of “sameness”, studies on ethnic matching illustrate the tendency to conflate religion with culture and the necessity to understand the two as distinct but overlapping entities. This may encourage clients to continue therapy and avoid dropping out as well as enhance our own knowledge as practitioners of the “diversity among the diverse” (Nezu, 2010). Although ethnic matching is generally preferred (for most minorities considered thus far in multi-cultural Western metropolises), issues such as over identification and self-disclosure must be acknowledged.

Some of the questions that have been left unanswered from previous literature are (i) what of PM therapists in the UK? (ii) how do SGPM therapists in the UK experience the impact of their culture and/or religion with their clients, if at all? (iii) does their faith or culture allow for greater exploration or confusion? (iv) what motivates SGPM therapists to modify CBT with their ethnically similar clients, if at all? (v) how is CBT experienced when discussing culture and religion in therapy? The gap identified is the perspectives of SGPM therapists practising CBT, which has led me to formulate the following research question:

“How do SGPM therapists experience practicing CBT with ethnically similar clients in UK?”

#### **4.1 Relevance and Contribution to Counselling Psychology**

This research may be useful in helping practitioners engage with Muslim clients from diverse cultural settings. Trainees may also benefit from exposure to a broader range of literature within the field, encompassing diverse belief systems, thinking comprehensively about their own cultural heritage and in what form they bring this into therapy (Leung, 2003).

As stated by Post and Wade (2009): ‘the majority of psychologists believe in the positive relationship between religiosity and mental health, however, does not mean that they necessarily have the knowledge and skill to work with religious clients effectively’ (p. 133). This echoes a need to hear the voices of those who do have the knowledge of faith, culture and psychological theory. In keeping with the philosophical foundations of Counselling Psychology to ‘respect first person accounts as valid in their own terms; to elucidate, interpret and negotiate between perceptions and world views’ (BPS, DCP, 2005, p.1-2; Hill & Cooper, 2016), Counselling Psychologists have the potential to bridge the gap between

research and practice considering our dual roles as scientist-practitioners (Lane & Corrie, 2007).

Additionally, research findings may also be extended to other health care professionals including CBT therapists, GPs, religious members of society, community workers and other parties involved in the care or support of PMs and others.

## **Chapter 5. Methodology**

This chapter aims to outline a rationale for the utilisation of a qualitative research methodology and more specifically, an Interpretative Phenomenological Analysis (IPA) method for the present study. Additionally, ethical considerations and a discussion of the analytical process will also be discussed.

### **5.1 Rationale for a Qualitative Study**

This research aims to capture how SGPM therapists who use CBT, experience similarity in their practice with ethnically similar clients. For this, a qualitative rather than a quantitative approach is more suitable as qualitative methods take the view that subjective experiences are shaped by culture, history and language (Marks & Yardley, 2004), findings of this nature are assumed to be context relevant rather than an absolute truth (Willig, 2013). A qualitative approach therefore incorporates an integrated approach in exploring data deeply, as it sits in its broader contextual experiential surroundings.

Willig (2013) further contends that the employment of qualitative research is apt for the rigorous description, exploration and interpretation of experiences belonging to small-scale and well-defined groups of individuals.

As this study seeks to explore the multifaceted phenomenon of SGPM therapists using CBT with ethnically similar clients, the use of a qualitative research method therefore seems appropriate as it enables for what Willig (2013) calls “participant generated” meaning to be unearthed, allowing for novel and unforeseen findings to manifest.

Qualitative methods are also appropriate for exploring areas where there is not much knowledge or in-depth understanding of a particular phenomenon as is the case with SGMP psychologists in the UK, and so it aspires to hear experiences and contribute to current literature and practice (Barker, Pistrang, & Elliott, 2002).

Furthermore, a qualitative approach aims to capture the idiosyncrasies and complexities of subjective accounts, giving way to a richer analytic process which quantitative methods may not be able to capture. Quantitative methods employ a positivist-empiricist stance whereby the goal is to focus on nullifying or accepting a set of hypotheses in order to seek causal or correlational relationships

(Richardson, Denzin & Lincoln, 2000). Therefore, it would be difficult to attain objective knowledge of any given phenomena by utilising scientific tools bereft of personal involvement of the researcher (Coyle, 2007).

## **5.2 Ontological and Epistemological Position**

For reasons I will state below, this study seems to best lend itself to a critical realist paradigm, which assumes that a 'reality' exists, but that we must exercise caution regarding our findings because of the limitations of language, body and cognition, therefore, any knowledge we attain will not be 'absolutely' nor perfectly true. Harper (2006) relays that critical realists subscribe to the view that: "Although we cannot be directly aware of the material objects in the world, nevertheless our perceptions do give us some kind of knowledge of them (Harper, 2006, p.4).

Critical realism is, therefore, sceptical about accessing external reality but holds that we can find out about it, given we shed our assumptions.

According to Smith et al. (2009), researchers must immerse themselves into the participants' narrative attentively in order to understand as far as possible how they experience their world. However, while we can develop an understanding of participants' experiences of certain phenomena (Smith, 2008) we can never fully know our participants. As researchers however, we can nevertheless attempt to understand what it may have felt like for the participants to experience events and that this could even augment the potential for the researcher to comprehend the phenomena (Smith, 2008).

Critical realism states that people can experience different aspects of the same reality (Fade, 2004) and that these varying perspectives exist because of the different meanings we assign to our experiences. This aligns with Counselling Psychology values which highlights the significance of subjective meaning making in a given social context (Strawbridge, 2016). This context specific knowledge is accepted by critical realists as influenced by the perspective of the observer (Coyle, 2007).

Because of this, critical realists concede to an intrinsic subjectivity in how knowledge is generated, accepting that alternative viewpoints are also valid. Critical realists maintain that knowledge is context-specific and is impressible to being influenced by the perceiver's viewpoint (Lyons & Coyle, 2007).

Taking into account the present study, a critical realist position aids the view that for PM therapists, the experience of practicing CBT with ethnically similar clients exists and endeavours to gain a rich understanding of what that experience might be like for them.

In adopting a critical realist stance on the current study of PMs' experiences of CBT with ethnically similar clients, I believe that my experiences colour my understanding of reality, which can be elucidated upon in my reflexive statement.

In adopting a critical realist stance on the current study of PMs' experiences of CBT with ethnically similar clients, I believe that it is not possible to directly access the individual's world and that the outcome of results are in fact hinged upon her own perspective. This is relevant as IPA is founded in the study of interpretation (hermeneutics) which is critical of the notion that knowledge can be gained independent of an interpretive stance (Heidegger, 1927). As hermeneutics recognises that attaining access to reality can only be partial due to the boundaries of language, body and cognition (Smith & Osborn, 2004), critical realism is seen to be compatible with IPA, which is concerned with how we experience events (Willig, 2008).

In the present study, the researcher employed a critical realist stance whereby a myriad of interpretations can be concomitant with reality, therefore casting the focus on subjectivity. This is in alignment with the aims of IPA which are concerned with how individuals experience events and phenomena (Willig, 2008). This is further in line with Counselling Psychology aims in exploring how our clients perceive particular experiences in a sensitive and empathic way (Milton, 2016). IPA and Counselling Psychology thus share theoretical underpinnings in which clients (in practice) and participants (research) are experts in the living and telling of their own experiences.

The virtue of a critical realist stance is that it does not put pressure on the researcher or participant to come to a joint agreement on the nature of objective reality but rather, it leaves room for the researcher to consider her own obstacles in interpreting their world so that in doing so, the researcher can position herself within the worldview of the participant (Guba & Lincoln, 1994). For example, it is anticipated that different experiences of culture and/or religion may make it difficult for me to position myself within the participants worldview (see reflexive statements during Analysis in chapter six).

This is particularly relevant to the current study on ethnic matching and CBT as both culture and CBT entail a worldview and a set of knowledge claims. As highlighted in my reflexive chapter (Appendix M), it is incumbent upon me to as a researcher to acknowledge that my interpretation will be coloured by my background and experiences and thus to reflect on the origin of my line of questioning. To this end, I have intermittently interjected at points of analysis to share my own reflections.

This is in line with Smith et al. (2009) in that the researcher must assert themselves as much as they can, but to acknowledge that we cannot fully know everything.

In the context of the lived experience of ethnic matching, it can be argued that although individuals have some unique characteristics to their experiences, we nonetheless have shared influences – factors that to some extent render commonality in some of our experiences. The very focus on culture and religion is an example of this as one way of being a Pakistani Muslim will not map neatly onto another's experience of being Pakistani Muslim, although it is expected that there will be some common features to the PM experience.

It is my understanding, that where critical realism and Heidegger meet, is at the point in which a reflexive outlook, deep exploration, ideography, and phenomenology render a greater (but neither objective nor absolute) understanding of the client's individual world and that this is a difficult but viable task. The "individual world" in this sense is metaphorical in that while we have our own experiences and perceptions, ontologically speaking – we're part of a common experience and so it is not possible to completely remove oneself from one's cultural ideological context (Clancy, 2013).

In summary, the CR stance is that there is a "real world" which is independent of our perceptions. Nonetheless, Heidegger may be useful in relation to how we "access" knowledge in this context which is via interpretation.

Phenomenology, linked intricately to IPA, believes the only way to access any 'reality' on any phenomenon is via those who are experiencing that phenomenon.

The concept of gaining a kind of universal truth seems very unrealistic. Not only because we're asserting that even if such a reality does exist, that may never be accessed, but also because whatever knowledge we might be generating utilising phenomenology, as with IPA we are engaged in a double-hermeneutic, there are two layers of interpretation. Thus, it may even be possible that, even if we believe

we can gauge our participants' realities via our interview and qualitative investigations, on some levels, whatever our results bring up will always be also the result of our own interpretative act: filtering, picking out, excluding and highlighting what for us researchers feels relevant (see Appendix I, J, K and L regarding how this manifested during Analysis).

It is indeed not possible with certainty to say that we have accessed an individual subjective world, because even in the act of attempting that, such individuals are interpreting their experiences. Even if that was as accurate as possible, it would still not be necessarily aligned to the external, objective 'truth', as CR tells us that such reality is independent of our perceptions, thus including our own as researchers, and that of our participants.

In relation to the wider thesis, I accept that my involvement in this research will constitute an oscillation between being connected to my cultural/religious ideas, and my professional ideas, i.e., my PM values and my adherence to protocol led therapy.

This supposed tug of war can be conceptualised as an attempt at cultural reflexivity, quite similar to the concept of “double hermeneutics”; a process in which the researcher observes themselves as “active listeners” constructing cultural realities – listening to myself, listening to the client and noticing where my input is coming from.

### **5.3 Rationale for Employing IPA**

Phenomenology refers to the methodical investigation of conscious experiences, within a specific context (Howitt, 2014). As a researcher I acknowledge it is difficult for one to fully comprehend another's' experiences retrospectively which is why IPA is also referred to as a “double hermeneutic” whereby the researcher is taking part in interpreting the participants subjective interpretation of their own experiences (Eatough & Smith, 2017).

IPA invites the researcher to understand how individuals make sense of their subjective world (Smith, Flowers & Larkin, 2009) while holding the awareness that researchers' assumptions may influence the researcher-participant interaction (Willig, 2008). The researcher however has decided to utilise IPA (Smith, 2011) in order to bring about an understanding of the individuals lived experience of a particular phenomenon. Through interpretative engagement with the text and transcript (Smith, 1998,

p.189) the researcher endeavours to understand how they make sense of these experiences. It is suggested that the researcher embark on entering into the world of the participants in order to gain a perspective as close to the inside as possible (Conrad, 1987).

IPA draws mainly upon three philosophical positions: hermeneutics, phenomenology and idiography with influential threads drawn from symbolic interactionism (Eatough & Smith, 2008). The latter is premised on employing significant communication as a means to understanding the individual's comprehension of the world as developed through socially interacting with others.

With regards to phenomenology in psychology, there are arguably two rudimentary approaches (Giorgi & Giorgi, 2008): Heidegger's interpretive phenomenology and Husserl's descriptive pre-transcendental phenomenology. The former approach stresses the interpretative elements of analysis whereas the latter emphasises on the descriptive aspect of a particular experience. Heidegger's interpretive phenomenology primarily focuses on the vast array in individual's experiences and proposes a more flexible approach which together supports a more interpretive methodology. It is grounded within this approach that IPA is positioned. IPA's phenomenological constituent therefore focuses on how participants' think and perceive their experiences. IPA aims to explore the subjective viewpoints of each participant's unique account and does not attempt to conceive objective explanations or descriptions (Smith, 1996; Smith & Osborn, 2008). In holding a Heideggerian as well as a critical realist stance, I believe that both approaches complement each other in an epistemological sense. In this sense, Heidegger's interpretive stance is useful (Smyth et al., 2008). There is an overlap that I find useful in that there is an emphasis on reflexivity and both discourage espousing an absolute truth. Hermeneutics is a branch of knowledge that is concerned with people as interpreting and sensemaking individuals - a branch which is one of the touchstones of IPA. Ricoeur (1970) described hermeneutics as involving the "restoration of meaning" (p.8) which IPA draws as it seeks to uncover meanings embedded in human experience (Wagstaff et al., 2014).

It is worthy of note to make reference to a vital aspect of reflexivity - that I will not only be exploring participants' experiences from my role as a trainee Counselling Psychologist but also as a British Pakistani, as a female and as somebody who has, in the past, been at the receiving end of CBT therapy. As I will gather the data, specifically - interviewing, transcribing and analysing, my own biases

and assumptions will be taken into account which is congruent with the reflective practitioner identity of the Counselling Psychologist (Hanley et al., 2013).

IPA was also deemed suitable for the current study due to its idiographic application. IPA focuses on how particular phenomena are understood in a specific context by a particular individual and thus is dedicated to an in-depth analysis of the participants lived experience. For this reason, it considers purposively select small sample sizes as appropriate (Smith et al., 2009). This is in line with the purpose of the current study which is to offer a nuanced understanding of SGPM therapists' experiences of using CBT with ethnically similar clients.

#### **5.4 Other Qualitative Methods Considered for the Current Study**

Other approaches were considered but disregarded for IPA. For example, Glaser and Strauss' (1967) Grounded Theory (GT) which was a primary alternative to approaching lived experiences (Willig, 2013). There are other forms of GT such as Charmaz's (2006; 2008) constructivist approach (Smith et al., 2009) and that of Corbin and Strauss (2015). The latter argue that data saturation is necessary to gather data and therefore a larger sample size is generally required. More importantly, the process of research and the aim, rather than the sample size, is what makes GT different from IPA. Additionally, GT aims to generate a theoretical analysis based on an explanatory model to make sense of a particular phenomenon (Holloway & Todres, 2003) as opposed to capturing personal experience. The current study however does not seek to formulate a theory and instead hopes to gain a new understanding of these experiences and is therefore rendered more suitable than GT. The strengths of IPA for this particular research is the focus on understandings, views and perceptions of participants; the subjective positioning (Reid, Flowers & Larkin, 2005). It is also possible within IPA to aim for adequate analysis which allows for the surfacing of group level themes to manifest, thereby moving beyond just a description of the data (Smith et al., 2009). Thematic analysis was an approach considered for this study but due to its lack of pre-existing theoretical framework and the flexibility offered during analysis stage, this made it difficult to follow specific guidelines for deeper, richer analysis. (Braun & Clarke, 2006). In this sense, thematic analysis is considered having limited "interpretive power beyond mere description" (Braun & Clarke, 2006, p. 27) and is not able to preserve continuity as well as contradiction in individual accounts. This could be

problematic as these divergences and consistencies across individual accounts may be illuminating. Moreover, thematic analysis would have required a larger sample than IPA, which may have stymied a detailed analysis of the participants' experiences as was requisite for this study.

A quantitative approach was considered for this study but since there is a significant gap in the literature regarding the lived experiences of ethnically matched therapists and clients using CBT, the objective is to make sense of participants' experiences as a whole which is in contrast to quantitative methods that attempt to explain associations/correlations between events via hypotheses testing and measuring particular variables (Anzul et al., 1991; Smith et al., 2009). Since meaning making is the driving force of this study, a qualitative approach was deemed a better fit (Smith et al., 2009).

Lastly, Silverman's (1993) Discourse Analysis (DA) explores language and as a contributing factor to how participants construct their world, rather than exploring their individual subjective accounts (Willig, 2012). IPA however is concerned with the personal meaning making of these experiences while holding that this may be mediated through linguistic nuances (Smith, 2015). IPA states that individuals are not solely discursive agents but also ascribe meaning to their lived experiences (Willig, 2013). Rather than being solely concerned with the individuals' use of language to construct their experiences, the current study takes interest in the subjective experiences of the individual, the meaning-making process that underlies this and how they make sense of their experiences. For this reason, IPA is deemed more suitable and will be the method used for the current research. Had the focus of this study been on talk and texts as social practices (Potter & Wetherell, 1988), DA may have been suitable, however, this research topic was approached without preconceptions and with a view to explore the processes through which participants make sense of their own experiences.

## **5.5 Reflexive Statement Part 2**

In accordance with Willig's (2008) recommendations, as a researcher I have established a methodological stance befitting for the objectives and aims of my study and which mirror my personal outlook on the world around me (Etherington, 2004).

During the research process, I reflected upon why a qualitative approach such as IPA was most fitting for my topic and how this sits with me as an individual.

During my earlier years, I recall viewing the various events around me as though I was a camera, taking snapshots from different vantage points to later dissect and decipher. I had a desire to make sense of the ascribing of meanings to certain events rather than what caused them. Undoubtedly, this method of dissecting phenomena enabled me to remain theoretically aloof while still being physically and practically immersed in these experiences. So far in my training, this dynamic has been repeated in my approach to working with clients – traversing the theoretical and clinical terrains. Coming from a large traditional Pakistani family, I witnessed my family members struggle with psychological issues both on an individual level and as a result of wider systemic influences. On the one hand, I wanted to understand the meaning of these difficult experiences for my loved ones and develop a richer understanding in order to help them. In the same vein, I wanted to better understand myself, my origins and where the crossroads between self and other existed in the context of my family. This somewhat mirrors the idiographic focus of IPA which explores how a person in a given context makes sense of a phenomenon (Cohen et al., 2007).

It is important for qualitative researchers to understand how they make sense of their realities (Willig, 2008). My avid interest in understanding the subjective lived experiences of individuals underlies my theoretical position and grounds in in a method aligned with IPA. Rather than seeing my own personal background as a hindrance, I perceived it as an enriching tool allowing me to connect empathically and emotionally with my participants (Etherington, 2004). This could have potentially impacted my preference for IPA and disregard for alternative nonphenomenological methodologies. I was aware of this during the research process and endeavoured to select a methodology most apt in addressing my research question. At the crux of my reasoning behind choosing IPA was to address, “what it is to be human” in all its essence (Smith et al., 2009, p. 38).

With regards to the methodology process, I acknowledge that while I have tried to keep certain worries at bay, namely the desire to secure certainty, that this cannot be wholly achieved as some element of uncertainty is inevitable. Some of these worries include my rush to complete the thesis, my relationship with uncertainty and my difficulty in establishing an epistemological stance.

## 5.6 Participants

As per Smith, Flowers and Larkin (2009) guidelines, a purposive sampling approach was used to select participants for the semi-structured interviews. This method ensures that the researchers' judgement is used to ascertain which traits are of interest to the research and thus sets out to seek participants who are willing to offer their experiences by virtue of their expertise within the topic of interest (Bernard, 2002).

It was believed that six participants were sufficient to recruit for the present study, keeping in line with Smith, Flowers and Larkin (2009) who state that four to ten interviews would be a reasonable sample size for a Doctoral study. Furthermore, this allows for a commitment to providing a detailed account of interpretation, i.e., "sacrificing breadth for depth" (Smith & Osborn, 2004 p. 56). For the purposes of this research, participants were required to have had experience using CBT with clients from a similar ethnic background.

The inclusion criteria stated that the participants be:

- Second Generation Pakistanis in the UK. The term second generation refers to individuals born in the UK to first generation parents.
- Practicing psychotherapeutically as a therapist in the UK
- Experienced in using CBT with ethnically similar clients on an individual basis and have been qualified for at least two years
- Affiliated with the Islamic faith and consider themselves Muslims

The exclusion criteria stated that participants will not be recruited if they:

- Are, at the time of recruitment, receiving treatment for anxiety or depression or have received it in the twelve months prior to recruitment.
- Have limited command of English

Other studies (Naeem et al., 2010, 2015; Rathod et al., 2010; Smith & Cabral, 2011) on ethnic matching in therapy do not specify how long the therapists/psychologists have worked with ethnically similar patients. However, for the purpose of ensuring that there had been continuity in the therapist's exposure and experience with ethnically similar clients, this study sought participants who had at least two years of experience with ethnically similar clients, which was self-identified. It is also important to note

that here, ethnic similarity refers to sameness, i.e., Pakistani psychologists working strictly with Pakistani clients as the premise of this thesis is centred on intra-cultural therapy.

This table outlines the demographic information of each participant. To ensure anonymity, names have been given pseudonyms throughout.

**Table 1.** Participant demographics.

Name	Age	Place of birth in UK	Qualifications	Professional title	Duration as qualified therapist	Sessions with PM clients (hr)	Duration of practice in the UK	Model of therapy
Aisha	46	Manchester	BSc Psychology; CBT Dip; PWP	CBT therapist	10+ y	100+	10+	CBT + integrative
Tahsin	43	Gloucester	BSc Psychology; MA Counselling	Counsellor	8 y	100+	8	CBT + Integrative
Nadira	33	Bristol	BSc Psychology + Prof Doc Counselling Psychology	Counselling Psychologist	4 y	50+	4	CBT + integrative
Rani	28	London	BSc Psychology; MSc Psychology; PWP	CBT therapist	3 y	50+	3	CBT + integrative
Neena	46	London	BSc Pharmacology + MA Counselling + MSc Integrative Psych	Integrative Psychotherapist	15+ y	200+	15+	Integrative
Naina	45	London	BSc Psychology; Dip Counselling; MSc Integrative psychotherapy	Integrative Psychotherapist	18+ y	250+	18 +	CBT+Psycho dynamic

\* All participants were female, Muslim and of Pakistani ethnicity.

### 5.7 Recruitment Procedure

The recruitment of participants was attained via contacting counselling services, beginning in the London area, and working outwards, via email alongside an information sheet detailing the research aims and requesting interested participants make contact with the researcher. This study was made open to practitioners practicing in various organisations including the NHS, private practice, or charitable organisations.

A poster was sent to organisations such as Islamic Association of Muslim Psychologists, Nafsiyat Intercultural Therapy Centre and the British Psychological Society (BPS). Administrators were contacted via email and telephone. A search via the BPS website was also conducted whereby I estimated the ethnicity from the therapists' names and following this up with emails or telephone calls.

It has been considered that the duration of sessions a therapist can work with (Leichsenring et al., 2014; Waller, 2009) and whether or not a protocol-driven framework is used (Addis & Waltz, 2002; Cukrowicz et al., 2011) may affect the therapeutic experience (i.e., a Counselling Psychologist employing short term protocol driven framework vs longer term therapy in a private setting). In order to account for this, one of the interview questions explored whether or not this played a role in the therapeutic experience. Although neither the duration of sessions nor the setting is the focus of the research, the implications were acknowledged and anticipated to surface during the analysis stage.

Furthermore, in order to select practitioners who practiced CBT, there was no strict criteria on whether the participants belonged to a Counselling or Clinical Psychology background which is why the research question reflected the need for participants practicing psychotherapeutically from any training background.

## **5.8 Data Collection**

The qualitative data was obtained via audio recordings conducted by myself. Prior to interviews, information sheets and consent forms were obtained. However, the researcher continued to reassure the participants of complete confidentiality and their right to withdraw at any time from the study during a 3-week period post-interview for the purposes of the overall analysis.

Interviews were conducted using a face-to-face semi-structured format, with each interview lasting between 60 and 75 minutes. Guterman (1994) recommends a semi-structured interview enabling both participant and researcher to establish a good rapport which augments the research experience for the participants, unlike structured or unstructured interviews. In line with IPA, a semi-structured interview allows for more flexibility to reveal other avenues that might emerge during the interview process (Willig, 2013). This also encourages a collaborative process allowing the participant to be involved in the research process. The use of non-directive questions in semi-structured interviews can also facilitate the participant in narrating their own stories as well as encouraging wider responses (Smith et al., 2009).

## 5.9 Data Analysis

The analytic procedure for IPA followed Smith's (2015) guidelines. All background noises, hesitations, pauses and inaudible words/sentences were noted during transcription as per the orthographic transcription method (Howitt & Cramer, 2014). As per Smith et al.'s (2009) recommendations, large margins were created on each side of the text for writing comments and transcripts were read repeatedly to ensure that the participants' voices remained central to the analysis. The left-hand margin was used to note feelings, thoughts and any contradictions that arose in the participants' narrative, as well as similarities in emergent themes. The right-hand margin was used for more refined and psychologically relevant interpretation of the initially taken notes. Participants' recordings were listened to in order to enable and maintain immersion in their accounts (Smith, 2011).

Transcripts were read several times noting down emerging themes which were further distilled in a chronological manner. The researcher continued to stay close to the initial texts on either sides of the margin which were transformed into higher level interpretation and distillation (Smith & Eatough, 2006). Connections between themes were explored from the emerging themes and then grouped together to create clusters of themes, all the while moving between the participants accounts to preserve integrity of their narratives (Smith, 2004).

Clusters of themes were given titles and then put into a summary table detailing all the emergent themes alongside relevant quotes.

The next stage involved seeking for patterns among the individual summary table of themes to create a single table of master themes for all the participants. At this point, some of the themes were relabelled to encapsulate the depth of participants' experiences. It is recommended that themes should be selected on the basis of the richness of description that they provide (Smith et al., 2009). The final Master table of themes for all participants was formed, entailing superordinate themes and related sub-themes. Verbatim quotes were extracted from the transcript to provide evidence for each theme. A "reflective journal" (Kasket, 2013) was used throughout this process in order to maintain transparency in the interpretation of data which helped in increasing the quality of the research.

## 5.10 Ethical Considerations

The study gained ethical approval in accordance with London Metropolitan University Ethics Committee (See Appendix H). As the focus of this study is not on recruiting solely from NHS services or patients from within it, it was agreed that the London Metropolitan University Ethics approval would suffice. Before conducting the interviews, all participants were briefed on what the interview would entail and consent forms (Appendix B) signed. A copy of this was given to the participant and the remaining copy was kept by the researcher. Participants were also reassured that at the end of the interview there would space to talk about any concerns that may have surfaced regarding the research.

All study data was stored on an encrypted password-protected computer, in accordance with BPS Code of Human Research Ethics (BPS, 2014) and Code of Ethics and Conduct (2014). The participants were advised that all interview material would be retained securely for 5 years, after which all data would be destroyed. Participants were reassured that the audio recordings would solely be used for the purpose of this research and that anonymized data would be used for publication purposes and related wider literature. Anonymity was maintained throughout the study by using pseudonyms for all interviewees with all other identifiable markers being modified or omitted to protect confidentiality (Act, 1998; Bond, 2010).

It was not anticipated that participants would experience excessive distress during the interview process, however the researcher planned to continuously monitor their emotional state throughout and by having a distress protocol in place (see Appendix D).

Participants were debriefed at the end of the interview and provided with material related to relevant organizations in case they required support for any distress experienced during the interviews. The researcher's contact details as well as those of the researchers' supervisor was provided in case of any complaints or concerns regarding the study.

With regards to the disclosure of confidential information, the interviews were thought to elicit potentially private and confidential information about participants' identity and personal lives. However, anonymity was ensured, and confidentiality of participants as is reflected in the BPS Code of Human Research Ethics (2014) whereby it states, "Psychologists value the dignity and worth of all persons equally, with sensitivity to the dynamics of perceived authority or influence over others and with

particular regard to people's rights including those of privacy" (pg. 10). As a result, researchers and practitioners have a duty to develop and adhere to procedures which ensure valid consent and confidentiality.

It is acknowledged that a disparity in power exists between researcher and participant even if we seek to minimize it (BPS, 2014). Therefore, sensitivity is vital, particularly as this research will talk about ethnic identity. Similarly, in the HCPC Standards of conduct, performance and ethics (2014), all reasonable steps must be taken "to reduce the risk of harm to service users, carers and colleagues as far as possible" (2014).

It was anticipated that interviewing via a video-link would need to take place. Indeed, four out of six interviews took places over Skype. It was considered that this may not be an appropriate platform to discuss sensitive subjects which may otherwise be better discussed in a more "sensory interview experience" (Waller, 2015 p.44). However, providing the video and audio quality is good, this medium can offer flexibility and an informal element that physical interviews might lack (Waller, 2015). It also aided in decreasing travel and cost time allowing the researcher to access participants in hard-to-reach areas as well as increased safety of the interviewer (Novick, 2008). The remainder of the interviews took place in a public setting where privacy was ensured.

### **Research Quality:**

In order to improve the validity, 'participation validity' was considered. Giorgi (2008) states that participants may not be well placed to validate the researcher's findings because they may not recognise the interpretations of the researcher or consider them relevant and might also not be aware of the connections in their own accounts. Kvale (2003) and Finlay (2008) however suggests that participant involvement could improve validity, later echoed by Willig (2013) who argues that participant feedback is valuable in phenomenological research.

A summary of findings was sent to all participants to review to which four did not respond and two expressed their contentment with the overall summary of their accounts.

A peer review was also conducted in order to ensure that the chosen themes were grounded in the participants narratives. This was done with two fellow trainees who were familiar with the IPA process.

Angen (2000) argues that although peers lack the same involvement with the findings as the researcher, they can nonetheless assist in making sure the themes are coherent. Peer review feedback revealed that the researcher's analysis was too descriptive at times and names of themes were at times too lengthy. This allowed the researcher to improve her interpretative skills and remain grounded in the participants words, allowing for a reconsideration of labelling themes. Despite this, the overall analysis made sense and corresponded with the participants' narrative.

## Chapter 6. Analysis

Three superordinate themes emerged from the IPA analysis of the six interviews as illustrated in the table below. Throughout the analysis section, reflexive statements are made which have been typed in italic bold font throughout.

### 6.1 Superordinate Theme – Intra-cultural Influences

The first superordinate theme reflects the salience of collectivism in Pakistani culture. Loyalty to the member group is integral to Pakistani culture, and I thought it important to start here given the prevalence of it throughout the participants’ accounts. In light of the participants’ experiences with ethnically similar clients, the following emerged.

**Table 2:** Summary of superordinate and sub-themes with relevant quotes

Superordinate Theme	Sub-theme	Relevant quote/extract
Intra-cultural influences	Relatability for trust	“I mean overall I feel like, with people from an ethnically similar background [I] have been able to relate to them more” Rani, p.2, line 44-45
	The benefit of linguistic competence	“I think it helps being able to speak their language...they can’t always explain it in English so I will make them as comfortable as possible” Tahsin, p.3, line 68-70
	Gendered experiences and Kinship	“...she was a bad Muslim, bad girl, bad Pakistani girl” Naina, p.13, line 494-495
	Communal anxieties	“worried that I’m of a similar background to you...worried that we might know somebody in common” Aisha, p.2, line 70-72

Professional compass	Quest for impartiality	“I have my own experiences and my own perspectives on things in culture and religion, but I also have to be mindful that I don’t put my own views on clients as well” Nadira, p.8, line 306-310
	Religious considerations	“Ultimately Allah is the judge. But then I do remind them, is your God...a bad thinking God or a good thinking God” Tahsin, p.2, line 68-69
Negotiating CBT boundaries	Therapist’s frustrations and limitations	“they have to do the work and they don’t want to do the work” Naina, p.4, line 145-146
	Client’s frustrations and limitations	“there’s always that slight reluctance still within the community about coming to therapy.” Rani, p.2, line 61-63
	Need for integration	“I also integrate...the cultural element, the kind of systemic context in which they live – that might be culture, family, religion.” Neena, p.10, line 370-376

**6.1.1 Sub-theme 1: Relatability for Trust**

It appears that most of the therapists perceive from early on that they need to show an understanding of their client’s cultural frame of reference. A reason for this is based on the premise that cultural acknowledgement leads to trust; trust is forged through this cultural relatability, rather than solely through the professional credence of the therapist. The cultural acknowledgment, i.e., relatability, seems to breed trust. Five out of six participants express this, as conveyed by the following quotations from Rani:

“...there’s usually this sort of “well you know what it’s like” and generally I do know what it’s like so...it’s been easier to connect in that way.” – L.23-26, Rani

“...overall, I feel like, with people from an ethnically similar background have been able to relate to them more...” - L. 44-45, Rani

Through Rani’s perspective, the cultural background she is superficially associated with perhaps signals an insider knowledge, creating a therapist-client dyad that allows her to connect and “relate” to her clients more. This superficial association may be based on her appearance and her name. Based on these ethnically-similar indicators, it appears as though her clients’ trust stems from an unspoken acknowledgment that she must “know what it’s like”, which she generally does.

Further, it seems that Rani’s cultural affiliation is more pertinent than her professional status as she states it is “easier to connect” on a cultural wavelength. This “knowing” aspect is echoed by Tahsin and associated with the two-way trust:

“We all make mistakes...I’ve been there you know I’ve got the t-shirt...just allowing them to feel a bit more comfortable and allows the therapeutic relationship to build up again, assuring them they can trust me and I trust them”. – L. 115-121, Tahsin

The repetition of “trust” here shows a willingness on Tahsin’s behalf to delve into the clients’ cultural frame of reference. The use of the collective personal pronoun “we” suggests Tahsin’s willingness to share in the experiences of her clients. It is as though this sharing is offering Tahsin a new lens through which to look at “the t-shirt” with which she identifies or at one time identified in order Her reference to “build up” is apt for this superordinate theme as it connotes the beginning of a relationship and thus a beginning of a story. The notion of insider knowledge and the trust inherent in that is also shared by Neena:

“...working with ethnically similar clients, I have a greater insight let’s say on their values, on their kind of expectations, on nuance of behaviour within their communities let’s say of the assumptions they tend to make...that kind of knowledge I’m able to use in understanding them in a way that perhaps a therapist from a different sort of racial group might not be able to.” – L. 9-17, Neena

Neena suggests an anticipated set of assumptions and the complexity of ancestral ethnicity in therapy. It seems that Neena acknowledges the advantage she has as a therapist with that insider knowledge of ethnically similar clients. However, the relatability aspect seems to be communicated here in a less “enmeshed” manner than illustrated through Rani and Tahsin’s comments. Terms such as “working with” and “their communities” imply that her trust-deriving relatability to the client is a professional stratagem rather one that is all too familiar. She later states:

“I’ve lived away from Pakistan long enough and I’m also part of an inter-racial marriage myself for me to understand both sides.” – L. 58-61, Neena

Neena appears primed to view her clients’ matters from within and from the outside, giving her a dual perspective and allows her to engage multi culturally as well as intra-culturally. She posits this as an advantageous ability to connect with her clients.

Yet it can be argued that an ability to understand through an ethnically-similar lens does not necessarily translate into the therapist actually connecting with her patient on this level, or herself accepting that cultural connectability.

Naina also recognised that her clients’ motivations can be culturally-led:

“...culture wise she picked me, um I think she picked me because she thought culture wise I might understand”. – L. 289-291, Naina

Although there is a clear element of relatability here on the particular client's behalf, the use of "might" qualifies the nature of cultural relatability -the client "thought" that the therapist would understand, yet for the therapist this is not a given. There is a hesitance for Naina to accept that relatability may foster and cultivate a trusting relationship, which can be further seen in:

"...they asked for a Pakistani cos they said...we've had a non-Asian therapist before and we thought maybe that's the issue. And I thought, it's not the issue – the two of you are the issue actually." – L. 253-256, Naina

The above quote is in relation to a couple who sought Naina for therapy. Naina's tone here appears to dismiss the idea of ethnic relatability, and seems to rather underplay the need for cultural connectivity. Ironically, Naina's judgement appears to be another cultural trait, in which in-group members regard another's motives with an air of suspicion. This is consistent with Naina's other accounts as she displays negative relational experiences with this particular client group where ethnic similarity is, for her, problematic, and the concept of trust is not one that is formed easily.

Although to some degree, all clients will mesh their earlier experiences with the PM client group, Naina's accounts appear overtly heavily informed by her earlier adverse experiences with PMs.

*Naina's use of the expression "the two of you" triggers a retrospection of scenes from my past where arguments involving couples within the family would involve such an expression used in a reprimanding and accusatory manner, as if giving a telling off. I wonder whether Naina is also subjecting her clients to a cultured passive-aggression in this way, brandishing them the problem because she is informed by the cultural practices they adhere to. Her hastiness in placing the couple's issues outside of the cultural realm and into the individual domain makes me wonder if she is frustrated with the collectivising of experiences.*

However, in terms of language and familiarity she related a lot more to her clients, much like her peers in the participant group. This is possibly for a number of reasons, not least because language is the baseline for all communication, so when there is an avenue to go beyond the host language (English) and

communicate through the mother tongue (Urdu/Punjabi) then this facilitates a richer therapist-patient collaboration. This is expanded upon in the next sub theme.

### ***6.1.2 Sub-theme 2: The Benefit of Linguistic Competence***

Once the relatability was established and engendered trust, it seemed through the participants accounts that they traversed the interaction with their patients through the most practical means: code-switching. This practice allowed for certain linguistic cultural proclivities to metaphors and storytelling to manifest. Client's would dip into this mode of interaction and the therapist would feel obliged to accept it and respond.

The benefit of linguistic competence seems important as a therapeutic eye through which the PM client can be better understood and validated, as shared by Aisha:

“I was able to understand it and talk about it very openly and address it and she could use certain words, phrases and slip in and out of different languages as well...we were just mixing our languages as we were talking as a way of expressing ourselves.” – L. 120-124, Aisha

Aisha makes reference here to “slip[ping] in and out” perhaps referring to the ability to code switch, enriching the dynamic. It appears her PM client in this case cast aside any negative derivations of shared culture (as expanded on in the sub theme Communal anxieties) and has rather embraced it as a channel for greater understanding and synchronicity, making the relationship a unique one. Culture thus becomes the shared metalinguistic property between the two, yielding a richer access into self and other expression.

Later, Aisha delves further into the metaphorical communication that she often encounters:

“They will not say that they are feeling a certain way...they relate it another way.” – L. 529-531, Aisha

Here, she refers to her PM clients as relating their concerns in “another way”, denoting a “way” that is not traditionally perceived by the therapist in regard to the “feeling[s]” of the client. Yet this way

allows for the conceptualisation of images and metaphors related through this hybrid communication style:

“...she said it in Punjabi...if you have a claypot and you put some stones or small rocks in it and you move the pot around...it’s that same rattling noise that’s inside of my head.” – L. 540-549, Aisha

The metaphorical communication here elucidates the patient’s state and may be suggestive of a larger cultural issue of a restricted emotional bank, therefore making it easier to communicate analogies based on inanimate objects. Metaphors also remove the onus on the speaker to convey thoughts or feelings literally. On the other hand, this can be interpreted as the PM clients emotional bank not aligning with that of the Western traditional perception and therefore the relatability factor is more significant in needing to illuminate the client’s emotions from a different angle.

Aisha later uses the image of the claypot to metonymically chart the events in her client’s life, allowing for an indirectness that the client is comfortable with. From this, Aisha is able to synaesthetically immerse herself within the client’s realm of experience. The image of the “claypot” is interesting here as it is potentially a telling metaphor of a Pakistani housewife whose role it is to remain resourceful and “contained” simultaneously. It is no accident that the claypot is also a traditional Southeast Asian utensil, so a fitting metaphor alluding to the domesticity of female PM homemakers.

What is more, is that linguistic relatability itself is also nuanced, as Aisha uncovers the inherent complexities involved in the dialectal variations of the shared language:

“Personally...I wouldn’t call that Punjabi, I’d call that Patwari...when we say Patwari then we get looked down upon so we just call it Punjabi.” – L. 1112-1115, Aisha

Here, Aisha’s ethnic subscription to Punjabi establishes the parameters of this spoken code. Through defining or containing the remit of Punjabi, it could be interpreted as a type of insider cultural appropriation, and her repetitive use of the personal pronoun “we” is somehow meant to validate her linguistic judgment as the accepted standard. Additionally, there is an acknowledgement of psycho-

sociolinguistics in the sense that Patwari has connotations of inferiority and therefore Aisha peels away some of the linguistic associations she encounters in therapy. Her use of “Personally” renders her statement a type of language-ownership that perhaps stems from a strong affiliation to her culture. This process of dialectical deciphering allows for greater relatability nonetheless, given her background knowledge of the linguistic and cultural nuances.

Tahsin too illustrates the importance of linguistics in within the CBT dynamic:

“It’s just the language that needs to be changed, not CBT. CBT is actually okay...they can understand it in their language...you can relate them back to Urdu...especially Pakistanis, they would be able to understand the same words in Urdu.” – L. 838-845, Tahsin

Here, Tahsin discusses CBT as theoretically sound but linguistically impervious. Tahsin acknowledges that CBT nomenclature can at times create barriers to this demographic, wedging a social distance between therapist and client. As discussed in the literature review, CBT is considered a product of Euro-centric intellectualisation insofar as the original terminology neglected a pan-linguistic approach. It is interesting that Tahsin suggested a change in CBT language particularly as language and culture are mutually dependent and derived. This touches upon the domain of culturally-adapted CBT, as what seems to be necessitated is an approach that goes further than a mere translational exercise (English to Urdu). Tahsin’s account extrapolates this further, as she states:

“...the British English have a very different way of speaking, the Pakistani’s have a very different way of speaking.” – L. 40-42, Tahsin

This could be read as anomalous to Tahsin’s earlier account of PM clients being able to understand the same CBT terminology in Urdu. Here, Tahsin clarifies the cross-cultural distinctions in expressions. As with Naina’s quote above, British English is seen as the standard to which to compare the Pakistani “way of speaking”, perhaps revealing the therapist’s own oscillation between the Western and Eastern way, thereby making it difficult to subscribe to any single one. On the other hand, the mention of

British English and the Pakistani language perhaps highlights the dual-channel communication, which Tahsin can use to facilitate the breadth of information she is able to elicit from her PM clients.

Language, for all the participants, offered a practical means to relate to the client and further embed the trust in the therapeutic relationship. However, language offered just more than a mode of communication and revealed underlying themes and dynamics that help shed light on understanding the client's frame of reference.

### ***6.1.3 Sub-theme 3: Gendered Experiences and Kinship***

It seems noteworthy to mention that although all six participants are female, the theme of gendered experiences and family arose organically and meshed with the larger theme of intra-cultural influences in a way that seemed too significant to omit.

Once the trust has been built (via relatability) and once they have established a practical communication (language), barriers ease amongst PM clients and it seems the participant has made her way into the safe space of the client. Because of the majority of the participants clients being female – it colours their cultural experiences in a very gendered way which comes through in therapy and which the participants explore. This is also discussed through the lens of kinship and the wider systemic network which spanned all six participants accounts.

The next two subthemes highlight intra-cultural influences in light of kinship generation. Aisha and Neena's quotes seemed an appropriate place to start in understanding cultural norms, influences, traditions and the role of gender:

“...it's the older generation...we see it so much in Pakistani women, those who have been housewives all of their lives or those who've had to look after their families with the children who've flown the nest. They fall into depression because they've got nothing to do. Their purpose has been fulfilled...sat there in an empty home, pots rattling, just looking at four walls – that's when they start to develop the physical symptoms because they want the attention.” – L. 234-244, Aisha

“...with the older generation, I am so struck by the fact that – particularly in this population, that there is such a lack of understanding about the emotional life. ...their parents in the previous generation have just focused on...are they fed...clothed, have they been educated, have they gone to good homes after marriage...not, are they happy.” – L. 552-560, Neena

Firstly, Aisha talks about the limited realm of experience she encounters in Pakistani women, who become wholly subsumed by cultural and traditional norms. Perhaps as a result of cultural diktats, preventing or at least discouraging work beyond the home (or even activities/hobbies), have resulted in a type of redundancy for these women, creating a void otherwise occupied by family service. It seems depression or a sense of vacancy occupies that void.

Neena’s statement points to a similar void in the elder PM women who struggle to find the tools to traverse and access their own emotional map. By dint of the overarching practical and survival needs of their migrational context; they were perhaps conditioned to address life’s urgent practical needs whilst their emotional well-being went unnoticed. It was believed that Neena’s statement referred to both the cultural assertions placed on both men and women owing to her reference to “go[ing] to good homes after marriage” as a reference to the female rites of passage from daughter to wife. This emotional neglect to some degree may inform a detrimental domino-effect on the younger generation, born and bred in the West but unequipped with the emotional access, as their elders had been bereft of it. It appears that Neena has experienced the spectrum of such experiences.

There is a duality in Aisha’s statement of motion and stillness, especially pertinent to older generation Pakistani women for whom their children and their homes fulfil their purpose until a certain point. Reference to “an empty home”, “pots rattling” and “four walls” depict the domestication of these women and the resulting emptiness that ensues.

Nadira too relates her views on PM culture and its place in the wider system of collectivism and the family:

“They have more of a collectivist culture...the particular systems that especially Muslim women live within – sort of like sexism and patriarchal cultures and particularly South Asian...a little bit of subordination.” – L. 61-67, Nadira

Nadira outlines a recurring paradigm in the cultural philosophy of PMs, whereby those within the culture, by default of tradition, practice herd-simulation with little room for individualism. The de facto governing system of patriarchy perpetuates “sexism”, leaving women to bear the brunt of masculine cultural enforcers. Closely resembling Tahsin’s accounts, Nadira too overlays these cultural edicts to her clients experiences with culturally identifiable markers, such as the hijab:

“...she was a minority within her school...she was feeling really self-conscious especially like as a young teenage Muslim woman wearing a headscarf...I don’t know how her experiences would have been if she was to see somebody who was different to her.” – L. 223-235, Nadira

Nadira’s sessions appear to revolve around the visual emblems of being PM and the knock-on impact on the client’s emotional/ideological (dis)comfort with their superficial existence in society. Nadira elsewhere also recounts her earlier experiences whereby her gender and role in the family setting impacted her in a way that allows her to understand her clients’ worlds. This raises questions around enmeshment and the vast array of literature that iterates its potential harm in a clinical setting, however, it is interesting that five out of six of the participants acknowledge the intra cultural influences that ultimately manifest in some form or another in the therapeutic relationship with their PM clients.

Naina however diverged slightly in her accounts as compared to the rest of the participants which also reflected her earlier kinship experiences and gender role conflicts:

“...then her brother got on the phone with me and started shouting at me saying – just write her a letter, she’s been coming to see you...In the end he bullied me into writing a letter...that was very early on in my private practice...I think it was probably to do with my own family

dynamics, bullying men...it's that whole thing of "I'm entitled" because you're one of mine...whereas an English client has never done that." – L. 27-45, Naina

Naina displays a grudging allowance for bullish behaviour. She appears to have enacted some sort of displacement by familiarising her experience of "bullying men" with her client's brother, allowing his directed duress to force her into the culturally-common position of a docile, compliant woman. Naina recognises the pattern as per her own family dynamics and juxtaposes this with English clients who would "never have done that". As a result of her own earlier experiences, she perhaps interprets her clients' behaviours and patterns through her cultural lens and subtly "others" the culturally-assertive behaviour while aligning with the host culture.

There is also an association here with her experiences and possibly having been naïve earlier on in her private practice. With time and experience, it seems Naina has harnessed a stancher approach to PM clients.

"...they found her gym bag...so you know, she was a bad Muslim, bad girl, bad Pakistani girl." – L. 493-495, Naina

In this example, the client is marked by her failure against the standards of a cultural and religious paragon. Naina unpicks the client's own ability to debunk the familial belief system – reversing ownership of beliefs from them to her. The repetition of "bad" juxtaposed with religion, gender and culture hyperbolically explains the client's failure against culturally-tabooed activities.

#### ***6.1.4 Sub-theme 4: Communal Anxieties***

Whatever the client's worries may have been, they appear to be culturally related and are therefore hypervigilant regarding judgement or exposure from an ethnically-similar therapist. The participants acknowledge these anxieties and base their responses accordingly. They may allow the cultural affinity and cultivate it within therapy by utilising it as a springboard in the dynamic, or they may accommodate the client to reduce the threat of perceived exposure.

In accordance with the literature review and the participants accounts, it is acknowledged that the PM culture is a collectivist one, as Aisha remarks:

“...my culture is a very social and community orientated culture.” – L. 3-4, Aisha

Here, culture is immediately conflated with the collective experiences, giving a sense of intertwined-ness. Aisha also overtly states her acknowledgement of collectivism being the fabric of PM culture. Aisha informs her client of her options:

“I have colleagues from all different backgrounds and culture, so let’s talk about it. So I’m bound by my code of conduct that even if I was to see you in the street, I wouldn’t acknowledge you until you acknowledged me....everything else you’re thinking and you’re seeing, that doesn’t matter right now.” – L. 79-97, Aisha

Beyond the superficial offer from Aisha in recounting the options for the patient, she is also projecting the patient’s inherent prejudices back on to her. Moreover, citing professional standards allows Aisha to quash the client’s cultural misrepresentations and instead supplants it with her professionalism. This allows a sort of re-writing of their dynamic, whereby Aisha presents herself as a construct of her profession rather than a construct of culture, acknowledging meanwhile that the latter exists and needs to be dealt with. Aisha is also hypothetically demonstrating the binary worlds of culture and psychology. The former is seemingly governed by ancestral codes of conduct, often arbitrary and unchallenged, whilst the latter is a tested and regulated discipline. It seems here that Aisha attempts to bridge this gap through hearing, understanding and challenging the client while maintaining that her fears are real. Thus, the client’s culturally enforced distrust is potentially demystified to create a new, clinical world, free from socially normative practices and beliefs.

*This quote made me think of my relationship with the BPS code of conduct throughout my trainee programme. Initially I felt rather stifled by it and considered it, at times, a hindrance in entering my client's worlds. However, Aisha's statement above reminds me of times during my clinical practice whereby the code of conduct offered a template in which I felt safe and buttressed, particularly during times with PM clients whereby I was able to lean on and feel supported by the code of conduct, through which my client's too felt held and safe.*

Unlike the previous subthemes that posed more of a channel through which the shared culture can be embraced and used to decode once inside the therapy room, the present subtheme identifies a “big brother” style of culturing and fear of judgement on a mass-scale to those potentially monitoring or judging from outside the clinical room. This dichotomy between the external social domain and the internal strife (outside and inside the safety of the clinical room) interestingly symbolises the public and private self often associated with this cultural group and reflected in Nadira's statement as follows:

“...an incident around abuse happened and she disclosed that to me but then she was like...“please don't like, I don't want anybody – the police or anybody to get involved” because of that shame. And she was like “oh it's okay my mum knows...my family is dealing with it”, but they weren't really...I kinda felt quite helpless...” – L. 83-91, Nadira

Nadira highlights the social protectionist attitudes as overriding the needs of self and inner survival. Nadira's feelings of helplessness are informed by factors beyond the individual within the therapy room; for Nadira, she is having to grapple with the mentality of the masses, which is not sustainable therefore potentially leading to a general sense of deflated-ness in the face of overwhelming traditionalism.

By contrast, but with arguably similar goals, Tahsin's approach to meeting the clients' social and communal needs appears slightly more determined:

“...I’ve chosen that particular area because where all the Muslims, all the Asians live, it would be very difficult for me to practice there...the whole community would know...they can drive to where I am...I also offer home counselling...so whoever’s on the street...would just think that somebody’s visiting.” – L. 336-349, Tahsin

Here, Tahsin embodies a type of therapist-gone-incognito whereby she takes a stealthy approach to avoid communal judgement or suspicion. Interestingly, Tahsin highlights the operational concerns driven by areas with a large PM demographic and the inability to practice or attend therapy without discrimination.

Naina appears starkly contrasted to Tahsin’s approach where communal matters are concerned as explicated in her statement:

“...you know what bothers me is that kind of...we’ll make an exception....I’m a professional person here. I’m not your friend, I’m not your buddy...I’m not a community person.” – L. 55-62, Naina

Naina seems to display an active rejection of cultural affinity, despite the assumption of her clients. It seems she elevates her professionalism against any kind of cultural subscription expected of her in an explicit manner. Unlike the other participants, Naina does not seem to “give in” to what is expected of her however subtly or otherwise her clients’ expectations are communicated. This approach has implications on the therapist’s remit, their experiences of subjectivity and objectivity and the scope of their involvement which will be explored in the second superordinate theme.

## **6.2 Superordinate theme 2 – Professional Compass**

To varying degrees, all of the participants are perceived by their clients as some kind of intercessor, to whom they weigh up their investment in the patient-therapist interaction. This raises questions around being too subjective or involved, calling into question the therapist’s objectivity or measured involvement. These dynamics play into the way therapy then manifests. In this regard, the

analogy of a compass needle constantly swaying from one end to the other, comes to mind, with the needle representing the fluctuating professionalism of the participant. At such moments one may question whether their professionalism has been upheld for the sake of a subjectivised investment in the patient-client dynamic.

### ***6.2.1 Sub-theme 1: As Impartial as Possible***

Given that the therapist-patient rapport building is, to a large degree, dependent on cultural affinities, the professionalism of the participants undergoes a recalibration of objectivity. It seems partiality is measured, through which some therapists become hyper-objective whilst others will allow their subjectivity to facilitate therapy.

The participants noticed that the clients were becoming too attached or familiar and that made them question their partiality; it made them check their approach. Five out of six participants alluded to measuring their partiality as encapsulated by Tahsin's comment below:

“I have to remain as impartial as possible.” – L. 384-385, Tahsin

There appears to be a sense of urgency in this chosen quote that demonstrated a fierceness to Tahsin's approach in needing to remain impartial and further highlighted in her discussion with her supervisor:

“I'll go back to my supervisor who is white....and I say to her...what is that transference going on...projection. And I say that I found that very similar to how I was growing up...she said just be very careful, the fact that you're not bringing yourself in it. Don't start feeling sorry for yourself.” – L. 415-425, Tahsin

Tahsin's feedback to her supervisor indicates a type of vicarious trauma which resulted in her supervisor warning her to remain objective and separate. Not only does this potentially emphasise the rawness of the matter for Tahsin but also highlights the difficulty for PM therapists to remain impartial when faced with clients who mirror or trigger experiences that are to some degree intrinsic to the PM

culture. The client is almost used as a proxy to gauge her own experiences, but this was acknowledged in supervision. Tahsin therefore must measure and moderate how much she invests of herself emotionally as it could become derailing. By highlighting that her supervisor is “white”, she is also illustrating the perspective of a supervisor who is perhaps able to be objective due to having the “blank slate” necessary to discern engagement from overidentification.

*I wondered what kind of response Tahsin may have received from an ethnically similar supervisor, if at all different. I reflected on my own PM clients as a trainee and speaking about some of the dynamics with my white supervisors who often offered me a perspective I had not thought about. I also received equally beneficial supervision from supervisors who were ethnically similar, but I recall feeling more comfortable and able to speak about my own enmeshment with the latter and detangled my material from the clients in a way that was conducive and often elucidating. The perspectives offered by my white supervisors often made me feel slightly dissociated from my client, although clinically more robust and able to assert boundaries. During my last year, I made an effort to speak more about cultural issues and dynamics with my non-PM supervisors which more often than not, helped the supervisory process in the long run.*

Rani discusses boundaries in light of generational influences:

“I think boundaries become a lot more difficult for me to establish when they’re a bit – of the older generation...I think culturally, you’re always told to respect your elders...” – L. 474-480,

Rani

Rani declares the impact of the clients’ age; the older clients elicit a cultural deference engrained in the communicative make-up of Rani. Rani acknowledges conforming to a cultural predisposition to show respectful consideration of the client’s age; it can cause difficulties for the therapist’s professional desire to maintain impartiality. Such deference may also be construed as acquiescence and complaisance

on Rani's part. It is perhaps the professional compass that mediates and facilitates the therapist when met with an opportunity or an invitation to become involved beyond the therapist's remit.

Neena summarises an approach that takes into account the nuance and diversity within the PM culture:

"...the safe bet is, you focus on the individual and assume that there'll be individual differences."

– L. 420-422, Neena

Neena highlights a tentative approach though one that is in alignment with the client's own level of subscription to the shared ethnicity. Given her own worldview is broad, she appears to endow her patient interaction with the same dignity by beginning from a place of acknowledging culture but assuming that differences will arise rather than a culture-free "very blank slate" as Aisha aforementioned. Neena here alludes to the sheer nuance in cultural and religious practice for this demographic and the advantage in "not knowing", despite it being potentially effortful. Her reference to a "safe bet" made me wonder about the kind of dangers she envisions in the alternative, and about her struggles with maintaining impartiality. The "safe bet" therefore could be the point of reference that guides Neena towards her journey in helping the client.

Religious and spiritual considerations also evoked within the participants a stance that at times they thought could compromise the therapeutic relationship and required various points of reference to manage in therapy. This will be explored below.

### ***6.2.2 Sub-theme 2: Religious Considerations***

From the transcripts, religion seemed to emerge as a factor potentially compromising partiality. In most cases, religion must be weighed in and sometimes merged within the delivery of CBT. I thought it represented a magnetic force partially driving their 'professional compass'.

Religion does not just affect the way the client feels or behaves; it seems to be their fall-back. This religious contemplation has the potential to affect partiality, arguably because everyone's religious leanings are somewhat different; some more liberal, some more orthodox. Aisha below highlights the

importance in making space for the metaphysical and the frictions between psychology and religion, or rather their co-existence:

“...part of the issue was, they felt they were losing their faith...because they were going through depression...why would God let that happen.” – L. 332-334, Aisha

Here, Aisha’s role appears to merge therapist and pastor; she attempts to understand the spiritual and the psychological experience concomitantly, allowing religion a valid presence. The juxtaposition of “losing their faith” and “depression” highlights the interwoven relationship between faith (or lack thereof) and mental health. The question posed by Aisha’s client is not atypical and perhaps highlights the widely held stigma in the PM community that mental health concerns are a sign of ungratefulness or a spiritual deficiency, which can often result in depression and anxiety. This is also echoed in Tahsin’s account:

“You know I’ve sinned, I’ve asked Allah’s forgiveness and I’m trying to pray but do you think I’m a bad person”...I’m having to say no that’s not for me to judge...ultimately Allah is the judge. But then I do remind them...Is Allah angry is Allah good, so that’s the bit that helps them to understand Islam as well.” – L. 64-72, Tahsin

Tahsin also exhibits the traits of a therapist-cum-pastor. She seems to remove the onus from upon herself and places it back onto divinity, thereby apparently refraining from acting as an intercessor. Nonetheless, she appears to pose a question to her client in an attempt to reconcile religion and counselling by calling upon an eschatological understanding to overcome her client’s feelings of religious betrayal. Tahsin is also guided somewhat spontaneously, dependent on the client’s revelations and particularly when dealing with a terminologically and emotionally weighted term such as “sinned”. Her efforts can be seen as non-judgemental, yet there is arguably a perception of her as a therapist-cum-intercessor between client and God.

Aisha’s comments below also resonate with Tahsin’s:

(discussing funeral rites) "...this is all from Hindu culture (R: Yeh) it's not Islamic. And she said, I don't do these things and this family are putting pressure on me, what do I do? ...this is completely innovation, it's not allowed." – L. 362-367, Aisha

"So we made that as a compromise...she was in the family, she kept the peace, she did khizmet (duty)...which is also you know a Sunna (traditional practice) ...you get adhar (reward) for it." – L. 388-391, Aisha

In both these instances, it seems the therapist-client ethnic similarity allows Aisha to comprehend the patient's predicament. Aisha is also asked by the client to help discern the inception of religious or cultural practices and to help the client dismantle any seemingly "innovative" associations. In the latter quote, traversing the client's personal tenets of faith with those practised around her, diplomacy is opted for the sake of social survival and blending.

Applying a professional compass to the client's religious dilemmas here was important to navigate and help steer the therapy in a direction most conducive to the client's social and individual standards as well as that which sits comfortably with the therapist judging by Aisha's mention of sunna and the client getting adhar for her actions. In this regard, it seems that the traversing of religious considerations must also entail and capture the therapist's stance.

Naina also seemed to embody this triangulation of considerations between herself, the client and those being discussed:

"...and we started talking about well you know what do you believe about everything you're told...what are their beliefs and she said well, they're very religious...what do you know about religion...do you know that the Prophet's first wife actually had a business...you know that the first university was...created by a Muslim...I was showing her actually there's another side of Islam." – L. 497-522, Naina

Naina tentatively unpicks the client's own ability to debunk the familial belief system, reversing ownership of beliefs from them to her. The use of "they're" and "their" appear to demarcate the client's family-attitude from her own religious views, making this differentiation perhaps to untangle others' religiosity from the client's own identity. By referencing religious figures and their achievements, Naina deploys the client's religious frame of reference to offer a different nuance, contrary to her family's message but not diminishing the client's faith system. She references a religious archetype to perhaps overlay the client's prior beliefs about what girls can or can't do within the Islamic paradigm and offers a more validated model (the Prophet's wife) to challenge present religious diktats.

Furthermore, it seems Naina allows her client to independently unpick religious semantics; to access her own sense of religious/scriptural authenticity. Following a stepping back from the pitfalls of imposing her own understanding of religious doctrine, Naina is then able to reorient herself and her client in demystifying the origins of her beliefs and establishing an alternative way for her client to keep in line with her faith while adopting agency in how she interprets these core beliefs. Naina later shares her views regarding oppression and the need to candidly talk about religion:

"...it's so oppressive a society, you can't discuss religion – it's just imposed on you...culture and religion is so mixed up...it's really hard to distinguish...she found it really really helpful to kind of talk through the religious values that really mattered to her." – L. 650-656, Naina

Naina here exposes a potential correlation between her own thoughts and feelings regarding religion and what she thought helped her client. It is plausible that what helped Naina to "distinguish" between culture and religion was also employed to help her client. From this perspective it is conceivable that due to religion being so intertwined with culture from a young age, the dismantling of it can only manifest through questioning the purpose of what they believe in which is difficult to do in a society that has a collective set of beliefs which informs the individual.

*Naina's statement regarding the difficulty in distinguishing culture and religion hit home, particularly as it is something I have, and still do, grapple with. Taking heed of her words, regarding religious values that matter, I felt a sense of comfort. This made me realise how pervasive the issue of religious-cultural commingling is particularly in the PM community and how important it is to discuss religion and our relationship with it, without fear of feeling undermined or deemed deviant.*

In relation to this dynamic between the metaphysical and the wider collective, Nadira points to what can be considered a current and very relevant common denominator for Muslims: Islamophobia. She states that:

“...they are quite sensitive issues to discuss and things like Islamophobia as well...there are certain realities that we know about in terms of hate crime being on the rise and things like that...it's a little bit difficult to acknowledge the reality of things... seeing it as like...how much is this going to impact you...what can you do to counteract that.” – L. 261-269, Nadira

Nadira collectivises the reality of Islamophobia by terming it a reality “we know about”. Nadira is open to creating a therapeutic alliance to not only engender trust but to use her experiences and her outlook on this reality to help her client make sense of what it means to be a Muslim today. Because the client's therapy sessions have been furnished with a religious context, they can own the goal-creating process by engaging in conversations about the effect of such realities on the individual. Nadira acknowledges the role of religion not only in the day-to-day life of the PM client but also in the socio-political context of the UK today. Due to the heightened vulnerability in the Muslim population and in the topical political climate in Britain, Nadira takes the opportunity of the therapeutic space to discuss pertinent matters.

The notion of a compass is relevant here on account of its association with direction and orientation, in Nadira's case, acknowledging that Islamophobia is a very real threat to the Muslim community; she follows this up with suggestions that can potentially re-route her client from despair to one of agency.

Nadira further offers her perspective on the divinely defined parameters of religion and the more arbitrary nature of culture:

"...we are often taught just to rely on God or just to pray...people seem to be more open about culture...it's not something that you can really hide as much as religion." – L. 404 – 408, Nadira

According to Nadira, religion is in a binary 0/1 position – there is an unquestionable divinity whose tenets against every personal act is measured. Culture on the other hand appears to bend according to the traditions of various communities who may all fall under the banner of one culture.

Of all the participants, Neena posed a diverging stance whereby she experienced religion as causing the problem rather than an entity to utilise within therapy. Neena is an example of the cultural and religious nuances that exist in the PM identity, whereby despite sharing the PM surface identifier with her clients, her inner held beliefs and values are discordant to theirs.

"Those rules can be quite oppressive...it's very interesting that as a therapist I'm trying to encourage and foster responsibility and cognitive flexibility – whereas the religion has very clear guidelines...I have a difficulty with the rigidity." – L. 245-256, Neena

"I think a lot of the religious sort of beliefs tend to focus all on their own dogmas...and considering that those are correct and those are the way of being and I frankly don't buy into that." – L. 335-338, Neena

Neena appears to be frustrated by the religious protocols that some of her clients are bound by, as this becomes a pertinent obstacle in therapy. The self-awareness and ownership of one's own mind that is encouraged in therapy is seemingly compromised by the religious orthodoxy and by-the-book process of

interacting with the world. Neena can't bend the client's will to perhaps perceive their situation beyond the lens of their religion. In Neena's latter quote, she conveys that such steadfastness to religious tenets becomes almost antithetical to therapy and resemble to some degree a kind of hoax, given her comment about not "buy[ing] into that". It seems that a way in which therapy and religion can co-exist is in the former being able to challenge the latter. Neena views CBT particularly as encouraging open-mindedness and enacts a correction strategy to pre-conditioned ways of thinking. This particular focus will be explored in the final section.

### **6.3 Superordinate theme 3 - Negotiating CBT boundaries**

Following an attempt to acknowledge and make sense of their intra-cultural influences and experiences, participants' inclination to professionalism with ethnically similar clients established a point of reference that guided or oriented their approach to their clients. This hinged on their own experiences and current stance with their clients. One of many inevitable endings to this voyage is to explore the experience of the participants working with ethnically similar clients using CBT – an additional entity in the therapeutic relationship incorporating its own worldview - whereby they all question CBT's sole efficiency in working with this demographic.

#### ***6.3.1 Sub-theme 1: Therapist's frustrations and limitations***

On the whole, it seemed the onus was still acknowledged as being on the client and since in this particular culture, therapy is still considered taboo, the full delivery of CBT on the whole became frustrated when the client did not fulfil certain prerequisites of therapy. Therapy thus was not able to extend itself beyond the therapy room. This seemed to feed into the therapist's frustrations and limitations.

Aisha aptly outlines her experiences with CBT and its parameters:

"I think with Islam, CBT goes a certain amount of the way...it's more Islamic psychology that will take care of that...because then we go into concepts like the soul, which CBT doesn't touch...CBT doesn't have any concept of faith." – L. 608-612, Aisha

Aisha states the finite nature of CBT as a model; she communicates that it only serves patient's needs to some extent, after which an eschatological discourse becomes necessary. Her faith in Islamic Psychology as "tak[ing] care of...concepts like the soul" demarcates the disciplines of Eastern and Western psychology paradoxically akin to the demarcation of modalities in the analytic field. This type of "boxing in" and allocation of disciplines to different subsets of the psyche outlines both the significance of acknowledging the individual within his/her context as well as a need to identify and understand the bordered terrains of modalities. Arguably, Aisha's reference to CBT not having "any concept of faith" could be interpreted in a binary fashion. At first glance it appears her frustration lies with CBT not acknowledging the metaphysical realm as a separate value-laden entity (for which Islamic Psychology is better suited). However, at second glance, she could be referring to CBT not having the terminology to discuss faith, in the same way that it perhaps has the language to talk about behaviour and cognition. In this sense, it perhaps has the capacity to incorporate faith but lacks the lexical tools to do so.

In this same vein of limitedness, Aisha shares her experiences with protocol led therapy:

"I struggle with sticking to the protocol...because I go on what I see...not on what I'm being told...I've had arguments with my supervisors." – L. 632-635, Aisha

The quote above seems somewhat confessional. Aisha's ethical pitfalls emerge from her practical challenging of the accepted framework of therapy. She cannot robotically pursue solely what has been mandated and will improvise according to the patient's presented needs. In this sense, the frustration arising from the bounded nature of CBT leads to a bending of "rules". Her reference to "go on what I see" makes clear the importance of "being with" rather than "doing to" echoing the malleable nature of CBT and its delivery. This type of eliciting information on non-verbal cues also speaks of Aisha's surrendering of protocol for the sake of delving into her client's world using her visual senses and not solely theory.

A secondary frustration as a result of this appears to be Aisha's encounters with her supervisors when discussing protocol-led therapy. Aisha reveals a potential initiating of arguments as though she is highlighting the demarcation between theory and practice in a supervisory setting. She seems to be placed

in two different landscapes: one inside the clinic room with her clients, and the other justifying her choices outside the clinical room.

Aisha goes on to relate her experience working in the NHS:

“When I’m not working in the NHS, for example...i have a lot more flexibility there...I can tailor make my plans according to the clients in front of me.” – L. 662-666, Aisha

Here, Aisha is aware of the regulated domain in which she operates and therefore presents a willingness to defy protocol. There is an assumption that since Aisha can tailor her approach with non-NHS clients, that within the NHS there is little room to manoeuvre, suggesting a frustration associated with the institution in which CBT is practiced. This begs the question of whether or not CBT is limited because of its operationalisation in the NHS. Modality in this case would only be as useful (or not) as the environment in which it is practised. Aisha thus indulges a certain professional license beyond the shackles of the regimented mental health service sector based on her discerning capacity to gauge a client’s individual needs.

***In critiquing CBT, I have become more conscious of placing it in its context, both historically and today. I wonder if for Aron Beck and his associates at the time, CBT was employed differently, given its lack of ties to a larger institution through which it has now become touted as cost efficient and “quick”.***

Arguably, such clients do not fare well with CBT’s method of independently conducted exercises. However, when juxtaposed with culture and religion, CBT poses challenges for the therapist as Rani conveys:

“...you don’t want them to feel defensive, you don’t want them to feel like you’re telling them to not value their religion or culture...we have to be kind of hypersensitive...once you recognise how ingrained sometimes those core belief systems can be.” – L. 675-686, Rani

For Rani, re- or undoing the wires that constitute a client's will and testament is tricky territory for fear of putting the client on guard which can defeat the central purpose of therapy. CBT here is used tentatively so as not to disturb or intrude upon these belief systems that govern most actions and even thoughts. This is another delicate matter as the prime focus of CBT is at some point, addressing current ways of thinking and behaving and helping clients in addressing maladaptive cognitive patterns with a view to replacing or modifying these to be more "adaptive". Her choice of the superlative form of the adjective "hypersensitive" seems to indicate the sheer precariousness of such a situation for her. Otherwise, it appears the disquietude will be experienced by Rani as a therapist and as a PM, as well as the client. Thus, the frustration here appears valid and appears to mark a limitation of CBT in this specific context.

In another vein, Naina shares her account of a frustration in the sole efficiency of CBT:

"I worked for the NHS for eight years...I do like six sessions...It does not work, it's not terrible but it depends on how you do it...I don't like to do that whole just think positive thing, I just think it's utter baloney." – L. 717-719, Naina

In describing CBT as "not terrible", Naina appears to apathetically use litotes as a half-hearted validation of CBT. She almost apologetically follows up "It does not work" with "it's not terrible" perhaps to justify her usage of CBT in an NHS setting considering its institutional prolific status. There is a noticeable conflict in this quote related to Naina's loyalty to CBT on account of her role in the NHS but also her weakened estimation of CBT as "baloney" and therefore somewhat tripe when delivered holistically.

In defence of CBT, it is interesting that it has garnered an association with the over-simplified and misleading notion of "thinking positive". I wonder if Naina's prior belief of "Pakistani avoidance" (L. 872) is conflated here with a perception of CBT as disregarding or avoiding negative life events. In this sense, we can hazard a guess that the therapist's attitude towards the client group supersedes and to some degree influences their view on a modality which is at times protocol led. I wonder if it is this procedural

format of CBT that is likened to the procedural and often protocol-led facet of culture and religion, which is off-putting for therapists to subscribe to without hesitation and scepticism.

Neena's experience seems to balance this professional and personal quandary through what appears to be a divergence:

“Catastrophising, magnifying...generalising and labelling...some of the things that unfortunately religion does...a right way to think... a right way of believing...CBT itself has made me question some of these assumptions.” – L. 320-327, Neena

Neena employs vivid terms to demonstrate the way in which those with hyper-scrupulosity fear retribution for potential wrongdoings. This, she believes, seems to be the fault of religion; it besieges individuals with a despondent attitude, when their scripture tells them that they've faltered. It appears that such steadfastness to religious tenets becomes antithetical to CBT.

For Neena, CBT encourages open-mindedness and enacts as a type of correction mechanism to pre-conditioned ways of thinking. For Neena, CBT is considered as an almost great awakening and an opportunity to challenge faith. Interestingly, it seems that for Neena, the cognitive distortions often discussed in CBT (catastrophising, magnifying, generalising) are associated here with religious attitudes. It seems that for Neena, CBT has provided her with the terminology to interpret her own pre-conditioned beliefs which has potentially influenced how she delivers CBT, and generally therapy, to her clients.

On the flip side, there were frustrations and limitations to CBT from the client's side, whether through practical reasons or simply not responding to the model for various reasons. These will be explored, via the participants' perspectives in the next subtheme.

### ***6.3.2 Sub-theme 2: Client's frustrations and limitations***

The participants frequently cited longevity as one of the key frustrations with the process of CBT with their P.M clients, by their lack of dedication to therapy for the long haul. This was sometimes considered to be a limitation of CBT and sometimes down to the client themselves.

Aisha begins with a quote to highlight the difficulties in using CBT with younger people:

“...when you’re working with young people you can’t use those same kind of protocols, it’s too rigid.” – L. 672-674, Aisha

This is also echoed in Nadira’s statement below:

“...like doing the cross section formulation...thought record...even with behavioural activation diary...she didn’t sort of carry it on...there was kind of more of an issue of helplessness...[her] issues are also...school and pressure from...parents...and doing BA is not gonna work with that.” – L. 501-510, Nadira

Nadira too highlights the rigidity of certain CBT interventions such as behavioural activation and its restriction with regards to younger people. Interestingly, it seems Nadira’s client here engaged with CBT as a younger person would engage with schoolwork, pertaining to its pressure and requisite time commitment. The client in this instance may develop a frustration towards CBT because of its parallel with other time-consuming activities which naturally coincide with teenage years. Considering it is often touted as a practical approach, and one that aligns with the PM community, interestingly, there is also a suggestion of BA being incongruent when commitment is directly warranted elsewhere.

BA involves work that can be thought of as similar to the exams and assignment-based work a student often faces for lengthy periods. For this reason, the client’s frustration with certain CBT interventions may derive from this. In addition, pressure from parents to succeed and at times fighting against the cultural odds to carve out a path in education, regardless of CBT, can limit the modality’s ability to address problematic family dynamics.

Tahsin similarly shares her experience and highlights a parallel frustration borne from a lack of community knowledge when delivering CBT:

[on CBT’s utility for the PM client group] “...I’m inclined to say yes but then again I’m thinking because of the nature of how they’ve been brought up and the way they like to talk...they don’t

know what the boundaries are...” – L. 223-229, Tahsin

Tahsin here tempers her judgement on the usefulness of CBT for this demographic. Her treatment orientation appears to be informed by her thoughts about the general Pakistani upbringing and an inability to bitesize their issues. The lack of boundaries for Tahsin seems to imply that CBT cannot be deployed holistically. I sense in her account almost a defeated acceptance whereby her own admiration of CBT as an efficient tool, clashes with a culture that struggles with compartmentalisation. It appears that for the client, this is a greater frustration as the “model of choice” as peddled by the mental health sector, may not reveal itself as fertile ground for the PM landscape.

Rani stipulates:

“CBT is potentially, you’re challenging core belief systems...influence of religion and culture can be deep rooted. And getting them to kind of think of more helpful ways...can be a challenge, when they’re attached to their religion or culture...can feel almost like they’re going against those things...can sometimes be uncomfortable...separating that can be the challenge.” – L. 637-647, Rani

One of the potential hazards Rani seems to face is harmonising CBT with her clients’ culture and faith. If they have, all their lives, viewed issues through the cultural approach or the lens of religion, then this suggests a difficulty in the wholly clinical approach of CBT when such clients present with intensely established spiritual and social mechanisms that have taught them to process emotions somewhat discordantly to CBT. It is this discordance that would potentially create a frustration or a hindrance for the PM client as it may induce a sense of threat to a staunchly held worldview.

Neena however, highlights clients’ frustrations with CBT in the context of the therapeutic setting and so posed a divergence in comparison to prior quotes from other participants:

“...some of them have been through the IAPT service...not really worked long enough on those issues...they report that actually, the therapist had a very fixed sort of...format...concerned

about measures...there was not that sense of really hearing the client...it only scratched the surface.” – L. 517-532, Neena

Neena here seems to expose the issue with the finite resources of state-backed therapy, resulting in inflexible sessions more concerned with quantifiable output than qualitatively reaching any depth with the client. This comes across as a limiting experience for some of the clients in need of therapy, according to Neena’s critique. Neena’s quote above also highlights the age-old tug of war between the oft polarised medical and psychological schools of thought; doing to versus being with, the latter of which Neena seems to be more an adherent of.

### ***6.3.3 Sub-theme 3: Need for integration***

Frustrations appeared to be inevitable for both the client and the therapist regarding CBT and the journeying they have hitherto embarked upon. In order to limit the frustration, it seemed there was a need to take an integrative approach to practice in order to provide a more comprehensive approach to the P.M client. All participants alluded to a missing element when using CBT in an unadulterated fashion.

Tahsin’s quote below illustrates this:

“I did like CBT but I just felt there was something more that I needed. So that’s why I went for the integrative model...so I did the psychodynamic and person-centred...I’ve just been building it up.” – L. 195-203, Tahsin

Tahsin values CBT as a foundational method but believes it has limitations and therefore relies on combined methods. She is proactive, versatile and adaptive in her choice of therapy. Tahsin appears to be inclined to encourage a creative process that allows for a productive interaction. Interestingly, this quote also likens Tahsin as therapist to that of an artist with a palette, choosing her colours and brushes carefully and “building” up a portrait of her client that gives justice to their narratives. It seems her desire to learn about different modalities allows her the skills to be able to deliver therapy in a more authentic and culturally sensitive manner.

Neena too talks of an integrative approach but states that a culturally adapted CBT is not necessary:

“...there is not a program that I follow in a rigid fashion...But this is the advantage of having a more integrative approach...CBT has its place in trying to help people see their thought patterns...but I also integrate...culture, family, religion, you know stage of life, existential issues, um psychodynamic influences....I don't think it's necessary frankly to have a culturally adapted CBT.” – L. 364-376, Neena

“...if you're coming from it with an awareness of cultures and the importance of culture in shaping a person's worldview...you don't need the model to be adapted, you just have to use different models.” – L. 376-380, Neena

Here, Neena converges with most of the other participants in her view of CBT not being solely efficient. However, rather than modifying the model of choice, she advocates for more open-mindedness, flexibility, and a consideration of systemic factors. For Neena, it seems that the religio-cultural elements are necessary to acknowledge but then need not be blended into any particular therapy. They are pertinent peripherals to therapy. Her use of the word “frankly” implies she is vehemently against any notion of CBT requiring adaptation. It seems she will deploy various methods but not dictated by culture/religion, rather these are incorporated discreetly. For Neena, it is a given that culture and its ability to shape one's worldview should be taken into account and so developing an entire approach based on incorporating these into an existing model, seems perhaps futile. Considering it is the culture that shapes one's worldviews, Neena emphasises that it is through this lens that one can gain greater awareness into a client's concerns, and it is the modality that is the tool to aid this awareness. In this regard, an integrative approach can be seen to utilise the client's context as well as an ability to practise different approaches.

Aisha similarly advocates a culturally sensitive, as opposed to adapted, approach, necessitating a sociological within the psychological approach.

“I’ll just say “well tell me – tell me about your culture”...What’s the norm and what’s not, you know what do you think would be considered quite unusual here in the West now that you have an understanding of...the culture here.” – L. 1064-1068, Aisha

Here, Aisha shows a willingness to understand the societal norms in her client’s culture as well as a curiosity in understanding what they find “unusual here in the West”. By posing the host culture as the “other”, she allows the PM client to maintain a grasp on their cultural norms whilst exploring what it is that is different about the norms of the West.

*When listening to Aisha’s accounts, I thought about some of the implicit and explicit conceptions of what entails a “cultural norm” and how our notions of what constitutes this will have an impact on our ideas of mental health and appropriate interventions. Working with ethnically similar clients, I often fought between two cultures – that of my parents and what had been instilled in me growing up, and that of what I had immersed from my surroundings growing up in London. I was cautious of this cultural wrangling muddying the therapeutic process but later realised that it was helpful to acknowledge this as a process that perhaps my clients were also going through but through a different lens; wondering if their norm should be subdued in favour of the host culture, monitoring their language so as to fit the Western mould or perhaps accustomed to keep their culture or any semblance of it silent or unimportant. It is no doubt therefore that the business of therapy is entangled with socio-political grounds and to deny, avoid or keep this outside the clinical room would be to view only a part of the wider setting.*

I found Nadira’s statement below striking in its reference to Jungian psychology and its ability to work with the PM community:

“I’ve been exploring a little bit more about the spiritual side of myself and my work...my approach is like psycho-spiritual, like that’s what I aim for...that’s where more of the like, the Jungian stuff comes into it.” – L. 600-608, Nadira

Nadira appears to have shifted her interest from CBT to that of Jungian psychology or psychodynamic theory. For Nadira, one of the main reasons that she is a proponent of the integrative method was its ability to account for cultural mechanisms and core religious beliefs that can appear discordant with CBT. For her, and others, it is imperative to be familiar with the nuances of cultural backgrounds.

Perhaps in an effort to adopt an integrative practice, we can place ourselves in our client's shoes and attend to the personal, psychological, academic and professional fission that occurs. What the participants' accounts have elucidated is that the similarity between therapist and client may stem not only from a shared ethnicity but also a shared frustration with the experience of that ethnicity. This frustration manifests in the therapeutic process, at which point the therapist must establish the best-fit solution as per the client's needs, and it seems clear that CBT neat is not sufficient as it stands to handle the PM client's psychological needs. Realising this, the therapist becomes fluid in her approach, weighing how much of an input cultural acknowledgement has; how much overt professionalism to contour the dynamic with; how subjective or objective to be with their clients.

## **Chapter 7. Discussion**

This section discusses the findings in relation to the existing literature and the implications for theory, practice, and research. An evaluation will be provided regarding the findings from this study and some suggestions for future research will be made.

### **7.1 Research Findings, Existing Literature, and Implications**

#### ***7.1.1 First Superordinate Theme: Intra-cultural Influences***

Theories of social psychology spearheaded much of what used to characterise research on client-therapist match (Cabral & Smith, 2011) which posited that similarity would engender likeness and relatability. Such likeness fosters a sense of comfort and understanding which social psychology supports (Ames, 2004; Simons et al., 1970). Although studies since then have found mixed results, it has been noted that client outcomes are not affected in a clinically meaningful way (Cabral & Smith, 2011; Shin et al., 2005), casting doubt on the effectiveness of matching. Perhaps more research is needed on understanding the process, rather than outcome, of ethnic matching in therapy so as to understand the nuances as highlighted in this research study: that of identity overlap; one's own prior experiences with culture and religion; the fluidity in what entails 'ethnicity' or 'culture'. From this perspective, accounts of participants, be they client or therapists, can enhance our understanding of the idiosyncrasies inherent in the intricacies involved in the therapeutic relationship.

The present study validates the current and existing research in a number of ways. This superordinate theme reflects the significance of collectivism and social structure in PM culture. It is perhaps this superordinate theme that provides the bedrock in our understanding of PM culture and the therapeutic territory that follows. As highlighted by Zaidi (2016), owing to the strong kinship ties in South Asian culture, the communal structure plays a larger role than any other relationship. The sub theme of "Communal Anxieties" is testament to the interconnectedness of the individual and the wider group, as explored by Ayyub (2000), and illustrated eloquently by Aisha:

“...my culture is a very social and community orientated culture.” – L. 3-4.

Through the participants’ accounts, it was clear that they actively considered the entity of the larger family unit and its maintenance through socio-cultural protocols in order to preserve that social sanctum called ‘honour’. This cultural knowledge bred trust in the therapeutic relationship, supporting previous literature by Morrison (1977) and later, Farsimadin et al. (2007) who had suggested that ethnic minority therapists generate a trusting space as a result of their shared backgrounds. In addition, Chang and Yoon (2011) highlighted that non-matching client-therapist dyads entailed a fear of being misunderstood and a hesitancy with entering in-depth talks. However, this current study supports the notion that it is perhaps the ethnic similarity that allows for sufficient empathy which over-rode disadvantages such as overidentification.

A unique finding in this study is the nuanced perspective that issues such as overidentification may be transient and inevitable at the start of the therapeutic relationship, eventually making way for empathy, understanding and immersion into the client’s world. The sub-theme of “Relatability for trust” was methodically placed at the start of the “themes journey” so as to illustrate the organicism and fluidity of the matching relationship. Tahsin’s comment encapsulates this:

“We all make mistakes...I’ve been there you know I’ve got the t-shirt...just allowing them to feel a bit more comfortable and allows the therapeutic relationship to build up again, assuring them they can trust me and I trust them.” – L. 115-121.

It seems that through some kind of qualitative proximity to the patient’s sense of self and their ordeals, trust is built and nurtured.

Although language was not a focal point of this present study, it featured as a relevant theme as a means to further cementing the trust in the therapeutic relationship. Language and gender have been two facets which were mentioned briefly in the literature review but prominent enough to have sub-themes of their own in the analysis. In addition, and more importantly, language emerged organically from the

transcript analyses. While it may be argued that the scope of any one study can only focus on so much, it is nonetheless important to view these factors as vast in their own right. Language, stigma, culture, and religion were highlighted by Tabassum et al. (2000) as barriers for clients in seeking professional help. As outlined in the analysis, clients would dip into a linguistically familiar mode of interaction and the participants would feel obliged to respond. Beyond merely being a facet of ethnic similarity, language proved to be much larger and more suggestive of a need to understand the relationship between language, the host culture and what can be expressed through language when thought of as a gateway to expressing emotions. Naina condensed this expressively in her comment:

“...there’s that kind of familiarity and I can have this backup...we talk about language around shame, around, um, not being able to speak perfect English...English is the kind of...dominant language... if you don’t know a word you can just dip into your own language can’t you” – L. 603-613.

Linguistic competence is cited as a gateway to effective therapy, via the “familiarity” and the code switching that becomes available as a result and allows for an enriching of the dynamic. Previous literature in this field has touched upon language as a practical benefit as well as one that can enrich the therapeutic relationship, yet this is a unique finding of the current study, having delved a little deeper beyond merely understanding the dynamics between therapist and client but rather elucidating on some of the historical, emotional, metaphorical and resourceful aspects.

Due to the all-female participant recruits, this coloured their cultural experiences in a gendered way, allowing for further exploration with their clients. As with language, participants were cognizant of the types of gender socialisation integral to the PM culture, particularly for girls, as explored in the sub-theme “Gendered experiences and Kinship”. The current study has added to previous literature by extending some thought to the therapists navigating and tapping into their own experiences of gender socialisation in order to empathise and better understand their clients. It could be argued that male therapists may be bereft of the insights gained from gender socialisation, rendering an enquiry into this aspect of male therapists working with female clients. It would be interesting to unearth whether or not this gender socialisation exists for male therapists talking to male clients and whether it is non-existent

when male therapists talk to female clients. This study has also highlighted the importance of understanding gender roles in the context of larger kinship ties, as the latter informs the former and the former appears to maintain the latter. All participants alluded to a type of pigeonholing of women/girls into the domestic sphere for the betterment of the wider family. This was seen illustrated poignantly through Aisha's account:

“...the family that she was living with, they were more cultural...she said, I don't do these things and this family are putting pressure on me...there are certain things you've got to do to keep your home going...you're not actually involved in the cultural practice...you keep coming out with a tray of something or collecting something so everyone knows you're there, but you're not there.” – L. 351-385.

In alignment with Dwyer (2000), gender socialisation is integral to the PM fabric, particularly for girls who socialised according to the patriarchal and religious diktats of the culture.

Arguably, participants manifested a type of over-stretching as a way to perhaps compensate for the lack of opportunities historically not afforded to them because of their gender. As second-generation women, they introduced either clinical and/or personal experiences related to discord in the home and community environment. They allude to the lack of space for individualism which was also expressed by Zaidi et al. (2016) who discussed the cultural dilemmas, differences and demands on the South Asian population when exposed to the competing value systems of the West and the East. The relative “different lifestyle scripts” (p. 233) as mentioned by Zaidi and colleagues was mirrored by the participants accounts via this particular sub-theme, partly owing to the familial role in upholding values of the East. Naina offered an example which made reference to this culture clash, particularly for women:

“...they found her gym bag because she went to the gym from work and so...she was a bad Muslim, bad girl, bad Pakistani girl” – L. 493-495.

This poses a stark contrast between what is considered a “Western” activity and the PM belief system.

In relation to this demarcation of the East and West, another profound insight offered by the participants is that both entities exist side-by-side, in and of one another. Given the prescribed gender roles, linguistic nuances and cultural relatability, this study supports earlier notions that therapeutic alliance is one of the most significant aspects of the psychotherapeutic relationship, and one that is non-transferential (Ardito & Rabellino, 2011). This gives rise to communal anxieties, which was a sub-theme of this superordinate theme and one that seemed relevant across all participants' accounts. Sethna et al. (2018) discussed cultural norms and the impact of speaking of one's problems lest it tarnish the family name. This resonated with participants who allowed their culturally collective experiences to nurture and cultivate the therapeutic relationship or at the very least, acknowledge it as an extension of the PM experience, to which both therapist and client are allied. Thus, to assume that East and West are markedly disparate theoretically, conceptually and geographically (pockets of traditional PM communities exist in the UK) is to ignore the inevitable overlap and intertwined nature which arguably rests in both camps. With the younger generation particularly, this is more manifest, given a number of variables such as their heightened sense of Muslim identity, desire to break away from elders' traditions and greater awareness of their sense of self tied up with the political arena. In a sense, the participants in this study symbolised a bridging of both worlds whereby they utilised their own knowledge and experiences of the cultural terrain as a torch to shed light on their clients, and themselves in the process. This dynamic did not occur seamlessly for participants, suggesting that the process of traversing and making sense of their client's frame of reference was at times mired with their own. The participants tended to be women who had succeeded in overriding their Eastern culture and accepting a Western focus. The clients very often were still struggling with the problems engendered by the East vs West cultural split. This raises the implication that the East vs West split was out of synchronisation between the participants and their clients, this deserves extra investigation.

With regards to Irfan et al.'s (2017) study regarding the facets of therapy, 'awareness of cultural issues' was mentioned as playing a crucial role in delivering effective therapy. In support of this, the present study offers the additional perspective that the therapists' awareness of their cultural interactions with their clients must also be moderated given their remit and scope of involvement. The second superordinate theme sheds further light on this.

While previous literature has emphasised the significance of the collective and family support for South Asians and Pakistanis (Bowl, 2007; Netto et al., 2003, Tabassum et al., 2000), it can be inferred from the present study that ‘communal anxieties’ are, by contrast, an enabling factor in maintaining mental health problems for this community. For the participants, there was a grappling of the mentality of the larger group that inevitably leads to a sense of hopelessness in the face of overriding traditionalism. Participants, to varying degrees allude to a type of “big brother” style of culturing, as reflected in Nadira’s statement:

“...an incident around abuse happened and she disclosed that to me...“please don’t like, I don’t want anybody – the police or anybody to get involved” because of that shame. And she was like “oh it’s okay my mum knows...my family is dealing with it”...I kinda felt quite helpless” – L. 83-91.

Thus, this cloistered communalism may enable mental health crises through a neglect of the issue at hand and calls for a deliberate and considered acknowledgement of the social and communal constituents of the PM individual.

The dichotomy between the social domain and the internal discord can be seen as symbolic of an interweaving of the collectivist/individualist argument, which is not as polarised as some of the literature infers (Laungani, 2005). The PM therapist in this regard has the unique and often challenging task of steering, differentiating and sorting out the public and private self in relation to their parallel embodiment of the collectivist and individualist cultures from which they both emanate and co-exist.

All participants touched upon the theme of ‘shame’ associated with stigma related to the client’s psychological concerns and fear of losing face in the community. This is in line with Bowl’s (2007) and Tabassum et al.’s (2000) study that societal stigma regarding mental health concerns significantly affects South Asians. This was prominent in the present study from the perspective of ethnically-similar therapists who took into consideration the anxiety experienced by their clients and the additional anxiety stemming from the sameness in the clinical room. Interestingly, this dynamic forged a response from the therapist which would essentially shape their delivery, albeit in a fluctuating manner. This is an important

facet of intra-cultural therapy for practitioners and a reminder to be mindful of their remit in the professional realm. This forms the basis of the next superordinate theme.

### ***7.1.2 Second Superordinate Theme - Professional compass***

Participants found themselves weighing up their investment in the patient-therapist interaction, giving rise to the degree of their involvement and how this manifested in therapy. A type of fluctuating professionalism was inferred from the participants' accounts which has not been explored with this demographic before. Although it has been noted that Pakistani therapists working with Pakistani clients may be more effective - given their awareness of cultural and religious factors, than non-Pakistani therapists (Naeem et al., 2015) - the focus has generally been on the therapist's cultural identity and the modality of choice.

Fernando (2005) stated that while therapist-client matching allows for greater understanding and space to self-disclose, issues also arise such as overidentification; therapist disclosure; fear of shame and dishonour on the family (Hussain and Cochrane, 2003) and most notably, difficulty in managing boundaries (Eleftheriadou, 2003). This also surfaced in the present findings contributing to the notion that therapist and client experiences of ethnic matching is manifold. More recent literature (Cabral & Smith, 2011; Mir et al., 2015) has explored the question about the specificities of a therapist's ethnic identity that help or hinder therapy outcomes. The present study posed the following question as one of the research aims: 'Does their faith or culture allow for greater exploration or confusion?'. Overall, participants acknowledged the need to maintain a professional distance in theory but found it difficult to apply this in practice. Nadira alluded to this:

"I have my own experiences and my own perspectives on things in culture and religion, but I also have to be mindful that I don't put my own views on clients as well...with non-Muslim clients...I feel like I can be a lot more objective" – L. 307-315.

Despite the ethnic similarity, participants could not overlay their own purview onto therapy. Rani similarly alluded to boundaries being difficult to maintain with the older generation:

“I think boundaries become a lot more difficult for me to establish when they’re a bit – of the older generation...culturally, you’re always told to respect your elders...” – L. 474-480.

It appears there is a struggle to maintain professional credibility in the face of an overriding protocol-led discourse pattern between young and old Asian interaction; this is an almost innate or conditioned habit, borne from the collectivism of the culture. Much of Pakistan and other parts of South Asia, is governed by this type of social etiquette, where adopted epithets such as “Uncle” or “Aunty” are a manifestation of respect/good upbringing and filial obeisance. It is starkly contrasted to the individualism of the nuclear family within the British culture. Partiality was therefore measured, as professional credibility and boundaries were constantly at play. This aligns with Reddy’s (2019) findings whereby participants (South Asian therapists) often experienced their professional boundaries being pushed through a rejection of certain procedures to better accommodate and engage with South Asian clients. In Reddy’s study, participants found that sessions lasted longer, and an informal/familial tone became attributed to dialogue, at times being viewed as “daughters” or “sisters”. This was also discovered in the present study, however, just as in Reddy’s research, professional boundaries were sometimes compromised due to the affinity formed, calling for a quest for impartiality. Participants in the present study appeared to favour a holistic and often integrative practice in order to reside in the client’s world. This illustrates that the essence of being a practitioner working in an ethnically-similar dyad coalesces with examining assumptions related to identity and carefully steering professionalism in culturally-tinted waters. This resonates with Sue (1998) who asserted that therapists must avoid perpetuating stereotypes that can make one lose sight of their own influences and thus going against the practice of cultural competence. On the other hand, there is the potential risk that if the ethnically-similar therapist consciously banish the evident cultural proximity for the sake of professional objectivity, this could then induce a client-distrust or disappointment, in that the therapist, clearly equipped to gauge the cultural nuances of the dynamic, has refused to do so. The therapist risks sacrificing the full trust of the client, for the sake of professional neutrality thereby stunting the therapist-client relationship.

Religious and spiritual considerations also evoked a stance within participants that they considered could potentially compromise the therapist-client relationship and required managing in therapy. For clients who did bring religion into the room, participants were obliged to call upon a religious or spiritual understanding to elucidate the client's concerns so as not to disregard their world view; this is in alignment with Springer et al. (2009). The participants believed there was a benefit in acknowledging the differences between culture and religious practices, often requiring diplomacy on the participant's behalf. For participants who seemed to eschew cultural practices, interestingly, they tapped into their knowledge and interpretation of religious text/dogma to help the client reframe a situation. Here there is a benefit to knowing the differences between cultural and religious practices, especially when the client brings it up. From this perspective, culture and religion for the PM society is intertwined and requires not only a "knowing" of culture and religion but interestingly, the participants' own journeys and re-evaluation of culture and religion impacted their approach with clients more than the knowledge per-se. Naina shared her views regarding religious dogma:

"...it's so oppressive a society, you can't discuss religion – it's just imposed on you...culture and religion is so mixed up...it's really hard to distinguish...she found it really really helpful to kind of talk through the religious values that really mattered to her." – L. 650-656

It seems here that what helped Naina to distinguish between culture and religion was also utilised to help her client. This supports literature pertaining to religion in therapy (Worthington & Berry 2001; Hussain & Cochrane 2002), which states that when religion and culture are matched together, this is more effective in tapping into the nuances of the client's world. However, in the current study, there was no indication that religious matching was necessary but rather how they have reflected upon and then utilised their own experiences with religion in the session with clients. This allowed for a congruence and authenticity - rather than a success or a hindrance - in orienting themselves to their clients' world and guide them to a place of agency. This is an essential finding for practitioners as it pulls from the most rudimentary tenet of the field of Counselling Psychology, that is, our respect for the individual's autonomy and a prioritisation of the subjectivity of the client above that of the therapist's (Cooper, 2009).

The next and final section of this chapter will focus on the therapist's views and experiences using CBT, which entails its own worldview, whereby participants question CBT's sole efficiency in working with PM clients.

### ***7.1.3 Third Superordinate Theme – Negotiating CBT boundaries***

As explored in the previous section, participants' professional compass hinged on their prior experiences and current approach with their clients. The role of CBT thus evoked interesting responses in relation to incorporating a value-laden modality into a value-laden therapeutic dyad.

The current study appears to affirm previous literature regarding the "universalist service" (Levinson & Rodebaugh, 2012) that is often used to refer to CBT and the notion that it assumes a 'one size fits all' approach. Given that the origins of CBT stem from primarily non-minority, Caucasian middle-class participants (Miranda et al., 2005), this suggests that ethnicity, race, religion and class may not have been accounted for at the time. Since then, literature has attempted to explore the effectiveness of CBT with different cultures and religions (Pecheur & Edwards, 1984) including the PM culture (Rathod et al. 2013; Naeem et al. 2015) with discussion from clients' perspectives but little from therapists' perspective.

Overall, participants found CBT to be effective at times, particularly its stance on practicality and ability to challenge cognitive distortions. However, CBT becomes lacking and limited when confronted with a faith-orientated discourse. Interestingly, some participants advocated for a type of Islamic Psychology or an adapted CBT, while others maintained that the modality is only as effective as the client's investment into the process. This is interesting as it suggests that the environment in which CBT is practiced makes a difference to the delivery, effectiveness, and outcome. Whereas in an NHS setting there is a struggle to stick with protocol and a frustration embedded in the participants ability to adapt CBT in a manner that is most beneficial to their client.

In the context of the PM client, this raises questions as to who decides what is maladaptive or adaptive; how does one navigate the maladaptive in a manner that does not render a client's religious or cultural system to feel endangered or faulty; to what degree does the replacement cognitive/behavioural pattern allow for the client to exist inside of it without the threat of disrespecting age-old traditions and

dogmas; and how does one align the worldview of CBT with one that is theoretically, politically and socially different to the worldview of the client?

This is interesting from the perspective of prior literature, some of which suggests that Islam and CBT complement one another due to shared characteristics such as a focus on education, rational discussion, and forward thinking (Hodge & Nadir, 2008). One can argue that while these are indeed shared commonalities – just as with the ethnically-similar client/therapist dyad – the essence of aligning the values of two entities may very well reside in the one who delivers: in this case, the therapist. It seemed participants required a kind of cognitive matching with clients to critically think and apply CBT in a fashion that allows this modality to be traversed and utilised as a tool, rather than as synonymous with religion. This is important as it makes space for integrative practice and an appreciation of differences within systems and modalities, in the same way we are encouraged to appreciate diversity in ethnicity, culture, race and religion.

Carter and Rashidi (2004) stated that the Islamic perspective of reflection and goal setting to change for the better is in line with the premise of CBT and its emphasis on reason and rationality. In order to apply this in practice, participants needed a level of critical thinking and tact in being able to utilise CBT from an Islamic perspective when need be. Rani shares her account of managing culture and religion when using CBT:

“...you don’t want them to feel defensive, you don’t want them to feel like you’re telling them to not value their religion or culture...we have to be kind of hypersensitive...once you recognise how ingrained sometimes those core belief systems can be.” – L. 675-686

CBT is used speculatively so as not to intrude upon critical belief systems which at times constituted part of the therapist’s frustration. Aisha also recounts her experiences with the parameters of CBT:

“I think with Islam, CBT goes a certain amount of the way...it’s more Islamic psychology that will take care of that...because then we go into concepts like the soul, which CBT doesn’t touch...CBT doesn’t have any concept of faith.” – L. 608-612.

CBT thus accounts for some of the way, but not all. The above quote indicates the duality of approach therapists need to take with Muslim clients to ensure that CBT may be effective.

Previous literature has not explored in depth the frustrations that may arise as a result of carrying out a faith-adapted CBT in a setting that is protocol-led. Rather than to assume a deficiency in CBT per se, it is worth questioning whether or not CBT is limited due to its operationalisation in the NHS, thus calling for future research to investigate the practice of CBT in different settings with ethnic minority clients.

Participants did not merely ‘use’ CBT in a pure fashion, rather what led to frustrations and limitations was the mere fact that the delivery of CBT and any adaptation of it was motivated by their own earlier experiences, scepticism, lexical abilities and the wider setting. This resonates with Irfan et al.’s (2017) findings that cultural adaptation of CBT is not simply a translation exercise but entails various facets to operate together. One such facet is a critical consideration of the parameters of protocol led therapy and when to improvise; Aisha’s comment seemed to touch upon this:

“I struggle with sticking to the protocol...because I go on what I see...not on what I’m being told...I’ve had arguments with my supervisors.” – L. 632-635.

Here, she could not pursue what was mandated in its entirety and had to improvise according to what she was seeing in front of her. She was also cognizant of how this clashed with supervisors, suggesting a need for supervision to entail an honest, non-judgemental, and open space for such discussions. Nadira too outlined a frustration with using CBT on younger people:

“...like doing the cross section formulation...thought record...even with behavioural activation diary...she didn’t sort of carry it on...there was...an issue of helplessness...[her] issues are not

just this, [her] issues are also...school and pressure from...parents...and doing BA is not gonna work with that.” – L. 501-510

Thus, an approach that considers such various facets that exist outside of the clinical setting is necessary. Furthermore, this study also supports the notion that a systemic exploration of the PM individual is necessary in order to assess the origin of their belief systems (Irfan et al., 2017). With regards to an indigenous model, in line with Rathod et al.'s (2010) study, the current findings suggest that rather than a new model being devised, it is more conducive to incorporate socio-cultural-religious beliefs into CBT, including the use of stories, images and metaphors associated with PM culture. This approach may be limited incorporating so much religio-cultural material, that the purpose of CBT is undermined and becomes ineffective.

From the client's perspective, participants found that prior to applying CBT to their presenting problems, it was necessary to ascertain to what degree clients formulated their issues through the lens of culture or religion, particularly as the latter would have taught them to process emotions differently to CBT. From the participants perspective therefore, an entirely clinical approach to CBT in this sense may create discord in the therapeutic relationship as it may evoke a sense of threat for the client.

Maki (1990), as outlined in the literature review, in his study on Japanese Americans, found a high level of identification with the sharing of common ethnic experiences rooted in a group's historical experience and altered by generational status. Japanese American therapists invested a lot of themselves with ethnically-similar clients and spent more time with them in sessions than with other clients. This intensity of identification can be seen in Reddy's (2019) study, in that working with ethnically-similar clients transcended the clinical realm and into one of social justice. For this reason, working integratively seemed all the more necessary so as not to be pigeonholed by any one approach. It seems that the high degree of similarity in the therapist-client's cultural background may result in both the therapist and client holding common feelings and perspectives, particularly given the gendered element in the case of the current study. The more intensive this identification, the more useful its nature. Certainly, this investment is also moderated by the therapist's reaction, thus enhancing identification through countertransference. Maki's results as well as those of the current study share a common denominator:

sharing of dynamics (as opposed to mere ethnic similarity) increased identification and thus intensity. For participants in the present study, overidentification in similar dyads were not simply due to ethnic matching but rather the sharing of ethnic experiences as rooted in one's socio-historical experience (such as discrimination or difficulties with parents). This is evidenced with Nadira's following point, who appears vested in the hardships of her client facing religious discrimination:

"...Islamophobia as well...[these] are certain realities that we know about in terms of hate crime being on the rise...it's a little bit difficult to acknowledge the reality of things... seeing it as like...how much is this going to impact you...what can you do to counteract that." – L. 261-269

Nadira owns her client's tribulations, as a common denominator between the two. Another point of convergence with Maki's study is that ethnic similarity produced a sense of over identification and vulnerability. This can be seen with Naina, who coalesces with her client to rail against the strictures of their shared ethnicity:

"...it's so oppressive a society, you can't discuss religion – it's just imposed on you...culture and religion is so mixed up...it's really hard to distinguish...she found it really, really helpful to kind of talk through the religious values that really mattered to her." – L. 650-656

It could be that identification is crucial to the process of empathy whereby the therapist thinks 'with' the client as opposed to 'about' the client. As Maki contested, problematic countertransference reactions can occur, and this process of empathy can be disrupted during the point at which the experiential plane ceases to be shared.

In relation to the notion of 'knowing' and 'not knowing' (Toledano, 1996), findings from the current study propose that despite participants being (knowingly or unknowingly) allocated the role of intercessor or cultural representative, a certain degree of knowing is necessary to facilitate relatability for trust. With regards to suggestions of cultural awareness training as purported in prior literature (Burman et al., 1998; Rajan & Shaw, 2008), while this may be a worthwhile endeavour and one that can certainly

aid the pursuit of multicultural competence, participants in this study collectively alluded to a type of cultural congruence and authenticity alongside a knowledge of limitations, that may be more fruitful in both understanding the client and the parameters of the therapist. Aisha for example advocates a culturally sensitive approach which sits in the client's frame of reference:

“I’ll just say “well tell me – tell me about your culture”...What’s the norm and what’s not, you know what do you think would be considered quite unusual here in the West now that you have an understanding of...the culture here “– L. 1064-1068

This kind of cultural consideration goes beyond the parameter of CBT and endeavours to make sense of what “normal” is or is not. Arguably, this is a type of integrative practice that makes room for the client’s vantage point, without which assumptions can be made, and blind spots overlooked. This can also extend to an acknowledgement of CBT parameters and an appreciation of its limitations, lending the practitioner an affordability to integrate.

## **7.2 Conclusion**

### ***7.2.1 Evaluation, Limitations, and Applications for Future Research***

Counselling Psychology stresses diversity and plurality and thus the teaching of multiple therapeutic models. With this in mind, although the grasp of multiple techniques can advantage the therapist professionally, it may also run the risk of locating the role of the therapist’s ‘self’ amongst theoretical array (Edward & Bess, 1998). In this study, the prerogative lay with the participants to negotiate their personal sense of self, their subscription/protestation to a collective cultural identity and CBT. All of this entails biases; avenues to greater awareness; limitations; frustrations and most importantly a call for integrative practice.

From a phenomenological stance, these three superordinate themes and their associated sub-themes are tightly woven together, so that omitting any one of them would unravel the meaning associated with this unique overall experience. A primary reason for this study’s focus on PM therapists was due to

the proclivity of prior literature to refer to ethnocultural groups as representing the sum of the parts (e.g., South Asians), often negating the deep-seated cultural and ethnic differences found among group members. Trimble and Bhadra (2013) refer to this as 'Ethnic Gloss'.

While this study has highlighted some of the collective influences of the PM culture, it has also shed light on the unique thought-ways of this group in its diversity of language, norms, religious practice and mores. Dwight Heath (1978) argued that categories of people under the caption of "ethnic groups" are often not as meaningful socio-culturally as the manner in which people define and uphold social boundaries among or between self-identified categories. This is important for practitioners in gathering information on a client's natal background.

The current study provides some useful insights as to how this group of SGPM therapists experience working with ethnically-similar clients using CBT. Results from this study consider that therapists consider themselves able to work with similarities to their clients allowing them to create an honest and open space for clients. Sensitivity was also deployed in handling culture and religion, given its rootedness in the social sphere. In this vein, having a personal understanding of the community allowed them to work effectively, whilst their professional compass empowered the powerful religio-cultural facets of the interaction. Barring this negotiation of cultural and religious influences and how these are navigated when using CBT, it is believed that having an interest in clients' backgrounds, avoiding assumptions and stereotypes and endeavouring to work congruently is undertaken by many therapists, regardless of matching. For this reason, suggestions related to professional practice can be applied to all therapists. This raises the question, whether the findings of the study are applicable to other ethnic groupings. For instance, Hindu therapists with Hindu clients or Jewish therapists with Jewish clients. In both of the examples given, there is a shared aspect of socio-cultural and religious elements, which may result in an increased empathy between therapist and client. This deserves to be investigated further.

I derived much enjoyment exploring the experiences of second-generation Pakistani Muslim therapists and believe that the aim set out was achieved in relation to this particular under-researched population. Through reflecting on the participants comments and the results of this study, it seems fitting to acknowledge that matching of this type manifests in other professional relationships such as GPs with their patients, within the realm of social care, supervisors and supervisees, and the work of interpreters. It

is appreciated that the nature of these experiences would be different, but it would offer an interesting perspective as an extension to this study, if those relationships were also explored to see how their experiences differ from those of the participants in this study and in what ways. This would allow a further insight into matching, insight into what different professional roles entail and the needs of different professions. Various parts of health care (not solely mental health) can benefit from insights like this as they can review the needs of employees, trainees, and other South Asian individuals who require services besides psychological therapy.

The current research is not without limitations which will now be discussed alongside potential future avenues for research and practice. This topic area was inspired by my own experiences working with ethnically-similar clients using CBT and so there was an underlying assumption that other PM therapists would share experiences similar to my own. At times during the interviews, participants would echo this shared experience and I may have followed a desire to want to affirm my own beliefs at the expense of maintaining objectivity. However, in order to prevent this, I continuously reflected on my personal stance using a reflective diary and cross-checked themes and notes in as thorough a manner as possible. Moreover, I had continuous discussions with my supervisors and peers to help me maintain distance from the data.

Secondly, the participants were all female and so accounts of male therapists were omitted. The gendered nature of this study has raised issues concerning the interaction between female participants and female clients. An implication of the interviews was that, apart from the religious and cultural aspect, the fact that the participants and clients had the same gender greatly increased their empathy. The question raised, that needs more study, is - are female PM therapists more effective with female PM clients, than male PM therapists? This would have implications for clinical practice in that it might be desirable for female therapists to be matched with female clients.

Though CBT formed the crux of this study, other therapeutic modalities may also benefit similar exploration in its delivery from the PM therapist's perspective to ethnically-similar clients. In discussion with the participants, many had expressed a tendency to deploy other modalities, hence it would be interesting to study whether other approaches are also influenced by the ethnic similarity between therapist and client.

Lastly, four out of six interviews were on Skype and two were in a public setting which raises questions about the challenges around conducting interviews online vs in person; both may entail a different experience. In-person interviewing is frequently believed to be the gold standard (McCoyd & Kerson, 2006) in qualitative research. Rapid development of technology over recent years, however, have offered alternative interview channels such as video calling – arguably the closest alternative to the in-person experience. Skype is one of the most well-known of these tools, with over half a billion users at a given time (Cater, 2011). Geographically hard to access participants can be reached and the cost/time savings are mirrored in saving the environment from emissions which would otherwise be generated by travelling (Hanna, 2012). Moreover, it has been identified that video calling is safer, given neither the interview nor participant must travel to an unfamiliar location, particularly as some people may not want their space intruded on (James & Busher, 2009). However, despite these benefits, necessity of access to adequate high-speed Internet and digital literacy can affect the nature of the interview (Deakin & Wakefield, 2014).

Building rapport in-person is different to that of online. Previous research has illustrated that online interviews can pose problems for building rapport due to a lack of visual cues (Chen & Hinton 1999; Hay-Gibson 2009). However, studies on the experiences of PhD researchers using online platforms have suggested that rapport building online still yielded a qualitative dialogue and posed very minimal difference to the experience of in-person interviews (Deakin & Wakefield, 2014; Denscombe, 2003).

In order to surpass issues associated with rapport building via Skype, a number of emails were exchanged with the participants prior to the interview. This allowed a connection to be developed beforehand, reframing the notion of rapport building online.

### ***7.2.2 Implications for Practice, Counselling Psychology and the Wider Community***

A number of unique internal processes manifested when working in an ethnically matched dyad surrounding the role of assumptions, moderating objectivity and negotiating boundaries around CBT. Participants were able to highlight their distinctive experiences working with PM clients, through over-identification or acknowledging the role of culture and religion as sometimes creating hindrances in therapy.

The experience of internal conflicts and the ‘push and pull’ factors of working in an ethnically similar dyad were also highlighted. The experience of delivering CBT was also illustrated as entailing benefits and limitations. The use of CBT was affected by the environment in which it was practiced, it is notable that participants found the more rigid protocols of the NHS more difficult to negotiate than those of private practice.

Echoing Cabral and Smith’s (2011) conclusions that research on racial/ethnic matching is manifold, this study, particularly through the first superordinate theme has contributed to the suggested research avenue. That is, that there is some understanding of the ‘matching’ variables (reliability for trust, linguistic competence, gendered experiences and communal anxieties) that help to understand the process of ethnically similar dyads. These matching variables could be considered a more significant factor in establishing a productive collaboration between client and therapist.

When asked about suggestions for cultural competence in therapists, most participants advocated education for all therapists working with PM clients in order to inculcate an understanding of the workings of PM society and for the concepts of mental health within that society. This is in line with Cabral and Smith (2011) who suggested that future research attend to areas such as communication skills and cognitive matching rather than concepts such as ethnicity. This may be limited by the PM participants worldview stemming from their experiences of religion and culture. Nevertheless, a greater acknowledgement of trans-cultural counselling in training is necessary. Whilst training approved by most accredited bodies suggest that all training programmes entail learning about cultural diversity, further teaching with more focus on working and carrying out assessments with BAME clients is required. Training programs can also incorporate workshops and group discussions around existing literature or exploring themes such as those found through this research. Training on diversity and culture can be extended to incorporate practices and techniques in this realm. Furthermore, training could be conducted by therapists working within a matching service or those who have extensive experience with matching in therapy, to provide knowledge to those interested in this domain.

Results from this study also indicate a robust need for therapists working in a matching service or primarily in matched dyads, to have a space whereby their own needs are met. A crucial insight into PM therapists’ experiences involved an important inner dialogue and struggles in defining their identity and

purpose of their work. Moreover, almost all of the participants in this study reported after their interviews, that they enjoyed reflecting on their work and speaking to others who were interested in their experience and desiring further opportunities to talk to others in the same realm.

Following from this, ensuring personal therapy and adequate supervision time is vital in meeting these needs. The unique practices of matching have been highlighted in the Discussion chapter and further space for discourse around this should be welcomed. This may take place in the form of support forums, groups, or peer supervision through which networking with other therapists can be established.

A further implication for trainees could be to provide reflective spaces to discuss and explore the constituents of ethnicity as vast and meaningful in their own ways. For instance, a unique finding in this study was the acknowledgement that rather than merely being a feature of ethnicity, language holds a much weightier role and one which elucidates historical, emotional, metaphorical, and resourceful aspects of the client's world. It is therefore crucial to embed in training programmes that an active listening to the language our clients use as well as the language of therapy itself is vital in understanding where we meet with our clients and why.

The suggestion to place primary emphasis on modifying treatments to match a particular client's worldview (Benish et al., 2011; Cabral & Smith, 2011; Smith et al., 2009) may lead to better outcomes and efficiency but may run the risk of becoming outcome dominated and relegating process to a minor role. One of the essential values of Counselling Psychology calls for an understanding of the client as a relationally- and socially-embedded being (Cooper, 2009). The current study has endeavoured to understand this from the perspective of the PM therapist working with the PM client using CBT and how these worldviews interact, tuning to the client's unique subjective experience. It is through the interaction with the therapist that enables a 'self-otherness' to take place, to be validated and to be respected (Cooper and Hermans, 2007).

Finally, on a societal and political level, many Muslims have experienced oppression in the way Islam has either been exploited for power, in their homeland or used for discrimination in a foreign setting. On a parallel micro level, there are power dynamics borne from a patriarchal framework within the traditional PM house, whereby gender roles are fixed, and traditions observed. Participants referenced the inner conflicts that generate as a result of these dynamics such as shame, guilt, identity confusion, loss

and rage. From this perspective it is arguably the case that the PM world view is embedded in this identity-flux at its core; from the poetic and metaphorical manner in which the Qur'an was written and transmuted to the Muslim world, with its symbolic stories and archetypal creatures to the turbulent genesis of Pakistan in 1947. A potential implication therefore could be for this study to be replicated from a psychodynamic perspective rather than CBT. This lens may offer insight on this demographic given its pattern of unstable identity, unstable relationships, and fearful attachments. This may also contribute to the healing of the age-old split between the East and West, or rather, spirit and matter.

Undoubtedly, practitioners should assemble as much as they can in the way of their client's cultural background with particular attention to the client's beliefs, values (family focus, the role of the elderly, the individual and the community). Moreover, sensitivity to the client's mode of acculturation to the host culture, cultural commitments and difficulties in acculturation are also crucial (Berry, 2003).

However, given it can take years to know a culture adequately, it is reasonable to ask how much of any one culture one can know. Reassurance can be found in qualitative data which suggests that more often than not, problems stem from assuming knowledge than not, since perspectives from clients in previous studies point to cultural incompetence rather than cultural competence. Even when we do think we understand a person's cultural background, an inquisitive, open, and empathic approach of not knowing (enough) might be the best course of action.

More ethnic matching should be offered than is currently available. Professional bodies in counselling fields and universities should make a concentrated effort to recruit more trainees from ethnic minority backgrounds. Mental health services should place greater emphasis on career promotion and recruitment of ethnic minority professionals.

Training practitioners to work with clients from ethnic minority backgrounds is an ethical duty and can help but the data suggest it is not adequate. Nevertheless, ethnic matching should be offered, not coerced. Even though at first glance, ethnic matching may appear to foster avoidance or segregation, adopting an approach that denies the difference is not the answer.

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## Appendix A – Participant Information sheet

### PARTICIPANT INFORMATION SHEET

Title of Study: Intra-cultural CBT – Perspectives of Pakistani Muslim therapists utilising CBT with ethnically similar clients.

What is the purpose of the study?

Past research has suggested that ethnic and religious similarities between the therapist and client has been reported to impact the therapy process in many ways, both in terms of challenges and strengths.

Currently, literature states that Pakistani Muslims tend to view mental health services as a last resort due to mistrust and fear of stigma. Even fewer studies look at generational differences or the many nuances which exist between culture and Islam within the Pakistani group. As the majority of Muslims in the UK are second generation, it is crucial to shed light on these perspectives, particularly in regard to potential conflicting values.

This research aims to shed light on some of the nuances that exist in what is otherwise considered to be a culturally homogenous group as some literature has assumed similarity among all South Asian Muslim communities. Furthermore, I am interested in hearing about how culture, Islam and CBT is experienced with clients from a therapist's point of view, particularly as CBT is seen as being the most congruent model to use with this client group. Your voice is important in understanding some of the nuances which exist among Pakistani Muslims.

This research hopes to fill the gap in knowledge with regards to working more effectively with cultural and Islamic matter in therapy as well as to engage better with diverse worldviews.

Why have I been invited?

This research aims to explore the lived experiences of SGPM therapists using CBT. I will be carrying out six interviews and will use the resulting data as part of my thesis. Through your participation as a research participant, I hope to understand the essence of how intra-cultural CBT is experienced. I hope you will give me this opportunity to carry out this research at your convenience.

Do I have to take part?

Participation in this study is voluntary and you may withdraw at any stage up until the analysis of data commences. You do not have to answer all questions which are believed to be too personal or intrusive. You will not be penalized if you choose to withdraw and can do so without giving any reason.

Costs

You will be reimbursed for any travel expenses.

What will happen if I take part?

- It is estimated that the interview will take an hour to complete give or take 10 minutes
- A consent form and a demographics form must be completed and signed prior to interview
- Interviews will be semi-structured, and audio recorded
- You will meet the researcher once only for the interviews, however contact details will be made available should you need to get in touch.
- The interview will take part in a mutually agreed place, either in a pre-arranged meeting room or a public forum.

What do I need to do to take part?

Please read the following as it will determine your eligibility as a participant in this research study:

<p>Inclusion Criteria:</p> <ul style="list-style-type: none"><li>- Second Generation Pakistanis in the UK. The term second generation refers to individuals born in the UK to first generation parents.</li><li>- Practicing psycho-therapeutically as an accredited therapist in the UK for at least two years (This includes Applied Psychologists, Psychotherapists, CBT therapists, BACP/UKCP therapists, etc). This is to ensure that sufficient time has been spent working with ethnically or religiously similar clients.</li><li>- Therapists who are interested in taking part must consider themselves Muslims or have an affiliation with Islamic faith. There is no particular emphasis sects or branches of Islam.</li><li>- Therapists must have practiced CBT in the UK with ethnically similar clients on an individual basis.</li></ul> <p>Exclusion criteria:</p> <ul style="list-style-type: none"><li>- Receiving treatment for anxiety or depression or have so in the last 12 months. This is because the topic guide could elicit distress.</li><li>- Limited command of English</li></ul>
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What are the possible risks or disadvantages of taking part?

Some of the topics covered may evoke distress or discomfort. In order to manage this, should it arise, attempts have been made to adhere carefully to the London Metropolitan University guidelines and Distress Protocol. So that you feel relaxed about sharing your experiences you may take short breaks

during the interview and are not obliged to answer questions which make you feel uncomfortable. You will be offered support after the interview if this is required if you have any concerns. You will be given ample time to discuss these with me post-interview and given a list of resources for support should you experience any distress.

Will my taking part in the study be kept confidential?

- The researcher will be the only person who will have access to the participants' information and data.
- Audio recordings of the interview will be saved on a computer and password protected.
- Future use of personal information will respect the identities of the participants and will remain anonymous.
- Data will not be shared without consent
- Confidentiality will not be breached
- Records will be stored as a hard copy in a filing cabinet which is locked with a key. Electronic records will be password protected on the researcher's laptop and encrypted.

What will happen to the results of the research study?

Whether or not the study will be published in the future, anonymity will be ensured regarding identities and names of participants. If there are future publications, participants may request to receive a copy of the summary of results. Permission will also be sought in the consent form. Contact details will be provided in order for participants to obtain this.

What will happen if I don't want to carry on with the study?

You are free to withdraw from the study without an explanation or penalty at any time. However you cannot withdraw from the study post analysis stage. Dates will be provided.

What if there is a complaint or a concern?

If you wish to make a complaint or raise a concern about any aspect of the research process or how you were treated during the course of this study then please get in touch with the research supervisor, Dr Raffaello Antonino, contact details below.

Has this study been reviewed?

This research study has been reviewed and approved by the Ethics Committee at London Metropolitan University.

How do I get involved?

If you are happy to participate in this study, please see contact details below for more information or to express interest.

Further information and contact details:

Researcher: Rozina Anwar, Trainee Counselling Psychologist

Email: roa0510@my.londonmet.ac.uk

Research supervisor: Dr Raffaello Antonino

Email: antonir1@staff.londonmet.ac.uk

Telephone number: 020 7133 2448

Thank you for taking the time to read this information sheet.

## Appendix B - Consent form

### CONSENT FORM

Title of Study: Intra-cultural CBT – Perspectives of Pakistani Muslim therapists utilising CBT with ethnically similar clients.

This consent form is to ensure that you are pleased with the information provided about the study and aware of your rights as a participant.

Please tick

1.	<p>I agree to take part in the above London Metropolitan University research study. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records.</p> <p>I understand this will involve</p> <ul style="list-style-type: none"><li>● be interviewed by the researcher</li><li>● allow the interview to be audiotaped</li></ul>	
2.	<p>This information will be held and processed for the duration of her course and for publication purposes.</p> <p>I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published.</p> <p>I consent to the use of sections of the audio transcriptions in future publications.</p>	
3.	<p>I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project (during a 3 week period post-interview) without being penalized or disadvantaged in any way.</p>	
4.	<p>I agree to London Metropolitan University recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on</p>	



**Appendix C - Demographics sheet**

DEMOGRAPHICAL DETAILS

Age: .....

Gender: .....

Religion: .....

Place of birth: .....

Culture/ethnicity: .....

Religion: .....

Qualifications: .....

Professional title: .....

How many years have you been practicing as an accredited therapist? .....

Number of sessions with ethnically and religiously similar clients: .....

How long have you been practising in the UK? .....

Model of Therapy: .....

## **Appendix D - Distress protocol**

### London Metropolitan University Distress Protocol

This will be followed if participants become distressed or anxious during the interview process.

Some participants may become distressed during the interview while discussing their experiences and a distress protocol is designed to deal with this possibility.

As a Trainee Counselling Psychologist, the researcher has accumulated a set of skills for working with and identifying psychological distress, ensuring the safety of participants. Severe distress is not anticipated during this research study as attempts will be made to ensure that unstable, psychotic or suicidal participants be excluded from the study.

Should the participants become unduly distressed, the following steps and actions will be taken to ensure the participants' wellbeing:

Mild distress:

Mild distress tends to be characterised by signs such as tearfulness, redness of the eyes, crying, difficulty in speaking and restlessness. In such cases, to ensure that the appropriate action be taken, the researcher will ask the participants if they are experiencing distress and if they are, the researcher will give them time to compose themselves and ask if they would like to continue with the interview.

Severe distress:

Signs of severe distress are characterised by uncontrolled crying, tremors which are uncontrollable, an inability to speak coherently, panic attacks and difficulty breathing. The appropriate action to take in this take will be to stop the interview following by debriefing immediately. The researcher will attempt to utilise relaxation techniques to resume normal breathing and reduce agitation. The researcher will also reassure the participant that their experiences are normal reactions to abnormal events and that such experiences are recoverable. Unresolved issues which arise during the interview will be validated sensitively and the researcher will suggest that they may want to talk about their experience with a mental health professional. At this point, participants will be reminded that the interview and research study is not aimed to act as a therapeutic interaction and details about therapy services will be offered to the participants.

Extreme distress:

Extreme distress is characterised by signs such as severe agitation and at times, verbal or physical aggression. In an extreme case, a psychotic breakdown can occur whereby the participant relives incidents which are traumatic and lose touch with reality.

An appropriate course of action if this were to happen would be to first maintain the safety of the participants and the researcher. If the researcher has concerns about the safety of the participants or others in general, then he will take this as reason to inform the participants that his duty of care is to notify mental health services or the participants GP. However, if the researcher feels there is immediate danger regarding the participants or others, then she will suggest that they go to the nearest A&E and ask to be seen by an on-call Psychiatric team. If the situation exacerbates and the participant is not willing to seek help immediately, followed by outwardly violent behaviours, then the Police may have to be called and asked to use their authority under the Mental Health act to detain the participant and take him/her to a place of safety followed by psychiatric assessment. This latter option would only be used in extreme emergency situations.

## Appendix E: Poster



Are you a **Second**  
**Generation Pakistani**  
**Muslim mental**  
**health therapist in**  
**the UK?**  
Do you use **CBT** in  
your practice?  
Have you had  
experience working  
with **ethnically**  
**similar** clients to  
yourself?

IF YOU HAVE ANSWERED YES TO THE ABOVE, WOULD YOU BE INTERESTED IN TAKING  
PART IN A DOCTORAL RESEARCH STUDY?

IF YES THEN PLEASE READ ON.....

My name is Rozina Anwar and I am a Trainee Counselling Psychologist at London Metropolitan University. I am conducting a study on Intra-cultural CBT – Perspectives of second generation Pakistani Muslim therapists in the UK in order to hear your experiences. I am looking to recruit second generation Pakistani Muslim therapists who have practiced Cognitive Behavioural Therapy in the UK with ethnically similar clients on an individual basis and have been qualified for at least two years.

Your participation will entail a 60-75 minute interview with me at a mutually convenient time and secure location where you will be asked to share your experiences. This research project has been reviewed by and gained ethical approval from the London Metropolitan University Ethics Committee.

If you are interested in taking part or would like more information, please contact me on.....or  
at.....

Thank you

## **Appendix F: Debriefing form**

### Debrief Sheet

Title: Intra-cultural Cognitive Behavioural Therapy– Perspectives of Pakistani Muslim therapists utilising CBT with ethnically similar clients.

Thank you for taking part in this interview. This study will hopefully make a significant contribution to understanding the role of culture, Islam and Cognitive Behavioural Therapy when working with ethnically similar clients and hopes to contribute to the growing literature on difference and diversity.

#### Purpose of research

Past research has suggested that ethnic and religious similarities between the psychologist and client has been reported to impact the therapy process in many ways, both in terms of challenges and strengths. Currently, literature states that Pakistani Muslims tend to view mental health services as a last resort due to mistrust and fear of stigma. Even fewer studies look at generational differences or the many nuances which exist between culture and Islam within the Pakistani group.

This research aims to shed light on some of the nuances that exist in what is otherwise considered to be a culturally homogenous group as some literature has assumed similarity among all South Asian Muslim communities. Furthermore, I am interested in hearing about how culture, Islam and Cognitive Behavioural Therapy is experienced with clients, particularly as this is seen as being the most congruent model to use with this client group. Your voice is important in understanding some of the nuances which exist among Pakistani Muslims.

#### Procedure

Participants are required to meet with the researcher who will then carry out a semi-structured interview on your experiences of using CBT with ethnically similar clients. A convenient meeting place and time will be arranged.

If you were distressed or upset by taking part in this study, please make contact with one of the following agencies or individuals:

Supervisor details:

Research supervisor: Dr Raffaello Antonino

Email: [antonir1@staff.londonmet.ac.uk](mailto:antonir1@staff.londonmet.ac.uk)

Telephone number: 020 7133 2448

If you have any questions, concerns or complaints about this study you are encouraged to contact Rozina Anwar at [roa0510@my.londonmet.ac.uk](mailto:roa0510@my.londonmet.ac.uk)

Your participation is much appreciated.

## Appendix G - Interview Schedule

### Interview Schedule

Literature has told us that some of the cultural values of Pakistani Muslims therapists working with Cognitive Behavioural Therapy are associated with Islam and is related to identity of the therapist which may prompt psychologists to alter Cognitive Behavioural Therapy accordingly. It is this experience of how they modify CBT and their own thoughts about how/if they bring culture and religion into the therapy room that we do not know enough about.



These questions have arisen from published articles and journals and have guided the formation of the following interview questions:

- Can you tell me a little about the role of your culture in practicing therapeutically?  
Prompt: Could you tell me a little about how culture plays a role in therapeutic outcomes?
  
- Could you tell me a little about the role of your religion in practicing therapeutically?  
Prompt: Are you able to give an example of how it felt to....
  
- Could you tell me a little more about how you relate to CBT?  
Prompt: Could you talk a little more about your experiences of using CBT alongside culture /religion?
  
- Could you tell me a little about how you perceive your professional identity?  
Prompt: Could you say a little more about your professional identity when discussing culture/religion in therapy with your clients? Could you say a little more about the setting in which you practice and whether or not this impacts your professional identity?
  
- What is your experience of working with ethnically similar clients to yourself?  
Prompt: How well do you think CBT is equipped to work with ethnically similar clients?
  
- What do you think would help other therapists who use CBT to increase their competence to work with Pakistani Muslim clients?

Other prompts:

When you say X, what do you mean? Are you able to give an example of that? Can you say a bit more about that? What is it about culture that you.....? What is it about Islam that you.....? What is it about CBT that you.....? What does X mean to you?

## Appendix H – Ethics approval email

**Angela Loulopoulou**  13 February 2019 at 13:16  [Details](#)

Approval of Ethics

To: Rozina Anwar, Cc: Raffaello Antonino

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Dear Rozina,

your amended Ethics form has been reviewed and approved by the Chair of the Ethics committee for the School of Social Sciences.

You can proceed with your recruitment and data collection.

Kind Regards,


Angela

***Dr Angela Ioanna Loulopoulou, PhD; AFBPsS; FHEA***

**Principal Lecturer in Counselling Psychology  
Programme Director of the Professional Doctorate in Counselling Psychology  
School of Social Sciences  
Chair of Subject Standards Board for PG Psychology  
Chair of Ethics Review Committee for PG Psychology**

**Office hours 9.30-17.00 Tuesday to Thursday**

**Please email me if you would like an appointment, as I am not often at my desk.**

Read my article at: <http://www.tandf.co.uk/journals/banners/readmyarticle/ccpq.gif> 

Contact address:

London Metropolitan University  
Room T6-20  
Tower Building  
166-220 Holloway Road  
London N7 8DB  
Tel: 0207 133 2667

Appendix I - An example of the participant's (Rani's) annotated transcript

Interview with Rani (a pseudonym)-

R= Researcher P= Participant

1 **R: So, I'll start with the first question. Overall and just**  
 2 **generally, what's your experience of working with**  
 3 **ethnically similar clients to yourself been like, just**  
 4 **generally?**

5 P: Ethnically similar so...

6 **R: Yep, so Pakistani clients.**

7 P: Um I've had a handful I'd say of ethnically similar  
 8 clients and I think the biggest difference I think I've noticed  
 9 is when - is the age range, because obviously you know  
 10 we're ethnically similar but kind of more like my mother's  
 11 age or they've been sort of more my age and that I think is  
 12 obviously quite different. Um people my age - I think it's  
 13 tended to work quite well just because I think there's a lot  
 14 of kind of empathy and understanding of their situation.  
 15 They don't have to go into too much depth about their  
 16 situation. Um where I work at the moment with domestic  
 17 violence victims often there's a language barrier as well so  
 18 sometimes I've noticed in sessions they'll want to kind of  
 19 describe certain situations and they'll wanna quote like  
 20 something that the mother in law said or something that the  
 21 husband said to them in a different language and they don't  
 22 have to kind of translate it, they'll just kind of say it. And  
 23 that's been quite helpful for them I think. Um and there's  
 24 usually this sort of "well you know what its like" and  
 25 generally I do know what it's like so there's um - it's been  
 26 easier to connect in that way. I think with the older  
 27 generation, one thing that I - a similar sort of thing whereby  
 28 I've been able to relate to them kind of on a more deeper  
 29 level. But with the older generation unfortunately there's  
 30 that sort of dynamic of kind of them looking at you as being  
 31 quite younger.

32 **R: Right okay, how does that change things in the**  
 33 **relationship?**

34 P: I think in terms of like the relationship, it becomes a bit  
 35 more - it becomes a bit more friendly but then also not in a  
 36 helpful way in a sense that, they're a bit like...I mean some

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*Rani finds that the variable of age supercedes the ethnically-similar harness*  
*Age-similarity is lucrative as it aids in the genesis of rapport.*  
*The therapist's perceived background signals her communicative-competence that validates code-switching for the client, who can relay the experience authentically without the chore of translation.*  
 *owing to cultural insider-knowledge, the therapist can gauge the micro-aggressions inherent in the ancestral tongue. Moreover, the age-parity allows for a deeper comprehension of the wider cultural expectations the client experiences and the greater the likelihood of communication being readily understood.*  
*Therapist's youth is misconstrued as inexperience / lacking insight.*

*Age as superceding variable*  
*Age = correlative empathy.*  
*rapport-building.*  
*code-switching practicality.*  
*therapist-client dyad*  
*ageism*

In Rani's experience, certain female clients slip into matriarchal mode, creating a symmetry between Rani and a known figure of resemblance, i.e. daughter as a marker of her youth/ puerility; inferiorising Rani.

Rani's experience of the older gen. delineated with adjectives "cynical", "skeptical" & "reluctance" creating a semantic field of distrust & suspicion. Perhaps this mindset is borne from their routine limitation of autonomy, where such women have ordinarily faced restrictions. When faced with a woman like Rani, they perceive her professional independence as anomalous to their cultural purview. This means Rani must endeavour doubly hard to earn their trust and ~~be~~ her systemically sifting through her feelings.

37 of them have been quite open minded and they're kind of  
38 willing to listen to you but I also had experiences whereby  
39 its kind of like you're trying to counsel like an auntie so I  
40 don't really like to use that term um whereby they're a bit  
41 kind of sceptical about what you're saying, suggesting  
42 because you're like the same age as their daughter, so yeh  
43 that's been... it's been a mixed bag between obviously - I  
44 mean overall I feel like, with people from an ethnically  
45 similar background have been able to relate to them more,  
46 it's just - the age really plays a part in it.

**R: Right, so the generation**

P: Yeh definitely

**R: So, what would you do differently with say the younger generation that you wouldn't with the older generation, in terms of interventions or approach or just generally how your therapy pans out...?**

P: I think, I think with the older generation, I'm just trying to think of my experiences now...

**R: Yeh, give an example if you can...**

P: Yeh, like - I'd say they like a bit of, I think there's more psychoeducation going on there, where they like to kind of understand processes more and I think more basically of what I have to explain, why we're doing what we're doing.

Um I think they need a bit of more an explanation in that regard. I think with the older generation as well, there is a kind of - I mean there's always that slight reluctance still within the community about coming to therapy. When they actually do come, there is a bit of a - they're a bit cynical about the process, they're a bit sceptical about the process so I think building that trust with them about the process is really important and I think one of the ways to do that is through kind of psychoeducation and explaining to them why they feel certain feelings, why - I think normalising a lot of their feelings um like explaining certain interventions to them and kind of yeh, it's more kind of explanation. With the younger generation, I think they're more kind of open to trying different things (R: Right ok). With the older ones they need a bit more sort of convincing.

**R: Ok yeh, and explaining why you're doing what you're doing.**

— youth = inexperience

Generational differences in help-seeking.

— Gender roles

— earning trust

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P: Yeh definitely

**R: Okay, um so in terms of culture, tell me a bit about the role of your culture in practicing therapeutically. Like how does culture or that shared culture you have with your client - how does it play out in terms of therapeutic outcomes or your relationship, being Pakistani?**

P: Yeh um, that's an interesting one. I'm trying to think of all the Pakistani clients I have at the moment and um I think it goes back to what I was - I think relationship-wise they, they tend to. I don't wanna say that we bond quicker or anything like that, that's a weird way of describing it but I feel like there is this sort of common ground that they come to therapy and they sort of - I guess it's sort of comforting for them because like I was saying before and they say things like - when they talk about culture, I'm more likely to kind of understand where they're coming from. The sort of family dynamics um also like I said they'll put me with people who speak other languages, that's been helpful. Um and I don't know if this is a positive or a negative but I'll just mention it - it's um, I think when people find that shared um kind of common ground with you like, when they see you instantly and they're like, oh they become curious like oh, like what are you - are you Pakistani. Um it's interesting cos a lot of people - a lot of my clients don't know I'm Pakistani until they ask and they're like oh I didn't know you were Pakistani and once they find out that I am, there's an added curiosity, you know, where are you from, like my family...and obviously I have to maintain those boundaries so I think that's a little bit of a tricky thing when there is that kind of - that shared culture whereby things become quite friendly which can be helpful but also I need to make sure that I maintain that sort of counsellor-client boundary of obviously not sharing too much of myself, not allowing it to become a friendship cos - and it was that common thing of oh you're like one of me...

**R: That familiarity...**

P: That familiarity that they get, that they like which like I said can be helpful in them opening up but I have to be strict about my boundaries because I get also a lot of - I find

And yet she does say it, suggesting an undeniable affiliation is forged between both homo-cultural agents. It could be argued that Rani's professional status is secondary for such clients behind her pertinent status as a fellow P.M.

Rani compels and encouraged intrigue in such clients who discover her P-K status. Yet Rani appears professionally hesitant not to become too taken in by their curiosity & questioning. The familiarity must be measured.

Common ground

Inter-cultural assumed awareness.

measured familiarity

boundaries

measured boundaries

In order to preserve the sanctity of the therapeutic space for the client, Rani finds herself punctuating bounds. The relational depth does not exceed the necessary answering of "basic questions" which she feels ~~is~~ essential for the initial laying of a foundational rapport. She seems rattled by the prospect of excessive familiarity. Dissociation becomes a survival strategy.

She understands the manifestations of religious nuances and is wary of overlaying their religious inclinations with her own, alluding to the multi-sectarian status of Islam. Muslim is not a

117 that with people who have that, from the same culture,  
118 they'll tend to ask a lot of questions about me so...  
119 **R: When you mentioned boundaries with people, that**  
120 **got me thinking about self-disclosure, how do you**  
121 **manage it then so that you've got that balance between**  
122 **building a rapport and relationship but not giving away**  
123 **too much of yourself and letting that take over their**  
124 **sessions, how do you manage that?**  
125 P: I mean, the way I work personally is that some basic  
126 questions I don't mind answering like about where I'm  
127 from, my age or things like that but when it gets a bit -  
128 when I get talking to people - victims of domestic violence  
129 um when they ask me things like am I in a relationship, do I  
130 have any children, I think that's where I kind of remind  
131 them that I can't unfortunately disclose too much about  
132 myself and that this space is for them and just kind of  
133 reminding them of that because the moment I start talking  
134 about myself that's like (coughs) ...sorry..  
135 **R: It's okay**  
136 P: (coughs)...that boundary becomes blurred and um yeh I  
137 think then it can go into kinda dangerous territory and being  
138 too friendly, yeh.  
139 **R: Yeh and what about - so that's culture, what about**  
140 **religion? Tell me a little bit about the role of your**  
141 **religion in uh practicing therapeutically.**  
142 P: I think religion is quite an important - I dunno it's an  
143 interesting one because despite being from the same  
144 religion I think I'm always mindful of the fact that people  
145 interpret faith in different ways. So whilst - and I think I'm  
146 very client-led in the sense that if a client talks about  
147 religion or brings up religion then you know I don't shy  
148 away from bringing it into the room and discussing it but  
149 I'm always mindful of the fact that discussing it from I  
150 think their um their point of interest rather than any of the  
151 beliefs of my own because yes it's the same religion but  
152 then I've also found that the interpretation of that same  
153 religion can be very different so using their frame of  
154 reference is really important for that (R: Yeh). But I think  
155 yeh - I definitely don't shy away from bringing it into the  
156 room if they brought it up. If they haven't brought it up I

- dissociated  
- distanced  
familiarity

blurred boundaries  
dangerous

religious  
nuances

of undifferentiated  
monolithic identity

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157 don't bring it in. Sometimes I think for the clients it can be  
158 a huge source of comfort as well and they like it, but then  
159 once again exploring what their understanding of faith is  
160 and what they're understanding is (inaudible). And I'm  
161 always mindful of doing that because I think there's been a  
162 few times where I've noticed that in the past when I've  
163 brought up religion and then I noticed that actually yes we  
164 are from the same religion but their understanding of things  
165 is very different. So it's always important to ask them, I  
166 guess yeh...work off what they're saying.

**R: So putting them at the centre of their own narrative.**

P: Yeh and their own understanding of their faith because  
168 that's different from - I mean not only different families or  
169 communities but also different individuals. I think religion  
170 is a very personal thing.

**R: Mmm and do you find that differs from culture and  
bringing culture into the room?**

P: Yeh I think it does um...actually yes and no because I  
174 think culture is another one like this - it's like religion  
175 whereby everybody's experience of it is different and my  
176 interpretation or my experience of Pakistani culture is  
177 gonna be very different to someone else's and it's gonna be  
178 different for our clients and that's been quite interesting for  
179 me kind of working with - it's been eye opening for me I  
180 think, working with Pakistani clients because you'd think  
181 we have a lot in common well you'd think there'd be a lot  
182 of shared understanding and yes I can relate to them on a  
183 level to an extent but then culture is very different for  
184 everyone. Um, yeh people, people's families, people's  
185 upbringing can play a huge part of that, um part in that. I  
186 used to - I used to also have this kind of sort of stereotype  
187 that, this is just me being like honest now (laughs)...I think  
188 a slight stereotype of people being born - I mean I guess  
189 depending on when they were born and their different kind  
190 of understanding of culture and then that's also - like I said  
191 I've also become a lot more open minded of that over time  
192 because where someone's born or where someone's been  
193 brought up doesn't necessarily impact that - it really  
194 depends on their family and their upbringing. um yeh...

the way in which culture is enacted  
disallows her from making sweeping  
the manner in which her clients  
Pakistani identity; even more fractious

same religion  
but different  
understanding of  
it

She doesn't  
conflate it  
with culture  
but...

whereas  
religion is a  
set of practices  
defined by a  
larger, widespread  
rhetoric imparted by

some school of  
thought/scholar  
Rani denotes  
the very  
inchoors &

personal input  
of culture in  
a client's life.

She connotes  
it to family  
& upbringing  
& the domestic  
sphere of being  
in one's home  
assumptions of  
possess their

trying to  
be objective

religion  
as somewhat  
untouchable

- family +  
upbringing  
- culture -  
creation

- domesticated  
application  
of culture.

- culture defined  
from within.

considering the history of this relatively young country.

## Appendix J - An example of the participant's (Rani's emergent themes) with line numbers

Culture-rooted Experiences

Faith-inclusive Therapy

Limiting Subjectivity

Emotional Competence

Familiarity breeding Trust

Code-switching Capacity

Age Correlating Confidence in CBT

CBT Gendered Variances

Moulding CBT

CBT Restrictions

Age as superseding variable – lines 8-11

Age – correlative empathy/rapport building – lines 12-14

Code-switching practicality – lines 16-23

Therapist-client dyad – lines 24-26

Ageism – lines 29-31

Youth=inexperience – lines 39-42

Generational differences in help-seeking – lines 61-74

Intra-cultural – assumed awareness – lines 87-95

Measured familiarity – lines 102-112

Dissociated/distanced familiarity/measured self-disclosure – lines 125-138

Religious nuances – lines 143-154

Religion as somewhat untouchable – lines 170-171

Family + upbringing – lines 184-186

Culture defined from within – lines 192-195

Cultural sensitivity/competence/assumptions – lines 210-225

Measured/moderated familiarity/overidentification – lines 238-242

Neutralising culture – lines 251-256

Domestic violence religiously maintained – lines 279-286

Excessive caution – lines 290-296

Tentative challenging – lines 301-305

Mirroring clients' frame of reference – lines 325-328, 331-333, 344-352

Encouraging sense of agency – lines 365-371

Realism/self-awareness (therapist) – lines 381-383

Culture as routine (therapist) – lines 384 – 387

Religious values supersede culture – lines 387-389

Cultural complications – lines 390-392

Heritage and identity/cultural reduction (therapist) – lines 393-395

Religious identity (therapist)/culture redundancy – lines 398-400

Religion and therapy overlaps – lines 406-411

Potency of religion/personal religious validation – lines 431-435

Removal of the subjective self from clients safe space – lines 437-439

Integrity/duty – lines 441-446

Moderating perception – lines 446-449

Linguistic practicality – line 451-

Implied familial bonds – lines 468-474

Compromising professionalism and therapeutic dyad/hierarchy – lines 475-480

CBT + positive youth uptake – lines 507-509

Youthful adaptability to trust – lines 513-521, 526-529

Client resistance and readiness – lines 537-544

Eclectic approach – lines 545-546

CBT timing/chronological placement – lines 554-557

CBT gendered regard – lines 565-570

Pacing CBT/Safe environment – lines 572-577

CBT as space restricted – lines 584-587

CBT + self-awareness – lines 608-613

Troubleshooting inner emotions – lines 614-616

Lacking emotional comprehension – lines 620-630

Spiritual and social obstacles to CBT/maintaining integrity of religio-cultural roots – lines 637-647, 662-664

Integrating religious attachment – lines 656-658

A balancing act – lines 666-672

CBT dissonance/managing clients needs and expectations – lines 675-680

Addressing spirituality/culture – lines 684-687

**Appendix K - A participant's (Rani's) list of subthemes, superordinate themes and corresponding page and line numbers**

Culture-rooted Experiences

Family + upbringing [184-186]  
Culture enacted routinely [192-195, 210-225, 384-387]  
Measured/moderated familiarity/overidentification [238-242]  
Neutralising culture [251-256]

Faith-inclusive Therapy

Domestic violence religiously maintained [279-286]  
Religious values supersede culture [143-154, 387-389]  
Religious identity (therapist)/culture-redundancy [398-400]  
Potency of religion/personal religious validation [170-171, 431-435]  
Moderating perception [441-446, 446-449, 684-687]  
Implied familial bonds [468-474]  
Spiritual and social obstacles to CBT/maintaining integrity of religio-cultural roots [406-411, 637-647, 662-664]

Subjective Approach to Therapy

Excessive caution/Tentative challenging [290-296, 301-305]  
Encouraging client-agency [365-371]  
Removal of the subjective self from client's safe space [125-138, 437-439]  
Emotional competence [614-616, 620-630]

Familiarity breeding Trust

Measured familiarity [24-26, 87-95, 102-112]  
Mirroring clients' frame of reference [325-328, 331-333, 344-352]  
Realism/self-awareness (therapist) [381-383]  
Client resistance and readiness [537-544]  
Code-switching practicality [16-23, 451-453]

Age Correlating Confidence in CBT

Age – correlative empathy/rapport building [8-11, 12-14, 39-42]  
Ageism [29-31]  
Generational differences in help-seeking/CBT positive uptake in youth [61-74, 507-509, 513-521, 526-529]

CBT Gendered Variances

Heritage and identity/cultural reduction (therapist) [393-395]  
CBT gendered regard [565-570]

Moulding CBT

Compromising professionalism and therapeutic dyad/hierarchy [475-480]  
Eclectic approach [545-546, 572-577]  
CBT timing/chronological placement [554-557]

CBT + self-awareness [608-613]

CBT Restrictions

CBT as space restricted [584-587]

Integrating religious attachments [656-658, 666-672]

CBT dissonance/managing clients needs and expectations [390-392, 675-680]

**Appendix L - Summary of superordinate and sub-themes with the relevant quotes for all the participants**

Superordinate Theme	Sub-theme	Relevant quote/extract
Intra-cultural influences	Relatability for trust	“I mean overall I feel like, with people from an ethnically similar background [I] have been able to relate to them more” Rani, p.2, line 44-45
	The benefit of linguistic competence	“I think it helps being able to speak their language...they can’t always explain it in English so I will make them as comfortable as possible” Tahsin, p.3, line 68-70
	Gendered experiences and Kinship	“...she was a bad Muslim, bad girl, bad Pakistani girl” Naina, p.13, line 494-495
	Communal anxieties	“worried that I’m of a similar background to you...worried that we might know somebody in common” Aisha, p.2, line 70-72
Professional compass	Quest for impartiality	“I have my own experiences and my own perspectives on things in culture and religion, but I also have to be mindful that I don’t put my own views on clients as well” Nadira, p.8, line 306-310
	Religious considerations	“Ultimately Allah is the judge. But then I do remind them, is your God...a bad thinking God or a good thinking God” Tahsin, p.2, line 68-69
Negotiating CBT boundaries	Therapist’s frustrations and limitations	“they have to do the work and they don’t want to do the work” Naina, p.4, line 145-146

	Client's frustrations and limitations	"there's always that slight reluctance still within the community about coming to therapy." Rani, p.2, line 61-63
	Need for integration	"I also integrate...the cultural element, the kind of systemic context in which they live – that might be culture, family, religion." Neena, p.10, line 370-376

## Appendix M - Reflexive Statement

A reflexive statement was written at the start of my thesis in relation to the Critical Literature Review; it primarily outlined my reflections and thoughts prior to obtaining results. This reflexive statement will, by contrast, be a consideration of my reflections regarding methodology, analysis and findings. During the research process, I have reflected on my beliefs about the world, others, therapy, culture, religion and my role within these paradigms as well as the impact of my preconceptions on the study. In an attempt to “bracket” (Smith et al., 2009) my personal views and feelings and to minimise the impact of this on the data, I sought feedback from peers, supervisors, my personal therapist and a reflective journal. This was particularly useful during the interpretation of excerpts from the transcripts (Ashworth, 2003). I then randomly selected interpretations of my data and submitted these to peer researchers of different religious and cultural backgrounds and also discussed this with my non-Muslim supervisor so that I could monitor my elucidations from the chosen passages. The feedback received highlighted the necessity in staying close to the participant’s account in general to ensure my interpretations were grounded in their narratives.

Regarding the methodology chapter, I initially pursued the domain of ontology and epistemology like I would have done a complicated restaurant menu – eager to consume but not quite sure of the recipe or ingredients.

I recall looking at a list of epistemological positions and wondering where I could “slot” myself in. On reflection, I was daunted and intimidated by the breadth and depth of what was being asked of me and how it sat within the wider research aims. I only began to grasp the concepts when I asked myself, “what exists, and how do I know it exists”. Working my way from here, I returned to my research and questioned what I could contribute and why I wanted to. How can this research be useful in understanding something that might not have been understood so far – that is, the lived experience of ethnic matching in light of CBT. It also dawned on me that the choice of ontology/epistemology is a political process since culture and religion is represented in different ways in people’s minds.

This project commits me to the world and my participation within it. It allows me to investigate something as its lived, not merely as I conceptualise it. It allowed me to reflect on the essential themes which characterise the phenomenon. It allowed me to describe phenomena via writing and re-writing. I’m also able to witness the articulation of the participants sense making

I was able to utilise a pedagogical relation to the phenomenon and I was able to balance the research context by considering parts and the whole. This latter point influenced my research and motivation to focus on the Pakistani diaspora, not merely South Asians.

As a developing therapist, I am increasingly learning that the most important things that I have to offer to my clients are my genuine interest in their phenomenological experiences, my presence to provide a safe environment as they explore their internal worlds, and a relationship with me based on mutual trust as they learn to bridge the gap between their internal and external worlds.

During the interviews and analysis stage, I recall being conscious of how the participants regarded me; being of a female, SGPM background may have had advantages and disadvantages to the study. Although gender was not an aspect I wished to study, all my participants were female and belonged to the same culture and religion as myself. As a results, I considered myself as an “insider”. However, I also felt detached at times owing to some of the life altering experiences I went through during analysis stage and my re-scripting of culture and religion. For this reason, I considered myself as belonging neither inside nor outside but rather in between. This may have influenced some of my interpretations of their experiences which I address using Rogers’ (1957) rudimentary principle of adopting an empathic and non-judgemental attitude throughout the interview and transcribing stage.

The research process has encouraged me to examine and question my own identity markers as a female, SGPM and how this may have impacted my research development.

Reflecting on this has been pertinent to my methodological process as I found myself at times over identifying with my participants when they shed light on my own internal dynamics and seeking clarity at other times for not having my expectations met. In these circumstances I was aware I could not unrestrainedly separate myself from my research but rather be aware of my own cognitive and emotional processes and utilise the connectedness to the study from an objective standpoint. I also took heed to the notion that the individual is not a passive recipient but rather an active and engaged interpreter of their subjective world in which there is no objective truth (Lyons & Coyle, 2007).

Conducting this piece of research has not been the driving force to question my identity but rather has acted as a catalyst in attending to my then cognitive dissonance. I have been questioning my cultural and religious identity – and for that matter what it means to be these things from a female perspective – since I started to make mistakes. For the majority of my adult life, I have been adhering to social, cultural and religious norms. Following the demise of my previous marriage, I allowed myself to turn inwards and question the origins of my grief. It became clear that my grief was a mourning of my past self, combined with a terror of who I would be otherwise. Consequently, or rather subsequently, I made a decision to lean towards authenticity and refrain with all my might the psychological feeding I had received without any agency. Currently, I still refer to myself as having my toes dipped in the British, Pakistani Muslim world I came from. I have selected what I value from these paradigms and have rejected what I do not. More blandly, I refer to myself as where I most feel at home and that is as a Londoner, who has been sculpted, strained, filtered and framed by her experiences in this medley of a city where East and West have met on every corner of every street. In this regard, I identified with my participants more so when they revealed their inner most thoughts about being many identities simultaneously – more so when these identities each held a lot of weight. I do not find it to be a coincidence that the two participants who diverged the most during my analysis stage were given similar anonymous names (Naina and Neena); as though to categorise them as what would be seen as the cultural anomalies.

In addition, my ideas of what success means in my first year versus what it means now has been truly revealing of my ideas of what I thought failure meant. For example, success in my first year meant to meet my goals seamlessly and as quickly as possible. I was also conscious of pleasing others and seeking approval via feedback for my work from lecturers. My motivations were thus led by my need for validation and a desire to mesh myself with my material, be it placements or academic work, so as to avoid my ‘self’. In the last six to seven months in particular, these notions have been re-evaluated. Success for me currently entails pace and serenity in the midst of stillness and strife and thus I am inclined to the tale of the tortoise, not the hare.

**Appendix N – Manuscript intended for *Ethical and Racial Studies***

Perspectives of second-generation Pakistani Muslim therapists utilising CBT with ethnically similar  
clients:

An Interpretative Phenomenological Analysis.

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## **Abstract**

The aim of the proposed research is to explore the experiences of second-generation Pakistani Muslim (SGPM hereafter) therapists practicing Cognitive Behavioural Therapy (CBT) with ethnically-similar clients, that is, Pakistani Muslim (PM) clients verbatim accounts of six semi-structured interviews were analysed using Interpretive Phenomenological Analysis (IPA). Participants were SGPM therapists aged between 28 and 46 who had worked with ethnically similar clients in the UK. Three superordinate themes were generated: Intra-cultural influences; Professional Compass and Negotiating CBT boundaries. Participants accounts highlighted that they appeared able to work with similarities to their clients allowing for an open and honest space in which to traverse cultural and religious terrain.

Terms such as ‘therapist-client matching’; ‘sameness’; ‘matching’; ‘ethnic similarity’ are used interchangeably to express the plethora of ways in which matching has been understood and outlined in the literature.

## **Pakistani Muslims in the UK**

Pakistan’s population is at about 220 million (Worldometer, 2020) with the majority of Pakistanis being Muslim. Tabassum, Macaskill and Ahmad (2000) reported high levels of psychological distress for immigrant Pakistanis to the UK, such as social isolation, language barriers and alienation. Statistics have shown an increase in the number of Pakistani Muslims (PMs) in the U.K. from 747,285 in 2001 to 1,175,983 in 2011 (ONS, 2011).

For SGPM the pressure becomes greater in trying to preserve Pakistani culture whilst also assimilating Western norms, values and expectations (Hutchison et al., 2015). This has been reflected in studies whereby affiliation to one’s own culture has been deemed compromised in order to fit into the dominant host culture (Dhillon & Ubhi 2003; Jacobson 1997).

## ***Psychological Wellbeing of Pakistani Muslims in the UK***

Literature pertaining to PMs in mental health services in the UK is limited, particularly from the perspective of the PM therapist. However, a number of studies have explored the experiences of South

Asians. It has been stated that UK mental health services are not suitably addressing the cultural and religious needs of the South Asian community (Bowl, 2007; Netto, Gaag & Thanki, 2006). Bowl reported that one of the reasons South Asian communities underutilise therapy is due to a fear of being discriminated against or stigmatised by mental health therapists.

Tabassum, Macaskill and Ahmad (2000) qualitatively studied the mental health issues and needs of first- and second-generation participants in Pakistani families in the UK. Language, stigma, cultural and religious practises were highlighted as barriers to seeking professional help. Notably, the voices of therapists were absent from Bowl's (2007) research and there was limited discussion on how the modality may have impacted the outcomes. There is limited research on PM therapists, particularly on how religion and ethnicity impact the therapeutic process and concepts surrounding the "same" and the "other" (Sue, 1998).

Researchers have found a direct link between the emotional well-being of Muslims and Islamic beliefs (Ali, Liu & Humedian, 2004). Religious beliefs play a prominent role in providing psychological treatment (Weatherhead & Daiches, 2010). For the majority of Pakistanis, Islam offers societal boundaries; parenting styles; education; relationship conduct and mental health treatment (Datillio & Bahadur, 2005).

Despite constituting the largest group of Muslims in the UK, PMs are presently under-represented in the literature regarding psychological therapies (Bhui & Bhugra, 2002; Rathod, Naeem & Kingdon 2013). Given that the views of PM therapists are also absent from scholarly research, this review will focus on the experiences of SGPM therapists and the use of CBT, considering this is the treatment of choice in the NHS (NICE, 2009).

### ***CBT***

The inclusive approach taken in CBT makes it co-function with an Islamic framework, as it takes into account cultural and religious nuances when practiced correctly (Carter & Rashidi, 2004).

CBT has been recognised to meet the Positive Practice guidelines (Stiles et al., 2008) developed for ethnic minority clients, rendering it culturally competent. However, CBT has been referred to as a "Universalist Service" (Levinson & Rodebaugh, 2012), based on the premise that problems can be

understood using a standard framework of ideas (Falicov, 1995). The origin of CBT stems from randomised controlled trials primarily on non-minority, Caucasian middle-class participants (Miranda et al., 2005). Thus, this would have been deemed the dominant social group and their values (individualism) may have been considered the barometer on which CBT would be applied (Hays & Iwamasa, 2006).

Although it is recognised that CBT cannot be adapted for all cultures or religions (Rathod et al., 2013), certain studies have looked at the concept of adapting CBT to work with minority clients.

A large portion of published literature has focused on the adaptability of CBT to individuals from Judaeo-Christian backgrounds (Pecher & Edwards, 1984) with a few who have explored the usefulness of CBT with Muslims, predominantly more in the USA than in the UK (Mahr et al., 2015; Naeem et al., 2015; Rathod et al., 2013; Razali, Aminah & Khan, 2002).

It has been noted that Islam and CBT can complement one another as they share common features such as the focus on education, rational discussion, and forward thinking (Hodge & Nadir, 2008). However, there can be a divergence between Islam and CBT, considering Islam, and many faiths that hinge on the concept of an afterlife, tends toward an eschatological trope in which death and final destiny are promoted as a promise for the believer as a reminder of this life's temporariness. Against this spiritualising, the Muslim mindset may have already compartmentalised their issues as a given or a 'test' that may not necessarily be resolved in this life.

### ***CBT with Pakistani Muslims***

Naeem and colleagues looked at therapist-experiences of providing CBT in Pakistan (Naeem, Gobi, Ayub & Kingdon, 2010). All therapists in the study agreed that CBT was not fit for use with clients in Pakistan who espouse mainly a collectivist cultural outlook. Although modifications were said to be necessary, it was unclear as to how therapists experienced CBT with their clients or how they modified their approach.

Naeem and colleagues highlighted a key issue to consider when working with Pakistani Muslims in the West:

*'A Pakistani therapist working with Pakistanis is more likely to be aware of the cultural and religious factors and can easily adjust therapy compared with a therapist from a non-Pakistani background, who might not be aware of the patients' culture and religion'* (Naeem et al., 2015. p.5).

This statement foregrounds the importance of ethnic matching between therapist and client.

Reporting on the mental health situation in Pakistan, Irfan et al. (2017) suggested that cultural adaptation of CBT is not merely a matter of translating from a therapy manual but rather involves various facets of therapy

Rathod, Kingdon, Phiri and Gobbi (2010) studied the experiences of (predominantly white) CBT therapists in the UK. As with Naeem et al.'s (2011) study, interviews explored the positive and negative experiences of using CBT with Black, Asian and Minority Ethnic (BAME) clients and whether or not the CBT manual was used. Although South Asian Muslim participants were studied, it constituted Bangladeshis and Pakistanis. Cultural diversity exists amongst Muslims, so a uniform exploration of Pakistanis, or any other Muslim culture for that matter, may have shed light on some of the intracultural differences.

### ***Culture, Islam and CBT when Practiced with Clients from a Similar Background***

Previous studies have shown an overlap between CBT and PMs such as cultural modifications to CBT, therapist identity and the values inherent in CBT. These seem to suggest that the values of a modality and those of the therapist are somehow involved in why cultural modifications are needed.

Mir et al. (2015) conducted a qualitative study on the adaptation of CBT with Muslims in the UK, which entailed discussion on patient-therapist matching. Key findings suggested that religion was often conflated with culture, indicating a need for knowledge of the two disparately. Participants thought that matching brought about more understanding, however, for both Muslim and non-Muslim therapists, there was anxiety around when to discuss religion and the impact on their professional role. Though this disconnect was not explored further, it highlights the nuances that exist in culture and religion that a quantitative study like Cabral and Smith's meta-analytic review (2011) may not have been able to capture.

### *Professional and Cultural identity*

Some of the studies previously explored highlighted a conflict with Muslim and non-Muslim therapists with regards to the role of religion and culture in therapy. One can assume that there is perhaps a separate but overlapping professional identity at play which may mediate the decision-making to incorporate religion.

Chreim, Williams and Hinings (2007) refer to professional identity as ‘an individual’s self-definition as a member of a profession’ (p. 14).

It has been noted that ethnic minority professionals often undermine the resources that they can competently bring into the therapy room, particularly with a similar “other” (Bell et al., 2003). Nolte (2007) suggested that second generation family therapists who had come to Britain experienced a sense of connection to clients from similar backgrounds as they could understand the clients’ frame of reference – politically, historically and socially.

Some of the questions that have been left unanswered from previous literature are (i) what of Pakistani Muslim therapists in the UK? (ii) how do SGPM therapists in the UK experience the impact of their culture and/or religion with their clients, if at all? (iii) does their faith or culture allow for greater exploration or confusion? (iv) what motivates SGPM therapists to modify CBT with their ethnically similar clients, if at all? and (v) how is CBT experienced when discussing culture and religion in therapy? The gap identified is the perspectives of SGPM therapists practising CBT, which has led me to formulate the following research question:

“How do SGPM therapists experience practicing CBT with ethnically similar clients in UK?”

This research may be useful in helping practitioners engage with Muslim clients from diverse cultural settings. Research findings may also be extended to other health care professionals including CBT therapists, GP’s, religious members of society, community workers and other parties involved in the care or support of PMs and others.

## Methodology

### *Participants*

A purposive sampling approach was used to select participants for the semi-structured interviews. It is believed that six participants are sufficient to recruit for the present study (Smith, Flowers & Larkin, 2009).

The inclusion criteria states that the participants be:

- Second Generation Pakistanis in the UK. The term second generation refers to individuals born in the UK to first generation parents.
- Practicing psychotherapeutically as a therapist in the UK
- Experienced in using CBT with ethnically similar clients on an individual basis and have been qualified for at least two years
- Affiliated with the Islamic faith and consider themselves Muslims

The exclusion criteria states that participants will not be recruited if they:

- Are at the time of recruitment receiving treatment for anxiety or depression or have received it in the twelve months prior to recruitment.
- Have limited command of English

The following table outlines the demographic information of each participant. To ensure anonymity, names have been given pseudonyms throughout.

### **Table 1.**

*Participant demographics.*

Pseudonym	Age range	Sessions with PM clients (hr)	Duration of practice in the UK (years)	Model of therapy
Aisha	45-50	100+	>10	CBT + integrative
Tahsin	40-45	100+	8	CBT + Integrative
Nadira	30-35	50+	4	CBT + integrative
Rani	25-30	50+	3	CBT + integrative
Neena	45-50	200+	>15	Integrative
Naina	45-50	250+	>18	CBT+Psychodynamic

*Note.* Participants were female, Muslim and of Pakistani ethnicity born in the UK.

### ***Procedure***

The recruitment of participants was attained via making contact with counselling services, beginning in the London area and working outwards, via email alongside an information sheet detailing the research aims and requesting interested participants make contact with the researcher via the university email.

Interviews were conducted using a face-to-face semi-structured format, with each interview lasting between 60 and 75 minutes. Guterman (1994) recommends a semi-structured interview enabling both participant and researcher to establish a good rapport which augments the research experience for the participants, unlike structured or unstructured interviews.

The analytic procedure for IPA followed Smith's (2015) guidelines. The researcher read the transcripts several times noting down emerging themes which were further distilled in a chronological manner. This stage involved a hermeneutic process as it required the research to interpret the participants' interpretation as well as the researcher attempting to comprehend the meaning making of the participants experiences. Connections between themes were explored from the emerging themes and then grouped

together to create clusters of themes. Clusters of themes were given titles and then put into a summary table detailing all the emergent themes alongside relevant quotes.

The next stage involved seeking for patterns among the individual summary table of themes to create a single table of master themes for all the participants. The final Master table of themes for all participants was formed, entailing superordinate themes and related sub-themes.

***Ethical considerations***

The study gained ethical approval in accordance with London Metropolitan University Ethics Committee. Before conducting the interviews, all participants were briefed on what the interview would entail and consent forms signed. A copy of this was given to the participant and the remaining copy was kept by the researcher.

**Results**

Three superordinate themes were identified (see table 2).

**Table 2.**

*Summary of superordinate and sub-themes with relevant quotes*

<b>Superordinate Theme</b>	<b>Sub-theme</b>	<b>Relevant quote/extract</b>
Intra-cultural influences	Relatability for trust	“I mean overall I feel like, with people from an ethnically similar background [I] have been able to relate to them more” Rani, p.2, line 44-45
	The benefit of linguistic competence	“I think it helps being able to speak their language...they can’t always explain it in English so I will make them as comfortable as possible” Tahsin, p.3, line 68-70
	Gendered experiences and Kinship	“...she was a bad Muslim, bad girl, bad Pakistani girl” Naina, p.13, line 494-495

	Communal anxieties	“worried that I’m of a similar background to you...worried that we might know somebody in common” Aisha, p.2, line 70-72
Professional compass	Quest for impartiality	“I have my own experiences and my own perspectives on things in culture and religion, but I also have to be mindful that I don’t put my own views on clients as well” Nadira, p.8, line 306-310
	Religious considerations	“Ultimately Allah is the judge. But then I do remind them, is your God...a bad thinking God or a good thinking God” Tahsin, p.2, line 68-69
Negotiating CBT boundaries	Therapist’s frustrations and limitations	“they have to do the work and they don’t want to do the work” Naina, p.4, line 145-146
	Client’s frustrations and limitations	“there’s always that slight reluctance still within the community about coming to therapy.” Rani, p.2, line 61-63.
	Need for integration	“I also integrate...the cultural element, the kind of systemic context in which they live – that might be culture, family, religion.” Neena, p.10, line 370-376

Due to the limited scope of the current article, one superordinate theme will be explored. The chosen superordinate theme is ‘Intra-cultural influences’, given the emphasis on collectivism in Pakistani culture and the significance of the related sub-themes in creating a groundwork to understand the experience of PM therapists working with PM clients.

***Sub 1: Relatability for trust***

It appears that most of the therapists perceive from early on that they need to show an understanding of their client’s cultural frame of reference. A reason for this is based on the premise that cultural acknowledgement leads to trust; trust is forged through this cultural relatability, rather than solely through the professional credence of the therapist. The cultural acknowledgment, i.e. relatability, seems to breed trust.

...there's usually this sort of "well you know what it's like" and generally I do know what it's like so...it's been easier to connect in that way. – L.23-26, Rani

...overall I feel like, with people from an ethnically similar background have been able to relate to them more... - L. 44-45, Rani

Through Rani's perspective, the cultural background she is superficially associated with perhaps signals an insider knowledge, creating a therapist-client dyad that allows her to connect and "relate" to her clients more. This superficial association may be based on her appearance and her name. Based on these ethnically-similar indicators, it appears as though her clients' trust stems from an unspoken acknowledgment that she must "know what it's like", which she generally does. The notion of an 'insider knowledge' and the trust inherent in that is also shared by Neena:

...working with ethnically similar clients, I have a greater insight let's say on their values, on their kind of expectations, on nuance of behaviour within their communities let's say of the assumptions they tend to make...that kind of knowledge I'm able to use in understanding them in a way that perhaps a therapist from a different sort of racial group might not be able to. – L. 9-17, Neena

Neena suggests an anticipated set of assumptions and the complexity of ancestral ethnicity in therapy. It seems that Neena acknowledges the advantage she has as a therapist with that insider knowledge of ethnically similar clients. However, the relatability aspect seems to be communicated here in a less "enmeshed" manner than illustrated through Rani and Tahsin's comments. Terms such as "working with" and "their communities" imply that her trust-deriving relatability to the client is a professional stratagem rather one that is all too familiar.

Neena appears primed to view her clients' matters from within and from the outside, giving her a dual perspective and allows her to engage multi culturally as well as intra-culturally. She posits this as an advantageous ability to connect with her clients.

By contrast, there is a hesitance for Naina to accept that relatability may foster and cultivate a trusting relationship, which can be further seen in:

...they asked for a Pakistani cos they said...we've had a non-Asian therapist before and we thought maybe that's the issue. And I thought, it's not the issue – the two of you are the issue actually. – L. 253-256, Naina

The above quote is in relation to a couple who sought Naina for therapy. Naina's tone here appears to dismiss the idea of ethnic relatability, and seems to rather underplay the need for cultural connectivity. Ironically, Naina's judgement appears to be another cultural trait, in which in-group members regard another's motives with an air of suspicion. This is consistent with Naina's other accounts as she displays negative relational experiences with this particular client group where ethnic similarity is, for her, problematic, and the concept of trust is not one that is formed easily.

However, in terms of language and familiarity she related a lot more to her clients. This is possibly for a number of reasons, not least because language is the baseline for all communication, so when there is an avenue to go beyond the host language (English) and communicate through the mother tongue (Urdu/Punjabi) then this facilitates a richer therapist-patient collaboration. This is expanded upon in the next sub theme.

### ***Sub 2: The benefit of linguistic competence***

Once the relatability was established and engendered trust, it seemed through the participants accounts that they traversed the interaction with their patients through the most practical means: code-switching. This practice allowed for certain linguistic cultural proclivities to metaphors and storytelling to manifest. Client's would dip into this mode of interaction and the therapist would feel obliged to accept it and respond. Naina discusses this with regard to the experience of shame:

...there's that kind of familiarity and I can have this backup...we talk about language around shame, around um not being able to speak perfect English...English is the kind of...dominant language...if

you're with an English person...there's some shame attached to that...if you're with your own, if you don't know a word you can just dip into your own language can't you – L. 603-613, Naina

Here, the client and the therapist's ancestral language is purposeful for its facilitation of the therapist-client dynamic. The mention of English is perceived as the host language and therefore seemingly far removed from the client's inner self and security. Linguistic competence is cited as a gateway to effective therapy, via the "familiarity" and the code switching that becomes available as a result. The mention of English being the "dominant" language suggests that linguistically there exists a hierarchy perhaps for this client group and a comfort in being able to "dip in" to the ancestral language. The notion of dipping in and out of languages also resonated with Aisha's accounts:

...she said it in Punjabi...if you have a claypot and you put some stones or small rocks in it and you move the pot around...it's that same rattling noise that's inside of my head. – L. 540-549, Aisha

The metaphorical communication here elucidates the patient's state and may be suggestive of a larger cultural issue of a restricted emotional bank, therefore making it easier to communicate analogies based on inanimate objects.

Aisha later uses the image of the claypot to metonymically chart the events in her client's life, allowing for an indirectness that the client is comfortable with. From this, Aisha is able to synaesthetically immerse herself within the client's realm of experience. The image of the "claypot" is interesting here as it is potentially a telling metaphor of a Pakistani housewife whose role it is to remain resourceful and "contained" simultaneously. It is no accident that the claypot is also a traditional Southeast Asian utensil, so a fitting metaphor alluding to the domesticity of female PM homemakers.

### ***Sub 3: Gendered experiences and Kinship***

Once the trust has been built (via relatability) and once they have established a practical communication (language), barriers ease amongst PM clients and it seems the participant has made her way into the safe space of the client. Because of the majority of the participants clients being female – it

colours their cultural experiences in a very gendered way which comes through in therapy and which the participants explore.

The next two subthemes highlight intra-cultural influences in light of kinship generation. Aisha and Neena's quotes seemed an appropriate place to start in understanding cultural norms, influences, traditions and the role of gender:

...it's the older generation...we see it so much in Pakistani women, those who have been housewives all of their lives or those who've had to look after their families with the children who've flown the nest. They fall into depression because they've got nothing to do. Their purpose has been fulfilled...sat there in an empty home, pots rattling, just looking at four walls – that's when they start to develop the physical symptoms because they want the attention. – L. 234-244, Aisha

Firstly, Aisha talks about the limited realm of experience she encounters in Pakistani women, who become wholly subsumed by cultural and traditional norms. Perhaps as a result of cultural diktats, preventing or at least discouraging work beyond the home (or even activities/hobbies), have resulted in a type of redundancy for these women, creating a void otherwise occupied by family service. It seems depression or a sense of vacancy occupies that void.

There is a duality in Aisha's statement of motion and stillness, especially pertinent to older generation Pakistani women for whom their children and their homes fulfil their purpose until a certain point. Reference to "an empty home", "pots rattling" and "four walls" depict the domestication of these women and the resulting emptiness that ensues.

This is also reflected in her later account when discussing a PM client experiencing issues with her husband's family after a funeral:

...the family that she was living with, they were more cultural...she said, I don't do these things and this family are putting pressure on me...we looked at the actual practical situation....there are certain things you've got to do to keep your home going...you're not actually involved in the cultural

practice...you keep coming out with a tray of something or collecting something so everyone knows you're there, but you're not there. – L. 351-385, Aisha

It appears that Aisha's ethnic similarity to the client allows her to comprehend the patient's predicament. There is a benefit to knowing the cultural practices and the inception of those practices to help the patient dismantle it. When reading this at first glance, it appears to contradict Aisha's prior statement (L. 234-244) where she mentions the plight of Pakistani women for whom their purpose has become devoid later in life due to having their purpose fulfilled. In the above quote, Aisha certainly recognises the importance of "keep[ing] your home going" and letting others know 'you're there but you're not there' – female silencing and pacifying for the sake of familial peace. This may be tactful given the particular client's frame of reference and affinity to cultural practices, even though Aisha herself advocates a functionality for the Pakistani woman that goes beyond domesticity.

Nadira too relates her views on PM culture and its place in the wider system of collectivism and the family:

They have more of a collectivist culture...the particular systems that especially Muslim women live within – sort of like sexism and patriarchal cultures and particularly South Asian...a little bit of subordination. – L. 61-67, Nadira

Nadira outlines a recurring paradigm in the cultural philosophy of PMs, whereby those within the culture, by default of tradition, practice herd-simulation with little room for individualism. The de facto governing system of patriarchy perpetuates "sexism", leaving women to bear the brunt of masculine cultural enforcers.

#### ***Sub 4: Communal anxieties***

Whatever the client's worries may have been, they appear to be culturally related and are therefore hypervigilant regarding judgement or exposure from an ethnically-similar therapist. The

participants acknowledge these anxieties and base their responses accordingly. They may allow the cultural affinity and cultivate it within therapy by utilising it as a springboard in the dynamic, or they may accommodate the client to reduce the threat of perceived exposure.

In accordance with the literature review and the participants accounts, it is acknowledged that the PM culture is a collectivist one, as Aisha remarks:

...my culture is a very social and community orientated culture. – L. 3-4, Aisha

Here, culture is immediately conflated with the collective experiences, giving a sense of intertwined-ness.

Unlike the previous subthemes that posed more of a channel through which the shared culture can be embraced and used to decode once inside the therapy room, the present subtheme identifies a “big brother” style of culturing and fear of judgement on a mass-scale to those potentially monitoring or judging from outside the clinical room. This dichotomy between the external social domain and the internal strife (outside and inside the safety of the clinical room) interestingly symbolises the public and private self often associated with this cultural group and reflected in Nadira’s statement as follows:

...an incident around abuse happened and she disclosed that to me but then she was like “oh please don’t say anything to anyone” or “please don’t like, I don’t want anybody – the police or anybody to get involved” because of that shame. And she was like “oh it’s okay my mum knows...my family is dealing with it”, but they weren’t really...I kinda felt quite helpless – L. 83-91, Nadira

Nadira highlights the social protectionist attitudes as overriding the needs of self and inner survival. This cloistered communalism may enable mental health crises through a neglect of the issue. Nadira’s feelings of helplessness are informed by factors beyond the individual within the therapy room; for Nadira, she is having to grapple with the mentality of the masses, which is not sustainable therefore potentially leading to a general sense of deflated-ness in the face of overwhelming traditionalism.

## Discussion

This section discusses the findings in relation to the existing literature and the implications for theory, practice and research. An evaluation will be provided regarding the findings from this study and some suggestions for future research will be made. This section will focus on the first superordinate theme.

### *First Superordinate Theme: Intra-cultural influences*

The present study validates the current and existing research in a number of ways. This superordinate theme reflects the significance of collectivism and social structure in PM culture; it is perhaps this superordinate theme that provides the bedrock in our understanding of PM culture and the therapeutic territory that follows. As highlighted by Zaidi (2016), as a result of strong kinship ties in South Asian culture, the communal structure plays a larger role than any other relationship. The sub theme of “Communal Anxieties” is testament to the interconnectedness of the individual and the wider group, as explored by Ayyub (2000), and illustrated eloquently by Aisha: “...my culture is a very social and community orientated culture.” – L. 3-4. Through the participants’ accounts, it was clear that they actively considered the entity of the larger family unit and its maintenance through socio-cultural protocols in order to preserve that social sanctum called ‘honour’.

A unique finding in this study is the nuanced perspective that issues such as over-identification may be transient and inevitable at the start of the therapeutic relationship, eventually making way for empathy, understanding and immersion into the clients’ world. The sub-theme of “Relatability for trust” was methodically placed at the start of the “themes journey” so as to illustrate the organic-ness and fluidity of the matching relationship. As mentioned by Knipscheer and Kleber (2004), it is perhaps owing to matching that allowed for adequate empathy to traverse the therapeutic relationship and perhaps the notions of overidentification may allow the therapist to gauge the utility (or futility) of their similar traits. Tahsin’s comment encapsulates this: “We all make mistakes...I’ve been there you know I’ve got the t-

shirt...just allowing them to feel a bit more comfortable and allows the therapeutic relationship to build up again, assuring them they can trust me and I trust them.” – L. 115-121. It seems that through some kind of qualitative proximity to the patient’s sense of self and their ordeals, trust is built and nurtured.

Although language was not a focal point of this present study, it featured as a relevant theme as a means to further cementing the trust in the therapeutic relationship. Language and gender have been two facets which were mentioned briefly in the literature review but prominent enough to have sub-themes of their own in the analysis. In addition, and more importantly, language emerged organically from the transcript analyses. Beyond merely being a facet of ethnic similarity, language proved to be much larger and more suggestive of a need to understand the relationship between language, the host culture and what can be expressed through language when thought of as a gateway to expressing emotions. Naina condensed this expressively in her comment: ...”...there’s that kind of familiarity and I can have this backup...we talk about language around shame, around um not being able to speak perfect English...English is the kind of...dominant language...if you’re with an English person...there’s some shame attached to that...if you’re with your own, if you don’t know a word you can just dip into your own language can’t you.” – L. 603-613. Linguistic competence is cited as a gateway to effective therapy, via the “familiarity” and the code switching that becomes available as a result and allows for an enriching of the dynamic.

As with language, participants were cognizant of the types of gender socialisation integral to the PM culture, particularly for girls, as explored in the sub-theme “Gendered experiences and Kinship”. Due to the all-female participant recruits, this coloured their cultural experiences in a gendered way, allowing for further exploration with their clients. The current study has added to previous literature by extending some thought to the therapists navigating and tapping into their own experiences of gender socialisation in order to empathise and better understand their clients.

Arguably, participants manifested a type of over-stretching as a way to perhaps compensate for the lack of opportunities historically not afforded to them because of their gender. As second-generation women, they introduced either clinical or personal (or both) experiences related to discord in the home/community environment. They allude to the lack of space for individualism which was also expressed by Zaidi et al. (2016) who discussed the cultural dilemmas, differences and demands on the

South Asian population when exposed to the competing value systems of the West and the East. The relative “different lifestyle scripts” (p. 233) as mentioned by Zaidi and colleagues was mirrored by the participants accounts via this particular sub-theme, partly owing to the familial role in upholding values of the East. Naina offered an example which made reference to this culture clash, particularly for women: “...they found her gym bag because she went to the gym from work and so you know, she was a bad Muslim, bad girl, bad Pakistani girl.” – L. 493-495. This poses a stark contrast between what is considered a “Western” activity and the PM belief system.

In a sense, the participants in this study symbolised a bridging of both worlds whereby they utilised their own knowledge and experiences of the cultural terrain as a torch to shed light on their clients, and themselves in the process. This dynamic did not occur seamlessly for participants, suggesting that the process of traversing and making sense of their client’s frame of reference was at times mired with their own. Tahsin offered her own experience in relation to this dynamic: “...so and so’s girls wear the hijab, you must wear it...they’ve thanked me afterwards...I’ve often had, “you’re doing something great in the community”...for the girls of the future to do something...I find it weird that it’s still happening now that girls have to still work as hard to break those barriers.” L. 393-407.

While previous literature has emphasised the significance of the collective and family support for South Asians and Pakistanis (Bowl 2007; Netto et al., 2003; Tabassum et al., 2000), it can be inferred from the present study that ‘communal anxieties’ are, by contrast, an enabling factor in maintaining mental health problems for this community. For the participants, there was a grappling of the mentality of the larger group which inevitably leads to a sense of deflated-ness in the face of overriding traditionalism. Participants, to varying degrees allude to a type of “big brother” style of culturing, as reflected in Nadira’s statement:

“...an incident around abuse happened and she disclosed that to me but then she was like “oh please don’t say anything to anyone” or “please don’t like, I don’t want anybody – the police or anybody to get involved” because of that shame. And she was like “oh it’s okay my mum knows...my family is dealing with it”, but they weren’t really...I kinda felt quite helpless.” – L. 83-91. Thus, this cloistered communalism may enable mental health crises through a neglect of the issue at hand and calls for a deliberate and considered acknowledgment of the social and communal constituent of the PM individual.

All participants touched upon the theme of 'shame' associated with stigma related to the client's psychological concerns and fear of losing face in the community. This is in line with Bowl's (2007) and Tabassum et al.'s (2000) study that societal stigma regarding mental health concerns significantly affects South Asians. This was prominent in the present study from the perspective of ethnically-similar therapists who took into consideration the anxiety experienced by their clients and the additional anxiety stemming from the sameness in the clinical room.

### ***Conclusion***

***Considerations and Further Research.*** One of the reasons why this study chose to focus on the experiences of Pakistani Muslim therapists was due to the proclivity of prior literature to refer to ethnocultural groups as representing the sum of the parts (e.g. South Asians), often negating the deep-seated cultural and ethnic differences found among group members. Trimble and Bhadra (2013) refer to this as 'Ethnic Gloss'.

While this study has highlighted some of the collective influences of the PM culture, it has also shed light on the unique thought-ways of this group in its diversity of language, norms, religious practice and mores.

Results from this study consider that therapists feel able to work with similarities to their clients allowing them to create an honest and open space for clients. Sensitivity was also deployed in handling culture and religion, given its rootedness in the social sphere. In this vein, having a personal understanding of the community allowed them to work effectively, whilst their professional compass empowered the glaring religio-cultural facets of the interaction. Barring this negotiation of cultural and religious influences and how these are navigated when using CBT, it is believed that having interest in clients' backgrounds, avoiding assumptions and stereotypes and endeavouring to work congruently is undertaken by many therapists, regardless of matching. For this reason, suggestions related to professional practice can be applied to all therapists.

Though CBT formed the crux of this study, other therapeutic modalities may also benefit similar exploration in its delivery from the PM therapist's perspective to ethnically-similar clients. In discussion with the participants, many had expressed a tendency to deploy other modalities, hence it would be

interesting to unravel why those modalities are judged a better fit than pure CBT or at least worthy of integrating.

**Implications for Practice, Counselling Psychology and the Wider Community.** Echoing Cabral and Smith's (2011) conclusions that research on racial/ethnic matching is manifold, future research can ascertain the particular mechanisms through which proximal variables - such as shared language, interpersonal trust and cognitive adaptability – help to improve treatment outcomes. This study, particularly through the first superordinate theme has contributed to the suggested research avenue in that there is some understanding of the 'matching' variables (reliability for trust, linguistic competence, gendered experiences and communal anxieties) that help to understand the process of ethnically-similar dyads. By pinpointing potential particular mechanisms such as these, this may have implications in practice such as consciously and intentionally utilising such variables rather than considering them as periphery factors, that may or may not assist in the process of an ethnically similar dyad.

When asked about suggestions for cultural competence in therapists, most participants advocated education and a strong inclination towards forming a strong working alliance and an interest in the systemic networks affecting their clients that operate outside the clinical room. They also attempt to articulate and take seriously the clients' conceptualisations of health and dysfunction. This is in line with Cabral and Smith (2011) who suggested that future research attend to areas such as communication skills and cognitive matching rather than more distal variables such as ethnicity. Having said this, it can be argued that given the participants' worldview stems to some degree from their experiences of ethnicity, this will no doubt manifest as a variable related to intra-cultural influences as opposed to isolated therapist characteristics.

The current study has endeavoured to understand this from the perspective of the PM therapist working with the PM client using CBT and how these worldviews interact, tuning in to the client's unique subjective experience. It is through the interaction with the therapist that enables a 'self-otherness' to take place, to be validated and to be respected (Cooper and Hermans, 2007).

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