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Culturally Sensitive Counselling with Hispanic/Latino Clients

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**Thesis submitted in fulfilment of the requirements for the
award of Doctor of Psychology**

City University of London

Department of Psychology

School of Arts and Social Sciences

London, March 2017

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Declaration

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Key Abbreviations Used Through Doctorate Portfolio

In this Doctorate Portfolio, the abbreviations below have the following meanings unless the context requires otherwise:

Abbreviation	Meaning
APA	American Psychiatric Association
BPS	British Psychological Society
BPD	Borderline Personality Disorder
BME	Black Minority Ethnic
CBT	Cognitive Behavioural Therapy
DBT	Dialectical behaviour Therapy
DSM-5	Diagnostic and Statistical Manual of Mental Disorders
IPA	Interpretative Phenomenological Analysis
NIMH	National Institute for Mental Health in England
NLI	No Longer Invisible
NHS	National Health Service
OLAS	Onward Latin Americans in London
SES	Socio Economic Status
UK	United Kingdom

Preface to the Portfolio

This portfolio is primarily concerned with aspects of theory and practice in Counselling Psychology. I will outline the three elements of this Doctorate Portfolio and their connection throughout whilst explaining my personal motivations for each piece of work. This portfolio reflects the culmination of my professional and personal experience over the course of my training.

Part A: I will present the research study.

Part B: I will present the journal article.

Part C: I will present a clinical case study.

The area of mental health is a crucial topic in our current socio-economic climate and cultural context. Different efforts have been made to meet an individual's needs within the mental health system. Counselling psychology, with its roots in a humanistic tradition and its commitment to a scientist-practitioner model, (American Psychological Association (APA), 2013; see British Psychological Society (BPS), 2004; Strawbridge & Woolfe, 2004) may help to advance research and/or focus minds on the relevant questions and perhaps shed light into relevant issues. By adopting clients' subjective experiences within the counselling psychology field, mental health professionals aim towards a coherent knowledge-base to inform practice which reflects their particular needs. As a trainee counselling psychologist, I believe it is important to avoid complacency by adopting a critical stance as a researcher and practitioner. It is hoped that this philosophy will be reflected within the research and clinical practice covered in this this portfolio.

For the purpose of this portfolio, I generally refer to culturally sensitive counselling with Hispanic/Latino clients as the counselling and/or therapeutic encounters between a client and therapist from different cultural backgrounds, and where the therapist/counsellor aims to introduce therapeutic interventions that consider the client's individual differences, enabling contextual/cultural congruence and respect for diversity.

Working with diverse clients has a cross-cultural aspect because of ethnic and micro-cultural differences which have always been a relevant issue for me from a personal and professional perspective, and taking into consideration the substantial differences at the level of individual characteristics and relational processes. Such differences tend to provide evidence of both universal (etic) as well as culture/context specific (emic) aspects of healing within the therapeutic relationship (Chang & Berk, 2009).

Cross-cultural issues are also becoming more relevant in the United Kingdom due to the rapid growth of ethnic minority groups (Office for National Statistics (ONS), 2001). This movement is reflected in counselling psychology in terms of clients' and therapists' diverse backgrounds. Such increased cultural diversity in the UK has generated greater interest and demand for cross-cultural therapy (Eleftheriadou, 2015; Lago, 2011). Therefore, the Professional Practice Guidelines for Counselling Psychologists (BPS, 2008) encourages a culturally sensitive and anti-discriminatory approach to practice. Accordingly, cross-cultural therapy should embrace culturally sensitive therapy, knowledge about a culture and a certain attitude towards engagement with it as a prominent feature of therapy. The central linking theme between the parts of this DPpsych portfolio is the consideration of

cultural awareness and sensitivity in research findings and clinical practice. This theme is illustrated, in different ways, by the three sections of the portfolio.

Part A. The research

This piece of work is a qualitative research study that investigates the counselling experiences of Hispanic/Latino clients with English-speaking therapists. A homogenous sample of 10 participants who identified themselves as Hispanics/Latinos who spoke Spanish as their first language and who had undergone counselling/therapy with English-speaking therapists took part in this investigation. One of my motivations for investigating cross-cultural relationships, particularly between therapists and clients, arose from my personal experiences as a counselling psychology trainee and client, meaning that as a Colombian and a minority individual, and accepting the view that all knowledge is situated Wetherell, Taylor & Yates (2001) and therefore so is training and counselling practice in the UK. I brought my cultural heritage into an academic institution and clinical setting that has a predominantly British cultural context. Hence, I experienced such training and experiences of therapy from my own cultural perspective. This experience indicates that there is a cross-cultural aspect within these roles that I undertook which in one way or another determine my actions and viewpoints. I, therefore, was interested in understanding how other minority individuals, in this case Hispanic/Latinos, experienced their counselling/therapy encounters with English-speaking therapists. In the context of semi-structured interview, participants answered some open questions that gave insight into their experiences of counselling/therapy. The interviews were analysed using Interpretative Phenomenological Analysis (IPA Smith, Flowers & Larking, 2009). This method provides the researcher with a perspective into participants'

subjective experience, and acknowledges the dynamic, interpretative interplay between myself as a researcher's and the participant's subjective world, in the process of meaning making (Smith, Flowers & Larkin, 2010; Smith & Eatough, 2006).

Whilst the mental health experiences of Black and Minority Ethnic (BME) users in the UK have been described as poorer compared to the majority White population (Mental Health Foundation, 2015; Department of Health, 2005) the present research reported both 'positive' and 'negative' counselling/therapy experiences amongst this Hispanic/Latino group. Accordingly, participants' cultural values were perceived/experienced as determinants for the development of rapport and participants' overall counselling experiences. It is hoped that these findings may potentially contribute to enhancing understanding of this minority ethnic group within the counselling/therapeutic context, so as to better serve them within the mental health care system in the UK.

Part B. The journal article

The journal article presents one of several themes that emerged from the research study. It refers to 'The healing presence', meaning participants' cultural expectations for their therapists to convey attitudes that they considered in agreement with their cultural values. Such therapists' attitudes were referred to as their ability to relate to participants either in an interpersonal manner or impersonal manner. These therapists' interactional attitudes were acknowledged as representing participants' cultural values of *respeto* (respect- Aguilar-Gaxiola, Loera, Mendez, Sala, Latino Mental Health Concilio & Nakamoto, 2012; Ho, Rasheed, & Rasheed, 2004), respect for their cultural differences and perspectives, and problems brought to therapy. Also, *personalismo* (personalism-

Garza & Watts, 2010; Comas-Díaz, 2006), a value that reflects participant's collectivistic world-views, and appreciated in positive interpersonal relationships, and **confianza**, trust that takes time to develop (Garza & Watts, 2010) or trustworthiness needed for engagement in the therapeutic process. Therapists' attitudes were therefore perceived as critical for the development of a therapeutic bond and successful therapy for this minority group. My motivation to elect this theme was encouraged by the paucity of literature that addresses this cultural value within the therapeutic encounters between Hispanics/Latinos and Western therapists.

This article is intended for the Counselling Psychology Review. Although presented here in a form consistent with this portfolio, it will be submitted in accordance with the journal's own guidelines (see Appendix N in part B of the portfolio).

Part C. The client study

The chosen clinical study was designed to reflect clinical skills, a nuance understanding of the chosen therapeutic model in relation to the client's presentation and to demonstrate cultural awareness and sensitivity within the therapeutic process. It explores the therapeutic collaboration between myself and a client (Lola), who wanted to address issues related to a previously given diagnosis of Borderline Personality Disorder (BPD), and for whom culture played an important role in the understanding and ways of dealing with her concerns (i.e., anger, interpersonal difficulties, emotional instability, hopelessness etc). When searching for literature about the interplay between culture and personality disorders that may have helped my understating of this client, it was difficult to find

related research (Coid, 2003; Maughan & McCarthy, 1997). Nevertheless, I endeavoured to explore Lola's subjective experience, whilst trying to adopt a culturally sensitive stance (Sue, Zane, Hall & Berger, 2009). Due to the complexity of her experience, Dialectical Behaviour Therapy (DBT Linehan, 1993) integrative model was chosen at the core to work with Lola. At the same time, cultural values/beliefs influencing Lola's perception and response to her experience were addressed within this integrative model, so as to foster understanding of Lola's concerns and progress throughout. This therefore illustrated the underlying cultural context between the client and the problem, that is, the communication facilitated by the BPD treatment and the cultural aspects that in some instances served as a function to access the client's underlying conflict during the therapeutic process. This case study demonstrates Lola's journey moving from anger to acceptance and change, while enhancing connection to her own feelings and needs, hence her own self and others.

Part A. The Research

An Interpretative Phenomenological Study of the Counselling/Therapy Experiences of Hispanic/Latino Clients with English-speaking Therapists

Supervised by Dr Jacqui Farrants

Dr Jessica Jones Nielsen

Dr Greg Madison

Abstract

The underutilization of mental health services by ethnic minorities has been a growing concern in research and clinical practice. This is of increasing importance for Hispanic/Latinos in the United Kingdom due to the rapid growth of this population. Further, there seems to be a paucity of research about the mental health needs and service utilization among Hispanic/Latinos in the U.K. In response to the dearth of literature for naturalistic studies of counselling/therapy with this population, this research adopted a qualitative approach using semi-structured interviews with 10 Hispanic/Latino, Spanish-speaking participants, exploring their individual counselling experiences with English-speaking therapists. Interviews were analysed using the guiding theoretical framework of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). Four master themes emerged: a) "Emotional Expressiveness", b) "Cultural Competence or Encapsulation", c) "The Healing Presence", d) "Cultural Liberation or Formulation". Each master theme yielded super-ordinate themes illuminating different aspects of the participants' experiences. The findings were discussed in relation to participants' ability to communicate and emotionally express and overall experiences of their therapists' attitudes towards them, their problems and cultural differences, particularly, cultural awareness and sensitivity. The findings provided insight into how participants' cultural values impacted the development of rapport and overall counselling experiences with their English-speaking therapists. It is hoped that the findings will be considered within both counselling/therapy settings and potentially more broadly in educational contexts, to enhance awareness and practice of a culturally sensitive approach for these clients. Efforts to reach the Latino population, implications for clinical practice and suggestions for future research are discussed.

Chapter 1: Introduction

In the U.K, the underutilization of mental health services by ethnic minorities has been a growing concern in research and clinical practice (Mental Health Foundation, 2015). Latin Americans make up a significant and growing proportion of the population in the UK today. In 2016 McIlwaine and Bunge, following the 2011 Census and the project “No Longer Invisible (NLI)”, suggested that an estimate of 250,000 Latin Americans live in the UK, of which around 145,000 live in London (Census 2011; McIlwaine, Cock & Linneker 2011; McIlwaine, 2012). However, the number of Latin Americans in the U.K was estimated as at 700.000 to 1,000,000, significantly more than any census figure of Latin American-born in the UK has shown (McIlwaine et al., 2011). Therefore, taking into consideration that the Latino population is rapidly growing in the U.K, it is important to ensure that they receive adequate mental health care.

Pertinent Terminology

It is important to define some of the ambiguous terminology used within this research before discussing any literature in this topic.

Hispanic/Latino

The term “Hispanic” refers to Spanish-speaking people in the Americas; and “Latino” refers to people from the Caribbean (Cuba, Puerto Rican, Dominican Republic), North America (Mexico), South America (Colombia, Venezuela, Ecuador, Peru, Bolivia, Chile, Paraguay, Argentina and Uruguay), and Central

America (Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama) who speak Spanish or a language derived from the Latin (Holden, McGregor, Thandi, Fresh, Sheats et al., 2014).

Hispanic/Latinos comprise a highly **heterogeneous population** with many between-group and within-group differences despite their common bond of cultural background, language, socio-economic, cultural and historical influences (Gonzales Burchard et al., 2005). For the purpose of this study, a more homogeneous group will include Hispanic/Latinos from developing countries whose first language is Spanish, namely participants coming from North America, Central America, and those from South American as the main nationalities, and those from Spanish-speaking Caribbean Islands of Cuba and the Dominican Republic (see Appendix C for list of developing countries).

The terms Hispanic, Latino and Latin American will be used interchangeably throughout this study. These are the terms most often used in the mental health profession, including counselling and psychotherapy literature, when referring to people from Spanish-speaking cultures or origins from North, Central, and South America (Marin & Marin, 1991). Similarly, and when referring to the therapeutic relationship, the terms therapeutic bond, therapeutic alliance, rapport, counselling relationship will be used interchangeably.

English-speaking Therapists/ Western Therapists

In this study by English-speaking therapists or Western therapists, I referred to native English-speaking therapists from within the U.K. and/or therapists who originated from other countries and who dominate the English language within the therapeutic setting.

Ethnic Minority

Ethnic minorities are those with cultural heritage distinct from the majority population (Royal College of Psychiatrists, 2009).

Culture

Culture is defined as a shared set-learned system of behaviours, beliefs/values and attitudes, as well as knowledge and norms that are shared by a group of people (Marsella & Yamada, 2000). Culture is also seen as influencing an individual's way of living and interacting, and their mental wellbeing, which impacts on various aspects of mental illness (Guarnaccia & Rogler, 1999; US Department of Health and Human Services (USDHHS), 2001; APA, 2003) and its treatment (Lopez, 1989; Donlan & Lee, 2010).

Cultural Diversity

Cultural diversity is defined as evolving from the unique nature of each culture. This encompasses the values, elements and context of an individual culture that is distinguishable from the others (Beebe, Beebe, & Redmond, 2005).

Black and minority ethnic (BME)

BME refers to populations and groups who are in a racial or ethnic minority. This term not only refers to skin colour, but also represents distinct racial and minority groups who may experience discrimination and disadvantage, such as those of Irish and Mediterranean origin and East European migrants (Department of Health, 2005 p. 11).

Individualism and Collectivism

One important dimension in understanding the differences between culture is individualism and collectivism. In collectivist societies rights are derived by mutual respect and understanding that every citizen has a responsibility/duty to carry out certain roles in society. On the other hand, individualist societies (Western Culture) believe that every citizen has certain rights that cannot be infringed upon by any individual, group or government body; for any reason. Consequently, the individual's betterment or success is paramount, rather than that of the family or group (Cardenas, 2007). Individualism is seen as characteristic of many Western countries, and collectivism of many Asian, African and Latin American Countries (Schwartz, 2009). In this instance, the meaning and relation of "self" and "personal identity" is different for Latin Americans, regarding their tendency to endorse collectivism at higher rates than non-Hispanic White Americans and other non-collectivists groups (Marin & Marin 1991; Marin, 1994).

For Hispanics, and as collectivists, family and/or the group activities are foremost, and responsibility and accountability is collective rather than individual functioning (Cardenas, 2007; Gudykunst, 1998). Latinos maintain a hierarchical family system, where the father is the head of the household and is responsible for providing financial and disciplinary roles. The mother follows the commands of her husband and anyone else on the husband's side of the family (Cardenas, 2007). Furthermore, name and reputation are key in collectivist societies, hence choice is made to uphold a family's reputation. Problems or disputes are considered private, so any public display of trouble in a family can destroy its reputation. Collectivist societies also emphasise the individual's ambitions may be sacrificed for the

betterment or success of the collective, which is not only paramount, but also honourable (Cardenas, 2007).

Hispanics' group orientation may serve as an advantage in terms of health promotion. For example, dissemination of information about good health habits can be easily achieved in a cost-effective manner (Sargent, n.d.). Latino migrants' struggle is to healthily meld the individualist and collectivist cultures into a win-win for the Latino that is a combination of and balance between these two cultures (Cardenas, 2007). Therefore, interactions amongst different groups is useful for the investigation of how these cultural values influence communication, perceptions of roles in their counselling/therapy interactions.

This chapter will review literature on cultural counselling with Hispanics/Latinos.

Literature Review and Problem Statement

Research suggests that one quarter of those affected by mental health disorders in the U.K receive regular treatment (Mental Health Foundation, 2015). In their project Towards Visibility, McIlwaine and Bunge (2016) indicated that Latin Americans in the UK receive fewer mental health services and their access to mental health support is lower than other groups, even though the prevalence of mental illness in this population is similar to that in other groups. For example, amongst Onward Latin Americans in London (Latin American migrants in London who previously lived in Europe before moving to the city (OLAs)) only 6% access mental health services, despite the fact that more than a quarter suggested that they had experienced stress and other difficulties due to migration status, implying that they are not receiving help despite the need (McIlwaine & Bunge, 2016).

Research available is however very limited and seems to imply that there is a lack of evidence of mental health services use in the U.K by Hispanic/Latinos.

Chapter overview

Due to the scarcity of literature on mental health services for Hispanic/Latinos in the U.K, and considering that most of the research on Latin Americans' mental health has been conducted in the United States (U.S), this chapter begins with an overview of mental health status of ethnic minorities in the U.K., whilst highlighting mental health status of BME in the U.S, especially Latinos' mental health. Following on, attempts to reach the Hispanic/Latino will be highlighted, as well as clinical approaches to working with Hispanic/Latino clients. Afterwards is an overview of some therapeutic interventions that have been developed, evaluated and proposed for Hispanic/Latinos and then an emphasis will be made about what is still lacking in the provision of Latinos' quality of care. Ultimately, follows a summary, as well as rationale for the study and implications for counselling psychology and aims of the research question will be illustrated.

It is important to note that the next two following sub-sections (prevalence and barriers to mental health care) do not intend to compare and contrast experiences in mental health between BME groups in the U.K. with BME groups and Hispanic/Latinos in the U.S..I Instead, and due to the scarcity of literature with Hispanic/Latinos in the U.K., the unique purpose is to illustrate data, thereby increasing understanding of the context of this ethnic minority group in mental health.

Prevalence of Mental Health Across Different BME Groups in the UK and the US

Some of the factors contributing to mental health problems for BME groups in the U.K. (McKenzie, 2008) and the U.S. (Stuber, Galea, Ahern, Blaney, & Fuller, 2003; Berrios, 2003; Office of the Surgeon General, 2001), and Latinos' mental health (U.S. Census Bureau, 2004; Berrios, 2003; Alegria, Mulvaney-Day, Torres, Polo, Cao, & Canino, 2007) include cultural, socio-economic factors, lack of support, racism and discrimination, adaptation and assimilation issues.

It is important to clarify that some of the studies addressed in the following two sections (prevalence and barriers to mental health) from both the UK and the US, discussed Black and White males and females without giving a clear explanation to whom the authors refer. I therefore illustrated them in this study under the assumption that White and Black male and females in the cited UK studies are referred to as European/Caucasian and African-Caribbean, and in the cited US studies, as European-Americans/Caucasians and African-Americans.

Depression

In the U.K, the prevalence of mental health disorders has been found to vary noticeably in different BME groups. For instance, a higher prevalence of **depression and anxiety** was found in South Asian women than Black groups (Rehman & Owen, 2013; Weich, Nazroo, Sproston et al., 2004; Bebbington, Brugha, Coid et al., 2007). South Asian women were also found to have much higher rates of common mental disorders (i.e., depression, anxiety) compared to white and black women (Bebbington et al., 2009).

Similarly, in the U.S, depression is identified as a leading cause of disability

amongst major ethnic and racial groups and of big concern in mental health, especially among Latino youth (McKenna, Michaud, Murray, & Marks, 2005). For example, in a study comparing the prevalence of psychiatric disorders in Caucasians, African Americans, and Latinos, higher rates of depression, depressive symptoms and diagnosed mental illness were found in Latinos (Radloff, 1977; Vernon & Roberts, 1982). However, higher rates of anxiety disorders, affective disorders, and substance use and dependency were found amongst non-immigrant Latinos when compared to immigrants (Grant, Stinosn, Hasin, Dawson, Chou & Anderson, 2004). Other studies showed Mexican Americans reporting significantly higher scores of depression than other Latino sub-groups (i.e., Cuban, Puerto Rican, other, Roberts & Sobhan, 1992). Moreover, samples comparing mental health prevalence among Latinos are broadly representative, comparative illness has been found to not assess individual needs and research frequently concludes that prevalence of an illness is greater in one group than the other. Nonetheless, one would expect greater within-group differences than between-group differences since much of the research with Latinos is mainly focused on Mexican Americans (Kouyoumdjian, Zamboanga, Hansen, 2003). This therefore calls for more attention to the inclusion of other samples so as to enhance applicability of studies' findings.

Schizophrenia

In the U.K **Schizophrenia** was found as the third most diagnosed mental health disorder amongst ethnic minorities in the U.K, with higher rates among Afro-Caribbeans than Asians (Rehman & Owen, 2013). Psychotic disorders were also reported by Afro-Caribbean men compared to Caucasian men (3.1% and 0.2% respectively, Bebbington et al., 2007; McKenzie et al, 2008; Mental Health Foundation, 2015; Livingston, Leavey, Kitchen, Manela, Sembhi & Katona, 2001;

Coid et al., 2008). Likewise, in the U.S., many individuals from BME communities (i.e., Black/African Americans (Schwartz & Blankenship, 2014; American Psychological Association (APA, 2016)) reported higher rates of incidence of psychotic disorders and are more likely to experience compulsory admission to psychiatric hospitals than Caucasians (Morgan, Mallet, Hutchinson et al., 2005). On the other hand, and although many studies in the U.S. suggest that Latinos are more likely to experience higher rates of psychopathology than Whites, Latinos were found to have lower overall population rates of psychiatric disorders than Caucasians or African Americans (Alderete, Vega, Kolody, & Aguilar-Gaxiola, 2000; Vega, alderete, Kolody, Aguilar & Gaxiola, 1998). In another study, both Hispanics and Blacks reported lower lifetime risk for psychiatric disorders than Caucasians in representative samples of the U.S. English-speaking population (Breslau, Kendler, Su, Gaxiola-aguilar & Kessler, 2004; Breslau, Aguilar-Gaxiola, Kendler et al., 2005). However, some of the possible explanations as to why research comparing the psychopathology prevalence rates between Latinos and other ethnic-groups has generated mixed findings include the heterogeneity of Latinos and/or the use of mainstream instruments to measure psychopathology may have validity problems when used with Latinos. Also, the possible inconsistencies of factors such as acculturation levels and acculturative stress, and the lack of control for confounding variables (i.e., age, sex, socio-economic status) may account for the discrepancies.

Post-Traumatic Stress Disorder

Furthermore, in the U.K the most common problem among **refugees** and asylum seekers is **Post Traumatic Stress Disorder (PTSD)**, psychiatric disorders, including depression, and suicide (Carswell, Blackburn, & Barker 2009; Department of Health 1999, p 17). Similarly, PTSD in the U.S has been found to

be prevalent among Black/African American refugees of all ages (APA, 2016). Also, Hispanic refugees that arrived to the U.S were found to be more prone to PTSD and depression than their Anglo and African counterparts (Pole, Gone & Kulkarni 2008), especially Central American refugees, who are said to have experienced violent experiences (i.e., witnessing beatings and killings, fearing for their own lives and/or those of their family members) (Sue & Sue, 2013). However, there is limited research/data about the incidence of psychiatric disorders and use of mental health services amongst both the male and female refugee population in the U.K. (Murphy et al., 2002) and the U.S. (Refugee Health, 2011).

Alcoholism

In the U.K higher rates of **alcohol** related problems have been reported amongst Indian men (Mental Health Foundation, 2015). The Irish also reported the highest rates of admission for depression and alcohol abuse compare to all other BME groups (Muinteras, 1996; Walls, 1996; Luce, Heather & MacCarthy, 2000). Similarly, in the U.S, and compared with a nationally representative sample of its population, American Indians were found to be at heightened risk for alcohol dependence (Beals, Manson, Whitesell, et al., 2005). Likewise, **alcoholism and drug abuse** were recognized as major problems among Latino' young males in the U.S. (Comas-Diaz, 2006; Galvan & Caetano, 2003). In a study, Puerto Ricans and Mexican-American males reported higher rates of alcohol consumption and binge drinking than Caucasian men and alcoholism amongst Latinos is also more likely to be chronic (Chartier & Caetano, 2010). Another study reported rates of alcohol dependence and binge drinking amongst Latinos as similar to those of European Americans and marginally higher than those of African Americans

(Substance Abuse and Mental Health Services Administration [SAMHSA], 2003, 2004). Some of the identified predictors of substance abuse among Latinos are socio-demographic variables and assimilation into the U.S culture. Treatment programs for Latinos/as in this regard have reported poorer outcomes, however there is limited empirical evidence that explains the problems Latinos experience in treatment (Alvarez, Jason, Olson, Ferrari & Davis, 2007).

Suicide and Self-harm

Research in the U.K indicates differences in the prevalence and incidence of mental illness between **men and women** (Mind, 2003a). For example, higher rates of suicide and self-harm have been found amongst Asian **women**, African-Caribbean and Irish people (Keating, Robertson & Kotecha, 2003). In the U.S, the Center for Disease Control and Prevention (CDC) reported higher suicide rates for 65+ Asian American women than those for Caucasian females, and young Latino females were nearly as twice as likely as males both to consider and to attempt suicide (USDHHS Office of Minority Mental Health, 2014). Although, literature about the mental health needs of women is very limited both in the U.K (Keating, Robertson & Kotecha, 2003) and the U.S (USDHHS, 2001). This suggests that there is a lack of systemic inquiry into the needs of BME women, as well as gender differences in the prevalence of mental health disorders among ethnic minorities.

Overall, problems with methodology, including sampling bias, diagnoses based solely on questionnaires and use of untrained interviewers may contribute to the explanations for the variability of psychopathology prevalence rates among ethno-cultural groups (Flaskerud & Hu, 1992). Also, the fact that certain BME individuals are less likely to access mental health services makes them less available for

studies that recruit through service contacts, hence they are under-represented in mental health research (Oliver, Pearson, Coe & Gunnell, 2005). Consequently, to better understand the psychopathology of Latinos, it is crucial to examine the influence of the given variables on their health status. Additionally, in the U.K, a possible factor contributing to the lack of acknowledgment of Latino Americans in mental health research is the lack of recognition of this ethnic minority group in the Census (Mas Giralt & Granada, 2015).

There is a probability that other studies may include other ethnic minority groups and/or show different statistics than the presented literature in this chapter, however these are not definite statistics for either the BME groups in the U.K. or the U.S.

Identified Barriers to Mental Health Services Among BME Communities in the U.K and the U.S.

Although minority ethnic groups have been identified as more likely to experience mental health problems, research in the U.K. (Butt et al., 2015; Sewell, 2012; Mental Health Foundation, 2015; Kovandžić et al., 2011; Suresh & Bhui; 2006; Dowrick et al., 2009) and the U.S. (Aguilar-Gaxiola et al., 2012; The National Healthcare Disparities Report, 2005; USDHHS, 2001) shows that BME communities have considerably poorer mental health outcomes and poorer experience of services, and are more likely to experience meaningful disparities when accessing mental health care pathways.

Attempts to explain mental health disparities and underutilization of services by minority ethnic groups in the U.K (Suresh & Bhui, 2006; Knifton et al., 2010; Gary, 2005) and the U.S. (Leong & Kalibatseva, 2011; Latinos: Christancho, Garces,

Peters & Mueller, 2008) include cultural factors/models of illness; stigma and variation in clinical practice and service provision, socio-economic factors, discriminatory practices or cultural misunderstandings.

Stigma

Studies in the U.K show that ***stigma*** of mental illness is one reason why some ethnic minority group members elect not to seek or adequately participate in mental health treatment compared to Whites (Memon et al., 2016; Corrigan et al., 2001). For example, amongst African individuals, for whom the fear of being labelled 'mad' or to be 'avoided by family and friends leads some of them to appear normal and undisturbed' (BME Health Forum, 2013; Memon et al., 2016), which prevents them from seeking mental health support (Holt Garner, 2006). Similarly, studies in the U.S. have also identified stigma of mental illness as preventing some minority ethnic individuals from seeking mental health support (Leong & Kalibatseva, 2011). For example, amongst Black/African American men (Agency for Health Care Research & Quality, 2014). Stigma in Asian Americans is said to be due to the concern regarding loss of face (see Zane & Yeh, 2002; Leong & Kalibatseva, 2011; Holden & Xanthos, 2009). Stigma is also seen as constituting a major factor preventing Latinos from seeking psychological treatment (Sue & Sue, 2013; Dichoso, 2010; Vega, Rodriguez & Ang, 2010). Accordingly, Latino/Hispanic immigrants are more likely to fear embarrassment or social discrimination from family, friends and employment if they acknowledge psychological distress, thus they are more likely to express psychological distress via somatic symptoms. Therefore, despite their social class and level of education, some Latinos may be hesitant to use mental health services because of fear of being labeled as mentally ill (Barrio, et al., 2008), or "loco" (crazy) (Dichoso, 2010)

and also experience distrust towards mental health professionals due to fear of stigma, deportation, and shame (Falicov 1998, 2009). Hence, many Latinos prefer to seek support for their mental health concerns from a physician to avoid the stigma of seeing a psychologist (Gonzalez, 1997), so treatment for their psychological difficulties will usually be medically based and referral to a mental health clinic may be unlikely (Acosta, 1979). It is likely that stigma, a lack of health knowledge among many Hispanics/Latinos and inadequate provider training will decrease the likelihood that mental health disorders will be accurately diagnosed or appropriately treated or referred, especially when the entry point into the health care system is primary care. However, the reasons why many BME individuals avoid needed mental health treatment are not yet fully understood, even though it is an enduring and concerning theme throughout the mental health system. Some of the identified reasons include:

Communication Barriers

In the U.K., one of the main barriers for many BME service users to access and adhere to mental health services is the lack of proficiency with English language (Grey et al., 2013; Memon et al., 2016). Tribe and Raval (2002) indicating that UK language difficulties, compounded with the lack of trained interpreters, increases the difficulty in making accurate assessments. For instance, in a study identifying barriers to mental health for Chinese individuals, Lee, Logan, Yee and Ng (1999); and Suresh and Bhui (2006) found that many Chinese individuals were not fluent in English yet only a few had access to an interpreter. This has been leading to the use of relatives or members of staff as interpreters, which although inappropriate, is a way to help meet the needs of this population.

Similarly, in the U.S., English proficiency and scarcity of bicultural and bilingual mental health providers also acts as barrier to seeking help for some BME individuals (Leong & Kalibatseva, 2011). For example, language difficulties have been reported as particularly challenging for recent immigrants from Spanish-speaking and Asian countries, who may be less likely to enter and stay in treatment due to lack of understanding (Leong & Kalibatseva, 2011). Actually, for many Latinos in the U.S., English proficiency is considered the main cultural barrier in the utilization of mental health services (Gaviria & Stern, 1980; Wells et al., 1987). This limits many Latinos' ability to communicate with monolingual therapists and contributes to dissatisfaction with services and early termination of treatment (Kouyoumdjian, Zamboanga, & Hansen, 2003). Lack of interpreters or lack of available information in the language of preference are also of concern to Latinos with Limited English skills trying to access mental health services (Alegría et al., 2007; Barrio et al., 2008; Sentell, Shumway & Snowden, 2007). Further, several studies found that bilingual patients were evaluated differently when interviewed in English as opposed to Spanish (Del Castillo, 1970; Marcos Urcuyo, Kesselman, Alpert, 1973; Price & Cuellar, 1981; Malgady & Costantino, 1998). For example, a study examining records with patients with bipolar disorder, found that in the past, both African American and Latinos patients were more likely to have been misdiagnosed as schizophrenic than Caucasians (Mukherjee et al., 1983). However, the extent to which these factors result in misdiagnosis is not known and more research is therefore needed to clarify how language and acculturation of patients influence symptom presentation, level of client disclosure and diagnosis (Vega et al., 2007).

Socio-economic Factors

BME communities in the U.K. may often have their mental health experiences aggravated by socio-economic difficulties (Marmot Review, 2010). For example, unemployment, poverty, poor housing and lack of support from statutory services (Beasor, 2011; Garre, Piddington & Nicol, 2014). Roma, Gypsy and Traveller groups in the U.K. experience significant social and economic disadvantage, though they are highly considered in mental health research (Karlsen, 2007; Karlsen, et al., 2005). Research in the U.K, however, mainly highlights socio-economic factors among BME group members in terms of poor mental health rather than a barrier to access mental health care.

Contradictorily, in the U.S, structural barriers such as low socio-economic status (SES), have been reported as making services unaffordable for some racial and ethnic minorities individuals with low SES. For instance, in a study examining variations in predictors of the use of mental health services amongst different racial and ethnic groups (White, African American, Hispanic, and other), and after controlling variables such as health insurance, health status, low-income, Dobalian and Rivers (2008) found that African Americans and Hispanics with low income were less likely to utilize mental health services than those with higher income and compared to Whites. Similarly, compared to Caucasians, African Americans experience mental health disadvantages due to social determinants such as poor education, lack of health insurance coverage, economic challenges (Treadwell, Xanthos, & Holden, 2012). Furthermore, for all the ethnic groups in the U.S., lack of health insurance reduces the possibility of accessing mental health care (Vega & Atdjian, 2005), however Latinos have been found to have the lowest rates of insurance coverage in the U.S. (Vega & Lopez, 2001; Bridges et al., 2012). For

instance, Mexican Americans from low-income backgrounds reported that lack of benefit from therapy, self-perceived improvement, and environmental constraints (i.e., financial cost, transportation, time off from work, language barriers) influenced their decision to drop-out of therapy (Acosta, 1980).

Low educational status and income were also identified as a barrier to the mental health of Latinos (Alegría et al. 2002, 2007). This suggests that when minority ethnic individuals suffer from a mental illness and cannot fulfil basic economic necessities, they are less likely to seek mental health support than those who are more able to meet their economic needs (Cabassa, Zayas & Hansen, 2006). Nevertheless, other studies have shown socio-economic status to be irrelevant to Latinos' treatment attendance (Simons, Levine, Lustman, & Murphy, 1984). Hence, this suggests that for some Latinos, differences in cultural beliefs and values may be a stronger predictor of treatment attendance than socio-economic status (Kouyoumdjian, Zamboanga & Hansen, 2003). It is important to highlight that unlike in the U.S, Latinos in the U.K may not experience difficulties to access mental health care due to variables such as transportation and financial cost since in the U.K. the welfare system (NHS) and transport services facilitates access to mental health care.

Racial Disadvantage and Discrimination

In the U.K., in a survey of BME communities experiencing mental health difficulties Rehman and Owen (2013) found that among BME groups 49% reported experiencing discrimination from mental health staff. Further, a report from the Sainsbury Centre for mental health (2002) reported that Black people's experiences of mental health services in the UK are characterised by fear and conflict. Accordingly, lack of cultural awareness, and direct and indirect forms of

racism, can result in people receiving poor quality care from practitioners and institutions. Based on detailed controlled studies, Cooper, Morgan, Byrne, Dazzan et al., (2008) found that incidence of psychosis is higher in this group, which is largely related to the impact of social circumstances and discrimination. Furthermore, U.K. Research also indicates that clients from minority ethnic groups are frequently reported as being more likely than White patients to be prescribed drugs and electro compulsive therapy rather than being offered treatments such as psychotherapy/counselling (Glover & Evison, 2009; Raleigh et al., 2007), and more likely to receive medication (Sainsbury Centre for Mental Health, 2002; Department of Health, 2005).

Similarly, in the U.S., the Institute of Medicine (IOM) identified discriminatory practices of providers (i.e., treating racial/ethnic patients differently) as a significant barrier for mental health access among minority ethnic groups (IOM, 2003). For example, African Americans are more likely to be miss-diagnosed than their Caucasian counterparts due to lack of cultural sensitivity amongst the training clinicians and diagnostic instruments that were standardized mainly with Caucasian samples (Neighbors, Jackson, Campbell, & Williams, 1989; Sue & Sue, 2008). This was also found amongst African Americans, American Indians, and Alaska Natives, Asian Americans, and Hispanic Americans (Balsa & McGuire, 2003; Byrd & Clayton, 2001). Similarly, the study Stuber et al., (2003) found discrimination to be an obstacle to mental health for Hispanic/Latinos. The authors suggested that discrimination contributed to poor self-assessed mental health, to marginalization, stigmatization, isolation, and exploitability which all impacted on Latinos help seeking behaviours (Sullivan & Rehm, 2005). Nevertheless, most published studies with Latinos were carried out to identified service utilization trends and barriers to access mental health care Cabassa, Zayas & Hansen,

(2008), though, such disparities in quality of care does not fully explain whether they reflect variation in actual BME mental health needs or are the result of cultural, socio-economic/demographic or institutional factors which disadvantage those from BME backgrounds (Vega et al., 2007).

Gender

Gender differences have also been identified as an influence on mental health utilization behaviours among minority ethnic groups both in the U.K (Memon et al., 2016) and the U.S (Kouyoumdjian, Zamboanga & Hansen, 2003).

In the US. Latino women were reported as not perceiving the need for mental health care (Nadeem, Lange, Edge, Fongwa et al., 2007). However, research does not specify whether variations in use of services relate to variations in prevalence of psychiatric disorders or age or other variables and how. Also, differences between subgroups/within-group diversity of Hispanics/Latinos are hardly regarded when investigating the particular mental health needs of these groups (Shattell et al., 2008; Guarnaccia et al., 2007). This could function as a barrier to efforts aimed at providing appropriate care to Hispanic persons and could be one factor contributing to inequalities in the availability, use, and quality of healthcare services in this population. Thus, studies that consider the diversity of the Latino population and the different demographic profiles of these groups and include bigger samples within group comparisons are required.

Although studies carried out in the U.S. on Latinos' mental health provide valuable information, Cabassa, Zayas and Hansen (2006) suggested that such studies still present numerous methodological issues related to design (cross-sectional design), sampling (generalizability of studies (scarcity of mixed Latino group samples), measurement (self-report measurements of service use without

reporting reliability and validity) and limited knowledge regarding Latinos' access to mental health services. This therefore calls for more longitudinal and prospective access studies in Latino mental health services literature, in order to examine the social, economic, and emotional consequences that result from the underutilization of mental health services amongst this population.

Moreover, although single group studies provide a basis for rough comparisons of the published literature for BME groups mental health, population-based studies that directly compare different ethnic minorities (i.e., African Americans, Asian, Latinos) to Whites are scarce or non-existent. The mentioned barriers to mental health access of Latinos in the U.S. are likely to differ from those in the U.K. due to the individual's migration status, cultural and socio-economic factors among others. Also, it is difficult to include all the barriers/factors impacting on mental health access and retention among BME groups in the U.K. and the U.S., however this literature intended to cover some of the most researched/prominent variables for the given groups.

Efforts to Increase Cultural Awareness and Competence

The primary aim on integrating culture into clinical work focuses on the cultural sensitivity of therapist and suggests that culturally competent therapists will produce superior outcomes in therapy (Cardemil & Sarmiento, 2009). Cultural competence has been defined in different ways, but, in general, it is understood to be a therapist's skill that consists of a variety of therapist attitudes, knowledge, and behaviors that allows for effective clinical work when working with culturally diverse populations (Sue, 1998; Helms & Cook, 1999; Whaley & Davis, 2007). To do so, therapists need to consider the value of self-awareness and how their

cultural background, experiences, attitudes and biases can influence clinical work. Also, it is important to familiarize with and acquire relevant knowledge about particular groups in order to work in individuals from diverse ethnic, linguistic and cultural groups (APA, 1993; BPS, 2005).

Cultural relevant techniques/interventions for work with Hispanic/Latino clients

Individualism Vs Collectivism

Cultural relevant techniques and interventions for work with Hispanic/Latino clients have been attempted to develop cultural competencies for clinicians (Comas-Diaz, 1990, 2006; Falicov 1998, 2009; Ho, Rasheed, & Rasheed, 2004; Sue & Sue, 2008). Hence, cultural competence to work with Latinos would include familiarity with, and knowledge of, the historical, cultural and political experiences of the numerous Latino ethnic groups (Arredondo & Perez, 2003; Gloria, Ruiz, & Castillo, 2004; Mezzich, Ruiz, & Muñoz, 1999). For example, when working with Hispanic/Latinos it is important to primarily consider the differences in values between the ***individualistic*** perspectives of the dominant culture and the ***collectivistic*** perspective that Latinos maintain (Comas-Diaz, 2006). Therapists should be aware that contrary to the ideal self of uniqueness and independence that Whites endorse, Latinos understand themselves through others, emphasizing interdependence, family, emotional and social bonds and they prefer collective goals. Therefore, therapists should avoid labeling Latinos' interdependence and the common expressions of effect seen in Latino family dynamics or in familism, as enmeshment or co-dependency (Falicov, 1998). It is important to understand Latino cultural values and how they influence Latinos' mental health to improve

treatment adherence among this group.

Familismo (familism)

Familism is one manifestation of Latino collectivism which demonstrates the divergence from Anglo or European American culture. Familism is defined as the interdependence of close family members and is considered by some to be the most important factor influencing the lives of Latinos (Coohey, 2001; Zayas & Palleja, 1988). As a cultural value, familism emphasizes ‘the obligations and duties of family members to one another’ (Zayas & Palleja, 1988). In Latino culture, families include both the nuclear and extended members, as well as friendship and are regarded as significant supportive influences when health care decisions are to be taken. Hence, family members become intrinsically involved in each other’s affairs and assume active roles in the lives of kingship (Añez, Paris Bedregal, Davinson et al., 2005). Latinos also have a hierarchical communication style within the family that defines boundaries between authority figures and others (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002). Latino sense of hierarchy is considered as having implications for family therapy due to their familial communication’ dynamics and problem solving course of action.

The cultural value of *familismo* is said to influence on treatment seeking behaviours. Accordingly, since mainstream values tend in general to be more individualistic, Latino clients may feel at odds when having to disclose familial matters and issues that they may perceive as negative, hence those Latinos with strong values of familism might be less likely to seek formal mental health services due to a desire to keep problems within the family (Añez et al., 2005; Cabassa & Zayas, 2007). Also, for many Hispanic/Latinos psychological disturbances carry a

shameful stigma (Frevert & Miranda, 1998) and is one reason some may feel guilty for seeking outside help (Altarriba & Bauer, 1998). However, when family is the only source of support against mental illness, negative consequences may result. For instance, Latinos with mental illness may develop a dependency on family members and experience worsening of symptoms over time. Also, those relatives who offer the emotional support may experience additional stress for the individual experiencing mental health problems (Canabal & Quiles, 1995). Research however, indicates that not much attention has been given to the role of family in the mental help-seeking process among Latinos (Cabassa & Zayas, 2007).

Personalismo (personalism)

The Latino value of ***Personalismo*** is defined as a preference for personal over institutional relationships (Antshel, 2002). This personal relationship may entail less spatial distance between two people and more emphasis on trust, warmth and physical contact. Research suggests that ***personalismo*** and ***respeto*** (respect) are crucial values to improving Latinos quality of care (Aguilar-Gaxiola et al., 2012). Since the cultural values of personalism and respect refer respectively to the importance of close relationships and the mutual regard desired in a relationship, they have been recognized as of significant relevance to the development of effective therapeutic relationships. For instance, for Hispanics in the therapeutic setting, ***personalismo*** refers to their preference for interpersonal contact that promotes getting to know the therapist as a person (Meyer, 2015). Therefore, when the opportunity to establish interpersonal connections is hindered by professionals and/or organizational channels, Hispanic clients are thus likely to

view professionals with distrust and disapproval (Añez et al., 2005). Similarly, due to loyalty to health providers, if the therapist moves to an inaccessible location, many Hispanics will discontinue treatment altogether, attributing any success in treatment to the relationship with that one individual (Grossman, 1994; Trevino, Moyer, Valdez, & Stroup-Benham, 1991).

Further, in health care, providers are, by virtue of their education, afforded a high level of *respeto* as authority figures (Reese, Balzano, Gallimore, & Goldenberg, 1995). However, if therapists do not work from an understanding of the hierarchical system, this behaviour may be viewed as disrespectful and may result in client's early termination of treatment. Additionally, *respeto* is a complex aspect of interpersonal relationships in the Hispanic culture and its recognition in the therapeutic setting can help establish a helpful therapeutic relationship (Santiago-Rivera et al., 2002). Values of *personalismo* and *respeto* are considered as translating into *confianza* (trust that takes time to develop) which is identified as strongly associated with engagement and treatment compliance (Garza & Watts, 2010). Considering intimate/personal issues are discussed within the therapeutic relationship, it requires Latinos to feel *confianza* in order to be successful. This knowledge is therefore vital for working with Hispanics to facilitate treatment compliance (Garza & Watts, 2010).

Religion/Spirituality

Latinos also attempt to make sense of illness through the use of non-medical explanation, such as supernatural perspectives and *religious and spiritual* exploration (La Roche, 2002; Velásquez & Burton, 2004). Catholicism has a powerful influence among Latinos and is regarded as a source of relief for

emotional distress for many Latinos. Because religion plays an important role in the lives of Latinos, they often seek support for medical and mental health needs from their own cultural healing traditions, such as priests and folk healers, together with standard medical-model forms (Delgado & Humm-Delgado, 1984; Rogler & Cortes, 1993; Mezzich et al., 1999). A study demonstrated that Latinos who endorse this collectivist perspective are less likely to utilize mental health services (Alvidrez, 1999) Although Latinos embrace these non-DSM supernatural conceptions of mental illness, they are not consistent across all Latinos. Clinicians are therefore encouraged to not to adhere so rigidly to the medical model of mental illness, as this perspective may not be well received by many Latinos (Arredondo & Perez, 2003).

Machismo and Marianismo

Gender roles of ***machismo***, which supports men's portrayal of images of self-reliance and strength (Torres, Solberg, & Carlstrom, 2002), and ***marianismo***, which encourages women to assume the burden of suffering in the family (Chiriboga, Black, Aranda, & Markides, 2002; Gloria et al., 2004), may be in disagreement with some of the fundamental treatment goals, including relying on others, seeking help, and recognizing difficulties in one's life. Awareness about the variability in adherence to these values both across Latinos and within Latino families is essential.

Socio-Economic Issues

Cultural sensitivity or cultural competence must consider **socio-economic** difficulties that disproportionately affect ethnic minorities both in the U.S (i.e, African Americans and Asian Indians, Dobalian & Rivers 2008; Segal, 1998 respectively) and U.K. (Beasor, 2011; Garre, Piddington & Nicol, 2014). Socio-economic difficulties are also key when working with Hispanic/Latinos (Ho, Rasheed & Rasheed, 2004). For example, the common experiences of prejudice, discrimination in education, employment, healthcare, and marginalization, poverty and other economic issues that many Latinos report experiencing as an ethnic minority group (Cardemil, & Sarmiento, 2009).

Acculturation and Assimilation Issues

As in other ethnic minority groups in the U.S. (DHHS, 2001) and the U.K. (Memon, Mohebati, Collins, Campbell et al., 2012) **acculturation and assimilation** issues have a significant impact on the mental health well-being and service utilization among Latino groups (Falicov, 2005). Some of the factors to consider are the need to preserve language and cultural characteristics (Acosta, 1979; Sandoval & De La Roza, 1986; Kouyoumdjian, Zamboanga & Hansen, 2003) and any experience stressors such as self-pressure to succeed in the host country, leaving behind the family, communication difficulties (Salgado de Snyder, 1987); additional factors are generational and intergenerational conflicts (Ho, Rasheed and Rasheed, 2004); migration and resulting cultural shock; “crisis of loss”, including possible post-traumatic stress (Cardemil, & Sarmiento, 2009). Yet, research is inconclusive and more research is needed to elucidate what aspects of

acculturation experience and/or contextual factors implicated in the acculturation experiences (i.e., prior immigration experiences, traumas experience during immigration, knowledge of health care system, retention of cultural values, development of new social support, stigma and attitudes towards mental illness) and their influence on Latinos' mental health service use (Cabassa, Zayas, & Hansen, 2006; Cabassa, 2003).

It is important to note that the above are the most common values/characteristics, which have been identified, observed, and analyzed during efforts to develop culturally competent and integrative approaches towards working with Latino populations in the U.S. mental health system. Although, this is only a superficial indication of these traits and emphasis on one of these over another clearly varies according to client's uniqueness, originating country or region and their relationship to the culture, family traditions, gender, religious beliefs, and socio-economic status (Amato, 2007). Additionally, the given literature search, mainly identified extensive work including clinical reports, articles, and books that often involve descriptive observations of beliefs, values and customs associated with Latino culture rather than their actual impact on treatment adherence or dropout.

Clinical Approaches to Working with Hispanic/Latino Clients

In a population estimate by ethnicity, the Office National Statistics (ONS, 2001) revealed the ethnic minority population as growing between 2002 and 2009 in England and Wales. This consequently demonstrates that the context in which British counselling psychology operates continues to have an ever-changing ethnic distribution. Most therapeutic approaches are seen as rooted in White individualistic Western Eurocentric societies "ethnocentric" (Orlans & Van Scoyoc,

2009; Eleftheriadou, 2006). Other authors suggested that Asian, African, Hispanic and other non-Western cultures and collectivistic ideas are not addressed either in current models or in actual therapy (Sue et al, 1996; Waldegrave, Tamasese, Tuhaka & Campbell, 2003). Therefore, considering the growing Latino population in the UK, it is important to identify and disseminate effective clinical approaches to working with this group. However, to help ensure that they receive the mental health services they need, it is important to consider that as their population grows, so does their heterogeneity (i.e., place of origin, socio-economic status, cultural values, English-language competency), hence, clinicians must consider shared characteristics, and significance within and between-group variability when working with Hispanic/Latinos (Kouyoumdjian, Zamboanga & Hansen, 2003).

Research indicates that Hispanics/Latinos tend to positively benefit from more **directive, brief, and problem-focused** therapeutic approaches (Kunkel, 1990; Sue & Sue, 2012). Family therapy has also been recognized and well accepted as an approach to family problem solving and for individual symptoms among Latinos (Ho et al., 2004). Garza and Watts (2010) stated that models that consider *familismo* as a strong value, and encourage family unity have better acceptance and results than those that do not. However, mainstream mental health programs usually provide services that contrast with Latinos' preferences and expectations of therapy, hence many Latinos may opt to not to seek mental health support (Kouyoumdjian, Zamboanga & Hansen, 2003).

Individual oriented Approaches

It is well documented that the clinical and counselling psychology profession has paid much attention towards developing culturally responsive approaches for

Hispanics/Latinos (Bracero, Segin, Hernández, Ranson, & Costantino, 2000; Costantino & Rivera, 1994; Ponterotto, 1987; Zuñiga, 1991, 1992). Different treatment modalities have been modified and culturally adapted to use with Latino clients (Comas-Díaz, 2006). For instance, Bernal and Scharron del Rio (2001) proposed the addition of multicultural awareness and culture-specific strategies to Cognitive Behavioral Therapy, person centered and psychodynamic approaches to therapy.

Cognitive Behaviour Therapy

Culturally adapted Cognitive Behaviour Therapy (CBT) has been found to be effective in reducing symptoms of depression amongst Latinos (Comas-Díaz, 1981, Miranda, Chung, Green, Krupnick et al., 2003a; Miranda, Azocar, Organista, Dwyer & Areán, 2003b). For example Muñoz and Mendelsohn (2005) modified CBT treatment for depression (as compared to standard interventions), including the provision of both English-and-Spanish-language manuals and culturally relevant metaphors and stories in order to convey key cognitive-behavioral principles, the identification and incorporation of cultural values into pertinent intervention strategies (i.e., acknowledging that cultural values of familism may make immigration difficult for those who have family members in their country of origin) and explicit discussion of relevant issues such as religion and spirituality, acculturation and experiences with prejudice and discrimination (Muñoz & Mendelsohn, 2005). Participants reported significantly fewer depressive symptoms than those randomized to the control conditions throughout 1 year of follow-up assessment.

Further, CBT's emphasis on education has been found to be consistent with Latinos due to their perception of life as a learning opportunity. The CBT technique of challenging and changing negative cognitions has also been adapted and found to be congruent with Latino cultural resilience, since resilience encourages coping mechanisms and adaptive reactions to trauma and oppression (Miranda et al., 2003a). An active coping style characterized by Latinos is **sobreponerse** (*to overcome*), a resilience factor that indicates Latinos ability to work through problems or overcome adversity (Falicov, 2005). Although CBT was helpful in reducing depressive symptoms in this diverse population, it is important to investigate how such cultural modifications and specific treatment components are associated with treatment outcome (Lopez, 2002). Further, although some empirical studies of CBT' interventions support the effectiveness of this approach with Latinos (Comas-Díaz, 1981; Muñoz, Ying, Bernal, et al., 1995), CBT has also been recognized as not addressing the collective needs of Latinos in that therapeutic goals in search of individual mastery tend to exclude cultural context and hence can be considered as unfavourable for many Latinos (Nagayama Hall, 2001). Similarly, CBT has been recognised as an effective treatment approach for Latinos who are mostly English speaking and more acculturated (Chavira, Golinelli, Sherbourne, Stein, et al., 2014), thus continued attention should be directed toward engaging this population when delivering such interventions.

Interpersonal Therapy

Another approach found suitable for Latino clients is Interpersonal Psychotherapy (IPT), which was primarily developed for depression. This approach focuses on interpersonal and attachment factors on mental distress and targets interpersonal

disputes, role transitions and interpersonal deficits (Klerman, Weissman, Rousanville, & Chevron, 1984). Most of the research has been found to be pertinent to Latinos who experience relational difficulties, loss, and cultural adaptation issues. When culturally modified with relational values of familismo and personalismo, IPT has been found to be successful in reducing depression amongst Latinos (Rosello & Bernal, 1999).

Psychodynamic Therapy

Psychodynamic therapies have also incorporated client's varied spiritual, communal and social orientations into their practices (Altman, 1995). For instance, adapted versions of Object Relations framework in which the progress of clients was measured through adaptive relational experiences instead of by the insights gained in the therapeutic process was introduced by Altman (1995). When comparing Altman's modified approach of Structural Family Therapy with Psychodynamic Child Therapy, the latter was found as effective as Structural Family Therapy in reducing behavioral and emotional problems in Latino children with conduct disorder (Coastworth, Szapocznik, Kurtines & Santisteban, 1997). Although, more efficacy of family therapy over child therapy was reported when protecting family integrity in the long term. Bach-y-Rita (1982) suggested that Psychodynamic treatment is adequate for Latinos since its central principles have relative cultural universality, so 'regardless of the client's socio-cultural values, his/her needs and requirements for therapy are basically the same'. However, neither the given author, nor the theoretical/conceptual literature provide empirical basis to support why and/or how this treatment can be used meaningfully and effectively with this client group (Gelman, 2003; Garzón & Tan, 1992; Valdés,

1983). In fact, a review of the literature on Latino mental health and practice uncovered a bias against relevance and usefulness of psychodynamic approaches with Latinos and yet it lacked empirical evidence to support such claims (Garzón & Tan, 1992; Valdés, 1983; Rosado, 1980).

Most of the theoretical work supports the use of psychodynamic therapy with Latinos, viewing it as a relevant approach once it is adapted to meet the sociocultural needs of this group (Bernal y del Río, 1982; Chin, 1994; Comas-Díaz & Minrath, 1985; Javier & Herron, 1992; Wohl, 1995). Others, however, do not support the adaptation of the theory and technique to accommodate culture and cultural differences, suggesting that 'cultural differences are simply a surface upon which the neurotic conflicts and infantile fantasies of the client and analyst can be super-imposed in the development of transference and counter-transference' (Cabaniss, Oquendo, & Singer, 1994, p. 611). Nevertheless, Rogler, Malgady, Costantino, & Blumenthal (1987) suggested that psychodynamic concepts and techniques would be unsuitable for most ethnic minorities, though does not exclude their use out-of-hand, and neither provides research-based evidence for such statements.

Psychodynamic theories are thus seen as struggling to integrate culture, both to apply the theory to different groups in an effort to arrive at universal principles (Kakar, 1985), and in an attempt to understand how culture influences personality structure (Bamford, 1991; Heald, Deluz, & Jacopin, 1994; Leary, 1997; Littlewood, 1988; Mattei, 1996). Furthermore, Sue and Sue (2003) suggested that 'from the initiation of the therapeutic relationship the theoretical orientation of mental health providers is often culturally-bound. Hence, psychodynamic theories and approaches are developed in a certain time and place by individuals who are experiencing, observing, and absorbing the culture which is influenced by the

deep-seated and historically specific characteristics of its environment, thus failing to fully account their diverse clients' social, political, and cultural context'.

Humanistic Approaches (Person-Centered)

Person-centered approaches that convey empathy, warmth, attentiveness, respect and may use physical proximity have been found to be suitable for Latino clients (Santiago-Rivera, Arredondo & Gallardo-Cooper, 2002). Based on the emphasis placed on building interpersonal relationships by Hispanics, advocates of the use of the person-centered, acknowledged a shared value between person-centered principles and Latinos' ways of relating, in that both placed an emphasis on building interpersonal relationships that are nurturing, loving, intimate and respectful (Altarriba & Bauer, 1998; Constantine, 2001). Flores et al., (2000) suggested that client's perceptions directly influence their commitment to therapy.

Similarly, Gelman (2003) supported these characteristics as being descriptive of the Hispanic value of *personalismo*, *respeto* (respect), *personal pride* and *integrity*, hence as suitable for interventions with Hispanic populations. Furthermore, since humanistic approaches convey acceptance, they are therefore helpful in decreasing stigma and ensuring a strong therapeutic alliance helping Latino clients to develop trust and foster treatment adherence. Nonetheless, some scholars suggest that the use of a person-centered approach with Latinos should be limited because Latino client's cultural values and preferences are embedded in a collectivist perspective (Kouyoumdjian, Zamboanga & Hansen, 2003).

Family Oriented Approaches

Family Therapy

Family therapy was found to be suitable amongst Latinos for family problem solving and individual symptoms (Ho et al., 2004). Based on their work in the Spanish Family Guidance Center in Florida Szapocznik, Scopetta, Aranalde and Kurtines (1978) suggested that family-oriented approaches in which the therapist takes a directive, active role and present-oriented leadership role is in agreement with Latinos population' attributes due to their cultural characteristics/values and their role in treatment. The impact of family therapy in work with Latino populations has been evaluated in different studies by Szapocznik and collaborators (Szapocznik et al., 1984, 1986; 1989) and these authors suggested that family interventions are effective in bringing about improvements in both individual and family functioning. Research also suggests that Latinos might be more inclined and responsive to treatment approaches that integrate family members (Cardemil, Kim, Pinedo, & Miller, 2005; Delgado & Humm-Delgado, 1984). Bernal, Bonilla and Bellido (1995) developed a framework for culturally sensitive interventions with Latino families based on the concept of contextualism, suggesting that an individual must be understood within the context of his/her family, and that that family in turn, needs to be understood within the context of the culture in which it is immersed. Therefore, it is important to stress that when working with Latino families, clinicians must pay attention to the increasingly multicultural and pluralistic context in which Latino families are embedded. Despite efforts to competitively work with ethnic minorities, more conventional treatment approaches promoting individualistic value systems such as: differentiation, individuation,

have been used rather than collectivistic values systems such as: familism within which some ethnic minority groups (i.e., Latinos) often interact. This therefore disagrees and/or creates possible conflict between the values of the Latino culture and the more mainstream values that are often used in traditional psychotherapies (Nagayama-Hall, 2001).

Post-modern Approaches

Due to the migratory circumstances and experiences that many Latinos have endured, especially considering those who have faced on-going civil conflict, many Latinos need help dealing with traumatic experiences. Issues that result from immigration and its hardships, relatives left behind, loss of national affiliation among others, becomes a source emotional, socio-economic and familial strength that leads to an emotional burden for many Latinos. These often translate into a source of family secrets, myths and rules governing individual and family behaviour. Those suffering from post-traumatic stress are hence less likely and/or willing to discuss potentially unresolved grief. Family therapists are thus encouraged to assist Latino families by helping them to externalize problems/emotional states evoked by traumatic experiences in their lives so that it is not internalized in the individual or within the family and other significant ones (Laird, 1998; White & Epsom, 1990).

Narrative Therapy

Narrative therapy has thus been recommended for Latino families who have gone through trauma (Ho et al., 2004), and is considered to be one of the most effective approaches to use with Latinos. Accordingly, the ability to tell one's story, in terms of pre and post migration status, allows the counselor to understand the client's

essence, background and family as well as helping the client to feel validated and connected to the therapist due to the perceived willingness to listen to the client's story Falicov (2007). The opportunity to re-story allows the client and/or family to locate the specific origins of immobilizing aspects of these experiences and losses (Laird, 1998) and also to find or create new ways of coping with experiences of migratory trauma (Rasheed & Rasheed, 1999). Falicov stressed the need to pay attention to the relational, community, cultural and socio-political contexts whilst listening to the client's narrative. On the other hand, whilst diverse interventions have been proposed and used accordingly to eliminate Latinos' disparities in mental health (Aguilar- Gaxiola et al., 2012), little has been reported about the appropriateness of suggested adaptations/documentated therapeutic modalities to Latinos, which may represent only slight adaptations of mainstream psychotherapeutic concepts and techniques.

In general, there has been limited research into the effectiveness of any type of treatment for Latinos, and most of the research that has been conducted has mainly focused on methodological and conceptual problems (Gelman, 2003). Therefore, current understandings of Latinos' mental health and practice are often based on inconsistent research, assumptions and opinions that may never or no longer hold, for this population (Gelman, 2003; Rosenthal, 2000; Sue et al., 1994). Hence, it seems important to advance investigations about what constitutes meaningful and effective psychotherapeutic treatment with Latinos, and what role any approach might play in this. Much systematic and rigorous work in this area needs to be done (Bernal & Scharrón del Río, 2001).

Based on the given research, clinicians and researchers are encouraged to modify traditional psychotherapy approaches and empirically supported treatments with various Latino groups, or to develop entirely new psychotherapy approaches that

are consistent with the values, beliefs and norms of the Latino culture in order to make psychotherapy more culturally sensitive. The above-mentioned approaches may not be equally effective for all individuals, hence special consideration should be placed on the specific and unique needs of Hispanics/Latinos.

Therapeutic Interventions That Have Been Developed and Evaluated for Hispanic/Latino Clients

The growing cultural diversity in the U.K. is reflected in counselling psychology with regard to cultural differences between clients and therapists, thus generating greater interest and demand for cross-cultural therapy (Sue et al, 1996). However, the British Psychological Society's *Professional Practice Guidelines for Counselling Psychologists* (BPS, 2005) and *Codes of Ethics and Conduct* (BPS, 2006) has encouraged a culturally sensitive approach to practice within individuals' context, to work with individuals from diverse ethnic, linguistic and cultural groups (BPS, 2005). Also, despite the fact that in the U.S, progress has been made in identifying mental health needs of Hispanic/Latinos, efforts and reported success in culturally adapting mainstream psychotherapy, limited attempts have been made to develop and investigate the efficacy of culturally competent interventions/approaches for these clients (Coastworth et al., 1997).

Bicultural Effective Training (BET)

Due to the impact that immigration and acculturation has on Latino families, Szapocznik, Santisteban, Kurtines, Perez- Vidal and Hervis (1984) developed *Bicultural Effective Training (BET)*. Through this intervention the authors attempted to enhance bicultural skills in two-generation Latino immigrant families

which addressed family conflicts that result from differential acculturation rates. To evaluate this intervention Szapocznik, Rio, Hervis, Mitrani, Kurtines and Faraci (1991) developed the ***Structural Family Systems Rating (SFSR)*** a measure for Latino families. The result was the (SFSR) which indicated that (BET) was as effective as structural family therapy in improving adolescents and family functioning. Although, BET was also shown to be appropriate to Latino families due to its focus on cultural content (Szapocznik et al., 1991).

Cuento Therapy (folktales)

Another attempt to develop culturally effective interventions was carried out by Malgady, Rogier and Constantino (1990) with the Hispanic Research Center of Fordham University, in which they suggested a treatment modality for Puerto Rican children, adolescents, and adults by integrating *cuentos*. *Cuento therapy* used native culture stories and characters to address a cultural theme and transmit a moral within a structure of modeling therapy. The results suggested usefulness of this modality, showing reduced anxiety symptoms in participants at different ages, decreased aggression and disruptiveness in school children, as well as increased self-concept (Malagy et al., 1990). In a qualitative study undertaken to address barriers for Spanish-speaking clients by implementing Cuento Therapy, Carreon (2015) found that cuentos were experienced as a appropriate therapeutic modality, this intervention created a comfortable non-threatening environment, and the cuentos group enabled participation in therapy of all group members. This author however recommended that appropriate therapeutic orientations such as Cognitive Behaviour Therapy, Psychodynamic Therapy, Narrative Therapy should be incorporated when using CuentoTherapy

(Carreon, 2015). Although many researchers are evaluating treatments that are culture-specific for Latinos, much still remains to be done in this respect (Romero, Edwards & Corkery, 2013).

Culturally Sensitive Therapeutic Interventions/Resources That Have Been Proposed for Latino Clients

Western practices are considered as limited in addressing the collectivistic nature of Latinos, or as “not Latino centered” (Comas-Diaz, 2006 p. 440). Accordingly, individualistic values such as free will (as opposed to interaction), separation and individuation, individual mastery and agency and “objective reality” are not in accordance with healing for collectivistic Latinos (Comas-Diaz, 2006). Consequently, the use of culture-specific treatment and Latinos’ own resources could help them to develop resilience and empowerment through the upholding of ethnic roots.

Sabiduría (spiritual and existential type of wisdom)

Comas-Diaz (2006) suggested the incorporation of “ethnic psychology” and its three core elements to identify culturally responsive and effective resources and intervention strategies that acknowledged the need of culturally sensitive psychotherapy for Latinos. They include contextualism (the relatedness to context as part of Latinos’ collectivist nature), interconnectedness (Latinos value of familismo that allows for the acceptance and inclusion of non-biological individuals as part of the nuclear and/or extended family). Also, magical realism (as an expression of interconnectedness, which involves an alteration of reality with

fantasy). Accordingly, Latino ethnic psychology fundamentally aims to achieve **sabiduría**, a spiritual and existential type of wisdom. Sabiduría comprehends the understanding of life's challenges as opportunities for spiritual growth. In this view, Latinos have the tendency to develop positive meaning out of adversity (Muñoz & Mendelson, 2005). Therefore, the attainment of sabiduría, is the reward for living life with meaning and purpose which itself represents wholeness, connectedness, and evolvment (Coelho, 2003).

Dichos (Sayings)

Furthermore, (Zuñiga, 1991, 1992) suggested the use of '**dichos**' in psychotherapy with Hispanic/Latino clients. Dichos are proverbs, or popular sayings in the Spanish language used by people from Latino cultures to express problems, dilemmas, perspective or a slant on situations and the paradox of human condition. For example, *Dime con quién andas y te diré quién eres* (Tell me who your friends are and I will tell you who you are). Dichos were described by de Rios (2001) as '*helping to link the phenomenological world of the Latino client with the symbols and metaphors available to psychotherapists when addressing and expressing emotional struggles and specific issues, also as helping to enhance communication and the therapeutic relationship*'. In Latino culture, dichos are socializing patterns in which values such as responsibility, courage, and traditions are passed on from one generation to another. Because much communication is carried out indirectly, dichos provide a channel by which comforting advice and feedback can be conveyed to the client (Añez et al., 2005).

Religion/Spirituality

Latino spirituality and religious beliefs comprise a significant dimension in ethnic psychology due to its influence in Latino life (Comas-Diaz, 2006). Different contributors in the literature of therapeutic resources for Latinos stressed the value for therapists to become sensitive to the persistent presence of religion/spirituality and folk beliefs in the lives of Latino clients (Comas-Diaz, 2006; Falicov 2009; Ho et al., 2004). Research suggests that some acculturated and non-acculturated Latinos tend to turn to the comfort and support of traditions and religious/spiritual practices during life's challenges and meaningful transitions as a way of coping with life circumstances, helping them to strengthen their sense of meaning and purpose (Muñoz & Mendelson, 2005). Actually, Latinos' everyday language is filled with allusions of God, saints, and angels. For instance, "Si Dios quiere" (God willing) is a common expression when a Latino is making plans or expecting something to happen in the near future. Falicov (2009) proposed that therapists explore Latino clients' beliefs about health and illness and their religious/spiritual beliefs. Also, once the therapeutic relationship has been established, heightening Latinos own ties to their primary ethnicity could be used as a therapeutic and/or supportive resource to increase families' coping strategies and enhance continuity and belonging. Although the role of spirituality in the healing process has been increasingly acknowledged in the mental health field, it has not traditionally been part of formal treatment approaches despite its possible intra and interpersonal role among ethnic minorities (Bernal & Sáez-Santiago, 2006).

Despite the high prevalence of mental health problems among Hispanic/Latinos, interventions to prevent and treat their psychological difficulties have been developed and tested mainly with and for White clients (Martinez, Callejas & Hernandez, 2010; Miranda, Bernal & Lau, 2005). Such interventions also tend to

overlook the role of cultural values, beliefs, and practices or account for cultural differences (Bernal & Domenech-Rodriguez, 2009; Lau, 2006). This suggests a need to identify and improve access to evidence-based treatments for mental health problems for Latinos and other ethnic minorities groups. An integrated approach could be more beneficial, as it will work with Latino clients from an ecological-systemic-contextual perspective (Guanipa-Ho, Talley, 1997).

What is Still Needed to Provide Latinos Quality of Care?

Despite efforts to reduce inequalities in mental health and the advocacy for a culturally competent workforce from existing principles, those principles that aim to increase understanding and critical exploration of race, culture, and diversity in mental health delivery (BPS, 2008; Health Care Professional Council (HCPC), 2014; Eleftheriadou, 2014). Also, despite different policy initiatives such as the Equality Act (2010) and the Health and Social Care Act (2012), aiming to reduce BME inequalities in mental health. In a recent review, Grey et al., (2013) found that 'BME continue to experience inequalities within the U.K. mental health system, and that policy directives still have little impact on narrowing the mental health gap at the national and local levels'.

Furthermore, whilst much progress has been made in the U.S. to increase awareness of the mental health needs of Latinos and efforts have been made to adapt services, therapeutic approaches and interventions to meet Latino cultural needs, little research has been conducted about their usefulness in the actual counseling experiences of Latino population. Hence, the current and projected growth of the Latino population in the U.K, along with research policies which will

make health-care more accessible to documented and future Black and minority ethnic migrants, suggests that it is crucial that counselling psychologists understand, from the perspectives of Hispanics/Latinos, what is relevant and/or should be implemented when working with them to enhance successful treatment adherence and outcome with this population. This is particularly important considering the scarcity of research in mental health with Hispanic/Latino clients in the U.K and I advocate for research into the counselling experiences of Hispanic/Latino clients with English-speaking therapists.

Summary

Although ethnic inequalities in mental health of BME groups have been of concern for decades both in the U. K. and the U.S., there is still a significant gap between policies and methods of implementation to meet the mental health needs of BME groups. Risk factors in the prevalence of mental health problems of Latinos in the U.S. include migration, socio-economic conditions and problems of assimilation. Similarly, some of the barriers contributing to the under-utilization of mental health services by this group are communication difficulties, socio-economic factors, cultural differences, and structural barriers. Psychotherapeutic challenges associated with client-therapist interaction, assessment, and therapeutic interventions also serve as a barrier. One of the difficulties in addressing Hispanics/Latinos' mental health issues is their vast cultural heterogeneity. Although research in the U.S. has increased awareness and understating of mental health utilization trends amongst Latinos compared to Caucasians/Whites. Latinos, as a minority ethnic group, still face barriers in terms of accessing culturally appropriate services. Therefore, to assist Latinos' access to and benefit from mental health services in the U.K., mental health professionals are

encouraged to increase cultural awareness and sensitivity for culturally competent practice with Hispanic/Latino populations. There is also a need to conduct research to better understand the mental health needs, service utilization trends and therapeutic outcomes of Hispanic/Latinos in the U.K.

Rationale of the Current Study

Having read this chapter, the reader may have noticed the paucity of empirical studies that focus on the counselling experiences of Hispanic/Latino groups in the U.K. Also, considering the different socio-economic and cultural factors that have been identified as influential on the mental health utilization, and un-meet mental health needs of Latino/Hispanic groups residing in the U.S. (Cabassa, Zayas, & Hansen, 2008). It is evident that compared to other minority ethnic groups, Hispanics/Latinos experience similar or greater stressors and thus higher susceptibility to mental distress (Mental Health America, 2014; Sue & Sue, 2013).

Furthermore, considering Latino Americans constitute one of the fastest growing ethnic minority groups in the United Kingdom (McIlwaine and Bunge, 2016), and although the importance of providing ethnic minorities with the mental health services they need has been recognized (Mental Health Foundation, 2015), not many efforts seem to have been undertaken to engage, increase access and/or report service utilization of mental health services for Hispanic/Latino population in the U.K. Therefore, this study attempts to bring insight to therapists (mainly English-speaking or non-Latino), about what is important to implement with Hispanic/Latino clients to improve provision of mental health care for this population. To achieve this objective, the present study aims to bring together “the voices” of Latino participants who live in London and experienced counselling with

English-speaking therapists which could highlight what is needed to enhance Hispanic/Latino counselling experiences.

Aims of the research Question

The aim of the present interpretative phenomenological analysis study is to explore the lived experiences of Hispanic/Latino participants in regard to counselling/therapy services with English-speaking therapists. The results should provide insight into what is helpful to better serve this ethnic minority group. This study could thus contribute to new initiatives towards the establishment and implementation of culturally competent treatment for Hispanic/Latinos.

Research Question

What are the counselling experiences of Hispanic/Latino clients with English-speaking therapists?.

Chapter 2 - Method

Chapter overview

This chapter will provide an outline of qualitative research paradigm and rationale for its use in this study. I will outline the different qualitative methods considered in this research study and a rationale for my choice of Interpretative Phenomenological Analysis (IPA), addressing Ontological and Epistemological positions and their suitability for the present research. Following is an overview of the data collection methods and procedures and an explanation of the steps and procedures for handling, analysing, and interpreting the data using IPA and lastly I have provided both a personal and epistemological reflexivity.

Section 1: Methodology

Overview of Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is an approach to psychological qualitative research which aims to explore how individuals make sense of their personal and social worlds (Smith, 2004). IPA emphasis is on exploration and understanding the meanings that underlie specific experiences, events or states achieved through a detailed examination of the participants' subjective experiences (Smith, 2004, 2007; Willig, 2008; Smith, Flowers, & Larking 2009).

Key theoretical underpinnings of IPA are phenomenology, ideography and interpretation (hermeneutics) (Smith, 2004, 2007; Smith, Flowers & Larkin, 2009). This is opposed to the nomothetic approach used in quantitative methods which aims to make probabilistic claims about individuals based on the measurements of

large groups or populations, as IPA encourages an idiographic approach with small and homogenous sample groups in order to ensure that the individual participants can give a detailed perspective on the phenomena under investigation (Biggerstaff & Thompson, 2008; Smith & Osborn, 2008; Smith, Flower, & Larkin, 2009). IPA's idiographic approach is also central in that the researcher is encouraged to look at the uniqueness in an individual's experience and behaviour, attempting to understand as much as possible from one case before moving onto the next. Setting aside findings from the first case, through bracketing, with the aim of maintaining sensitivity to each person's unique experience (Eatough & Smith, 2008; Smith, Flowers & Larkin, 2009), thereby explains the rationale in how the transcripts are analyzed.

IPA has theoretical roots in phenomenology, which is the study of 'Being', (i.e., of existence and experience), and has two historical phases: the transcendental and the existential or hermeneutic/interpretation (Husserl, 1931/1950; Heidegger, 1927/1982; Smith, Flowers & Larkin, 2009). It is suggested that Husserl saw phenomenology as a method of obtaining "true meaning" through enquiring further and further into reality which differs from the Cartesian dualism of reality being something 'out there' or completely separate from the individual (Lavery, 2003, p.5). Husserl's description of the life-world is perceived as central to phenomenology in that he rejected the scientific approach and maintained the view that each individual perceives the world differently (Smith, 2008) meaning as 'intentionality,' which allows objects to appear as phenomena. The process of '**bracketing**' is fundamental to Husserl's 'phenomenological reduction' (Giorgi & Giorgi, 2003; Smith & Osborn, 2008). Husserl's transcendental phenomenology recognizes that researchers' perceptions can be influenced by their own ideas and opinions, hence, he encouraged them to bracket these prior views, that is, engage

in the 'epoché' (Husserl, 1982). Accordingly, researchers should suspend judgement and/or set aside their own personal experiences, biases and preconceived notions about the research topic. Also, they should set aside previous research findings, theory and personal knowledge about the research topic, so that they do not influence their understanding of the collected data and other researchers' outlooks of such data. Only this way will the researcher be able to understand their participant's views/understanding of the phenomenon, and accurately describe their life experiences (Carpenter, 2007).

Other theorists have implied the perceiver and object as integrated in mutual co-formulation (Finlay, 2002), and reality is also seen as comprised of people's intentionality, for instance, how they consider the world and the meaning attached to those thoughts and beliefs. Although, while Husserl believes that description is foremost and interpretation is a unique kind of description (Giorgi & Giorgi, 2003), Heidegger (1927-1982) considers that interpretation is central and that description is a distinctive mode of interpretation (Giorgi & Giorgi, 2003). Additionally, Heidegger does not support the idea of bracketing as he considers that pre-understanding cannot be eliminated or bracketed, that it is not possible for an individual to completely separate their *priori* knowledge and history of experience (Heidegger, 1927; Koch, 1995). Also, and contrary to Husserl, Heidegger argued that consciousness is not separate from the world and indicated that "we live in an interpreted world and are ourselves hermeneutic, we are interpreters, understanders" (Smith 2015, p.19). Therefore, and according to Heidegger's theory of interpretation, human existence is fully and inextricably bound up in a world of people, things, relationships, language and culture. He consequently considered it impossible for either the researcher or participant to decide whether to surpass or disconnect from the rooted features of their lives in order to reveal some essential

truths about their lived experiences (Larkin, Watts & Clifton, 2006). That is, all enquiry starts from the enquirer's perspective and, from the basis of their experience, thus the technique of bracketing is found inconsistent within the hermeneutic phenomenological approach (LeVasseur, 2003). As an IPA researcher, I acknowledged that instead of keeping aside or bracketing my preconceptions and assumptions in advance of an enquiry, I should work from the Heideggerian's perspective and try to identify my basic understanding of the phenomenon under investigation, acknowledging that an awareness of these 'fore-conceptions' may not come to light until work has started in the interview or analysis or until the phenomenon has started to emerge (Smith, Flowers & Larkin, 2009). I thus aimed to adopt a 'sensitive' and 'responsive' approach to data collection and analysis that allows my preconceptions to be impelled and amended by the data (Larkin, Watts & Clifton, 2006, p. 108).

The careful attention to such participant's concerns creates a dynamic or cyclical form of bracketing, which is similar to the process of reflective practice. I therefore acknowledged the important role of, and engaged in, reflective practice as part of IPA research process (Smith, Flowers & Larkin, 2009). This means that what is captured by a participant's experience will always be indicative and provisional rather than absolute and definitive because I as a researcher, and however hard I try, cannot completely escape the contextual basis of my own experience (Larkin, Watts & Clifton, 2006). Although the aim is to reach a nuanced understanding of the phenomenon, a perfect understanding of the essence of the experience will always remain unidentified.

Two different types of interpretation (hermeneutics) are recognized (Ricoeur, 1970). One is "the hermeneutics of meaning-recollection" which requires informing other people about characteristics of an experience, aiming at "faithful disclosure"

(Smith, 2008, p.18). On the contrary, “the hermeneutics of suspicion” tries to comprehend a further reality beyond the thing that is being analyzed. This aims to allow a deeper interpretation to be constructed which can argue against the account that is seemingly apparent (Smith, 2008, p.18). However, Ricoeur (1996) suggested that neither of the two interpretative positions on their own can generate appropriate insight and therefore a combination of the two is required to reach a more complete understanding and explanation of the data. This therefore embraced an empathic/suspicious approach throughout the analysis process.

IPA has been suggested as a methodology to perform Heidegger’s “hermeneutics of factual life” in that objects and events which individuals are focused upon can be understood by investigating how the individual experiences and make sense of them (Eatough & Smith, 2008, p. 180). IPA is perceived as using a double hermeneutic circle (participant’s meaning making, interpreting their own experience and the researcher’s sense making and interpreting the participant’s experience (Smith, 2008; Smith, Flowers & Larkin, 2009), where the researcher is required to take an active role in trying to gain access to the participants’ ‘personal world’ (Smith, 2008). This process is seen as being influenced by the researcher’s own ideas which are deemed necessary to make sense of the participants trying to make sense of their world. Therefore, any generated understandings are perceived as a consequence of a thorough and comprehensive engagement with the participant (Finlay, 2002). Although the purpose of this methodology is to investigate the participant’s experience from his or her perspective, it is recognized that this exploration unavoidably encompasses my own viewpoint in addition to the type of interaction between myself and the participant (Smith & Osborn, 2003).

Different approaches were considered when choosing a qualitative research

method for the current research project. Such approaches included Interpretative Phenomenological Analysis (IPA), descriptive phenomenology (DP), grounded theory (GT), Discourse Analysis (DA), and Narrative Analysis.

Rationale for Adopting a Qualitative Methodology

Qualitative methods have been used mainly and extensively in health research and social sciences and they are designed to investigate meaning and subjectivity (Wertz, 2005). Whilst quantitative analysis alters and reduces data into numbers and is concerned with “determining how much of an entity there is” Smith (2008, p.1), qualitative analysis is seen as “encompassing the description of the constituent properties of an entity”, that is, “the interpretative study of a specified subject or problem where the researcher is central to the sense that is made” (Parker, 1994). Therefore, a significant difference between quantitative and qualitative methodologies is perceived in the degree to which our understanding of the world can be considered as objective knowledge or ‘true’ (Willig, 2001). However, these two methods widely vary in their research questions, theoretical foundations and in regard to their epistemological and ontological standpoints.

Paramount to qualitative research is the engagement in exploration, description and interpretation of personal and social experiences of individuals from a relatively small sample pool. That is, the understanding of the subjective experiences of the individual and exploration of the meanings they attach to those experiences, rather than testing hypothesis (Smith, Flowers & Larkin, 2009). In contrast, quantitative methods’ investigation’s aim is to reach a single ‘real’ or true account of phenomena and is considered as being upon ‘confirmation’ whereas, qualitative methods’ aim is to capture and preserve the complexities and

idiosyncrasies of experience, placing emphasis on 'discovery', socio-cultural context Nelson & Quintana (2005), and aims to highlight "human experience in its richness" (Ashworth, 2003).

A qualitative method is suitable for the current research as it is emic and idiographic in its approach (Morrow & Smith, 2000), so is concerned with a detailed examination of the subjective experience of counselling/therapy rather than outcome and causality. Therefore, I will be emphasising the importance of exploring each participants' attributes to their counselling experiences in London and with English speaking therapists, attending to the individual's account of their reality in order to understand their lived experiences (Parker, 2005).

Previously, psychology was mainly influenced by positivist research paradigms using quantitative research methods (Ponterotto, 2005). However, according to Willig (2008) the positivist position was seen as preventing the development of counselling psychology due to its emphasis on research as producing objective knowledge without the researcher's personal involvement thus perceiving description and observation as prejudiced. Therefore, rejecting the positivist view of the world as unitary, single and real Husserl (1931-1950), qualitative research proposes that each person has his/her own world can interpret any given event, feeling, perception and behaviour in a vast number of ways (Pidgeon & Henwood, 1993).

In London, studies in cross-cultural counselling have been highlighted by Palmer (2002); Moodley & Palmer (2006); Eleftheriadou (2010); and Lago (2011) amongst others, all raising cultural awareness and sensitivity in counselling practice. However, qualitative studies in this area still remain relatively limited in number compared to the volume of quantitative studies. Additionally, and to my

knowledge, qualitative studies in counselling with Latin American clients in London do not exist. So, and since the focus of this study is complex and relatively unexplored, this suggests that Latin Americans' experiences of counselling seem to be influenced by factors in which culture appears to have a prominent role and raises awareness of the need for its investigation to aid cultural sensitive practice.

In thinking on how best to address the particular research question of this study, which is itself a complex phenomena and following the belief that participants are more likely to modify their responses in a socially desirable manner during quantitative data collection, it was decided to adopt a qualitative methodology as the most suitable research methodology. Some of the benefits of this approach include the use of semi-structured interviews allowing for in-depth and detailed exploration of phenomena that is not easily quantifiable whilst also upholding participants as experiential experts on the phenomena under investigation (Smith et al., 2009). This aims to uncover 'participants-generated' meanings in order to allow for the possibility of organic, unanticipated, and virtually unlimited scope of data to emerge (Wertz, 2005), consequently hoping for a qualitative methodology to lead to a deeper, richer and holistic understanding of participants' experience.

Interpretative Phenomenological Analysis versus Descriptive Phenomenology

The principal differences between descriptive and interpretative phenomenology is that the latter rejects the possibility of separating description from interpretation (Todress & Wheeler, 2001; Willig, 2008), acknowledging that the findings produced by the researcher are an interpretation of the participant's experience rather than offering direct access to his/her subjectivity (Willig, 2008). Moreover, in

descriptive phenomenology, the researcher is identified as the main judge of validity whilst interpretative phenomenologists seek validation through an appeal to external judges (Rapport, 2005). This therefore leads to a personal preference for IPA over descriptive phenomenology.

Interpretative Phenomenological Analysis versus Grounded Theory

Although these methods take a similar approach to the analysis and data collection and also share numerous common techniques in producing data (Brocki & Wearden, 2006), IPA differs from GT on its theoretical grounding and its fundamental suitability for understanding personal experiences rather than social-contextual processes (Willig, 2001). Additionally, GT normally attempts to recognize and clarify social phenomena, being more considered as a sociological approach and drawing on convergences within a larger sample to support wider conceptual explanations and/or processes (Willig, 2008), whereas, IPA has been explicitly developed for the purpose of psychological enquiry (Langdrige, 2007; Willig, 2008), aiming to give a more detailed account of the personal experiences of a smaller sample (Smith *et al.* 2009).

A personal preference for IPA over GT, is that GT is seen as containing a deductive and empiricist approach towards discovering knowledge suggesting that knowledge acquisition depends upon the collection of data and is therefore unlikely to move one closer to the truth (Willig, 2008). Conversely, IPA adopts an inductive 'bottom up' approach with an idiographic emphasis, that is, making sense of and gaining insight into the individual's psychological world, highlighting its idiographic commitment to the participants' subjective experiences, and thereby identifying recurring patterns of experience among a group of people (Willig,

2008).

Furthermore, IPA was chosen over GT, given the present research was more concerned with describing and interpreting what participants' thought/felt rather than attempting to create or provide explanations or theorize from the interview data as is the case with GT. Also, IPA allows more freedom and creativity when gathering and analysing the data (Willig, 2008). This therefore takes into consideration essential factors when the research question is concerned with novelty, facilitating a more comprehensive and descriptive process of data collection and analysis. This is because IPA allows the researcher to engage hermeneutically both with current theoretical constructs (Larkin et al., 2006) and with reflexivity. Therefore, I appreciated the opportunity to work more reflexively considering my own personal commitment to the topic and engagement with interpretation of participants' accounts. Consequently, and in accordance with the aims of the present study, IPA was considered as a more suitable method for the present investigation, due to its commitment to explore the participants' counselling experiences rather than generate theory.

IPA Versus Discourse Analysis

Discourse analysis explores the psychological aspects of discourse and the role of discourse in the construction of meaning (Phillips & Jorgensen, 2002). IPA was chosen over Discourse Analysis (DA) since DA is sceptical about the accessibility of cognitions and considers language as 'productive', that is, as actively shaping and building individual's social reality (Willig, 2008). Therefore, psychological experiences are seen as constructed through the use of accessible discourses and based within local social interactions, thereby challenging the assumption that

language provides a set of unambiguous signs that directly label internal states (Bourne, 2009).

Discourse is therefore seen as taking a radical social constructionist approach to gathering knowledge. IPA, on the contrary, is concerned with cognitions and sense-making. Recognizing that cognitions are not clearly available from verbal reports, it engages with participants' subjective and contextual meanings given to their experiences, that is, the analytic process, hoping to say something about the sense-and-meaning-making engaged in such thinking rather than only conceptualizing experiences as a manifestation of situated discursive resources (Smith, Flowers & Osborn, 1997; Willig, 2008; Smith *et al.*, 2009).

By holding a symbolic interactionism connection, IPA considers that the meanings that individuals attribute to things are significant, and context dependent, that is, always contingent upon social, psychological, cultural and historical perspectives (Eatough & Smith, 2008; Smith, Flowers & Larkin, 2009). Therefore, and contrary to DA, IPA takes a more moderate social constructionist approach, identifying the individual as an experiencing, meaning-making, embodied and discursive agent (Eatough & Smith, 2006). Since the current research was not interested in what discourses were mobilised and instead aimed to map the participants' subjective views in relation to how they experienced their counselling encounters/relationships with English speaking therapists and contrary to the discourse position that is critical of "the existence of a psychological interior" Finlay and Madill, (2009, p.152), I embraced the relevance of psychological processes, allowing for the exploration of thoughts, feelings and perceptions, aiming to engage with each individual's intentionality of the phenomenon they experienced (Eatough & Smith, 2008).

IPA Versus Narrative

Narrative Analysis is also a social constructionist approach concerned with the investigation of the process of meaning construction, through analysis of the narrator's construction of their social world (Andrews et al., 2000). However, it could not be considered a possible research method because narrative is only one way of meaning-making (others include discourse and metaphor). Consequently, IPA was selected because it includes considerations of narrative in the sense-making of participants, without being constrained by this focus (Smith *et al.*, 2009).

Based on the previous information, I believe that a phenomenological study was required and deemed as more suitable rather than any of the other qualitative approaches mentioned in here. The rationale and philosophy underlying IPA is similar to that of Counselling Psychology, valuing individual's subjective experiences and the interpretation of meaning within the therapist-client dyad. A personal preference for IPA is also determined by a shared identity with the research participants, highlighting the need to acknowledge and explore the crucial role that the researcher plays in the research process. Consequently, IPA is a suitable method for this study, aiming to provide insight into a topic considered central to the work of the Counselling Psychologist.

Rational for Using Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a commonly used approach in the health and mental fields (e.g. Smith & Osborn, 2003; Smith *et al.*, 2009). My desire to research the counselling experiences of Latin American clients with an

English speaking therapist and to understand how they make sense of these experiences encouraged me to acknowledge IPA as the most appropriate method to use. Some of the reasons include:

IPA is sound with the research objectives in that it is committed to the examination of how people make sense of their experiences (Smith *et al.* 2009). IPA is an exploratory and dual approach, both descriptive and interpretative, and participants are the experts in their own subjective experience, thus, analysis is not concerned with the reality of an experience but rather with participants' perceptions of their experiences (Biggerstaff & Thompson, 2008; Creswell, 2007; Larkin, Watts, & Clifton, 2006; Smith *et al.*, 2009). I was also concerned with participants' experience of the phenomenon under investigation as well as making appropriate interpretation of their perceptions.

Eatough & Smith (2008) showed that in IPA, the lived life is viewed as far more than historically situated linguistic interactions between people and a great deal of IPA research has focused on how people make sense of their embodied experiences. Accordingly, IPA is suitable where the topic is dynamic, contextual, subjective and relatively under-studied. Additionally, "especially useful when one is concerned with complexity, process or novelty" (Smith & Osborn, 2008; p.55), and where issues relating to identity and meaning making are important (Smith, 2004). I consider that my research question meets these criteria. Further, I also valued IPA emphasis on individuals' perceptions, its alignment with hermeneutics and interpretation (Eatough & Smith, 2008). It is equally a suitable methodological approach for this study due to its data collection techniques (in-depth interviews) and its specific characteristics that allow in-depth analysis of participants' experiences and meaning-making towards seeking counselling support.

Furthermore, I decided IPA over Giorgi's (1985, 1994, 2000) proposed methodology which takes a more descriptive 'Husserlian' approach by not placing much emphasis on the individual (Giorgi & Giorgi, 2008), instead "seeking the general structure of phenomena" (Eatough & Smith, 2008). IPA, on the contrary, has an idiographic, inductive and interrogative nature which is more in line with my research due to its emphasis on individuals' lived experiences and insights, first allowing for exploration of unique participants' meanings at the same time and only after being able to say something in detail about the participant group (Smith et al, 2009). Smith (2004, p. 42) cited Warnock (1987) as suggesting that 'delving on the particular also takes us closer to the universal'. IPA's idiographic nature is therefore considered as being more in keeping with the aims of the present study.

The Husserlian approach uses techniques such as reduction and bracketing, IPA, on the contrary, does not use such key techniques, hence, some critics allege IPA is not considered to be phenomenological due to its weak use of phenomenological philosophy/theory, for instance, the use of epoché (Husserl, 1954). I consider that it is not possible to set aside my own experiences and understanding of the world. Consequently, I valued IPA's interpretative nature and employment of 'double hermeneutics' where the researcher aims to try to make sense of the participant's experience whilst at the same time the participant is trying to make sense of his/her own experience (Smith & Osborn, 2003; Smith et al. 2009).

Other reasons for choosing IPA included the hope that this research would highlight the quality and texture of an individual's experience (whereas understanding that the researcher would never be able to directly access such experience), even though this is a central aim to IPA (Smith & Osborn, 2003). Additionally, IPA is both phenomenological and social constructionist in that it is

concerned with personal experience but also involves interpretation, involving consideration of context. Is it therefore in accordance with both my ontological and epistemological positions of critical realism (Bhaskar, 1989; Archer et al., 1998) and constructivism–interpretivism (Schwandt, 1994; Guba & Lincoln, 2000). Amongst the mentioned reasons, I valued IPA’s structured approach and comprehensible nature as appropriate for a novice researcher like myself.

Epistemological and Ontological Standpoints

IPA can be widely used within psychological research as it does not claim a distinctive epistemological position, thereby becoming a flexible research option. However, when conducting research it is important for the researcher to identify the objective and be able to justify his/her choice, adopting and being explicit about both his/her ontological and epistemological views within the research (Madill, Jordan & Shirley 2000). Ontology is concerned with one’s view of the nature of reality whereas epistemology tries to provide an answer as to how that reality is known and the relationship between the knower/researcher and the known/participant (Morrow, 2007). There are four basic paradigms positivism, post-positivism, interpretivism-constructivist, and critical-ideological (Guba & Lincoln, 1994; Ponterrotto, 2005b).

With regards to my ***Ontological beliefs*** I consider myself a “***Critical Realist***”. From this position, I accept that there are stable and enduring aspects of reality that exist independently of human conceptualisation (Crotty, 1998). Therefore, the differences attached to individual’s meaning of their experiences are considered probable in that they experience different parts of reality. My assumption that reality exists encourages me to learn more about participants’ experiences of

counselling, nevertheless, I believe that when Latin American participants make a claim, they have a unique reality and express something about their feelings and thoughts contrary to the reality of the counselling experience per se. Consequently, when conducting this research, I considered myself as viewing the experience of each participant as a “person in context” (Larkin, Watts & Clifton, 2006). This perspective is in accordance with IPA’s philosophical assumptions, aiming to investigate how these participants make sense of their counselling experiences rather than trying to find their accuracy, that is, whether they are true or false or corresponding to an “external validity” (Willig, 2009).

When considering an *Epistemological position*, this research did not embrace a critical ideological epistemology regarding that and although it assumes that multiple realities exist and it is suitable for multicultural research (Ponterotto, 2005), it places much emphasis on a “real” reality related to power and oppression and challenges the status quo which is not the aim of the present research (Morrow, 2007). Instead, I consider myself a “**Constructivism–Interpretivism**” adhering to a relativist position, which as opposed to an objective reality, assumes multiple, constructed and equally valid realities (Schwandt, 1994; Guba & Lincoln, 2000; Crewell, 2007). This suggests that reality is constructed in the mind of the individual rather than it being an external singular entity (Hansen, 2004). This epistemological position is in accordance with this research due to its affiliation to hermeneutics suggesting that meaning is hidden and must be brought to the surface through deep reflection Schwandt (2000); Sciarra (1999) and encouraged by the interactive researcher-participant dialogue. Equally, this position forms the conceptual base for qualitative multicultural research Ponterotto (2005), hence attuned to the present study. This position supports a transactional and subjectivist standpoint suggesting that reality is socially constructed and

consequently the dynamic interaction between researcher and participant is essential to capturing and describing the participant's "lived experience" (Ponterotto, 2005).

This relativist position is suitable for the present study considering knowledge and knowledge-production is seen as relevant to context (material, intersubjective, cultural and societal), provisory and accepting the existence for multiple truths and realities instead of one single truth, equally concerning a bottom up, inductive approach to data (Lincoln & Guba, 2003). This therefore moves from the positivist/realist position of realism towards relativism through interpretivism. Where the process of interpretation from an interpretivism viewpoint moves from the objective to the subjective, it is more concerned with the function of data as linguistic resources and their use in the participants' meaning-making processes instead of the 'facts' it is conveying (Lincoln & Guba, 2003). The relativist paradigm is also appropriate for this research as it embraces discursively dependent multiplicity of views, experiences and accounts based on social constructionism (Willig, 2008). This position also acknowledges that existence and language can be experienced, interpreted and perceived in multiple ways (Gergen, 2001). Therefore, it is attuned to the present study and my epistemological position as it looks to interpret participants' accounts whilst regarding language and the cultural context in which they experienced the phenomena under investigation.

According to the social constructivist view, individual's experiences and perspective are mediated socially through language, culture and socio-historical influences. Therefore, when interpreting participants' experiences, I am not considering them as directly arising from environmental conditions, however they must be understood as specific considerations of these conditions (Gergen, 1985;

Willig & Stainton-Rogers, 2008). Also, and in accordance with Gergen (1985), I acknowledged that an individual's experience of the world is mediated and influenced by these conditions, hence, there are as many realities as people. Equally, perceiving language is important to this initiative and one's sense of self in part emerges from that flow of intersubjective communication (Willig & Stainton-Rogers, 2008). Equally, Scotland (2012) suggest that this position is based on the supposition that all knowledge is historically situated and culturally originated, accepting ideologies instead of questioning them. Consequently, different viewpoints can give different understandings into the same phenomenon, so conceptually speaking for the aim of the present study, participants' talk about their subjective experiences of counselling with English speaking therapists and the meaning attributed to those experiences, are perceived as being influenced linguistically, culturally and historically (Willig & Stainton-Rogers, 2008). These experiences are seen as significant and transcending outside the localized interview interaction and instead extending to their lives as a whole. Therefore, analyzing the way in which participants talk about and describe their experiences throughout the research interview may offer some insight into whether cultural values might have influenced their therapeutic' relationships.

Furthermore, according to Willig (2008), moderate social constructionism is considered as having a close affinity with critical realism (ontological position) which is seen as standing in contrast to naïve or direct realism, disagreeing with the assumption that data directly reflects reality. Hence, fundamentals of critical realism propose that reality cannot be known directly so that an individuals' relationship to it is always complex and requires interpretation. I embraced Larkin et al., (2006) IPA's view is that analysis can never produce an unquestionably first-person account, given that it is a construction between both the researcher and

the participant. I believe that human beings are a part of reality and not just a separated ego from the world. Hence, the researcher forms part of such context, and the interview itself can influence the constitution of reality that the participant experiences (Larkin et al., 2006), that is, referring to “contextualism” (Madill, Jordan & Shirley, 2000). Therefore, considering my belief of knowledge as being contextual and in accordance with Larkin et al., (2006), any findings I make in this research study will necessarily be determined by the relationship I have with my participants, hence, I consider that the context of this relationship needs to be explored. Furthermore, as a researcher, I accept that it is not possible to directly and fully access my participants’ experiences, instead, I am considering the participant in context so their claims are therefore interpreted accordingly. I am also aware of my involvement with the process of interpretation so I must consider my own relatedness to the topic and data at hand. In this way, I hope to illuminate participants’ understanding and meaning-making of their experiences.

Sampling and Participants

Phenomenological research aims to gather specific subjective information to access a deeper understanding of the participants’ experiences. Smith et al., (2010) suggest that IPA studies should use homogeneous and purposive samples and a general rule is to use between six and ten participants’ interviews to comply with an IPA study for a Professional Doctorate. I wanted to hear as many different subjective perspectives as possible to provide insight into the phenomenon, hence, ten participants took part in this study.

Recruitment of Participants

Initially I aimed to recruit participants within the whole of the United Kingdom, however after investigating the possibility of finding Latin American communities outside London, I found that great majority of Latino Americans in the U.K mainly migrate and are concentrated in London (McIlwine, 2009). Therefore, all participants were recruited in London by advertising the study via the internet and in places and organizations that provide counselling/therapeutic services to Hispanic/Latino clients, such as the NHS, GP surgeries, voluntary organisations and Universities (Appendix A for poster and B for recruitment email).

Inclusion, Exclusion Criteria

Inclusion criteria for this study were participants who were over 18 years old as this research aimed to investigate the experiences of adult clients and those who identified themselves as Hispanic/Latino males and females from any socio-economic and professional background. Also, those who were bilingual and fluently spoke Spanish and who had received therapy with an English-speaking therapist within the last five months prior to the interview. At first, the researcher considered the idea of recruiting only participants with specific psychological problems and who had undergone a specific length of time in therapy as well as a specific approach to treatment in order to maintain homogeneity. However, after discussing the possible difficulty in recruiting such participants with one of my supervisors, the researcher decided that it was sensible to recruit participants regardless of any taken approach to treatment and those with any emotional or psychological difficulty such as depression, anxiety or relationship problem,

amongst others, so as to avoid an unintentional discriminatory selection process. For the purpose of homogeneity, Latin Americans who did not speak Spanish, such as Brazilians (Portuguese-speakers) and those from Haiti (French-speakers), were excluded, also Hispanics from Spain as they originate from a developed country (Appendix C). Furthermore, for the purpose of gender equality within the study, both male and female participants were invited to take part, however only females volunteered to take part in this study. Also, those who volunteered had experienced therapy with an English speaking therapist within five months prior to the interview. This time was decided to help participants to enhance a more vivid recollection of their experiences.

Procedure and Ethics

Ethical Considerations

According to Wassenaar (2005) research ethics should serve to protect the participants' rights and well-being at all times. Therefore, this research was conducted in line with the BPS (2009) Codes of Ethics and Conduct. Ethical approval for conducting the research was also granted from the Department of Psychology, City University of London Research and Ethics Committee (Appendix D). No ethical approval was required from the NHS as participants could be anybody attending this system and for any reason other than for therapeutic purposes. Also, recruitment criteria required participants who had finished their counselling experiences five months prior to the interview.

Recruitment strategy

Participants were recruited via internet advertising and in settings that provide counselling/therapeutic services to Hispanic/Latino clients in London, such as the NHS (e.g. GP surgeries), voluntary organisations and universities. Participants who were interested in taking part contacted me either by phone or email to ask me to outline the research study. During this first contact and after my opportunity to check whether they met my inclusion criteria, we agreed that I would send them more information about the study and also the questions that they would be asked. This would allow them to decide whether to take part on the study or not and if willing, they would contact me to arrange a meeting for the interview. From the 10 people who initially made contact with me, all decided to take part in the study and contacted me again. Consequently, we arranged a meeting for the interview - eight participants agreed to meet at City University of London and two participants wanted the interview in a quiet room in their local churches.

Inform consent

Inform concern was assured through providing a Participant Information Sheet (Appendix E) that clearly set out information about the study, including the aim of the research, what would be required from them as participants, who would access the data and how it will be stored.

Before the interview, I made sure that participants had read and understood the contents of the consent form (Appendix F), and if they felt comfortable and agreed to continue, they were asked to give written consent by signing the consent form

before being interviewed. A signed copy of the consent form was given to the participants and a second copy was kept for my records. Participants were then asked about possible questions with regards to the study and all of them suggested clearly understanding the objectives of this study. Therefore, I then talked them through the participants' information sheet which they proceeded to sign after giving consent to take part. Before the interview began, the researcher tried to put the participants at ease so that they could more confidently talk about their experiences.

Potential distress

The research was designed in a way that avoided causing any harm to the participants, however, there was the risk that the interviews may be emotionally challenging or engaging for some of them. For instance, there was the potential for previously implicit understanding and/or feelings to become explicit. Therefore, this was addressed by providing sufficient information beforehand about what taking part would involve and participants had the opportunity to look at the questions before the day of the interview. Participants were made aware that they could stop and/or have the right to withdraw from the study at any time if they wished to and without having to give a reason. Equally, participants were made aware that they could take a break if they wanted and had the right not to answer particular questions if they did not want to. Informed by my clinical skills, I intended to conduct the interviews as sensitively as possible, whilst being aware of the need to offer some containment to the participants in case they felt distress, and maintaining my role as a researcher. All participants were debriefed after their interviews to check how they felt after the interview and how they found the

interview process (Appendix G 1). All participants suggested that the interviews helped them to make sense of their experiences and that they felt a sense of “relief” after being able to talk about their experiences. Whilst some participants stated that at times they found the interview emotionally engaging, only one participant had to take a short break as she felt emotionally distressed. A debrief sheet was given to all participants with detailed support sources, should they need them after the interview (Appendix G 2).

Confidentiality

Participants were informed about all confidentiality procedures. They were aware that the interviews would be translated by a professional translator and that, for this purpose, they would have to sign a translator’s agreement for confidentiality (Appendix H). Participants were also aware that some quotes from their interviews would be used during the write-up for the thesis and journal article and that any identifying information would be removed from the transcripts and write-up. They were also aware that my supervisor and representatives from academic and professional bodies would look at the anonymised transcripts.

Participants were made aware that no deception would take place during the study and hence were informed that the data gathered will only be for research purposes and will be kept confidential. Also, pseudonymous would be used to protect their identities and ensure anonymity (Durrheim, 2006). Should the study be published, efforts to maintain participants’ anonymity would be kept throughout. They were also aware that all material derived from the research process would be stored safely for a period of 5 years in accordance with City University of London regulations.

The sample

Participants were 10 adult females who had experienced therapy with an English speaking therapist, whose ages ranged between 25 and 45 years (see Table1 below). Alias names have been used to ensure participants' confidentiality). The sample was varied according to city of origin, however all of the women had been born in Latin America and were living in the U.K. during their counselling experiences and at the time of the interview. These demographics were gathered only for the purpose of identifying the participants within the group.

Table 1. Demographic details of participants

Participants	Age	Occupation	Family status	Spoken Languages	Place of Birth	Length of residency in London
Carolina	32	Managerial	Single	Spanish/English	South America	5 years
Anne	35	Healthcare	Married	Spanish/English	Central America	8 years
Chava	36	Managerial	Divorce	Spanish/English	South America	7 years
Monica	33	Housewife	Married	Spanish	South America	1.5 year
Lili	35	Healthcare	Married	Spanish/English	Central America	10 years
Mary	37	Healthcare	Single	Spanish/English	North America	6 years
Camila	33	Housewife	Married	Spanish/Limited English	North America	1.5 years
Sonia	28	Student	Married	Spanish/Limited English	Central America	1 year
Luz	36	Managerial	Married	Spanish/Limited English	South America	2 years
Marysela	42	Housewife	Divorce	Spanish/English	South America	3 years

Country of origin of participants was not stated to keep their anonymity.

Introduction to Participants

Before reviewing the literature, I will give a brief background information about the participants to contextualise their experiences within this research. Participants described their counselling experiences as either “positive”, “frustrating” or “negative”. This context represents the ground from which the themes emerged and will be further explored in the analysis chapter (Chapter 3).

Carolina

Attended individual therapy for depression for about 9 months. She expressed overall satisfaction with the received support: “*A positive experience (Carolina: 1. 3)*”. She considered her therapist as supportive, using helpful interventions and working according to her individual needs.

Anne

Attended individual therapy for about 2 years, sought for support for issues related to depression and anxiety. She stated having an overall positive counselling experience “*very positive (Anne: 1.1)*”. Considering her English language skills, her therapist’s attitudes and introduced interventions as benefiting her throughout her counselling process.

Monica

Attended individual therapy for about 6 months and looked for support for depression and relationship issues. Stated having two different therapists, a native English speaker and a Bilingual (Portuguese-English speaker) therapist. Suggested having a “*Frustrating and negative experience*” (Monica: 7. 74). Considered her limited English Language skills, a perceived lack of support from her therapist and the used of interpreters as hindering her counselling process.

Chava

Attended therapy for relationships' issues and for about 4 months. Suggested having a "*Very frustrating experience*" (Chava: 1. 9), and experienced lack of support, understanding and the lack of provision of an interpreter during the counselling process on the part of her therapist.

Lili

Attended individual therapy for about 2 years and looked for support for personal matters. Stated having a beneficial counselling experience "*Very nice experience*" (Lili: 1. 1-2) based on her ability to effectively communicate in English and aided by a helpful therapeutic relationship and interventions.

Camila

Attended group therapy (run by two Western counsellors) for issues related to adaptation, although stated being placed in a group for depression. Suggested having a "*negative experience*" (Camila: 4. 46-51). She expressed difficulty communicating in English, a perceived lack of support and understanding from her therapists and unable to meet her individual needs as the reasons for her overall perception of counselling.

Sonia

Attended individual therapy for depression, for 6 months. Stated having a "*negative experience*" (Sonia: 22. 263-264) due to an experienced difficulty communicating in English and a perceived lack of expertise from her therapist to offer her the needed support.

Mary

Attended individual therapy for depression and relationship issues, for about a year. Indicated having a “*very good experience*” (Mary: 1. 1) facilitated by her English skills, introduced interventions and the adequate support by her therapist.

Luz

Sought individual therapy for bereavement and for 3 months. Indicated that her experience “*Was not a positive experience*” (Luz: 1. 1), based on her limited English skills and an experienced lack of support and understanding from her therapist.

Marysela

Attended individual therapy for depression and anxiety for 6 months. Expressed having a “*very helpful experience*” (Marysela: 1.2),” based on her ability to communicate in English despite lack of fluency as well as the provided support from her therapist, and a perceived helpful therapeutic relationship.

Design

Semi-structured interviews

A semi-structured interview schedule was developed as it was considered relevant to the aims of the present study. Questions were designed in accordance with IPA, therefore open and exploratory questions that focused on meaning and process were employed as recommended by Smith and Osborn (2008); Willig (2008) on interview development sought through published guidelines (i.e. Smith & Osborn, 2003) (Appendix I). This schedule was flexibly used to allow exploration of anticipated areas that emerged. The interview schedule was designed in Spanish and the interview process itself was conducted in Spanish. This was decided in

order to allow participants to be more flexible and accurately access and express their feelings and thoughts and avoid possible difficulties with the English language when relating their counselling experiences. Nevertheless, the researcher was aware that the richness and meaning of language may have been slightly lost during the translation process as well as being aware about qualitative research's strong reliance on language, so I will be further discussing the implications of this decision in the discussion chapter (Chapter 4). The interviews were then sent, with the consent from the participants, to a professional translator to be translated from Spanish into English. The interviews were audio recorded, lasted for about 45-60 minutes and were later transcribed verbatim with all the identifying information removed.

Data analysis

The data was analysed using Interpretative Phenomenological Analysis (IPA) (Willig, 2001; Smith et al., 2009). In keeping with IPA's idiographic commitment, each interview was first analysed in-depth individually (Smith et al. 2009). Each recording was listened back to at least once and the transcript read several times. During transcription both verbal utterances and significant non-verbal utterances (i.e, pauses and laughter) were transcribed as suggested by Smith et al., (2009). After the process of translation, the transcripts were rechecked against the originals to verify the information content.

In the first stage, I was required to read and re-read the text and make a wide range of notes/exploratory comments that reflected initial thoughts and observations about the content, language used and more conceptual, interrogative comments (Appendix J Analysis Transcript Mary). During the second stage and whilst taking into consideration the hermeneutic circle Smith et al., (2009), and

after each transcript was re-read, emergent themes were identified drawing on the transcript and initial noting. Each interview transcript was then analysed in the same way until all 10 interviews were analysed to this level (Appendix K for Exploratory and Emergent Themes Monica). Afterwards, the emergent themes were listed chronologically and then moved around to form clusters of related themes. Then, and as suggested by Smith et al., (2009) super-ordinate themes were identified through *abstraction* (putting like with like and developing a new name for the cluster); *subsumption* (where an emergent theme becomes itself a super-ordinate theme as it draws other related themes towards it), *contextualization* (identifying the contextual or narrative elements within the analysis), and *numeration* (the frequency with which a team is supported) and *function* (themes were examined for their specific function within the transcript) (Appendix L for Sub-ordinate and Super-ordinate Themes Anne). The next step required looking for patterns and connections across cases. This was done by drawing up a list of themes for the group and clustering these into master themes representing shared higher-order qualities/themes to reflect the experiences of the group of participants as a whole (Smith, et al., 2009; Willig, 2008) (Appendix M for Master Themes and Super-ordinate Themes for the group).

Quality and validity

Quality and validity are advocated throughout all the phases of this research in order to maintain high standards of research. Therefore, and in accordance with Smith et al, (2009) this study adheres throughout to the four principles of Yardley's (2000; 2008) for validity of this qualitative research, looking at the research from the perspective of sensitivity to context, commitment and rigor, transparency and coherence, and impact and importance. This maintains, and with reference to IPA,

a commitment to the ideographic approach, upholding an experiential account of significance to the participants' interpretative, the hermeneutic analysis and wariness in moving towards general claims (Smith *et al.* 2009).

Sensitivity to context

Sensitivity to context may be proven by demonstrating sensitivity to existing literature and theory, the socio-cultural setting of the study (Yardley, 1999) and any material acquired from the participants (Smith *et al.* 2009). I have strived to demonstrate these aspects through the theory included in the Introduction section, description of the sample characteristics and study context, as well as through the mode in which I collected and analysed the data. For instance, I took this into consideration to avoid power dynamics between myself and the participants during the interviews. I also paid attention to my role in the interaction throughout the interview process, placing much consideration on ethical issues during all phases of the research process. I also demonstrated sensitivity to the data through conducting and describing an in-depth analysis and supporting my arguments with verbatim extracts. This therefore allowed participants' accounts to be heard throughout the project and allowed the reader to check the interpretations being made as claimed by Smith *et al.* (2009).

Commitment and Rigor

According to Yardley, ***commitment and rigor*** requires the researcher to demonstrate an in-depth engagement with the topic and through developing skills and competence in the method used. Therefore, this was demonstrated by placing much consideration to participants during data collection and taking care of the analysis which I have attempted to do and hope it will be demonstrated through

my interview transcript in (Appendix K) and the example of the different stages of analysis in (Appendix L). Despite being new to qualitative research and IPA, I strived to develop my skills in this approach through attending lectures and seminars as part of my clinical training and extensive reading. In addition, I attended workshops that helped enhance my interview skills through role-play and developing analytical skills through practicing on examples in order to advance my overall understanding about the interview and analysis process. Peer review was also carried out with some of my university colleagues, some of whom have advanced theoretical and practical knowledge of IPA. Additionally, I embraced the feedback from my supervisor and her agreement with any emerged themes after seeing how they were produced.

According to Yardley, *rigor* implies the thorough data collection and the depth and breadth of analysis. I recognized that the rigor of this study may have been affected by my status as a novice researcher and my limited skills with IPA method, and may also be due to practical constraints such as time, however I was at all times committed to conduct this study in a thorough and careful manner drawing on available reading, training and supervision.

Transparency and coherence

According to Smith et al. (2009) transparency indicates how clearly the stages of the research process are described in the write-up and that there ought to be coherence between the research that has been carried out and the underlying theoretical assumptions of the approach being utilised. I was committed to increase transparency of my analysis by including an audit trail in (Appendices J, K, L, M). Consideration of reflexivity is also included within the principle of transparency. A discussion of this is presented below in the reflexivity section.

Impact and Importance

This principal concerns are the value of the research, for instance, the contribution that it makes to the health care practice, challenging previously held assumptions and its contribution to a larger body of research and independently of how well or sensitively a piece of research is conducted. Accordingly, its evaluation is governed by how interesting and useful the information gathered is, whether it has a convincing argument and the power to capture the reader, that is, what can it communicate to the reader in terms of the ideals that the researcher aims to achieve in the study (Willig, 2008). In this respect, I will be including a consideration of the clinical relevance of this study in the Discussion section.

Reflexivity

According to Nightingale and Cromby (1999); Willig (2001) and Finlay (2008) an integrated part of IPA is the process of reflexivity, meaning the researcher's need to reflect upon how intersubjective elements influence data collection and analysis. I will therefore engage in reflexivity in order to critically and constructively explore the way in which my involvement with this study influences and informs the present research.

Personal reflexivity

I am a female in her late thirties, who was born and grew up in Colombia, South America. I was brought up in a lower middle class family, constantly aware of the difference, power and privilege that society and others exercised over my family and myself. Therefore, I experienced a constant struggle for survival which in turn increased my desire to succeed academically in order to improve the conditions of

my family and my own well-being. At the age of thirteen and due to familial difficulties, I discovered that I wanted to study psychology, nevertheless, due to financial and personal circumstances this opportunity was not possible whilst living in Colombia. In my late twenties, I had the opportunity to travel to London to work and the possibility of studying the English language. Moving to the UK brought many challenges, amongst them difficulty fitting in, learning a new language, living away from my family and trying to adapt and integrate myself into a completely new environment that I had no previous knowledge of. I then learned the language and gradually started to acquire sensitivity to the cultural values and expectations of the British culture. Then I engaged in my undergraduate studies in Psychology and after I studied my Masters in counselling, I subsequently moved onto the Doctorate program in counselling psychology. Therefore, I am a final year Counselling psychologist in training and I am undertaking this research as part of the Doctorate program. Prior to starting my training, I worked in the area of psychology and related mental health professions for the past 10 years.

My interest in this investigation was motivated by my own experience of being both a trainee counselling psychologist and counselling client having to undergo therapy with English speaking therapists. My therapeutic experiences proved to be challenging, not only due to cultural differences between my therapists and myself, but also due to socio-economic and language difficulties and the different contextual/environmental variables influencing during my process. The thought of giving up occurred to me many times but I kept reminding myself of the importance of being in the client's shoes. Frequently, I wondered what was contributing to my dissatisfaction with the experience and what factors motivated me to continue. That is when I began to formulate a research question and design that would allow different voices to emerge from the study to explore the

counselling experiences of other Latino American clients and see the meanings that they would attribute to their experiences in order to inform research accordingly. I wonder to what extent, and despite “bracketing”, my experienced difficulties may have influenced the questions I asked. For example, in therapy I always felt the cultural differences between my therapists and myself so I wondered how other minority clients felt in this sense. Despite having a good level of English, at times I struggled to make myself understood both within my training institution and counselling settings. So, I also wondered what was the participants experience in this regard. During my search for a therapist, I had many financial difficulties, and was inclined to have a culturally-similar therapist though I could not. Then again, these facts may have unconsciously also influenced my research questions.

Furthermore, despite my efforts to preserve the participants’ subjective experiences, my theoretical knowledge about Latinos, may have impacted the way I interpreted their accounts. My initial encounter and interaction with the participants during the interviews may have also shaped the way I interpreted their narratives. Similarly, all participant’s accounts had an impact on me and/or evoked different feelings in me (i.e, happiness, sadness, concern, fascination, admiration) which may have also impacted upon my interpretation of their accounts.

Moreover, my counselling psychology training, working within different ethnic minority groups in different organizations and NHS settings and my own experience of feeling alienated brought to me how migration, poverty, discrimination and social-isolation makes individuals feel more vulnerable and hence more prone to mental health difficulties. Based on these experiences, I may have unconsciously made assumptions that have also influenced my research questions and approach to the data. These assumptions may have been, for

instance, my initial concern about being an ethnic minority individual who may be denied access to care, concern as to whether mental health professionals would prioritize British clients for their service provision and whether my own cultural differences would be considered and understood during my therapeutic process.

I was equally influenced by my inclination to support and voice the needs of those in more disadvantaged positions and also to commit to amend in some way the power imbalance inherent in the system. Therefore, it became important for me to conduct this research to allow the needs, perspectives and experiences of those Latin American clients to be addressed, in the hope that it will help bring about some changes within counselling practices for this ethnic minority group.

Epistemological Reflexivity

My epistemological position requires that I view myself as a major contributor to the research process, meaning that I am closely bound up in the process and creation of the data, possibly in ways that I may not even be aware of or understand. Consequently, the most suitable manner to explore this issue is through thorough examination of my own beliefs, assumptions and interests McLeod (2003) to see how they might have shaped and influenced the research process and any given results (Willig, 2001).

When reflecting on my theoretical and philosophical positions, I affiliate myself to the social constructionism, integrative and narrative ideas, both in research and clinical practice, due to the emphasis on multiplicity of constructions and the value placed on social, historical and cultural context. Yet, in line with IPA, I also operate from a “critical realism” standpoint, suggesting that there is an underlying essence of reality as experienced that can be shared. With the adoption of these positions,

I aimed to give credence to both the reality of participants' lived experience and how language and context shapes and informs how this is experienced and communicated.

The decision for this research approach before I had any literature that explained the philosophical paradigms, suggests that it was my personal world-view that determined the orientation that this study should follow. This approach was also motivated by the learned theoretical foundations of IPA, allowing me to identify the specific research methods to employ in order to give voice to participants' narratives by uncovering the subjective meanings attributed to such experiences rather than limiting them to prearranged questionnaires. I consider that my decision to conduct the interviews in Spanish was the most appropriate in order to enable participants to more confidently and accurately convey their thoughts, feelings and emotions. However, the fact that the interviews were translated into English made me reflect not only about my interpretation of participants' experiences, but the potential for a "triple hermeneutic" instead of "double hermeneutic" due to the role of the translator within the translation process. I will discuss these issues further in the discussion chapter.

When reflecting on the relationship between meaning-making and the use of language, I am aware that the gathered data is language based (semi-structured interviews) and transformed into language by my interpretations of participants' accounts. Consequently, I am aware that it is impossible to access the gathered data's meaning outside of language, so instead I needed to undertake simultaneous interpretation of the language in order to access and capture its meaning. Hence, as a researcher, I needed to adopt a perspective on language to negotiate how to conceptualize my contribution by the particular use of language (i.e., terminology, choice of words, style of expression) to the meaning that is

being created and communicated in and through the research (Willig, 2012). Therefore, and regarding my approach to data interpretation, I embraced the constructionist view of language (Derrida, 2005), that is, I believe that experience is constructed and the product of the language that is used to talk about a particular topic. I therefore perceived language as performative and constructing meaning rather than simply reflecting it. Thus, participants' thoughts, feelings and experiences are produced as the researcher takes up positions within the discourses. For instance, participants' experience is constructed as part of a culturally specific repertoire, the meanings that they attribute to their experiences, the discourse of their counselling experiences, sets up their subjective positions (of the client, of the therapist, of the therapeutic experience itself and so on) that require particular routines. Hence, their talk about their "counselling experience" does not refer to an inner feeling rather than part of a socio-cultural specific repertory within which they experience themselves (Willig, 2012).

Since language plays an important role in the construction of meaning, as a researcher, I need to reflect on the ways in which such constructions are produced, how they change across cultures and history and how they shape the participants' experiences (Willig, 2001). Furthermore, I am aware that language in the present research does not only refer to the words, expressions and any other linguistic comments made by the participants, but also to language as a skill considering the interviews were conducted in Spanish and then translated into English. Therefore, I need to consider the context of language between the participant-interpreter (interpreter's translation of participants' accounts) and participant-researcher (researcher interprets participants' accounts).

Furthermore, through self-reflection and practices such as keeping detailed and reflexive diaries/journals for both my counselling experience and research process

as well as being in discussion with my supervisor, I became aware that the combination of my own life experiences will have inevitably shaped my contribution to co-construction of meaning with the participants in this study. However, and as suggested by Valle and King, (1978) instead of attempting to eradicate my influences through the research process, I endeavored to articulate my predispositions and biases through this process of self-reflection (bracketing) hence readers would be able to take my perspectives into account, and by doing so, the reader would be able to judge whether the phenomenon of interest has been illuminated from a particular perspective.

Some scholars regard the activity of doing qualitative research as highly allied with the activity of doing therapy (McLeod, 2001). Consequently, I am aware that to understand knowledge involves a mutual exploration of the experience of the other, in this case, my need to reflect about the relational interaction between myself as a trainee counselling psychologist/researcher in function of understanding the client/participant, whilst the client/participant is in function of understanding his/her problem/phenomena through the interpretation of his/her problem/phenomenon and interaction with me as a trainee/researcher. For instance, the way I draw understanding about my clients in my clinical work and how I translated that knowledge into my role and skills as a researcher in order to 'conceptualize' knowledge, analyse and interpret participants experiences in this research.

My primary therapeutic approach is integrative with a multicultural focus, valuing the socio-cultural context of clients and placing much emphasis on the therapeutic relationship. This suggests that knowledge and understanding about the client can be gained through his/her bio-psycho-social Willig, (2001); Smith, (2004) assessment and understanding whilst being in mind the dynamics within the

relationship and the associated experiences between both parts involved. Hence, taking into consideration how the experiences of the therapist are seen to be intimately bound within this relational dynamics, I must be vigilant and carefully examine and separate them in order to discover and understand what the client is communicating and experiencing. Similarly, the experiences, beliefs and thoughts of the researcher take on a related significance to that of the multicultural therapist in that they are seen to contribute to the process of uncovering meaning from the participant's experiences.

During my own counselling experiences, I underwent many challenges that included language difficulties and different cultural values and issues which were constantly reflecting in my training and clinical work. I attribute this to the fact that during my training I was acquiring the skills to better support my clients, though, during my own clinical work I was struggling to be myself a client. This meant that although I very much appreciate the support given by my therapists, I always felt that even if they tried to take a culturally sensitive approach to support me, there was always something missing. Nevertheless, something that I always left with from my therapist, was what I called "their unconditional love", meaning that I could feel their empathy, I could feel that they tried to uphold me and despite my problems and cultural differences. I believe this is another reason why I decided to conduct this research and I personally believe that for a therapist to be culturally competent takes more than just knowledge and awareness of his/her own values and the client's values and differences, instead it is more about using themselves and/or their presence to convey empathy and unconditional positive regard. Similarly, at times I felt that it was also about being curious, (i.e., what was important for me as a minority ethnic client, what was I bringing to the sessions as a minority client and what role were these differences playing in my problem) and

being recursive to use me (i.e, my own knowledge and understanding and cultural perspectives with regards to my problem) and use this to enhance rapport, problem solution, and change. I believe consciously or unconsciously this was one of the reasons behind my decision to investigate this topic, as I felt it was important to understand from the point of view of other minority clients, what was important/different for them within their therapeutic encounters with culturally different therapists.

My clinical work and my role as a researcher increased my awareness of subjectivity, meaning that as a counselling psychologist I believe that we all are inevitably subjective, that is, our learning, experience, beliefs values, contexts and investments always influence our perspective (Orlands & van Scoyoc, 2008). Therefore, as a counselling psychology researcher, I recognized how important it is to translate this value into being aware of my relationship to the topic as I try to actively manage this relationship and how it affects the research process, whilst being committed to understanding and interpreting participants' information from a subjective point of view.

Furthermore, my clinical practice advanced my research skills in that I acknowledged the value of being skilled, developing positive, respectful and collaborative relationships and to hold values of egalitarianism, cultural sensitivity and respect to guide me in my relationship with my research participants (Morrow, 2007). This required my disposition to be both participant and collaborator in the research, understanding my own context and making explicit my standpoints and the ways in which they co-create data with the participants (Olesen, 2005). Additionally, being aware that the research context also includes the environment where the participants made meaning of their experiences and my own perspectives as well as those from participants and the research process itself and

which must be informed so that the reader can assess the relevance, or transferability of the findings to their own context (Morrow, 2007)

In accordance with my research epistemology and by looking at the context, it is important to be able to relate or to imagine the experience of concerns of one's participants (Smith et al., 2010). I therefore reflected on the contextual interaction between my participants and myself within this research study. Additional factors were how the interview process and the participants' experiences might have been influenced by their perceptions of me as a researcher with a similar cultural background to them. Equally, how their accounts and perceptions of their therapeutic relationship might have also changed regarding that they were interacting with a Latin American researcher who possessed therapeutic skills and a background. I wonder whether this context during the research interview may have led to a different understanding/perception and accounts of their counselling experiences. Additionally, whether this knowledge might have encouraged them to talk, knowing I was likely to be empathic and fairly knowledgeable and understanding of their experiences. Nevertheless, I reflected upon and was careful about the possible power imbalance within this interactive relationship and tried to address this imbalance by making all aspects of the study collaborative and participant led where required by the ethical rules within this research study.

Both my personal and epistemological reflections will be further explored in the Discussion chapter (Chapter 4).

Chapter 3: Analysis

Outline of Chapter

This chapter presents the findings derived from Interpretative Phenomenological Analysis of ten semi-structured interviews exploring the counselling experiences of Hispanic/Latino clients with English speaking therapists. I will begin by presenting the master and constituent themes shared within the group and across the sample. Then, each of the themes will be explored in detail and illustrated by the participants' verbatim quotations. The chosen themes and quotations appeared to be the most appropriate in illustrating and providing insight into the complexity of participants' lived experiences in relation to the research question.

Themes

3.1 Overview of Themes

The derived themes are representative of the participants' process of meaning making, as related to their counselling experiences with English speaking therapists. After analysing the data using IPA, four master themes emerged, as well as respective super-ordinate themes. These themes reflect their counselling experiences in terms of what could have been helpful, and what facilitated or hindered their counselling experiences. The listed themes are below:

1. Emotional Expressiveness

- a) The Language of Emotion
- b) Themes from Latino Culture: Dichos (sayings, proverbs)

2. Cultural Competence or Encapsulation

- a) Family Centeredness (familism)

- b) Religious/Spiritual Healing
- c) Assimilation and Adaptation Issues

3. The Healing Presence

- a) Therapists as Interpersonal or Impersonal

4. Cultural Liberation or Formulation

- a) Culturally Concordant or Discordant Therapists

Although these master themes have been presented as divergent, there is an overlap between and within them. Findings therefore reveal both individual participants' accounts in addition to those that are shared within the group. Whilst all participants supported master themes and super-ordinate themes, not all the sub-ordinate themes were supported by all participants. Please see Appendix (M) for a table of manifestation of themes for all participants. The analysis is reflective of my interpretation of the participants' accounts and their experience with regard to the research question. During the interviews, I took notes about participants' embodied experiences and these reflections are presented in italic font throughout the chapter. Before addressing the master and super-ordinate themes, it is important to highlight the participants' overall perception of their counselling experiences. Accordingly, half of the participants cited positive/helpful therapeutic experiences, and the other half cited negative/unhelpful counselling experiences, such experiences were the context from which the master themes emerged.

3.2. Master Theme One: Emotional Expressiveness

All participants voiced emotional expression as being at the heart of relational encounter during counselling, perceiving it as being their opportunity to effectively communicate the meaning of their internal or affective states. In turn, this either encouraged or inhibited their opportunity to communicate their problems, to

emotionally express themselves, thus influencing the development of rapport during their counselling experiences. This can be seen throughout the participants' accounts and permeates all the other themes.

3.2.1 The Language of Emotion

All participants perceived language as not only related to culture, but as the main means of communication and their emotional expression. They implicitly or explicitly indicated the importance placed on standard English as a significant aid for the communication of their problems and their emotional expression, and as one of the principal cultural factors influencing their counselling experiences.

Lili, Mary, Carolina, Anne and Marysela suggested that having English skills and/or fluency was an important tool that assisted them in effective and spontaneous communication with their Western therapists. They also demonstrated a strong self-identification and self-reliance on their English skills, to more accurately reflect their thoughts and feelings, hence facilitating communication of their problems and rapport during their counselling experiences:

"I identify with both languages...However, from a therapeutic point of view, was that emotional disconnection, to use another language which is not so connected to your insights, that you can formulate things more easily like in English..."(Lili: 13,14. 198-202). Lili conveyed a sense of disconnection with her native language, hence having therapy in English was the most appropriate decision. Similarly, Anne stated:

"Sometimes I found that in English there were words that helped me express myself better than in Spanish (R:Mmm) Funnily enough there were more

words about not so positive feelings rather than positive ones..." (Anne: 1. 11-15).

Anne suggested that in English, she could freely express and/or liberate herself from negative emotions that she seemed unable to convey in her native language (Spanish) than if she had had therapy with a Latino therapist. Mary also expressed confidence with her English:

"I am bilingual from an early age, so language was not a problem" (Mary: 14. 217-218).

Carolina implied that she perceived English as facilitating a mutual understanding of her problem and a perceived sense of connection within the therapeutic encounter:

"I could express myself well in the English language, so this was not a problem for me...we understood each other in this sense..." (Carolina: 17. 145-146).

Although, in later statements both Mary and Carolina stated that at times they experienced difficulty communicating some of their thoughts and feelings in English:

Insinuations, subliminal words and blackmailing...I wish I could have told him the exact meaning or feeling of it, it could have been either stronger or not that strong... he tried to help me to find the right words but it was still difficult" (Mary: 15. 226-229).

Carolina also indicated:

“If I could not express something clearly, he tried to give my different options until I could communicate what I wanted or what I was feeling... all this contributed a lot to my improvement, all these things stimulated me to attend therapy...” (Carolina: 18. 156-160).

Moreover, Mary and Carolina shared a perceived willingness from their therapist to collaboratively understand their experiences, offering different words to assist the explanation and understanding of their thoughts and feelings to foster communication. Mary further implied that although her therapist assisted her, she still felt apprehensive communicating certain feelings and thoughts in English due to difficulty in to accurately translating them into English. Additionally, she perceived such thoughts and emotions as losing their emotional meaning when translated *“I wish I could have told him the exact meaning or feeling of it (Mary: 15. 228).* On the contrary and in her last two lines, Carolina suggested that her English skills and the experienced disposition and resourcefulness of her therapist to aid communication, helped her to feel emotionally understood and increased her motivation to continue with her counselling process (Carolina: 18. 156).

Chava, on the other hand, stated that despite being fluent in English, her counselling experience was hindered by a perceived failure from her therapist to provide an interpreter. Hence, this prevented communication and neutrality and led to conflict between all parties involved in the counselling process:

“I felt very frustrated because ermm I think it would have been a different experience because for me English wasn’t a problem, but for (relative) it was problematic. I mean, as (relative) did not have much English that caused confusion. While the therapist and I understood each other, (relative) understood something else or interpreted it in a different way, so this was

difficult I would say for everyone. Or (relative) would tell her something and she would look at me to translate (pause) then I would tell the therapist what (relative) was trying to say, then (relative) would understand something else...so this was problematic I would say for everyone” (Chava: 17, 240-249).

Chava further expressed that the perceived ineffectiveness from her therapist to aid communication between all parties, created negative dynamics within the therapeutic encounter. As a result, she felt her individual needs were disregarded and her problem was not explored or understood. Additionally, she felt forced into the role of a translator, which appears to have incapacitated her as a client, and emotionally disempowered her within the counselling relationship.

On the other hand, for some participants, the inability to fully communicate in English created a barrier to cultural understanding, which led to misinterpretation of their thoughts, feelings, emotions, and problems. This ultimately compromised the therapeutic relationship and quality of therapy.

Monica conveyed that her inability to speak English and the use of interpreters prevented her from emotionally expressing and communicating throughout her therapeutic experience:

The truth is that you cannot get something when you cannot even express yourself properly” (Monica, 19. 172-173).

Monica further stated:

“Unfortunately when the interpreter arrived to the session, I realised that she was a friend of (person)...imagine how I felt, especially thinking that if I told my problems to that interpreter, that she would tell (person)...ermm.. so I

refused to talk. But my therapist seemed not to realise what was going on and the translator told me not to worry that any information given would be kept between us, but I still did not feel comfortable to talk...Then, my therapist decided to assign me a new interpreter... but I felt that she was interpreting but without expressing any of the emotions that I was trying to tell her, I felt that in the process of interpretation all my feelings and thoughts were distorted..." (Monica: 2,4. 14-34).

Monica further suggested a perceived disposition from her first therapist in trying to meet her individual needs by providing an interpreter. However, she indicated that her opportunity to communicate, the genuineness of the therapeutic relationship and the counselling process itself were compromised by the use of interpreters. Accordingly, that she felt unable to communicate with her first interpreter, due to a perceived conflict of interest between them, which evoked feelings of mistrust, fear of exposure and anxiety, which further inhibited her from speaking "*Unfortunately*", "*I refused to talk* (Monica: 2. 14, 2.18)". With the second interpreter, Monica implied that she felt unable to convey her feelings and thoughts as she perceived the interpreter lacked expertise, as well as being deceptive, by inaccurately conveying the information she gave. Monica also demonstrated that she felt apprehensive to communicate, due to a sense of loss of meaning and genuineness of her thoughts and emotions during the process of translation "*All my feelings and thoughts were distorted*" (Monica: 4. 33-34). Consequently, the interrupted communication she experienced and the lack of interconnectedness with the interpreters, significantly hindered communication and rapport with her therapists.

Monica appeared relaxed and happy to talk about her experience. However, through the middle of the interview, she became distressed whilst recalling some

aspects that she lived during her experience. We stopped for a few minutes so that I could offer some containment and to decide whether she wanted to continue or not. At this point she suggested *"I need to get things out of my chest"*, hence conveying a need to be heard. Equally, demonstrating that this was her opportunity to help herself to liberate from "painful emotions", also "to protect other Latinos from experiencing the same". Therefore, the interview was continued.

Monica, Camila, Sonia and Luz also considered English or having to speak in English limited their ability to effectively communicate, decreasing their flow, spontaneity and desire for openness. This consequently, prevented the development of rapport and hindered their counselling experiences:

"To begin with the language, I could not have that experience of listening to somebody who had much difficulty communicating or trying to express his or her emotions or problem in English as I did..." (Camila: 12. 164-170).

Luz described how language was a limitation to understanding:

"I think one of the barriers was the language, that despite the fact that I was able to speak it, that I could get by with it, sometimes when your emotional side is involved or when it has to do with medical issues, the language becomes an obstacle...limiting the help that a therapist can offer to the client" (Luz: 1. 1-5)

Luz added that she found it difficult to find the right words to effectively access, elaborate and articulate complex thoughts, feelings and symptoms when feeling emotionally vulnerable *"When your emotional side is involved..." (Luz: 1. 2-3)*. She further implied a perceived lack of expertise and cultural sensitivity from her therapist to conduct a thorough assessment to identify any factors interfering with her process. Consequently, not providing an interpreter to facilitate the

communication, impeded the exploration and understanding of her problem “*Limiting the help...*” (Luz: 1. 5).

From this theme, it can be noted that for some participants, English fostered communication, enhancing rapport and facilitating their counselling experience. For others, their limited English skills, the used of interpreters, or the lack of provision of an interpreter hampered communication, the development of rapport, and ultimately the quality of their counselling experiences.

3.2.2 Themes from Latino Culture: Dichos (sayings)

Participants expressed a need and desire to use sayings as a potential tool to communicate and create culturally meaningful therapeutic experiences. This helped them address, reframe and/or give meaning to their thoughts, feelings and personal experiences. However, all the participants felt they didn't have the opportunity to clearly and confidently express their thoughts and emotions through the use of sayings. This could be either due to difficulty translating them into English, and risking a loss of meaning or they did not feel understood or encouraged by their therapist to elaborate on their emotions in the given manner.

Luz and Mary indicated a perception of sayings as more accurately echoing some of their experienced intense emotions or emotions that arose during vulnerable emotional states. However, they expressed difficulty in using them during their counselling processes. This was partly due to fear of losing their intended meaning when translated from Spanish into English, and partly a perceived inability from their therapist to aid exploration and mutual understanding of their experienced feelings and thoughts when conveyed through sayings:

“You know that in our own language or in our countries, we have certain ways of expressing our feelings ermm I mean, for instance in (country) when one wants to express certain emotions, you use “dichos”, those verbal expressions to communicate those feelings ermm like when you say “Yo estaba a tope” (Translator’s translation: I could not take it any more), these were some of the things that I found difficult because of the English language ermm and I could try to translate it but I still did not feel that she could understand what I really meant, she just smiled and said I know what you mean ermm and I found this kind of dishonest, dishonest because I do not think that she really care for what I was saying” (Luz: 1,2. 6-15)

Luz further conveyed an emotional reliance on cultural sayings to more assertively express some of her sentiments, however, her inability to use them prevented her from reframing her feelings and reduce emotional distress. Luz’s opening words’ *“You know that in our own language...”* conveyed her perceived cultural familiarity, connection and alignment with me whilst highlighting her difficulty within the therapeutic alliance due to her experienced inability to explore her feelings in the given manner. Moreover, Luz’s expression above suggested she felt emotionally overwhelmed and wished to drop out of treatment, due to her inability to emotionally communicate and establish a bond with her therapist.

Sonia, Marysela and Camila all suggested being prevented from using sayings throughout their counselling experiences, due to a perceived disregard from their therapists to foster emotional engagement and understanding:

I wanted to be understood if I was to use some cultural “Dichos”, cultural expressions that makes you feel better ermm but if my therapist could not

help me with my problem, much less to motivate me to talk about my feelings” (Sonia: 23. 276-278).

By using the conditional “*if*” and the statement “*Cultural expressions that makes you feel better*” (Sonia: 23. 276-277)”, Sonia conveyed a need to use *dichos* to express intense emotions, whilst demonstrating the contextual nature of her experience, as an individual embedded in her culture. However, she suggested she felt unable to use them during her experience, due to a perceived lack of expertise and interest from her therapist to acknowledge her cultural expressions, which would enhance communication and mutual understanding of her experienced feelings and thoughts. Consequently, she felt inhibited from emotionally expressing and meeting her individual/emotional needs throughout her counselling process “*If my therapist could not help me with my problem, much less...*” (Sonia: 23. 277-278). Camila also expressed difficulty in using sayings:

“I remember that once I used a saying to explain how sad and angry I felt when people were making inappropriate comments about me as a Latina, and I remember that my therapists and the group members all started to laugh ermm and one of the therapist said, “it is very difficult to understand what you are saying” ermm and then she said lets carry on and change the topic, I felt really hopeless...I felt like “Ayudate, que dios te ayudara” [Translator’s translation: God helps those who help themselves]”(Camila: 5. 59-65)

Camila demonstrated a sense of reliance on sayings to more explicitly convey some of her feelings although she implied that due to experienced feelings of discrimination outside the counselling setting, these were transferred to her counselling experience “*My therapists and...all started to laugh*” (Camila: 5. 60).

Perceiving one of her therapists as lacking empathy and having a challenging attitude evoked irrational feelings. As a result, she felt inhibited from explicitly expressing her emotions and being fully understood. This thereby increased her distress and led her to feel discriminated against, and verbally and emotionally disempowered by the counselling encounter “*I really felt hopeless*” (Camila: 5. 63). Camila further conveyed a perceived inability and readiness from her therapist to aid communication, that seemed to lead her to rely on her own religious coping resources to process upsetting emotions, rather than relying on her therapist for emotional support.

On the other hand, Monica indicated that her opportunity to emotionally express herself was hindered through sayings which illustrated a perceived incompetence from her translator to accurately understand and convey such feelings to her therapist:

“I felt that I could not express many things that I was feeling, I could not use certain sayings that we use in (country) to express our feelings...(R: Mmm), for example, I wanted my therapist to know that “I had una angustia tenaz” [Translator’s translation: Strong feeling of anxiety]...ermm but since the translator did not understand this, could not translate it to the therapist ermm and my therapist seemed not to realise what was happening” (Monica: 3. 32-36).

Monica also suggested a perceived lack of immediacy and willingness from her therapist to explore the accuracy of communication exchanges between her and the translator and foster communication “*My therapist seemed not to realise what was happening*” (Monica: 3. 36)”, which prevented clarification and understanding of her feelings and the opportunity to lessen her emotional distress. Monica’s

intended saying conveyed overwhelming feelings of anxiety, which were exacerbated by a perceived lack of empathy, understanding and support from both her translator and therapist. This consequently suggested that she felt uncontained and prevented from expressing and reframing her feelings to experience emotional balance, strength and healing.

Marysela, on the other hand, expressed a desire for her therapist to use sayings as a way to show interest and effort to understand her, and as a more familiar way of communicating and enhancing rapport:

“It would have been good if she had used a saying, that would have shown more understanding of my ways of expressing ermm to feel more connected” (Marysela: 4. 50)

The participants’ narratives demonstrated their need and/or desire to use sayings as a cultural tool for effective communication and emotional expression. However, they felt unable to communicate in the given manner, either because they had difficulty translating into English, or they didn’t feel understood and/or encouraged by their therapist to elaborate upon such thoughts and emotions.

3.3 Master Theme Two: Cultural Competence or Encapsulation

The participants talked about the desire for their therapist to be culturally knowledgeable, and sensitive, and/or have respect for and being interested in their cultural differences. When some therapists adapted interventions to meet some of the participants’ individual needs, they saw it as a way of contextualizing their experiences and showing understanding of their problems. However, other participants expressed experiencing the opposite, in terms of not benefiting from the introduction of such interventions. Furthermore, some participants made

explicit or implicit comments that suggested family and religious beliefs/values were most important and/or expected these values to be integrated into their counselling processes.

3.3.1 Family-centeredness (familism)

Some participants perceived their therapists as aware, interested and understanding and therefore able to address their cultural values of familism and ways of dealing with familial issues that they brought to therapy. Other participants however, perceived their therapist as lacking in cultural awareness and sensitivity in this respect and were thus unable to understand and/or support them accordingly.

Mary sought help for family relationship issues and conveyed a sense of liberation from traditional Latino cultural ways of addressing her relationship problems. This suggested she was able to model her therapist's Western familial values to aid her own familial relational values, instead of having to follow her cultural beliefs as a frame of reference:

“My biggest problem was that I did not get along with my (relatives), so the fact that his therapeutic approach was impartial gave me some kind of freedom and since this is another culture and here there is a big difference in the relationships between (relatives), then my therapist helped me understand my relationship with my (relatives) from another point of view...The fact that my therapist recognized the feelings and thoughts I had towards my (relatives), and did not put much emphasis on that I had a responsibility with my (relatives) to look after (relatives) gave me a lot of freedom... This is something that a Latin American therapist would have not told me because culturally we think and act differently in these respect... (Mary: 5,6. 65-80)

Mary further indicated she had the opportunity to reframe her familial relationships with the support of a therapist, whom she perceived as having expertise and was willing to use his own cultural/familial views to shape hers in a positive manner whilst maintaining neutrality. Accordingly, her therapist's views provided a reference to which she could compare other relationships and measure them against this supportive one to encourage positive change. This in turn enabled her to resolve differences and achieve more fulfilling relationships with relatives. Additionally, she felt free to express any emotions towards her relatives, without feeling judged and maintained personal and cultural values of respect "*I did not feel as if I was sinning against anyone ...*" (Mary: 6. 78-79). As a result, it aided self-acceptance and the opportunity to establish a better balance within her family system. Mary added:

"So it kind of gave me wings so that I could carry on, I felt like my therapist gave me the key to get to explore a world where there was not so much suffering..." (Mary: 7. 99-101) suggesting a sense of liberation and transformation from an unhelpful relationship into a more solid and meaningful familial relationship. It also, demonstrated a sense of appreciation for a bidirectional influence of culture in the therapeutic interaction, which facilitated healthy relationships within and outside the therapeutic encounter.

Carolina and Anne stated being able to work on their familial issues, whilst acknowledging the strength brought by family as a source of practical and emotional support during times of adversity:

"He took into consideration anything related to my family and my relationship with them, how I was coping without them ...this made me feel listened and

respected, I felt understood...especially during moments like the one I was living” (Carolina: 16,17. 139-145)

Carolina conveyed that she felt unconditionally upheld and valued whilst endorsing and nurturing cultural values of familism during her counselling encounter “*Made me feel listened and respected...*” (Carolina: 16. 142).

Marysela expressed benefiting from interventions that addressed family issues because her family was compounded of two different cultures:

“He made me acknowledge that now I live in London and that I have a British family who has a very different life style from my family in (country) (R: Mmm) So this helped me to put into perspective what was happening in my life and the pressure that I was experiencing...” (Marysela: 6. 90-94).

This conveyed a perception of her therapist as being culturally aware and skilled enough to address and understand her familial issues and the cultural context from which they arose. This enabled her to explore and understand her emotional involvement with and obligations for her nuclear and extended family and the stress that it seemed to cause “*The pressure...*” This encouraged her to consider ways in which she could demonstrate her commitment to her family and keep a balance of a well-functioning relationship within her nuclear and extended family system, without compromising her acculturation process.

Conversely, Lili indicated that she found it difficult to address and work on her familial issues, due to a perceived lack of knowledge and understanding from her therapist about her cultural background and personal characteristics, as well as that of her relatives to assist her accordingly:

“Sometimes during the sessions my therapist jumped into conclusions and assumed that because my (relative), my family and myself were Latinos, then that our relationship was in certain way, or that we as a family deal with issues in certain ways...so I kept telling her that that image or ideas she had of my (relative), of us as a family or me as a Latina was not right, that my (relatives) or I are not that kind of people...I felt really annoyed ermm it was like...do not put me in a box where I do not belong...”(Lili 5,140-148)

Lili added that such perceived lack of knowledge from the part of her therapist, led her and her family to feel generalised and/or stereotyped within the counselling encounter. Consequently, her progress was delayed throughout and her opportunity to explore her unique, personal and cultural perspectives from a familial point of view was impeded. Equally, she became defensive when she was repeatedly given an identity that matched a cultural’ stereotype *“I felt really annoyed...like...do not put me in a box where I do not belong”* (Lili: 147-148). Moreover, she had to keep giving an identity to her family and herself in order to make sense and address related issues.

Throughout the interview Lili appeared very relax, smiling and conveying a desire to talk about the different aspects of her experience. Though, from the beginning she always conveyed that although she had a *“very nice experience”*, she felt that she was not understood properly in terms of her *“unique differences as a Latina”*. As if conveying a need to raise awareness about *“Counsellors/therapists need to be aware and sensitive about the individual differences of their clients to more appropriately support them.*

Luz and Camila also suggested an experienced *“cultural clash”* because of the bi-cultural nature of their families, perceiving their nuclear family systems as

incohesive/inconsistent with their ideal, well-integrated extended family systems. Though, they implied they were unable to address and work on such issues during their counselling processes, due to a perceived lack of cultural understanding and sensitivity from their therapists to intervene accordingly:

"It was difficult for my therapist to understand my relationship with my (relative), that our difficulties were because we came from two different cultures...that we were too different..." (Luz: 14. 185-188).

Similarly, Camila expressed:

"I still have the same difficulty relating to my family and other people...integrating in a group with English people ermm including my own English family...."(Camila: 15. 209-212).

Chava, on the other hand, suggested that she felt disadvantaged throughout her counselling process by a perceived lack of cultural awareness from her therapist to understand the cultural context of her family issues:

"She did not see that our problem was different from that of an English family..... If we look at this from a cultural point of view... it has always been the (person) who provides for the house, and the Latino woman is always under that umbrella. It created more conflict and was putting my (relatives) at risk... so directly or indirectly she was dividing us as a family... I also believe that the poor connection between us had a negative impact on me and (person), I mean, we never managed to get something good out of our relationship..."(Chava: 14,15. 203-210).

Chava conveyed a perception of her therapist modeling Western interventions that seemed incompatible with her cultural experiences, whilst imposing her (therapist)

own cultural values during the therapeutic process. This consequently impeded the exploration and understanding of her problem from her own personal and cultural perspective. This equally suggested that she felt her opportunity to aid relationally was hindered and led to adverse consequences such as separating the family rather than promoting cultural values of family unity and/or connectedness “*She was dividing us as a family*”(Chava: 15. 208). Chava further conveyed a perception of her therapist being unaware of her familial hierarchy and gender differences within the Latino culture “*Latino woman...always under that umbrella*” (Chava: 14. 206) thus failing to understand Chava’s position in relation to other members of her family and the actual problem itself which further triggered familial conflict. She added that if her therapist had understood her position within the family, she could have guided and/or advanced treatment interventions in order to improve family relational and provide family safety from the individual level “*Not doing anything about that*” (Chava: 15. 209). In her last two lines, Chava suggested that the lack of development of a therapeutic bond also hindered her opportunity to establish more meaningful relationships within her familial network.

Monica also attended therapy for family relationship’ issues. However, she implied she felt unable to address such issues due to a perceived lack of awareness from her therapist in terms of her personal and cultural beliefs to maintain familial matters within the close family network. This therefore hindered her opportunity to bring such issues to the therapeutic process:

“For me this was risky because I was told not to discuss these things outside the family...you know, ermm like we say, “la ropa sucia se lava en casa” [Translator’s translation: Don’t bring your private matters into the open] (Monica: 23. 208-210).

This further implied that both her lack of trust of her therapist and translators and the lack of rapport within the counselling relationship impeded her opportunity for self-disclosure. In a later statement, Monica added:

"I never knew what concept she had about a family, or in relation to my problem.... All these things increased my uncertainty and my thoughts that it was best to stay quiet...I isolated myself" (Monica: 30. 255-260). This conveyed feelings of transference where her therapist's lack of disclosure seemed to lead Monica to believe that her therapist may hold prejudicial views about familial issues. This consequently implied that it not only prevented her from disclosing, *"it was best to stay quiet"*, but also her feelings of anxiety were exacerbated and she felt put at greater psychological risk *"I isolated myself"* (Monica: 30. 260).

Sonia indicated an experienced lack of understanding from her therapist about the value placed on her family as a source of support during times of emotional/psychological difficulties:

"I could never understand why my therapist did not even bother to ask me if I have my family to support me or how I was handling the situation without the support of my family...ermm...there were times when I told her that life in London was difficult without my family, but she just said "It must be difficult", can you believe it? "(Sonia: 12. 133-140).

This suggested a sense of frustration and disappointment with her therapist, who ignored the impact of her family's absence during her process of adaptation. This further indicated that her feelings of loneliness and vulnerability were increased *"...life in London was difficult without my family"* (Sonia; 12. 39-40). Additionally, and by stating *"Can you believe it?"*, Sonia conveyed a sense of disbelief and a

desire to perhaps bond and share with me her disbelief, as if looking to experience with me some empathic understanding that she seemed unable to obtain from her therapist.

In summary, most participants expected their therapist to have knowledge and/or be willing to introduce interventions that would aid understanding of their familial issues and family relational from their own personal and cultural perspectives. However, whereas some benefited from such interventions, others felt unsupported and/or misunderstood in this sense and hence unable to address such issues.

3.3.2 Religious/Spiritual Healing

A given theme for some participants was the way in which they experienced their therapist as showing an open, accepting, respectful and sensitive stance towards them and their religious/spiritual views. This, in turn, appeared to increase their trust and assisted with their coping skills and progress and the development of the therapeutic alliance. Other participants, however, experienced their therapist as unreceptive to their beliefs, which led to them feeling unsupported and misunderstood. However, other participants explicitly expressed a preference to not address their problems from a religious/spiritual viewpoint, in order to avoid generalised, cultural beliefs. Some participants used religion and spirituality terms interchangeably.

Carolina suggested that the introduction of religious interventions helped her make meaning of her experience:

“He was very respectful because he knew that I was Latina, that I have a Catholic background, and we worked with it.....he made much emphasis on

how this influence on my process. For example, once I told him my religious beliefs about my fear of dying, and my therapist told me “Think that we are just temporal passers-by, we occupy this body but later there will be another life, another way”, I must say that this was very useful for me, my fear vanished completely” (Carolina: 15. 134-140).

Carolina conveyed a sense of gratitude towards her therapist for accepting, respecting and being aware of the need to integrate her religious beliefs as part of her treatment. She indicated that she experienced her therapist as using his own religious beliefs to complement hers, that is, as a source of explanation and understanding of her uncertainty about the meaning of life and death. This encouraged her to use her religious views as a way of coping and to search for life’s meaning, whilst reducing her emotional distress. Similarly, Anne suggested that she had the opportunity to address, share and strengthen her spiritual being with a therapist who was non-judgemental, and instead knowledgeable, open and respectful of her religious/spiritual beliefs in relation to her problem:

“I could talk openly about my religion and he knew my religion... I never felt that he was judging me or that he was looking at my case from a specific spiritual angle, instead he was quite eclectic on his understanding....He also shared certain things, for example, “one does not experience pain only physically or emotionally”, but also on a spiritual level”, that is, he seemed to have that ability to see beyond my physical state (R: Mmm)...He was flexible and explored how to spiritually accompany a person from another culture and for me this was very important because throughout this therapeutic intervention he helped me to grow spiritually during the hard time that I was going through” (Anne: 4,5. 59-77).

By emphasising her therapist's statement: *"One does not experience pain...but also on a spiritual level"* (Anne: 5. 70-71), Anne implied that the introduction of religious/spiritual interventions enabled her to gain comfort, meaning and strength during the life event she was experiencing. It also gave her the opportunity to work beyond her psychopathological state, that is, working holistically to aid the understanding of her problem, thereby reducing emotional distress and enhancing her psychological and spiritual well-being *"... beyond my physical state"* (Anne: 5. 71-72). Likewise, Marysela indicated that the integration of some of her religious views during her process helped her to positively cope with her problem:

"We decided to explore how from a spiritual level I could overcome some of the difficulties that I was facing... also up to what extent my religious beliefs could keep me strong during that time and how some of my religious beliefs influence or not in some of the decisions that I would have to take...This opportunity gave me a kind of relief from all the difficulties that I had at that moment...my therapist made a good effort to help me and I valued her for this..." (Marysela 6, 74-80)

Marysela conveyed a perceived respect and collaborative effort from her therapist to enable a therapeutic encounter of accompaniment rather than imposing a religious/spiritual direction. This implied that she was encouraged to use religion as a coping source, to facilitate explanation, meaning and a sense of comfort during the moment of uncertainty that she was experiencing *"gave me a kind of relief..."* (Marysela: 6. 78-79). This consequently enhanced her psychological well-being and strengthened the therapeutic alliance *"I valued her for this"* (Marysela: 6. 80).

Conversely, Monica, Sonia and Luz, expressed a sense of frustration from a perceived lack of knowledge and openness from their therapists to enquire and/or turn to any of their religious beliefs, which they considered fundamental to their sense of self and well-being:

"I consider myself a believer in god, so I expected a person who understood why I felt that I had to be a good person, to please God, and to behave well. To understand why I had these beliefs ermm and how they could help me to cooperate with my problem. She never questioned me in this sense....To be honest, at times I felt as if I was talking to the wall" (Monica: 29. 248-252).

Monica implied that her experience was hampered by a perceived lack of sensitivity from her therapist to explore and understand how her religious beliefs influenced her self-perception and the perception of her problem. This suggested that her opportunity to rely on and strengthen her religious faith to cope during times of adversity was hindered, whilst evoking feelings of guilt and self-blame for revealing personal issues, which caused a negative self-perception. Equally this experience increased her feelings of anger and abandonment: "...*affected me spiritually...I walked away from god... I was angry against god*" (Monica: 17. 157-161). The expression "*Talking to the wall (Monica: 29. 252)*" suggests that Monica's perceived lack of immediacy and validation of her beliefs and feelings from the part of her therapist, created a barrier, "The wall", which ultimately seemed to prevent rapport within the therapeutic relationship.

Sonia and Luz expressed that they had to restrain themselves from making sense of their problems and/or use their religious beliefs as possible coping resources and comfort during their counselling experiences:

“At times I felt a strong desire to ask her for the possibility to see if in some way she could like to reinforce my religious part or spiritual side, especially in that difficult moment ermm to see if from there I could move forward in some way” (Sonia: 6. 140-142).

Luz expressed:

“Only God knows how I was feeling at that time....she could not even enquiry whether I had any beliefs, especially religious beliefs or anything that could give me some kind of relief during such a difficult time” (Luz: 2. 14-16).

This implied that they felt that their opportunity to strengthen their spiritual beings during times of adversity, alleviate their emotional distress and progress during their counselling processes, were hindered due to the lack of understanding and interest from their therapists to foster religious/spiritual coping.

On the other hand, Camila, Mary and Chava all conveyed a perceived avoidance of cultural generalizations and/or assumptions about their religious beliefs from their therapists, giving them a sense of freedom from religious/spiritual interventions, which seemed to be attuned to their particular needs:

“Fortunately they did not mention anything or look at my problem as steaming from religious beliefs....or because of I come from a culture where most of the people are in search of god’s help...” (Camila, 16. 213-217).

“Something I found interesting during my therapeutic process was the fact that it was not base on a religion or religious beliefs.... so the fact that his therapeutic approach was impartial gave me some kind of freedom” (Mary: 5. 63-67).

“I appreciate that my therapist never made any emphasis at a religious level simply because I am Latina...” (Chava; 15. 214-216).

In summary, some participants expected their therapists to introduce their religious/spiritual views and beliefs as part of their treatment. These participants perceived such interventions as necessary to find meaning, and as a source of comfort and support to help cope with their problems. Other participants experienced a lack of openness, respect and receptivity from their therapist to introduce such interventions, which impeded their opportunity to make sense of their problems and limited possible coping strategies. For other participants, however, the non-introduction of religious/spiritual views was experienced as a sense of freedom from such cultural assumptions.

3.3.3 Assimilation and Adaptation Issues

Most participants expected their therapists to consider and address issues of adjustment and adaptation that they have to face as immigrants in the UK.

Some participants reported that their therapists were aware, understood and supported them in this regard during their experiences of therapy. For example, Anne and Carolina expressed that they had the opportunity to address the emotional and psychological implications of their processes of adaptation, whilst being understood and upheld by their therapists:

“He also helped me to realized until what extent I belong to this country, and in his eyes I could see that I had already acquired many customs that one attributes to the English ermm He helped me to understand that I had already acclimatized to the English culture, to see how much I had grown

and how different I was to the person who came a few years ago..." (Anne: 3. 37-42).

Anne suggested that her therapist's introduced interventions helped her to become aware of her process of acculturation and self-identification within the dominant culture. The therapist fostered a sense of personal development and belonging that enabled her to function and succeed in a different cultural environment. Anne further conveyed a sense of projection, suggesting that her process of self-identification within the British culture facilitated her counselling experience and was enhanced by her therapist "*In his eyes I could see that I had already acquired many customs that one attributes to the English*"(Anne: 3. 37-38). Carolina also stated:

"I could talk to him openly about all the changes that I was going through and he understood my process...we discussed how I felt with the language, the people, the weather all these things that are different from (country)...I really felt that he accompanied me and understood me during this process..." (Carolina: 20. 172-177).

Carolina asserted that she felt able to address adjustment issues within a collaborative and culturally empathic therapeutic environment and it provided her with a sense of security whilst adding to her process of adaptation "*I really felt that he accompanied me and understood me..."* (Carolina: 20. 176-177).

Other participants, however, expressed that they felt that their therapist did not show any interest and were unable to understand and/or assist them with specific struggles that resulted for immigrants. Monica stated:

“The fact of being in this country made me feel more susceptible, I did not know what were the rules or regulations of this country, being in that situation was embarrassing for me (R: I understand)...I felt weaker...I could not trust anyone... I felt more frustrated not only because of the language but also the lack of support from my therapist... I was very afraid...” (Monica: 6,7. 61-72).

Monica conveyed that her lack of acculturation and/or identification with British customs, and the lack of provision of psycho-education about British codes of conduct in relation to her problem on behalf of her therapist, had a negative impact on her well-being. This accordingly increased her emotional distress *“Made me feel more susceptible...I felt weaker”* and evoked feelings of fear and anxiety *“I was very afraid”* (Monica: 6. 61, 6. 68, 6. 72). It also made her feel emotionally exposed and stigmatised *“Being in that situation was embarrassing for me”* (Monica: 6. 62). Monica also implied that such situations evoked in her feelings of mistrust towards her therapist and people outside the therapeutic setting *“I could not trust anyone”* (Monica: 6. 68). Consequently, she felt put at greater risk which created a cultural barrier both within and outside the therapeutic relationship.

Camila sought counselling for problems of adaptation to British culture, however, she explained that she was allocated to a group for depression, so from the beginning, her individual needs were not met:

“So in reality I could never make clear what was my problem, because they thought it was depression, but my problem was in the English world (R: Meaning..?) that in my Spanish world I was Camila, the one was able to manage the Latin American’ social conducts...Whereas in the English world I felt that I could not fit anywhere...it was really frustrating that my therapists

could not understand this...I then discovered that the British are not very welcoming ermm so I felt that I was treated like a second-class citizen..."
(Camila: 12,13. 168-175).

Camila implied a perceived lack of competence from her therapists to conduct an appropriate assessment, understand the cultural context of her problem and allocate her accordingly. As a result, she felt prevented from addressing and being supported with challenges that she faced as an immigrant, and/or problems of adjustment. Thus, arousing on her feelings of disappointment about the lack of support "*It was really frustrating...*" and leading her to experience a sense of loss of identity "*I felt that I could not fit anywhere*" (Camila: 13. 172). Equally, she felt discrimination both within and outside the counselling setting "*...the British are not very welcoming...I was treated like a second-class citizen*" (Camila: 13.174-175).

In summary, some participants experienced their therapist as being aware and prepared to address issues that arose from their processes of transition. These participants experienced such therapists' interventions as supportive, understanding and facilitating their processes. However, those participants who stated not benefiting from interventions that address assimilation/adaptation issues, suggested experiencing their therapist as lacking awareness and understanding of their immigration struggles which hindered their progress throughout.

3.4. Master Theme Three: The Healing Presence

This theme relates to participants' perceptions of therapists' attitudes that they considered to be fundamental qualities that foster communication and a good therapeutic relationship, irrespective of theoretical orientation. Participants'

emphasis was placed on the therapist's ability to convey empathic understanding, validation and to demonstrate a commitment to support them.

3.4.1. Therapists as Interpersonal or Impersonal

Some participants considered their therapist as being interpersonal when they conveyed a warm, genuine, supportive, understanding and non-judgmental attitude, experiencing such attitudes as fostering the therapeutic relationship and their progress throughout. Other participants suggested experiencing their therapists as impersonal when they perceived them as being distant, lacking care and sensitivity, being judgemental and failing to create a welcoming environment, and identified these reasons as hampering the therapeutic alliance and their processes of therapy.

Carolina and Anne conveyed an experienced opportunity to express and process their emotions, within a non-judgemental, validating, culturally accepting and empathic therapeutic relationship:

"At the beginning I thought that he might be cold because our difference in cultures ermm you know that we tend to be warmer, but in reality he was very warm and kind and gave me the space and the confidence to express myself...I always felt comfortable when talking to him" (Carolina: 7. 46-50).

Anne expressed:

"I found a companion, someone to be with me during a very difficult process in my life. A person who was there with me unconditionally, processing with me anything that was happening around me. It also helps that it is a place where no one judges you, but accompanying you in your humanity ermm (R: Hmm). He was a therapist who was very human, very tender, not very rigid"

in his approach...his attitudes helped me a lot to trust him, consequently to freely express my thoughts and feelings”(Anne: 2,3. 25-32)

Carolina and Anne further articulated a perceived empathy and engagement from their therapists “*very kind (Carolina: 7. 47); “very human, not very rigid...” (Anne:3. 29)*, which permitted a sense of mutuality and understanding across the differences in value expectations within their cross-cultural interchange. This suggested that such therapist’s attitudes increased their trust, enhanced self-disclosure, and the understanding of their issues. Additionally, it aided change within an accepting, collaborative, and non-judgemental therapeutic encounter.

Anne appeared very comfortable during the interview and expressed her ideas in a very confident manner. Always conveying a sense of satisfaction with every aspect of her experience, and clearly demonstrating that her individual needs were met all throughout.

Marysela expressed that she experienced a therapeutic encounter of containment, validation and respect for her individual and cultural differences:

“I was sceptical before I went to therapy about her attitudes towards me or my problem, you know that I was looking for help from the English, so I did not know what to expect from her...but in reality she treated me like another of her clients ermm...we worked well together (R: Mmm) I felt that throughout the sessions her behaviours towards me were always good...I felt that she care for me regardless of my cultural background....She did not judge me, she help me to understand that I was not the only one going through that situation...she helped me to increased my confidence, she understood me, she was warm” (Marysela: 4. 49-57)

Marysela further suggested that she entered counselling with the perception of English therapists as being rejecting of Latino clients and a fear of being stigmatized. However, she implied that she experienced her therapist as being accepting, respectful and creating a welcoming environment. The therapist was willing to see things from her perspective in order to assist her in deconstructing her world views and issues, and enabled her to normalise her experience, hence increasing self-awareness and encouraging self-growth.

On the other hand, Sonia and Chava expressed the dissatisfaction they experienced with their therapists and counselling processes was associated with a perceived disregard from their therapists in reflecting emotional understanding, as well as lacking care and sensitivity about their cultural differences and issues and not providing a welcoming environment:

“As a Latina I wanted to feel mmm not that my therapists likes me, but that she cares for me... but she was very cold, so she made it difficult for me to tell her how concern I was feeling...I felt that she had her own agenda...”
(Sonia: 16. 189-192).

Similarly, Chava stated:

“I remember that when I cried, I felt as if I was humiliating myself (R: Mmm)...I think that she was a very strict woman, a woman with very little compassion. I do not know if this is a cultural thing, but I work with a lot of English people and they have that understanding, sometimes they care for you...but my therapist was very cold...I felt sad because we always tend to make people feel more welcome, we are kind and smile, we try to listen, ask questions, but with her this connection was not possible” (Chava: 10,11. 135-149).

Both Sonia and Chava implied bringing cultural expectations for an empathic relationship to the therapeutic dyad suggested they felt disappointed by the perceived lack of acknowledgement of such cultural transference and empathy from the part of their therapists. As a result, their opportunity to emotionally express and reduce their emotional distress was hindered “*She made it difficult for me...*” (Sonia: 16. 190), “*I could not express myself*” (Chava: 10. 135). Sonia and Chava further suggested that the perceived distance from their therapists impeded their opportunity to achieve a sense of closeness in the therapeutic relationship “*I felt that she had her own agenda*”(Sonia: 16. 192), “*With her this connection was not possible*” (Chava: 11. 149). Moreover, Chava seemed to turn to social comparison as a way of understanding her therapist’s attitudes, suggesting that as opposed to other English people, she perceived her therapist as an individual who liked to exercise power and was emotionally invalidating. Consequently, she felt discriminated and emotionally disempowered within the counselling encounter “*I felt undermined*”, “*...I felt as if I was humiliating myself*” (Chava: 10. 35-36).

Monica and Camila indicated that they felt unable to explore and reframe their feelings and problems due to a perceived lack of effort and empathy from their therapists to fully engage, validate and understand their emotions and different cultural perspectives:

“She could not understand or help me with my painful feelings, so I felt that it was best to stay quiet erm at this moment I felt like the English were very cold, that they did not care much about any feelings, as if they were very self-centred. Also I thought that because I was as from another country, that they did not care about what was happening to me” (Monica: 16,17. 149-152).

Camila felt:

“It was more about them rather than understanding my case in particular, to understand me as a Latina, from my cultural point of view (R: How did you cope with this?) I would come out very upset, sometimes crying a lot. I felt very sad because I was not given the opportunity to be myself, they did not make me feel welcome in that environment...”(Camila: 7. 93-97)

Monica conveyed that she experienced a lack of care and understanding from her therapist, that changed her perception of British people in general, perceiving them as culturally non- empathic and detached *“Very cold... very self-centred”* (Monica: 16. 149-150). In her last two lines, she also implied that she experienced the cultural differences between her and her therapist as a barrier to empathy and feelings of rejection and/or discrimination within the counselling relationship. Similarly, Camila suggested that the lack of understanding from her therapists led her to experience a loss of identity *“I was not given the opportunity to be myself”*, that she felt rejected *“They did not make me feel welcome”*, and her emotional discomfort was heightened (Camila: 7. 94-95, 7. 95).

Chava and Luz shared similar views regarding their therapists as being unable to connect and showing no sensitivity to the issues at hand. They suggested that their therapists were more concerned with and/or disregarded environmental variables interfering in their processes, whereby they both felt that their feelings and problems were being disregarded:

“She was looking at the clock constantly, like every 5 or 10 minutes...that made me lose confidence, it made me feel more insecure...I thought that she was not interested in what I was saying... Then I started to make assumptions of what was she thinking about me because I was coming from

a different culture ermm I think she was not happy with me...” (Chava: 9. 118-127).

“My therapist often arrived very late...we would sit in a very small space, which did not even have a door but she would put a provisional one ermm then I thought what importance were they giving to my problem...I think they were treating me like that because I was a foreigner and this made me feel more worry and depressed” (Luz: 7,8. 98-104).

Chava asserted that she experienced her therapist as having an excessive preoccupation with time instead of focusing on the therapeutic process. This led her to believe that her therapist might hold prejudicial views towards her for being culturally different which increased her feelings of anxiety and she felt undermined *“Made me lose confidence...made me feel more insecure” (Chava: 9. 20-21).* Chava and Luz also implied that their therapists' attitudes led them to feel discriminated against as culturally different clients *“She was not happy with me”(Chava: 9. 127), “They were treating me like that because I was a foreigner” (Luz: 8. 103-104).* By using the word “They”, Luz suggested that her experienced lack of cultural sensitivity from her therapist, made her feel let down by the whole care system rather than by her therapist alone.

In this sub-theme, all participants demonstrated that they expected their therapist to convey an accepting attitude and cultural empathic understanding towards them and their problems. Some participants implied being provided with such conditions, which encouraged them to trust their therapist and more confidently communicate and emotionally express. Other participants, however, reported their therapist as being distant and lacking care and sensitivity which ultimately prevented them from communicating properly and/or feeling understood, which

hampered the development of rapport and impacted negatively in the therapeutic alliance.

3.5. Master Theme Four: Cultural Liberation or Formulation

This theme illustrates participants' willingness and/or need to undergo therapy with culturally similar or dissimilar therapists. Those participants who stated experiencing their Western therapist as able to recognise and make sense of how cultural values play a role in their problems, reported benefiting from seeing an English-speaking therapist. However, those participants who reported experiencing their therapists as lacking in knowledge and understanding of their cultural nuances and the embedded context of their problems, expressed an increased desire/need to undergo counselling with culturally similar therapists.

3.5.1 Culturally Concordant or Discordant Therapists

The majority of participants expressed a preference for seeing a Western therapist. However, some found such an opportunity beneficial, and stressed that they had the opportunity to explore their emotions and problems openly and perceived their therapist as able to recognise and make sense of how their cultural values played a role in their problems. This consequently aided deeper understanding of their issues and their embedded context, whilst providing a sense of liberation from the constraints of their Latino culture. Others, suggested that the cultural differences between them and their therapists evoked interpersonal and intrapersonal cultural conflict due to differences in their internalized belief system, which led them to feel misunderstood, unsupported and

dissatisfied with their counselling experiences. Hence, these participants felt the need and/or were forced to undergo counselling with culturally similar therapists.

Anne conveyed an experienced opportunity to explore her problem within a more genuine and explorative therapeutic encounter:

“I did not even give myself the opportunity to have a therapist who was Latin American, I think there is some risk that we Latinos believe that we share the same culture but in reality it is not like that. I think as my therapist was English and I am from (country) so both of us made an effort to understand the other's culture and not to take things for granted” (Anne: 2. 16-22)

Anne explained that she avoided Latino therapists as she felt apprehensive that they would intervene in a culturally generalised and/or stereotypical manner. Equally, she felt that the cultural differences between her and her therapist allowed for more exploration and engagement during the sessions *“Not to take things for granted” (Anne: 2. 16-17).*

Lili suggested that with her British therapist she felt more able to openly discuss certain thoughts, feelings and behaviours that did not conform to traditional Latino values:

“I believe that working on the things that I worked during therapy would have been very hard for me with a Latino therapist...But my English therapist was more open to my beliefs and differences...with a Latino therapist I would have felt like more exposed to certain assumptions from the therapist, looking at it in terms of cultural beliefs that I feel does not apply to me as they may apply to other Latin Americans. It would have been difficult to express certain things about certain people, just for the fear of being judge...” (Lili 12,13, 185- 215).

Similarly to Anne, Lili demonstrated that a rejection for a culturally similar therapist for fear of possible cross-group generalizations as likely to have hindered her experience *“Just for the fear of being judge...” (Lili: 13. 195)*. Instead, she suggested that therapy with a British therapist was an opportunity to liberate herself from traditional Latino customs and to more freely express her thoughts and feelings. Lili also implied a perception of her therapist as having expertise and managing their interaction in an egalitarian manner, whilst embracing her cultural differences *“She was more open to my beliefs” (Lili: 14. 208)*, which allowed her to meet her individual needs within a more genuine therapeutic encounter.

On the other hand, Mary, Chava and Luz suggested that the experienced lack of cultural understanding and sensitivity from their Western therapists, impeded the exploration and understanding of their problems, which in turn increased their desire to seek counselling support from Latino therapists. For instance, Mary indicated that although she preferred to discuss her issues and had the opportunity to more freely address issues related to familial relationships with her English-speaking therapist, she experienced a lack of understanding and sensitivity from her Western therapist to understand the embedded cultural context of her problem. Therefore, she ultimately chose to seek counselling support from a Latin American therapist:

“My biggest problem was related with the Latin American culture, in regards to how you relate to (relatives), in terms of your religious believes... However, I felt that at times he was not looking at things from my cultural perspective, that is, if I said this is what I believe is the right thing to do with my (relative), he would say “But why do you have to do such and such if in our culture we do not do that this or that”, for me this was like wow....(facial expression)... I felt that there was a cultural clash, a cultural shock in this

sense, he could not be in my shoes. As a Latina for me this was very strong as I wanted to be understood not only as a client but also as a different client...Actually, in one of the sessions he told me "you looked a bit different today", so I replied yes I am feeling different, and he asked me "what was it?", I told him I saw a Latin American therapist and she help me a lot, and he asked me "How did she help you?", I just answered she was Latina, she understood me completely..." (Mary: 13,14. 190-210).

Mary further suggested a perceived lack of cultural awareness and/or inability from her therapist to understand her issues from her own personal and cultural perspective, hence imposing his own values upon hers. Consequently, she felt exposed to logical explanations of the causation of her problem with little consideration of her unique viewpoint, which created conflict in the therapeutic encounter *"a cultural clash...a cultural shock"* (Mary: 14. 201). This also led to power dynamics and an evoked sense of *"oppression"* within the relationship *"as a Latina for me this was very strong..."* (Mary: 14. 204). Mary also implied that she did not feel understood *"He could not be in my shoes"* (Mary: 14. 203), hence she was forced to seek counselling support with an ethnically similar therapist, who seemed to appropriately meet her individual needs *"...she understood me completely"* (Mary: 14. 205-207). Chava also reported that after her counselling experience with her English therapist, she felt a need to seek counselling support from a Latino therapist:

"I would have changed the therapist (laughs), because English was not a problem for me, also I identified myself more to the British life style. Sincerely, I would have changed the communication...that she would have knowledge about my cultural customs...to paid more attention to what I was

saying and to my feelings and problem ermm...these were the reasons why I had to look for a Latino therapist” (Chava: 10. 128-132).

This further suggested a strong identification with the British culture and an open attitude to undergo therapy with a Western therapist which are factors that she perceived would facilitate her experience with her Western therapist. However, she implied that the experienced lack of understanding, guidance, rapport and support from her therapist, impeded her opportunity to address her problem, and hence forced her to dropped from treatment.

Monica implied that the experienced lack of support from both her Western and Portuguese-English-speaking therapists, and the use of interpreters, hindered her therapeutic experience. This eventually led to her dropping out of therapy and seeking counselling support from a Latino therapist:

“Neither my therapists nor the interpreters could really give me the support I needed, especially the understanding of my problem. From my side, I could not tell them what was my problem or ask for the support that I needed. For these reasons I had to look for a Latino therapist...” (Monica: 31. 267-270).

Luz attended therapy for bereavement issues and described a perceived inability from her therapist to incorporate relevant cultural values intended to help her to cope with her grief in a manner that was culturally familiar to her. She therefore felt misunderstood and unable to move on to a resolution of her grief:

“For her a loss is not considered a big issue, but for me it was a very significant event in my life. So this was the moment when I felt that there was a cultural shock ermm because she would say ...”do not worry everything is going to be fine”, like trying to persuade me to feel and think something that I could not assimilate as such... Also she did not understand

that culturally we view loss as something very significant in one's life, whilst my therapist made me feel like...what is done is done and lets look it from a different perspective" (Luz: 2,3. 24-34)

Luz further suggested a perception of her therapist's attitudes and comments as being dismissive of her experienced distress and lacking understanding about the psychological and emotional impact of her problem both at an individual and a familial level. Consequently, she felt unable to develop emotional resilience to promote coping and self-care and her feelings of uncertainty and emotional distress were heightened "a cultural shock". This suggested that cultural differences created a barrier in the counselling relationship. Luz added:

"After this experience my opinion about the service that they offer has changed, because if I was given again the opportunity to see a English therapist, I would not be able to trust him or her. I feel fear that they will not listen to me or understand me as I need..." (Luz: 4. 45-49).

This conveyed that such counselling experience predisposed her from seeking counselling support with another English-speaking therapist, perceiving them as being unable to work in a culturally sensitive manner.

It can be surmised that some participants had a preference to undergo therapy with English-speaking therapists and experienced such encounters as meeting their individual needs. However, other participants showed an open attitude to undergo counselling with Western therapists and the experienced lack of support and understanding from their therapists increased their need to undergo therapy with culturally similar therapists.

Summary

In summary, this chapter has presented an interpretative phenomenological analysis of the interview' transcripts of ten women. It outlined and explored four themes based on participants' accounts: "Emotional Expressiveness," "Cultural Competence or Encapsulation," "The Healing Presence" and "Cultural Liberation or Formulation". These themes demonstrate that participants' counselling experiences were significantly influenced by their ability to form a therapeutic relationship, and such relationship was strongly determined by participants' cultural values, and the therapists' ability to meet their individual needs. These themes will be further discussed in relation to the existing theoretical literature in the following chapter (Discussion chapter 4).

Chapter 4: Discussion

Introduction

This discussion will begin with a review of the themes emerging from the analysis, outlining their relatedness to the participants' counselling experiences. Findings for each master theme will be considered within the context of existing work, how each theme supports/differs/extends existing literature and how existing work sheds light on the present research findings. Clinical implications, limitations, suggestions for future research and personal reflexivity will be addressed, closing with a brief conclusion section.

As suggested in the previous chapter (Chapter 3), whilst the themes are presented as distinct, there is an overlap between and within the master themes which reflects the ideographic ways in which the participants experienced their counselling processes (Smith, Flower & Larkin, 2009).

Research Aims: Contextualising the findings within existing research

This study aimed to explore the counselling experiences of Hispanic/Latino clients with English-speaking therapists. Before beginning the discussion of the master themes, it is important to highlight that participants' overall experiences of counselling with English-speaking therapists were reported as "positive", "frustrating" or "negative". These overall perceptions are the context from which the master themes emerged and are consistent with or differ to existing literature.

In the present study, findings from those participants who had "frustrating" or "negative" experiences show feelings of frustration and disappointment resulting from an experienced therapist's lack of understanding of their unique needs as

culturally differing clients. Such experiences were also said to have resulted in feelings of distrust and hopelessness about the possibility of getting the necessary support out of this type of service.

These findings, therefore to some extent, may support literature in the U.K, reporting adverse mental health experiences among BME groups (The Sainsbury Centre for Mental Health, 2002; Suresh & Bhui, 2006), and lower utilization and retention rates in mental health services (Mental Health Foundation, 2015). They also identify client variables, client-therapist's variables and organizational and structural variables as the main factors/barriers to access, and adhere to mental health services among BME communities (Memon et al, 2016). Findings may also be consistent with literature in the U.S, suggesting that ethnic and racial minorities experience a disproportionately higher burden from un-met mental health needs (USDHHS, 2001). Similarly, findings may support U.S. literature about Hispanics'/Latinos' under-utilization of mental health services (Alegria, et al., 2007; Flaskerud & Hu, 1992; Miranda et al., 1996; Vega et al., 1999). As suggested by Sue and Sue (2012), the lack of responsive mental health support to the needs of ethnic minorities is one of the strongest predictors of under-utilization and early drop-out.

The above participants' experiences also support what Bean, Perry and Bedell (2001) acknowledged about the sensitive approach that Latinos expect to enable a satisfactory experience, as well as what Aguilar-Gaxiola et al. (2012) acknowledged about the criticality of understanding in the relationship between clients and clinicians. Supporting literature about the therapeutic relationship as a central component of mental health care (Priebe *et al*, 2005), and its association with improved outcome (Neale & Rosenheck, 1995; Martin *et al*, 2000; Couture *et al*, 2006) should also be noted. These participants not only confirmed what the

literature has already recognized as important factors for effectual therapy with this group but also provided additional insights reflecting the Latino clients' common expectations. A valuable insight that arose from these participants' accounts was that the therapists' lack of awareness and sensitivity for Latinos' needs and differences in perspectives, the therapists' inability to empathise with their problems and their lack of effort to try to bridge the gap, were the factors that contributed to their unsatisfactory experiences.

Nevertheless, the present study's findings also differ from existing literature in that half of the participants reported positive counselling experiences, thus challenging existing research on Latinos' mental health experiences. These participants provided valuable insights about the factors they experienced as favourably contributing to their experiences. Accordingly, their therapists' ability and/or willingness to be attuned to their individual needs and relate to their cultural differences and perspectives, allowed them the opportunity to more openly address their concerns and any resulting feelings and emotions. These, in turn, enhanced the therapeutic relationship and became significant strengths for their overall therapeutic experiences. As such, their views and experiences of therapy concur with those reported by studies with Asian clients in the U.K, indicating that most clients greatly benefited from their counselling experiences with English-speaking therapists (Netto et al., 2001).

This section will consider each theme in turn within the context of exiting literature and begins with consideration of the first master theme and respective super-ordinate themes.

Emotional Expressiveness

This master theme captures participants' ability and/or opportunity to communicate their problems and to openly express their thoughts, feelings and emotions during their counselling experiences, either through the use of English language or through the use of cultural sayings "dichos". For some participants, this opportunity was facilitated by their ability to communicate in English, as well as being encouraged by their therapists' approach, expertise and commitment to support them. For other participants, however, such opportunity was hindered by their limited English skills, the provision of or the lack of provision of interpreters and a perceived/experienced lack of support from their therapists to facilitate communication and emotional expression throughout their counselling experiences.

Research suggests that eliciting client's expression of feelings is paramount in counselling since for many individuals, various difficult situations in life are integrally linked to emotions, irrespective of population. Also, in all therapy approaches human change and development are often imbedded in emotional experience (Ivey & Ivey, 2003). Further, although discussing content is important, it is only a vehicle for facilitating clients' emotions. Case studies by Pitta et al. (1978) and Javier (1989) supported this claim in their findings with Mexican American clients who spoke Spanish and English. Accordingly, accessing emotions facilitated the counselling process and led to a significant breakthrough in therapy. This suggests that change may be prevented if a bilingual client is unable to access emotions related to the problem because the inappropriate language is used (Ramos-Sánchez, 2007). This research is in accordance with participants' accounts, in that all perceived the opportunity to communicate their

feelings and express their emotions as significant factors determining their overall counselling experiences. Therefore, those participants who had the opportunity to emotionally express and/or freely communicate their thoughts and feelings, felt enabled to address their concerns, enhancing the development of rapport and leading to satisfaction with counselling. However, the opposite was experienced by those who could not emotionally express or communicate.

Findings from this master theme also support research that suggested that individuals from some collectivistic cultures, such as Hispanics/Latinos, placed more value on the free, open expression of emotion (Soto, Levenson & Ebling, 2005). Some of the reasons for Latinos emphasis and/or need for expression of emotion may be accounted to cultural values of affiliation, group cohesion and the need to maintain strong interpersonal relationship (Carrillo, 1982; Eisenberg, 1999). Inter-personal relationships in Latino culture are also characterized by high levels of affection (Carrillo, 1982), and affect is more openly accepted and more valued than in Anglo culture (Garza, 1978; Guerra, 1970; Ramirez & Castañeda, 1974). In connection with this emotional openness, Triandis et al., (1984) a strong normative pressure in Latin American cultures to behave in a positive manner towards others is suggested.

Nevertheless, mental health professionals are encouraged to interpret Latinos' expressions within the context of cultural norms rather than directly interpreting such behaviours as reflecting pathology (Barona, Santos de Barona, 2003). In fact, research suggests that *'languages of collectivist cultures may not have separate words for certain aspects of psychological therapy, such as individual's thoughts and emotions, instead, that emotions may be expressed more in terms of relationships to family, group or the community'* (Benson & Thistlethwaite, 2009, p. 68). The present study findings are in line with this research in that for all the

participants, the therapeutic relationship and their overall counselling experiences were to a great extent determined by their ability and opportunity to emotionally express and communicate their concerns which were embedded within a different socio-cultural context from that of their therapist.

Clinical Implications of Emotional Expressiveness

Clinicians need to be aware that in the Latino culture the expression of emotion is either censored or overly expected. Therefore clients sometimes faced the dilemma that if they express too much “they may be exaggerating” and if they do not show emotions or expect emotions, “they may not care”. Consequently, Latino clients need their therapists’ encouragement and/or permission to freely express (Moitinho, Garzon, Freyre & Davila, 2005). Therapists are also encouraged to look at client’s emotional construction of psychological problems to give insights into the personal and cultural dynamics of emotional expression and expression-related interventions in mental health. Also, taking into consideration that Hispanic/Latino clients placed much emphasis on interpersonal relationships (Comas-Diaz, 2006), therapists should help the client to use his/her emotions to improve adaptive, interpersonal communication within the therapeutic context, which in turn will help them to improve adaptive and interpersonal communication outside the therapeutic setting. Despite the emphasis placed on emotions by some ethnic minorities, they have not been well studied in the empirical literature of emotion (Soto, Levenson & Ebling, 2005). This study therefore extends participants’ notions by promoting more insights into the need for emotional expression from Latinos.

The Language of Emotion

This super-ordinate theme explored participants' experiences of Standard English as a significant factor for aiding or hindering communication of their problems and emotional expression, as well as one of the main cultural factors influencing the development of rapport, throughout their overall counselling experiences.

How this Theme Supports or Contradicts Existing Literature

Research suggests that for many ethnic minority groups the principal aim of language is of conveying information about beliefs and cultural traditions and it is also related to the expression of emotional experiences (Barona & Santos de Barona, 2003). For many bilingual Hispanics/Latinos, the Spanish language is a vehicle for maintaining cultural traditions, a source of identity and pride and the means through which emotions are articulated (Santiago-Rivera & Altarriba, 2002). However, most of the research with BME groups in the UK (Grey et al., 2013; Memon et al., 2016; Cross & Bloomer, 2010), and the US (Atkinson, Morten, & D. W. Sue, 1989; Gutfreund, 1990; Marcos, 1979, 1988) indicates that language can be experienced as a barrier to communication and cultural value differences that not only contribute to the inaccurate assessment of client's verbal and non-verbal behaviours but also may lead to unsuccessful counselling.

Findings from the present research demonstrated that half of the participants experienced English language as the main channel for communication and as a significant aid for emotional expression and connection with their therapists. However, some of these participants experienced occasional difficulty elaborating and/or accurately conveying certain thoughts and feelings and/or perceived them as losing emotional content/meaning when translated into English., They

experienced willingness from their therapist to collaboratively assist in the explanation and understanding of such thoughts and feelings to foster communication, counselling engagement and the therapeutic alliance.

Findings from these participants therefore differ from existing literature with Hispanic/Latinos that recognised language as one of the predominant barriers leading to unsatisfactory experiences for many Latinos (Aguilar-Gaxiola et al., 2012). Though, the findings agree with literature suggesting that language proficiency is a fundamental element by which mental health providers can establish meaningful connections with Latino clients (Falicov, 2009). Although research contributions examining the role of language in therapy (Malgady & Costantino, 1998; Marcos, 1994; Santiago-Rivera & Altarriba, 2002) are significant, findings from these participants add insight into understanding how the use of the dominant language can be experienced as a strength rather than a deficit for minority ethnic groups, in this case for Hispanic/Latinos. As suggested by Santiago-Rivera & Altarriba (2002) understanding the role of language in therapy is central to effective treatment regardless of theoretical orientation.

Furthermore, research describing empirical, cross-cultural investigations of language representation in bilinguals, suggests that words that describe emotions are often abstract and not easily translated (Bond & Lai, 1986; de Groot, 1993; Jin, 1990). Moreover, this also suggests that emotion-laden words or experiences are normally better expressed in the client's native/dominant language and that the non-dominant language can be used to express thoughts or beliefs that are not associated with emotions. Accounts from Lili and Anne are inconsistent with this research in that they experienced the English language as enhancing effective and spontaneous communication with their Western therapists as opposed to their native language, Spanish, particularly, as more accurately reflecting their thoughts

and feelings. For example, Lili suggested an “*emotional disconnection*” with the Spanish language whereas she felt that in English she could “*formulate things more easily*”. Similarly, Anne stated “*In English there were words that helped me express myself better than in Spanish...more words about not so positive feelings rather than positive ones...*” (Anne: 1. 11-15). This indicated that in English, she could freely express and/or liberate herself from negative emotions that she seemed unable to convey in her native language (Spanish).

This finding demonstrates that language is not always a barrier for some minority ethnic group members to access, adhere to and benefit from mental health services. This suggests that there may be a great number of individuals from ethnic minority groups that would appreciate and benefit from working with Western therapists. Furthermore, language was not only about English proficiency, it was also about therapists’ use of themselves and their skills to collaboratively aid communication and understanding. Also, for these participants, language was not only a neutral, descriptive channel for communication, instead it had an active role in constructing and shaping their experiences, their therapeutic encounters and their overall counselling experiences.

On the other hand, accounts from the other half of the participants who reported experiencing language as a barrier to communication and emotional expression, are consistent with literature reporting language as one of the predominant barriers to communication, leading to unsatisfactory therapeutic experiences for many Latinos (Aguilar-Gaxiola et al., 2012). These participants suggested that having to speak in English limited their ability to effectively communicate and/or accurately articulate their feelings and problems, as well as decrease their flow, spontaneity and desire for openness. Language difficulties were thus considered to lead to misinterpretations of their problems and feelings, creating a barrier to

cultural understanding and compromising the therapeutic relationship and quality of therapy. Despite the faced difficulties by these participants, all underwent therapy in English, only one participant was provided with interpreters, and the others considered the possibility of having a language-concordant therapist, however only after their counselling experiences with English-speaking therapists.

The given findings also support existing research about language and mental health quality for Latinos in the US, suggesting that “*language plays an important role in the quality of mental health services provided to Spanish-speaking Latino clients*” (Eamranond et al., 2009, p. 494). Accordingly, those clients who do not speak the same language as their therapists tend to have problems understanding and communicating with language-discordant clinicians. Others may be prevented from expressing their thoughts and feelings as they may be more preoccupied with pronouncing words and phrases correctly rather than conveying meaningful therapeutic content (Marcos & Alpert, 1976; Marcos & Urcuyo, 1979; Marcos, 1988). Also, trying to convey in English experiences that are highly emotional will not necessarily convey the corresponding emotion (Marcos, 1988). Such lack of emotional expression is said to make sense given that emotions are tied to the individual’s mother tongue (Guttfreund, 1990). Therefore, language affects the expression of pathology since the inconsistency between what is said and how it is being communicated can lead to client’s responses being misinterpreted and to an inaccurate diagnosis, hence compromising the treatment effectiveness (Altarriba & Santiago-Rivera, 1994; Russell, 1988). The relationship between counsellor and client is also said to be negatively affected by the therapist’s lack of understanding of the Spanish language and Latino culture (Guilman, 2015). Therefore, this emphasises the need for therapists to accurately assess language proficiency as part of their evaluation process.

Nevertheless, findings from these participants also differ from existing research suggesting that when clients cannot communicate effectively in therapy, they are less likely to see the benefits of continuing treatment, resulting in early termination (Sandoval & De La Roza, 1986). These participants were willing to remain in treatment however, suggesting that the experienced lack of support from their therapists to aid communication impeded their opportunity to achieve their goals. Accordingly, for some of them, the lack of provision of an interpreter was perceived as a lack of support and cultural sensitivity on the part of their therapist, preventing appropriate exploration and understanding of experienced feelings and problems and not meeting their individual needs. For example, Chava suggested that the lack of provision of an interpreter forced her into the role of translator (for the relative in the room), hence emotionally disempowering her as a client and preventing her from communicating her feelings and issues. Monica, on the other hand, suggested that the provision of interpreters hindered her opportunity to communicate and emotionally express herself, resulting in a negative impact on the therapeutic relationship and her overall counselling experience.

Some scholars have demonstrated that the use of interpreters improves access and quality of care (Zigarus, Klimidis, Lewis, & Stuart, 2003). Others have shown that working with interpreters increases the client's understanding and relevant care options, enhancing rapport and trust in the process itself together with delivering better treatment adherence (Manson, 1988; Ramirez, 2003). Findings from Monica, however, challenge this research in that the provision of interpreters to help bridge the language gap was experienced as a barrier to communication and emotional expression. Monica suggested that conflict of interests with one of the interpreters and a perceived lack of expertise from interpreters to accurately convey information between the parties evoked in her feelings of mistrust and

anxiety which prevented her from addressing her concerns and expressing her feelings. This also, hampered the connection between her and the interpreters and the rapport between her and her therapists. Consequently, this compromised the genuineness of the therapeutic relationship and her overall counselling experience. On the other hand, Monica's account supports research indicating that the use of unqualified interpreters increases risk of serious miscommunication and inadequate care (Ebden, Bhatt, Carey, & Harrison, 1988). Also, the presence of an interpreter in the room unavoidably shapes the dynamics and ways for establishing "intimacy" (client's trust, genuine disclosure, and therapist' sensitive responsiveness) and the overall therapeutic alliance (Tribe & Tunariu, 2009).

Furthermore, research on the use of interpreters with Hispanics in the U.S suggests that interpreters who are not adequately trained can contribute to information distortion (Marcos, 1979), and concerns about confidentiality can arise creating client discomfort (Kline, Acosta, Austin, & Johnson, 1980). Monica's findings corroborate this research in that conflict of interest with her interpreter impeded her opportunity to self-disclose due to fear that her information would be disclosed to other parties. This raises the need for research on issues of confidentiality between client and interpreter and how this is experienced by the client.

Moreover, Monica's experienced lack of expertise from interpreters to accurately convey her feelings and emotions also supports literature suggesting that lay interpreters may also lack the necessary clinical knowledge and/or translation skills to accurately describe the client's mood or affect (Altarriba & Santiago-Rivera, 1994). Consequently, encouraging therapist and interpreters to ensure that communication exchange during this therapeutic triad (client-interpreter-therapist) is not only about conveying the actual conversation, but also about conveying the

client's emotional responses to the therapist and vice versa, since during the process of translation this may be overlooked.

Tunariu and Reavey (2003); and Weeks (2000) suggested that the individual's subjective experience is embedded within the rules for action, the rules for feelings, and the common language for sense-making bound to the dominant formulations and practices local to a specific culture. Therefore, to enhance communication and understanding between client and interpreter, thus between client and therapist, translators need to interpret and accurately convey information and intent communicated within specific therapeutic exchanges and across different world perspectives. This additionally conveys sufficiently attuned information to ensure high empathic accuracy from the practitioner towards the client, and pays more attention to the client's verbal and non-verbal communication and the process itself (Tribe & Tunariu, 2009). This approach may be beneficial to working with Hispanic/Latino clients due to the strong emphasis placed on emotional expression and interpersonal communication (Comas-Diaz, 2006).

Interpreters therefore need to work within the parameters of culture-specific norms and understandings to negotiate useful and ethical interpretations on behalf of their clients (Tribe & Tunariu, 2009). It is also important for therapists and interpreters to understand that Spanish may be spoken differently by individuals from different Spanish-speaking countries (Altarriba & Santiago-Rivera, 1994), It is therefore important to be familiar with the language and language nuances, as well as the cultural background of Hispanic/Latino clients to better serve them. Further, since the therapist holds clinical, ethical, and professional responsibility for the client, in the face of conflict of interest (i.e., in Monica's case), the therapist needs to focus on protecting the client. Tribe & Thompson (2008) also indicated

that it is important to consider the presence and management of power dynamics prior to and within a therapeutic encounter when an interpreter is used. Therapists are also advised to undertake training and skills for working with interpreters if they want to be resourceful and competent as clinicians (Tribe & Thompson, 2008).

Clinical Implications for Language of Emotion

Cultural sensitivity entails understanding an individual's cultural values, beliefs, and customs, as well as understanding the language in which these are expressed. A culturally sensitive treatment approach therefore involves a set of assumptions that are consistent with the client's value structure (Rodriguez-Gomez & Caban, 1992; Rogler et al., 1987; Szapocznik, Scopetta, & King, 1978). Consequently, since the initial assessment of the client's mental health is one of the critical components of the treatment plan, when working with minority ethnic clients and during the initial assessment, counsellors/therapists need to assess whether the client has a good command of English, whether it would be necessary to have an interpreter or whether the client needs to be referred to a language concordant therapist, wherever possible, as part of the treatment and to reduce language barriers. Further, for those therapists who are bilingual Spanish-English, it is advisable to contemplate the possibility of allowing the client to switch from the non-native language to the native language to enhance communication, emotional expression and self-disclosure as this has been shown to be advantageous when working with Latinos (Pitta, Marcos, & Alpert, 1978). Moitinho et al., (2015) suggested that even if Latino clients are English literate, it is still very important wherever possible, to integrate Spanish into the treatment, especially when processing highly emotional issues. Consequently, the present study's findings call for modifications on the therapeutic practices in ways that reflect

Hispanic/Latino clients' cultural and linguistic characteristics. Especially important is the need to assess language dominance or preference, and for an integrative framework that would help clinicians in training practitioners, and researchers to bridge cultural and linguistic factors and incorporate these in mental health practice.

Dichos (sayings)

This super-ordinate theme highlights participants' desire to use cultural resources such as using "dichos" as a way to elaborate on and to give more meaning to some of their thoughts, feelings and personal experiences as well as to enhance communication and understanding with their therapists. However, despite any efforts by participants to incorporate such Latino expressions, they expressed a failure to communicate in the given manner which evoked in them a sense of frustration.

Various authors have encouraged the use of dichos when working with Latinos due to the perceived significance they have to attain cultural credibility and validity (Zuñiga, 1992; Aviera, 1996; Bernal & Saez-Santiago, 2006; Comas-Diaz, 2006). Dichos have also been acknowledged and suggested as useful interventions for Latinos, given their preferred mode of communication discourages direct expressions of feelings and ideas (Aviera, 1996; Comas-Diaz, 2006). It is also a way of preserving the therapist-client relationship from ruptures in rapport and helps to overcome resistance due to their indirect and less-threatening nature (Zuñiga, 1992). Nevertheless, the given research has not demonstrated any direct evidence on how these interventions have been helpful or unhelpful or provided any account from the client's point of view. The present study's findings thus differ from existing research in that evidence presented here is derived directly from

participants' accounts. Most of the participants that attempted to use *dichos*, however, were unable to do so due to difficulty in accurately translating them into English (fear of loss of intended meaning), demonstrating that language was also an impediment in this respect.

Participants also perceived/experienced an inability from their therapists and/or interpreters to encourage the use of such resources as a meaningful way to show interest, a sense of familiarity, and respect for their cultural ways of communicating, hence to enhance rapport. Therefore, participants provided new and helpful insight in that they demonstrated a need to use *dichos* as a way to encourage communication, emotional expression and to enhance the therapeutic relationship, suggesting that there is much value in using them as interventions when working with Latino clients. Participants' accounts also provided insight into how their inability to use *dichos* impeded the development of rapport with their therapist, since the use of *dichos* is an indirect and friendly way of communicating and bonding with therapists. This is an attitude that is connected to values of *simpatia* (friendliness), and *cariño* (affection or fondness) that Latinos appreciate in interpersonal relationships (Moitinho et al., 2015; Ho, et al., 2004).

Clinical Implication of Dichos (sayings)

Therapists are encouraged to use 'dichos' when counselling Latinos as a way to 'link their phenomenological world with the symbols and metaphors available' to them (de Rios, 2001). In this way, they can help the clients to express problems, dilemmas, perspectives on situations, the paradox of human condition and to deal with client resistance (Zuñiga, 1991, 1992; de Rios 2001). *Dichos* as an intervention helps to enhance motivation and participation in therapy, stimulate emotional exploration and articulation of feelings and the development of insight. It

also assists clients in addressing specific issues, exploring their cultural values and identity and enhances the therapeutic alliance (Aviera, 1996). Zuñiga (1992) stressed that the use of dichos allows the therapist to help the client to experience the service as culturally accepting and less alienating. Zuñiga (1992) also motivates non-Latino (and non-Spanish speaking) therapists to use dichos/proverbs in therapy with Latino clients, suggesting that they are brief and therefore fairly easy to pronounce and memorize. However, it is advised they consult with a Latino clinician for guidance to avoid using them in an improper context and to avoid mispronunciations that may be counterproductive for the client. English-speaking therapists' effort in studying and using dichos demonstrates their respect for the client's culture and fosters cultural sensitivity. Although, when using dichos clinicians are advised to also be sensitive to client's age, status and especially their gender.

Some useful resources:

- *Brief Psychotherapy with the Latino Immigrant Client* (de Rios, 2001).
- Using metaphors in therapy: dichos and Latino clients (Zuñiga, 1992).
- Dichos as metaphorical tools for Latino clients (Zuñiga, 1991).
- List of dichos, Reframes, Sayings and Proverbs:

<http://www.spanishpronto.com/spanishpronto/spanishsayings.html#ad>.

Cultural Competence or Encapsulation

This master theme suggests that participants expected their therapists to be culturally knowledgeable, aware and sensitive and adapt and/or introduce interventions to meet their individual needs. Participants' findings infer that they

experienced either advantages or disadvantages by undergoing counselling/therapy with a therapist from a different culture. This implies that different perspectives resulting from different cultural backgrounds and life experiences were felt by them as either facilitating or interfering with the needed support and understanding, and influenced the therapeutic relationship.

“Cultural competence” requires mental health professionals to increase their awareness of the influence of culture on themselves as well as on their clients and trainees. Also, it acknowledges the value of multicultural sensitivity, knowledge and understanding about racially and ethnically diverse individuals (APA, 2003; S. Sue, 1998), therefore centring the client within his/her cultural context.

How does this theme support or differs from existing literature in relation to the super-ordinate themes of **“Family-centeredness (familism)”**, **“Religious/Spiritual Healing”**, and **“Assimilation and Adaptation Issues”**. For some participants, the introduction of such cultural values and/or therapists’ openness and receptivity to their cultural differences and perspectives was experienced as a sense of trust, respect, and acceptance which encouraged their own coping resources, and facilitated their progress. This enabled them to gain greater awareness of the cultural nuances of their difficulties, helping to reduce cultural differences and enhance rapport.

Findings from these participants therefore give insight into how they experienced their English therapists as culturally competent perceiving them as actively and positively engaged in cross-cultural discussions and demonstrating awareness of and sensitivity to their goals and needs in therapy. Also, demonstrating appropriate understanding and management of the cultural context of their

experiences and skilfully intervening to bring about positive change throughout their counselling experiences. This approach seems to be particularly beneficial to Hispanic/Latino clients struggling with issues where the values of Western and Latino culture may be in conflict, for instance, individual vs. collectivistic self-construals (Markus & Kitayama, 1991). Consequently, this finding challenges existing research with Latinos in the U.S, suggesting that system-barriers, that is, the lack of inadequate training in the delivery of culturally competent services, accounts for received inadequate mental health services (Cabassas et al., 2006; Johnson, et al., 2004; Lopez, 2002). It also challenges existing research with BME groups in the U.K, indicating that some of the factors contributing to their poor quality of care and treatment include lack of cultural competence (i.e. the ability of providers and organizations to competently deliver healthcare services that meet the social, cultural and linguistic needs of patients, McLean, Campbell & Cornish, 2003; Dowrick et al., 2009).

Another insight comes from Mary's accounts, suggesting that she experienced the given therapeutic encounter as an opportunity to be liberated from traditional Latino cultural values of familism and instead it was an opportunity to experience a **bidirectional influence of culture** in the therapeutic interaction, that is, to model therapist's Western family values to aid their own family relational. In this way, Mary felt more able to freely discuss familial issues and express any related emotions, hence to achieved better family systems, whilst upholding Latino cultural values of respect and affection for relatives and more fulfilling relationships within and outside the therapeutic encounter (*Mary: 5,6. 65-80*).

Similarly, Carolina (15. 134-140), and Marysela (6, 74-80) experienced their therapist as **complementing their religious views/beliefs**, demonstrating respect and a collaborative effort to enable a therapeutic encounter of

accompaniment rather than imposing a religious/spiritual direction. This served to strengthen their religious views and coping resources and make sense of their problems, whilst enhancing their psychological well-being and the therapeutic relationship. Findings from Carolina and Marysela thus give insight that it is not only about therapists learning how to be culturally aware and competent, but instead to have the capacity to use their own cultural background to aid the client's understanding and problem resolution, without imposing a cultural direction. It is especially important to be attentive to the client's level of acculturation and willingness to adhere to dominant cultural values. This finding supports research implying that client's perceptions of how culturally competent the provider is can influence the working alliance (Maxie & Arnold, 2006).

This highlights the value of empirical data testing specific features that enhance collaboration in multicultural therapy relationships, regardless of treatment modality (Asnaani & Hofmann, 2012). Similarly, if the client is open to new cultural perspectives in relation to his/her problem, it is for the therapist to encourage the client to discuss his/her views and collaboratively agree on integrating those aspects considered significant from the new culture and which may aid problem resolution. As Asnaani & Hofmann, (2012) stated "*cultural congruence between client and therapist plays a role in enhancing the moment-to-moment collaboration and alliance of the therapeutic relationship, regardless of treatment modality*" (p, 3-4). This stresses the need to incorporate cross-cultural features explicitly into the treatment to facilitate rapport.

In contrast, "***cultural encapsulation***" emphasises the difficulties that arise when the therapist fails to explore and understand the cultural context of client's problems and its influence on client's experience (Eikenburg, 2013; Wrenn, 1962,

1985). Cultural encapsulation may lead a therapist to apply his/her own experiences/assumptions to the client's experiences despite their differences in culture and values, resulting in potential harm to the client (Eikenburg, 2013). Similarly, this may lead to a rupture in the relationship and have negative consequences in the therapeutic process and outcome (Safran, Crocker, McMain & Murray, 1990). The present study findings corroborate this literature in that for some participants the perceived/experienced lack of expertise, awareness and/or sensitivity to explore and understand the cultural values of familism, religious/spiritual beliefs and struggles faced as immigrants, was a cause of misjudgement that influenced their therapists' ability to empathize with them and with their issues and provide them with the needed support. This therefore evoked feelings of loss of identity or mistrust towards the health system and/or feelings of discrimination within the therapeutic encounter which ultimately had a negative impact on the therapeutic relationship and their overall counselling experience.

These participants experienced their therapists as modelling Western interventions that seemed incompatible with them and their problems, whilst imposing their own cultural values during their counselling experience. This finding is thus consistent with literature suggesting that traditional methods of counselling psychology are 'culturally encapsulated within a White Western view, thus unresponsive and inappropriate in their mechanical application to all counselling situations' (Lago & Thompson, 2002. P,4). This finding also corroborates research in the US with Latinos, suggesting that the lack of knowledge, awareness and sensitivity by the therapist of the client's cultural differences (values and perspectives) and other interactional factors, has led to unsatisfactory therapeutic experiences for many Latinos (Aguilar-Gaxiola et al., 2012). As suggested by

Eleftheriadou (2006), it is better to avoid fitting people into 'pre-formulated' theory as it might lead to labelling.

Moreover, findings from other participants are also concordant with the given research, indicating that the experienced lack of knowledge and awareness from their therapists led to cultural generalizations and/or stereotypes within the counselling encounter, delaying their progress and preventing an opportunity to explore their unique and cultural perspectives. For example, Lili stated: *"Sometimes during the sessions my therapist jumped into conclusions and assumed that because my (relative), my family and myself were Latinos, then that our relationship was in certain way, or that we as a family deal with issues in certain ways... it was like...do not put me in a box where I do not belong..."*(Lili 5,140-148). This finding agrees with research suggesting that if the client is perceived as representing a certain culture, the risk is that the complexity and uniqueness of the individual's own learning and experience is underestimated and stereotyping and prejudice may arise as a result (Eleftheriadou, 2006). So, from this finding, it is suggested that therapist be aware that even if the client belongs to a certain culture, it does not necessitate that he/she holds that culture's views/values. Instead, therapists should encourage the client to discover himself/herself and his/her own uniqueness and work accordingly to better meet their individual needs. Implication for this theme will be address in 'overall clinical implications of study'.

Family-centeredness (familism)

Participants' accounts in relation to this super-ordinate theme also support literature with Latinos in the US stressing the strong emphasis Latino individuals place on the importance of the family as the center of one's experience and the

greater good of collective over individual needs (Andrés-Hyman et al., 2006; La Roche, 2002). This demonstrates that the family operates as a survival strategy that helps develop family cohesion in order to obtain greater life satisfaction and better health (Hill, Bush, & Roosa, 2003). Hence, further suggesting that if these participants have had the support from their families or close networks, they may not have accessed therapy. Equally, the therapist must be aware about Latinos' strong emphasis on interpersonal relationships and how the lack of acknowledgement of this cultural value can have negative impact at the individual, familial level, and the therapeutic context. Also, the value of exploring other sources of support, as well as the need to empathise and reduce emotional distress arising from lack of familial support, especially during the client's process of adjustment, so it is important to offer a sense of containment during such transitional periods.

Clinical Implications for Family-centeredness (familism)

Taking into consideration the strong emphasis Latinos placed on family cohesiveness and interdependence and the need to place their family and others needs before their personal needs, counsellors are encouraged to investigate Latinos connectedness with extended and nuclear family members and the value place on familismo and intervene accordingly (Baumann, Kuhlberg, & Zayas, 2010). Similarly, Latinos/Hispanics strong familial and social relationships, tend to prevent them from seeking help, as Latinos firstly exhaust resources from extended family and close friends before reaching for counselling support, even in cases of severe mental illness (Urdaneta, Saldana, & Winkler, 1995).

Religious/Spiritual Healing

The present study findings are consistent with existing literature in that some individuals from minority ethnic groups in the UK adhere to religious/spiritual beliefs that may interfere with their access and treatment retention in mental health services (Bhui, King, Dein, and O'Connor 2008). Findings are also consistent with US based research suggesting that Latinos endorse religion/spirituality as a way of helping them cope with life circumstances and provide a sense of meaning and purpose (Muñoz & Mendelson, 2005). Further, Latinos are said to frequently interpret problems and obstacles as challenges to endure in order to fulfil one's life mission (Coelho, 2003). Spirituality is also seen as comprising a significant dimension in ethnic psychology due to its influence in Latino life (Comas-Diaz, 2006).

Nevertheless, findings from other participants contradict the given research, in that they reported a lack of desire from their therapists to address/explore their problems from any religious/spiritual point of view, thus avoiding generalized Latino cultural assumptions in this sense. These participants experienced a sense of liberation from religious/spiritual interventions. This provides the insight that not all Latino clients have a preference for such interventions so the therapist must be cautious about the introduction of such beliefs/views with Latino clients. Instead, it is advisable to have a genuine approach with their clients, allowing them to discover themselves and their own uniqueness. Therefore, it is important to maintain a balance between being culturally aware/sensitive whilst avoiding stereotyping or making assumptions about Latinos on the basis of their culture and instead to value and work with client's unique preferences and context.

Clinical Implication for Religious/Spiritual Healing

Findings from participants who had and did not have the opportunity to address their religious/spiritual beliefs, raises awareness about the significance that religious/spiritual beliefs have in the lives of some Latinos, advocating that therapists are sensitive and maintain an open and receptive stance towards such beliefs/values (Ho et al., 2004; Comas-Diaz, 2006; Andrés-Hyman et al., 2006; Falicov 2009). Enhancing Latinos' own ties to their primary ethnicity could be used as a therapeutic resource to help them experience practices that could function as coping strategies, sources of support and moral guidance, thus enhancing continuity and belonging (Falicov, 2009). Therapists' receptivity to client's interpretations of their experiences could also be a helpful tool to rebuild a sense of hope and strength during life challenges and meaningful transitions (Andrés-Hyman et al., 2006).

Assimilation and Adaptation Issues

Participants' findings demonstrated that the majority expected their therapists to consider and support them with issues resulting from adjustment processes that they had to face as immigrants in the UK, and which they considered part of their problems. Hence, this supports existing research in the UK, indicating that due to their migratory status, many individuals from BME communities experienced problems of adaptation and assimilation to the dominant culture (Bhugra, 2004). At the same time, supporting research in the US suggests that compared to other ethnic groups, the role of acculturation is particularly important in Latinos because they maintain closer ties to their native country by preserving language and cultural characteristics (Acosta, 1979; Sandoval & De La Roza, 1986). Due to their

tendency to maintain a strong cultural identity, it becomes a difficult challenge for Latinos to integrate the cultural characteristics of the majority group with their traditional cultural beliefs and values (Kouyoumdjian, Zamboanga & Hansen, 2003). This finding therefore gives insight into how the provided or lack of support by therapist with issues related to adjustment and assimilation, was experienced by participants as either understanding and/or supportive and raised awareness about the participants/clients' processes of acculturation, whilst aiding self-identification and a sense of belonging that enabled them to function in a different cultural environment. Or vice versa, for those participants who did not feel understood and/or supported to explore and comprehend the impact of such variables in their mental health and well-being.

Clinical Implication for Assimilation and Adaptation Issues

Findings from the present study encouraged therapists to recognise and address factors considered to be key elements in working with Latinos. For example, their migratory experiences and resulting cultural shock or "crisis of loss" including possible post-traumatic stress; acculturation stress and assimilation processes such as intergenerational conflicts and issues, conflict between and within family members, experiences of discrimination that some Latinos faced in different settings, cultural, racial, and ethnic identity issues (Ho, et al., 2004). It is also important that therapists investigate the client's degree of adherence both to traditional values and to those of the dominant culture (Dingfelder, 2005) as these have important implications for their perception and response to treatment, as well as in the therapeutic relationship (Dittman, 2005). The use of psycho-education (explaining the counselling process and interventions) and an appropriate approach that addresses environmental stressors, acculturation conflicts, conflicts

between mainstream values and ethnic group values and feelings of isolation and powerlessness that the client is experiencing is paramount (Sue & Sue, 2013). In this way, both the client and therapist can collaboratively brainstorm methods/interventions for bridging these differences and help Latino American clients to overcome their difficulties with adaptation and treatment adherence (Sue & Sue, 2013). A bicultural orientation (i.e., preserving some components of the native culture while integrating practices and beliefs of the host culture) may be the most functional in most cases, considering that such perspective allows for the integration and negotiation of aspects from both cultures, should the client wish.

The Healing Presence

This master theme illustrates how the relationship between participants and their therapist was, to a great extent, experienced as dependent on their therapists' ability to relate to them either in an interpersonal or impersonal manner. The therapists' approach was reported as either enhancing communication and exploration and understanding of their problems or hampering such opportunities as well as impacting either positively or negatively in the therapeutic relationship and their overall counselling experiences.

Research suggests that although the therapists' interactional factors/attitudes towards the clients has been widely acknowledged as critical for a successful therapy (Norcross, 2010; Popescu, 2012; Aguilar-Gaxiola et al., 2012), Hispanic/Latinos may still be more susceptible to the therapists' approach to them due to differences in cultural values and experiences.

How this Theme Supports/Extends Existing Literature

Therapists as Interpersonal or Impersonal

The present study findings demonstrate that therapists' attitudes towards participants were a critical factor in determining the development of a therapeutic bond and their overall counselling experience. All participants expressed a general preference for a therapist with a sensitive approach, who could connect and empathise with them and their experiences and show commitment to support them during the counselling process.

Some participants experienced their therapists as being *interpersonal* when they conveyed empathy, respect and a genuine, supportive, flexible, validating and non-judgmental attitude towards them and their problems. Furthermore, experiences not previously addressed in the research with Latinos related to interpersonal attitudes from a therapist and shared by some participants was their preference for a flexible therapist i.e., someone willing and able to prioritise a client's needs rather than their own agenda. For those participants who experienced their therapists as present on immediacy and responding to their immediate concerns and presented needs was a sign of the therapist's care and sensitivity towards them and their needs. This in turn encourages participants' trust and the opportunity to more openly discuss their issues and feelings as well as strengthening the therapeutic alliance. This finding is in accordance with research that acknowledges empathy, rapport, and positive regard as fundamental elements of an effective therapeutic relationship which in turn makes significant contributions to psychotherapeutic outcomes (Norcross, 2010; Popescu, 2012).

Furthermore, according to these participants, a therapist that can convey warmth, develop rapport and sustain a respectful and sensitive approach, which was in itself, for the participants a sign of professionalism, will be able to engage clients and earn their trust.

Indeed, the Latino value of **respeto** (respect) has been acknowledged as the mutual regard that Latinos hope for in a relationship and is essential for all positive interpersonal and helpful therapeutic relationships (Aguilar-Gaxiola et al., 2012; Ho et al., 2004). The value of respect has also been regarded as necessary for the development of **confianza** (trust that takes time to develop) or trustworthiness needed by Latinos for engagement and treatment adherence (Garza & Watts, 2010). Garza and Watts further suggested that since the therapeutic relationship deals with intimate personal issues, Latinos must feel *confianza* for the counselling process to be effectual. The majority of participants considered that an open and validating attitude towards their presenting concerns and cultural values and perspectives when addressing sensitive issues was an important indicator of respect towards them as individuals and Latinos, enhancing communication, emotional expression and rapport within the therapeutic encounter. The current study's findings are thus consistent with what Ho, Rasheed, and Rasheed (2004) documented as effective approaches to Latino clients. Accordingly, a lenient approach to the Latino family is coherent with the value of **personalismo** (personalism) which reflects a collectivistic world view and is appreciated in positive interpersonal relationships by Latinos (Garza & Watts, 2010; Comas-Díaz, 2006). Furthermore, a gentle interpersonal style facilitates the *confianza* that is crucial for a strong therapeutic alliance with Latinos. Also, the therapist's less direct and confrontational approach with the Latino family is in accordance with Latinos' cultural transactional styles (Ho, Rasheed, and Rasheed, 2004).

Conversely, other participants experienced their therapists as *impersonal* when they conveyed a lack of empathy, effort, care and sensitivity, as well as a cold/distance and judgemental attitude. Moreover, other participants experienced their therapist as impersonal when they lacked that care and sensitivity by having a constant preoccupation with and/or overlooking environmental variables that interfered with their processes. For these participants such therapist's attitudes were experienced as critical factors for their communication, emotional understanding, engagement and participation in the counselling process, as well as indicators of not being valued as culturally different individuals. This therefore hindered their opportunity to openly discuss their issues and express their emotions, whilst some felt rejected and/or discriminated against based on cultural differences. This consequently impacted negatively in their emotional wellbeing and hampered the development of rapport and their overall experiences of therapy. Findings from these participants therefore support research that indicates that the lack of critical factors such as empathy, positive regard, and rapport, all account for therapeutic outcome (Norcross, 2010; Popescu, 2012). However, participants accounts suggested that such experiences were also influenced by their cultural values, preferences in interactional styles, and unique vulnerabilities faced as immigrants. In fact, a study with Mexican Americans Ruelas, Atkinson, and Ramos-Sanchez (1998) reported that Latinos satisfaction with their therapists was positively related to the degree to which they experienced their therapists to have acted consistently with their Mexican cultural values.

This could be explained by the aforementioned Latinos' cultural value of *personalismo*, highlighting the importance placed by Hispanic/Latinos in close personal relationships which reflects personal estimation of a person (Moitinho et al., 2015; Comas-Diaz, 2006). Personalismo may foster the expectation that the

clinician will interact in a caring manner and provide a more constant presence of assistance/support (Barona & Santos de Barona, 2003). In this way, personalismo transcends into **confianza**, thereby enhancing Latinos' engagement, participation and treatment compliance (Garza & Watts, 2010). This therefore, stresses the importance of clarifying client's expectations about the therapist from the beginning of the therapeutic process and also the need for therapists to develop understanding and/or sensitive attitudes towards their clients so as to enable a helpful therapeutic relationship and successful outcome (Aguilar-Gaxiola, et al. 2012). Then again, emphasising the need to explore and be cautious about individual differences in this sense.

Moreover, Hispanics/Latinos are sensitive to the recognition of their value as human beings and hence tend to feel an inner **dignidad** (dignity) and expect others to show *respeto* (respect) for that dignidad. Consequently, a therapist's lack of empathy, effort, care and sensitivity does not reflect this value and respect for Hispanics/Latinos. In participants' views, the perceived inability from their therapists to show sensitivity at critical moments or lack of proper care to express their opinions about sensitive matters were significant factors that led them to feel misunderstood, unsupported, unable to self-disclose and emotionally express, whilst others felt rejected and/or discriminated against based on cultural differences. These factors, in turn, were experienced by some participants as influencing their decision to discontinue the services and seek support from Latino therapists. These findings are consistent with research that acknowledged the preferred approach Latinos expect from their therapists. Accordingly, Bean, Perry, & Bedell (2001) suggested that the therapist's failure to approach Latino clients in a respectful and warm manner leads to early service dropout. This further supports research indicating that Latinos could be even more susceptible to the

quality of the therapeutic relationship which is considered fundamental for a successful therapeutic outcome (Norcross, 2010), and which has been demonstrated in the present study throughout the different participants' accounts within all of the themes.

These findings provide insight into an approach that allows more room for discussion of client's experiences and emotional expressiveness being preferred over a more directive or strategic approach to Latino clients. These participants' reflections thus differ from literature that has suggested Latinos as benefiting more from more directive, brief, and problem-focused approaches (Kunkel, 1990; Sue & Sue, 2012), and from a more directive counselling style (Ponce & Atkinson, 1989). On the other hand, findings from these participants are concordant with literature that highlights therapeutic approaches that work best with Latino clients. For example, Santiago-Rivera, Arredondo, & Gallardo-Cooper (2002) indicated that humanistic or person-centred approaches that stress empathy, warmth, respect, immediacy and even physical proximity are more favourable for Latino clients. Humanistic approaches are also said to be in accordance with Latino values of *respeto* and *dignidad*, and also a friendly, easy-going humorous style is said to be accord with Latino values of *simpatía* (sympathy) and *cariño* (affection) (Ho, et al., 2004).

Cultural Liberation or Formulation

This master theme demonstrates how some participants had a preference to undergo therapy with a Western therapist and avoided culturally similar therapists due to possible cross-group generalisations. However, other participants

suggested that their experienced lack of support and understanding from their English-speaking therapists led them to seek counselling support from Latino therapists.

Culturally Concordant or Discordant Therapists

This super-ordinate theme indicates that the majority of participants had a preference or an open attitude to undergo therapy with English-speaking therapists. This finding thus highlights the inconclusive research as to whether shared cultural background between client and therapist is helpful (Sue, 1998). These participants' accounts demonstrated a preference and benefits of undergoing counselling/therapy with a culturally different therapist. Suggesting a sense of liberation from the constraints of their Latino culture and allowing a more genuine therapeutic encounter. Additionally, providing a safe place to more openly and confidently address their feelings and issues from their embedded context, an opportunity that they perceived as unlikely with Latino therapists.

Similarly, the assumption of a preference for a client-therapist match and its benefits with clients who do not speak English (i.e., in the U.K with Asians and African Americans (Leong & Kalibatseva, 2011; Terrell & Terrell 1984 respectively), and the U.S (i.e., with Latinos (Jerrell, 1995; Ponce & Atkinson 1989; Sanchez & King, 1986) is also challenged by the accounts of those participants who demonstrated an open attitude to receive support from their English-speaking therapists. Nevertheless, they suggested that the experienced lack of understanding and support from their therapists, as well as the cultural differences between them and their therapists evoked interpersonal and intrapersonal cultural conflict due to differences in their internalized belief system,

leading to dissatisfaction with their counselling experiences and ultimately encouraged them to undergo counselling with culturally similar therapists.

This finding is therefore in line with empirical evidence that suggests that **client-therapist ethnic matching** has no influence on client perceptions about therapist credibility, nor is ethnic matching always a preference for ethnically diverse clients (Atkinson, Ponce, & Martinez, 1984). In fact, different studies have found that Latinos prefer language to ethnic matching when seeking mental health services (Griner & Smith, 2006; Folsom et al., 2007). This theme thus gives insight into the psychological process that seemed more fundamental in all participants' accounts such as: the therapists' competence and willingness to support them and ability to empathise with them and their issues (Jenkins, 1997). Also relevant is the therapists' understanding and trustworthiness as well as respect and interest for their unique and cultural differences and perspectives. In fact, many ethnic minority groups have been reported to prefer counsellors who have similar personalities, attitudes and values, who have more education and are older, over counsellors who are of the same ethnicity (Atkinson & Lowe, 1995). However, literature on ethnic match between client and therapist remains unclear (Sue, 1998). Therefore, to better understand the relationship between client-therapist interaction and variables such as client satisfaction, treatment adherence and outcome, further research that examines more proximal variables such as client and therapist similarities in cultural values and beliefs and client's acculturation level, are needed. A major implication of these findings is that cultural factors may inhibit the benefit of therapy services in some Latinos.

Overall Clinical Implications of Study

Whilst some progress has been made in the counselling psychology field in the UK in terms of cultural competency training programs by the NHS Trust and public health care services providers, the need to provide culturally sensitive services to ethnic minorities continues to be a key in reducing ethnic disparities in mental health care (Mental Health Foundation, 2015).

The present study therefore stresses the need for training programs for mental health practitioners which ensure the cultural competency of those delivering psychological treatment (Eleftheriadou, 2010; Heppner, Leong, & Gerstein, 2008). Additionally, Asnaani & Hofmann, (2012) suggested that despite the recognised need, there is still a gap between proposed intentions of incorporating cultural differences into current evidence-based treatments, hence actual clear guidelines for achieving this goal must be addressed.

On the other hand, despite the considerable emphasis placed on the need to develop cultural competency in cross-cultural therapy (Sue, 1998; Kaweski, 2010; Taylor, Gambourg, Rivera, & Laureano, 2006), studies investigating the impact of competency ratings by 143 patients of their therapists (N=31) found no significant association between client's perceptions of therapist cross-cultural competency and actual therapy outcome (Owen, Leach, Wampold, & Rodolfa, 2010). This finding is consistent with the present study's findings in that the process is likely to be more complex than simply acknowledging cultural differences and issues or clinicians' degree of experience with diverse populations. Indeed, in the present study those participants who experienced their therapist as lacking the expected cultural knowledge, awareness or sensitivity to meet their needs, conveyed that it was more about the lack of interest, curiosity and/or willingness to learn about

them and their cultural differences and perspectives, as well as the perceived/experienced lack of empathy and commitment to support them that increased their feelings of frustration and disappointment with the provided service, rather than the actual lack of cultural competence. This therefore, suggests that it was more about interpersonal connection between them and their therapist that determined their opportunity to address cultural issues, the therapeutic relationship and their counselling experiences. This therefore agrees with what Sue & Zane (2009) suggested, that it is not only about, or sufficient, or necessarily beneficial by instructing clinicians to simply be sensitive to cultural differences or familiarize themselves with the client's culturally specific norms. Hence, given this inconsistency in the research on the impact of cultural competency in the counselling process and outcome, a more systemic empirical study of this concept across diverse populations is required (Asnaani & Hofmann, 2012).

Reflexivity

As mentioned earlier in the Methods chapter, my interest in the counselling experiences of Hispanic/Latino clients is a result of my own experiences as a minority client and trainee. When reflecting about the relationship between meaning-making and the use of language, I am aware that the gathered data is language based (semi-structured interviews) and transformed into language by my interpretations of participants' accounts and the information conveyed in this research. I acknowledged that conducting the interviews in Spanish was the most appropriate decision to allow the participants to fluidly recollect and recount their experiences. This decision posed some challenges throughout the research which included time taken during the transcription, translation, and verification of

translations. Most important was my acknowledgement about the significance of language for the chosen method, and my concern that during the process of translation, participants' accounts would inevitably be shaped through such a process. At times, I even asked the translator to always remain as close as possible to the given transcripts, so as to preserve the participants' subjective experience. Nevertheless, I am aware that from the beginning of this study there was an unavoidable "triple hermeneutic" (participant-researcher-translator), instead of "double hermeneutic" (participant-researcher) due to the role of the translator within the translation process. Consequently, this 'triad' in one way or another, impacted the data interpretation.

I believe the information gathered and conveyed throughout this research may have been negatively influenced by my own English skills. The fact that I still translate from Spanish into English, leads to a 'loss of meaning' between the information I read, my interpretation of it, and what I convey in writing. I consider that my personal and cultural background also influenced my constructions of meaning as a researcher. For example, words, expressions and different linguistic comments may have raised some questions about the interpretations and elaboration of this research as a whole. When thinking about language and time, the fact that I had to return to Colombia for a length of time and take some time away from my studies, made it difficult to engage with my research again and gave rise to my approach to the data and how my interpretation of participants' accounts may have been shaped by the length in time and given circumstances. For these and many other personal reasons, my research process proved challenging, yet, my desire to make the voices of my participants heard and achieve my academic goals, kept me motivated throughout this process.

On the other hand, some of the participants' accounts made me more aware of

how by simply using the term 'minority' was positioning them and myself in a different place/circumstances compared to the majority group. I believe within myself there was always this inner desire to show myself and others that one does not always need to be outside of the mainstream, or of less importance by belonging to a minority group (Rawson, Whitehead & Luthra, 1999). Therefore, by following this career and undertaking this research, I hope the voices of my participants and my own voice position us in a more 'visible' place within the British academic and mental health context.

Overall, my role as a researcher and my clinical role increased my awareness of subjectivity, meaning that as a counselling psychologist I believe that we all are inevitably subjective, that is, our education, experience, beliefs, values, contexts and investments always influence our perspective (Orlands & van Scoyoc, 2009). This journey has been very emotional and at the same time very enriching in both a personal and professional sense. Above all, I proved to myself that coming from a disadvantaged socio-economic and educational background, a developing country, and as an ethnic minority trainee, client and researcher within the British context, I had the strength and determination to make my dreams come true. I look forward to embracing new opportunities in my life and to be able to make a difference in the lives of others and my own.

Future research

Due to the scarcity of research with Latinos in mental health in the U.K, it is important to conduct other studies that look at the prevalence of mental illness, service utilization trends and therapeutic outcomes among Hispanic/Latinos compared to Whites and other ethnic minorities. It will also be important to

investigate more closely how different culturally sensitive therapeutic models show increased validity compared to traditional therapy in the treatment retention of this minority group. Research programs are also required to attempt to close the gap by directing attention to underserved and/or understudied populations, in this case Hispanic/Latinos in the U.K. For example, ensuring culturally sensitive treatments and programs to make services free of bias, improving public awareness of effective treatment, tailoring treatments according to age, gender, race, culture and other areas are important to informed treatment. Also, it is important to continue training mental health professionals in cultural competency (Sue et al., 2009).

Recruitment and training professionals from diverse backgrounds is also encouraged, as well as the development of materials in different languages for educational purposes and the outreach of services to underserved groups. Also informing Latinos of what to expect from therapy before they enter the therapeutic process. Efforts to understand how Hispanic/Latinos cope with mental disorders, what factors influence their access to mental health services and how to deliver high quality mental health care for them are necessary, otherwise their mental health needs may not be adequately met. Studies that investigate the proportion of Latinos in care and factors that influence their seeking behaviours and the type, amount, and quality of mental health care that Latinos received is necessary in the U.K.

More qualitative studies using in-depth interviews, focus groups, and ethnographic studies, are also necessary to investigate Latinos' counselling/therapy experiences in accessing mental health services (Lopez, 2002). Also, to investigate whether the interplay of structural, socio-economic, and cultural factors influence Latinos' access to mental health services. As the Latino population

continues to grow, it is important to better understand their mental health needs and translate this knowledge into practices and policies aimed at creating an equitable care system within the U.K.

Limitations

Limitations of the present study include the sample inclusion, although half of the sample was composed from participants from five different Latino countries, of different ages and levels of education, the shared experiences could have been richer if the sample was composed by participants representing a wider sector of Latino American population (i.e., those from the North, South and Central America, and those from Spanish-speaking countries from the Caribbean). It could also be argued that other participants may have shared different experiences and that the participant's country of origin may have given rise to differences in counselling perspectives and experiences due to, within and between group differences. Participants were also recruited only in London, so a wider Hispanic/Latino population within the U.K may have contributed to different results.

The fact that participants' demographics, such as level of acculturation/assimilation, were not measured (given the nature of the used method to analyse the data) also poses a limitation for this study in terms of homogeneity and its findings. For instance, the fact that all participants experienced counselling during different stages post immigration (i.e., some during the first year and a half of their arrival in London, and others after 5 to 7 years of residency in London) was not only demonstrated by some participants to have an impact on their counselling experiences (i.e, in terms of language skills,

understanding of host culture and customs, therapeutic relationship etc), but also impacted on the results attained in the present study. Meaning that, those participants with low levels of acculturation demonstrated more difficulty adjusting and progressing during their counselling processes, and were more likely to have “negative/unhelpful” outcomes, as opposed to those who had higher levels of acculturation.

Another limitation of the sample was that only female participants took part in this study, hence limiting the findings to a certain extent by not having male perspectives. However, it is difficult to speculate possible reasons in the U.K, although research in the U.S suggest a lack of participation from Latino males in mental health relates to the machismo and self-reliant attitudes that Latino male usually present, as well as fear of stigma (Vega, Rodriguez & Ang, 2010; Pole, Best, Metzler, Marmar, 2005; Ruef, Litz, Schlenger, 2000; Torres, 1998).

Being a Latina myself means I could have been a participant myself, also given my own counselling experiences, my being a counselling psychologist and influences from previous literature. Meaning that despite my acknowledgment and efforts to “bracket” existing knowledge and preconceptions when conducting the analysis, such experiences may have influenced and/or led to possible bias during the interpretative process (Smith et al., 2009; Golsworthy & Coyle, 2001).

Similarly, it was my desire to conduct research with the Latino population to raise their “visibility” in a country that is composed of so many different cultures and from my position as a researcher. These reasons influenced my motivation to carry out this project which represents my own attempt to contribute in some way to the well-being of an under represented ethnic minority group in mental health care in the U.K.

Relevance of the Study for Counselling Psychology

Considering the current challenges that immigration and multiculturalism pose to the UK, counselling psychologists are faced with the task of recognising the context in which they work and possible impact on clients' experiences. To acknowledge the client's context and how it may affect his/her experience and incorporate it into the assessment process and practice is important. Particularly, to demonstrate high standards of anti-discriminatory practice and work in a culturally aware and sensitive manner to the pluralistic nature of today's society (BPS, 2005). Hence, considering the scarcity of literature on Hispanic/Latinos in mental health in the UK, exploration into their counselling experiences with English-speaking therapists may bring insights to mental health professionals about what is important to implement whilst working with this population.

Since awareness of cultural issues is a central principle of counselling psychology [Martin \(2010\)](#) and as evaluators of science, an integral role of counselling psychologists is to continue developing, modifying, and delivering effective interventions and insightful and flexible approaches to psychological theory which can be efficiently and competently applied to the various issues that are brought to therapy by their diverse clients ([Stoltenberg & Pace, 2007](#)). To do so, and although the concept of "cultural issues" is seen as "complex" ([Pederson et al., 2002](#)), it is important that counselling psychologists continue training and evolving in relation to the multiplicity of meanings by exploring and understand the influence of culture in their client's lives as well as the meaning that culture has in their own lives ([Martin, 2015](#); [Eleftheriadou, 2010](#); [Bhui & Bhugra, 2007](#)). As suggested by [Martin \(2015\)](#) we all have a unique combination of psycho-cultural and racial context. Nevertheless, in counselling psychology theoretical literature,

research studies and clinical practice, this has often not been acknowledged. Thus, we run the risk of missing something significant if we were to approach and/or relate to a client without taking into consideration their psychosocial context. Therefore, it is important for counselling psychologists in their different roles (i.e., as practitioners, supervisors, academics), to take the responsibility, to be aware of and to continue raising awareness about the professional's developing and evolving in anticipation of a given moment that constitutes "cross-cultural issues". In other words, to maintain the degree of humility and to be present in the immediacy of that therapeutic encounter, to be able to capture the client's attributed meaning and experience of culture with regards to his/her concerns. Improving the effectiveness and efficiency of treatments allows psychological knowledge to continuously evolve.

Nevertheless, Wikinson (2004) suggested that the counselling psychologists' job is to arrive at a meaningful narrative, instead of trying to fit their clients' experiences into particular theoretical models. Schön (1987) also stressed the role of the reflective practitioner, encouraging a holistic, artistic approach. I believe it is more about an integrative phenomenological approach to theory and practice, so as to better capture the essence of the client's subjective experience. Furthermore, as scientist practitioners (Jones & Mehr, 2007; BPS, 2004) counselling psychologists are encouraged to continue integrating science into practice (i.e., by conducting research, comprehending and administering research findings, by applying scientific principles of observation, and using empirically supported treatments to increase effectiveness and efficiency of practice), specially by not favouring a dominant group within the cultural mix, instead by operationalising in a meaningful way that favours the client's uniqueness and cultural context. Understanding of clients can also be achieved through a social construction of reality, whereby

social and cultural influences define multiple human realities (Gergen, 1985).

Counselling psychologists also recognised the value of, and are the facilitators for the emergence of a helpful/collaborative therapeutic relationship between them and their clients (Strawbridge & Woolfe, 2004). In keeping their humanistic roots and the notion of encounter and relationship, counselling psychologists operate within this relationship, the base of which allows that emotion and reasoning are aligned (Robinson, 2004). As some theories agreed, 'individual's psychological development only happens through interaction with others, a form of activity that is essential to human life' (Miller & Stiver, 1997: 17). This study therefore advocates for a balance between science, the therapeutic relationship and a phenomenological focus approach to enquiry in counselling psychology practice (Strawbridge & Woolfe, 2004), to counteract the boundaries of objectivity, and strive to maintain a balance between them (Bury & Strauss, 2006). Counselling psychologists are also advised to continue enhancing the subjective perspective through their practice, case studies, training, self-reflective practice, supervision and research.

Furthermore, a fundamental foundation for counselling psychologists' work comes from the humanistic principles of the need for empathy, understanding and unconditional positive regard for their clients (Rogers, 1961). It is therefore essential that counselling psychologists are able to recognise, be attuned to, and address the embedded emotional and cultural context of their diverse clients' issues. To do so, and in line with the humanistic values underpinning the counselling psychologist's work, the integration of the economic, political, and socio-cultural context in which their clients function is paramount, as they are not separate entities from their client's experience (Strawbridge & Woolfe, 1996). In this way, counselling psychologists can maintain a respectful attitude for the

personal, subjective experience of the client over and above notions of diagnosis, assessment and treatment, and to innovate, and encourage phenomenological methods for understanding human experience.

This study also emphasised the three dimensions necessary for cross-cultural competence, that is, therapists' attitudes and beliefs, knowledge and skills (Sue; Arredondo & McDavies, 1992). 'Their need to define goals consistent with the life experiences and cultural values of their clients, recognise client's individual, group, and universal dimensions, as well as advocating the use of universal and culture-specific strategies and roles in the healing process, and to balance the value of individualism and collectivism in the client's assessment and treatment' (D. W. Sue & Torino, 2005, p. 137).

This study findings can therefore help lessen the gap in the delivery of cross-cultural' counselling psychology services, enhance knowledge and skills of mental health professionals (i.e., therapists, supervisors, and educators of different cultural backgrounds) toward the Hispanic/Latino population, to increase their access and adherence to mental health care, as well as to represent them within the UK mental health system.

Conclusion

Participants' accounts demonstrated that cultural values played a significant role in their engagement, development of rapport and overall counselling experiences. Whereas some participants were able to achieve their goals and meet their individual needs within their therapeutic encounters with English-speaking therapists, others were unable to receive much-needed support from their mental health professionals and hence they were unable to meet their unique needs. For

participants, the therapists' cultural knowledge, awareness and sensitivity were significant factors in their ability to serve them. Participants also placed a strong emphasis on the therapists' attitudes towards them, their problems and cultural differences/perspectives, also in the client-therapist therapeutic relationship as crucial factors for effective psychotherapy outcome. The given findings thus give light/increase awareness into the expectations and needs that Hispanic/Latino clients may have in therapy, so as to help fill the gap.

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Appendices

Appendix A: Poster

Do You Speak Spanish?

Have you finished counselling/therapy within the last 5 months with an English- speaking therapist?

The aim of this study is to investigate the counselling experiences of **Hispanic/Latino** clients from **North, Central and South America** who live in London and have finished therapy with an English-speaking therapist within the last 5 months. Until now there is little or no research about the utilization of mental health services by this population in London. Therefore, by participating in this research you can help in the identification of research issues most pertinent to improving quality and effectiveness of mental health/counselling treatment for Hispanics/Latinos living in London.

If you take part in this study and you are age 18-65, this will be a chance for you to have your voice heard in a safe and confidential environment. The study will involve an interview lasting approximately 1 hour.

If you are interested in participating, please contact Maria Padilla for further information.

Email: Maria.Padilla-Leon@city.ac.uk or mobile: 07534423684.

This project is supervised by Dr Jessica Jones N. and it is part of a Doctorate Thesis carried out on the Professional Doctorate of Counselling Psychology at City University, London.

Appendix B: Email to Potential Participants

Professional Doctorate in Counselling Psychology (DPsych)

City University

Social Sciences Building

City University London

Northampton Square

London

EC1V 0HB

United Kingdom

Dear colleagues,

My name is Maria A. Padilla, I am currently undertaking my Doctoral training in Counselling Psychology at City University. As part of my training I am conducting a research project looking at the counselling experiences of Hispanic/Latino who had finished their counselling/therapy experience with English speaking therapists within the last 5 months. As such, I am looking for volunteer participants to take part in my study.

In completing this project I am hoping to develop insight and understanding into how those from Hispanic/Latino communities experience counselling in London with English speaking therapists, with the aim of integrating and meeting cultural sensitive practice in the provision of mental health services for Hispanic/Latino communities.

I am looking to recruit 10 male and female participants (age 18-65) who identify themselves as **Hispanic/Latino from North, Central and South America and who speak Spanish** as the main language.

If it was the case that you decide to take part in this study, any information given will be kept completely confidential. This means that I will not inform your university or any other party about your participation.

If you decide to take part, please find attached the participant information sheet explaining the study more fully. If after reading this information you have any questions, please do not hesitate to contact me by either email or phone:

Email: Maria.Padilla-Leon.1@city.ac.uk

Telephone: 07534423684.

Postal Address: as above

Thank you for your time.

Sincerely, Maria A. Padilla (Trainee Counselling Psychologist).

Appendix C. List of Developing Countries Included in this Study

Participants coming from:

- North America (Mexico)
- Central America (Guatemala, Honduras, El Salvador, Nicaragua, Costa Rica and Panama)
- South American (Colombia, Venezuela, Ecuador, Peru, Bolivia, Chile, Paraguay, Argentina and Uruguay) as the main nationalities.
- It will also include those from Spanish-speaking Caribbean Islands of Cuba and the Dominican Republic.

Appendix D: Ethics Form

Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) [Guidelines for minimum standards of ethical approval in psychological research](#) (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ↑ M.Phil ↑ M.Sc ↑ **D.Psych** ↑

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Counselling Experiences of Hispanic/Latino clients with English-speaking therapists. Implications for Culturally Sensitive Practice.

2. Name of student researcher (please include contact address and telephone number)

Name: Maria Amparo Padilla; Mobile number: 07952700210.

Email: Maria.Padilla-Leon.1@city.ac.uk

Address: 48 Sandringham Court Maida Vale, W9 1UA.

3. Name of research supervisor

Dr Jessica Jones Nielsen

4. Is a research proposal appended to this ethics release form?

Yes No

5. Does the research involve the use of human subjects/participants?

Yes No

If yes,

a. Approximately how many are planned to be involved?

10

b. How will you recruit them?

Participants will be recruited via internet advertising and in settings that provide counselling/therapeutic services to Hispanic/Latino clients in London, such as the NHS, (e.g. GP surgeries), voluntary organisations, also at universities.

c. What are your recruitment criteria?

(Please append your recruitment material/advertisement/flyer)

According to Smith et al., (2010), IPA studies should employ homogeneous, purposive samples. Inclusion criteria: 10 adult participants (aged between 18 and 65). Participants will be Hispanic/Latino Spanish speaking males and females from developing countries (e.g. North, Central and South America) and from any socio-economic and professional background. They will have completed a course of counselling/therapy within the last 5 months in London for any emotional or psychological difficulties. This homogeneous group is required in order to describe a shared experience of counselling with English speaking therapists. Exclusion criteria: Spanish-speakers from Spain or any other developed countries, plus Latin Americans (Latinos) whose first language is not Spanish. It is felt that recruiting Spanish-speakers from developing countries will facilitate a more homogeneous group.

Appendix 2-3 shows the recruitment advertisements.

Appendix 4 the Flyer.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent?

Yes

No

d1. If yes, will signed parental/carer consent be obtained?

Yes No

d2. If yes, has a CRB check been obtained?

Yes No

(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be asked to answer demographic questions and to take part in a one hour semi-structured interview, as well being debriefed after the interview. The interviews will be conducted in Spanish in order to facilitate participants' accounts of their counselling experiences with English speaking therapists.

7. Is there any risk of physical or psychological harm to the subjects/participants?

Yes No

If yes, a. Please detail the possible harm?

This research does not anticipate any harm to any of the participants.

b. How can this be justified?

The research is designed to avoid causing any harm to the participants (the interviews will only ask about their counselling experiences with monolingual

therapist), therefore allowing freedom of expression. However, it is possible that the interview may be emotionally challenging or engaging for some. For example, previously implicit understanding of their experiences may become explicit. Additionally, participants may experience mixed feelings about their counselling experiences after the interview, however this is not anticipated.

c. What precautions are you taking to address the risks posed?

Participants will be debrief, however if any of them feel emotionally distressed during or after the interview, I will use my skills as a counselling psychologist trainee to discuss any feelings and thoughts that have arisen, as well as coping strategies to help manage their mood. Additionally, if appropriate, they would be encouraged to seek support from their former counsellors. Participants will also be given contact information from Latin-American organisations that offer counselling services for this community:

Latin American Women's Rights (LAWRS) on 02073249807.

El Teléfono de la Esperanza (the phone of hope) on 020 7733 0471.

The Samaritans can be contacted 24 hours a day on 08457 90 90 90.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

No

(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers). Please see Appendix 4 (information sheet)

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes No

If no, please justify

If yes please append the **informed consent** form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers).

Please see Appendix 5 (consent form)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Demographics, debriefing information, Consent form, participants' information sheet, audio recordings of interviews, and interview transcripts.

12. What provision will there be for the safe-keeping of these records?

The audio recordings, interviews transcripts and any other information provided by the participants will be anonymized, encrypted and stored securely in a locked cabinet, as well as in an external drive.

13. What will happen to the records at the end of the project?

Any records obtained from the participants will be destroyed in five years' time in accordance with City University's ethical requirements.

14. How will you protect the anonymity of the subjects/participants?

All participants will be given a pseudonym in order to protect their identity throughout. All information provided will be kept confidential and no information that could lead to the identification of any individual will be disclosed in any reports on the project or to other parties. The results of this study may be published, consequently may appear in professional journals and at City University, however all efforts to protect their identity will be utilised throughout.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Please see Appendices 8 a) Debriefing 1 and 8 b) Debriefing 2.

Participants can contact me on Email: Maria.Padilla-Leon.1@city.ac.uk

Please refer to question 7 SECTION C of this form for organizations providing psychological support for Hispanic/Latino populations.

*(Please append any **de-brief** information sheets or resource lists detailing possible support options)*

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Signature of student researcher -----Date -----

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal ↑

Recruitment Material ↑

Information Sheet ↑

Consent Form ↑

De-brief Information

Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes No

If yes,

Please detail possible harm?

No personal harm is anticipated, although it may facilitate a shift in attitude/perspective towards my own personal therapy. However, any information provided by the participants may be taken as a constructive experience for my own personal and professional development.

b. How can this be justified

Same as above

c. What precautions are to be taken to address the risks posed?

In case of unexpected distress caused by exposure to information provided by the participants, I will seek psychological support from my personal therapist.

Section C: To be completed by the research supervisor

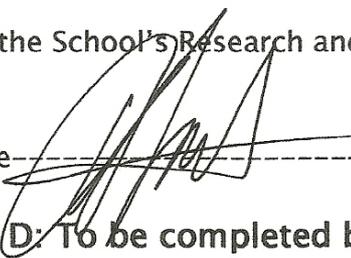
(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature  Date 09/04/13

Section D: To be completed by the 2nd Departmental staff member

(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)

I agree with the decision of the research supervisor as indicated above

Signature  Date 09/04/13

Appendix E: Participants Information Sheet

Project Title: Counselling Experiences of Hispanic/Latino clients with English-speaking Therapists. Implications for Culturally Sensitive Practice.

This paper provides you with information in order for you to understand why the research is being done and what it will involve. Please read the information below and if there is anything unclear, please do not hesitate to ask any questions before deciding whether or not to take part in the study. Your participation is entirely voluntary and you can refuse to participate without any consequences.

What is the purpose of this study?

This study is conducted in order to investigate the experiences of counselling/therapy of Hispanic/Latino clients living in London. Consequently to increase awareness on cultural treatment interventions when providing mental health services to Hispanic/Latino populations in order to meet their needs.

Who takes part?

The researcher is looking for 10 volunteers, age 18 to 65 who identifies themselves as Hispanic/Latino, live in London and who had finished counselling/therapy with an English therapist within the last 5 months. Individuals will be recruited from Advertisement through internet, GPs, NHS, Universities, Local Hispanic/Latino community organizations that provide services to this population.

Do I have to take part?

It is up to you to decide whether or not to participate. In the case that you decide to take part, I will contact you to set up a convenient time to explain the study further. Before the study you will need to sign a consent form, which you will be given a copy of. If for some reason after deciding to participate, you choose to withdraw at any point, you can feel free to do so without any further consequences.

What will happen to me if I decide to participate?

If you decide to take part, an initial meeting will take place at City University, London, or at the phone or a place of your convenience. It will be to explain that the study involves one single semi-structured interview lasting approximately one hour (conducted in Spanish). This interview will be (audio) digitally recorded with your permission. For the purpose of maintaining confidentiality, you will be assigned a pseudonym before I start recording the interview.

At the beginning of the interview I will ask you to read and sign the informed consent form and then to fill out a demographic questionnaire. Before and after the interview, you will be able to provide feedback to me and share your reflections if chose to do so.

Since the interview will be conducted in Spanish, I will be transcribing and translating them into English, however, with your consent, I will hire a competent qualified translator to verify the data or the transcribed interviews will be email back to you for comment/correction. The translator will be requested to sign a confidentiality agreement pertinent to all data collection_in this study. I will keep the digital recordings in a secure place after being transcribed and analysed. In

accordance with City University ethics' requirements, I will keep your audio records during 5 years' time, and then I will destroy them completely. The interview will take place in a private room at City University, London.

What will happen to the results of the research study?

You will NOT be identified by name at any point or in any report concerning the study. The audio will be encrypted and store in a locked safe and will be destroy in five years' time according to City University ethics. All information you provide will be confidential and no information that could lead to the identification of any individual will be disclosed in any reports on the project or to other party. You will be inform of the results of the study if you wish. The results of this study may be published, may appear in journals, and at city University library, however all efforts to protect your identity, keep anonymity will be maintained throughout.

What are the possible advantages and risk of participating in the study?

This research is design in order to avoid causing any harm to the participants, however it is possible that the interview would be emotionally engaging whilst talking about your counselling/therapy experiences. You will not be required to answer any questions that you are not comfortable answering or you feel are personal and intrusive. If it was the case that the interview would be emotionally engaging for you, we can discuss any issues arisen and coping mechanisms that help to improve your mood. Additionally, you can contact the following Latin organisations that offer counselling services for this community: Latin American Women's Rights (LAWRS) on 02073249807. El Telefono de la Esperanza (The Phone of Hope) 020 7733 0471. The Samaritans can be contacted 24 hours a day on 08457 90 90 90 (UK).

The benefits of this research include the opportunity to understand and get some more information about mental health provision for Hispanic/Latino communities. Furthermore, by sharing your counselling experiences you give the opportunity to more clearly identify and improve those issues that need to be addressed when providing culturally sensitive counselling/therapy to Hispanic/Latino communities.

Who has reviewed the study?

Research Supervisor: Dr Jessica Jones Nielsen

Email: Jessica.Jones.Nielsen.1@city.ac.uk

Comments or Concerns

If you have any comments about the research, please contact:

Anna Ramberg

Secretary to Senate Research Ethics Committee

Research Office, E214 City University London

Northampton Square

London EC1V 0HB

email: Anna.Ramberg.1@city.ac.uk

telephone: 020 7040 3040, asking for Secretary to Senate Research Ethics Committee (project name: The Counselling/Therapy Experiences of Hispanic/Latino clients with English-speaking Therapists: Implications for Culturally Sensitive Practice).

Thank you for considering participating in the study.

If you have any questions about the study, please contact:

Researcher: Maria A. Padilla

Email: Maria.Padilla-Leon.1@city.ac.uk Mobile: 07534423684

Appendix F: Consent Form

Title of Project: Counselling Experiences of Hispanic/Latino clients with English-speaking Therapists: Implications for Culturally Sensitive Practice.

Please tick box

1- I confirm that I have read and understood the participant's information sheet for the above study.

2- I have the opportunity to consider the information given by the researcher, asking questions and have these satisfactorily answered.

3- I understand that my participation is voluntary and that I can withdraw at any stage of the study without any consequences.

4- I agree to take part in the above study.

Participant's Name Participant's Signature Date:

.....

Researcher's Name Researcher's Signature Date:

.....

Appendix G: Debriefing Sheet 1

I WOULD LIKE TO THANK YOU FOR YOUR INTEREST ON MY RESEARCH.

- 1- Do you have any further questions regarding the research or the interview?

- 2- Is there anything that you would like to add to your comments during the interview?

- 3- What did you find helpful during the interview?

- 4- What did you find unhelpful during the interview?

Appendix G: Debriefing Sheet 2

Thank you for taking part in this study. Your contribution is both valuable and appreciated.

The purpose of this study was to investigate the counselling experiences of Hispanic/Latino clients with English-speaking therapists.

Having completed your participation in this study, if you have any further comments, please do not hesitate to contact either the researcher, Maria A. Padilla at: Maria.Padilla-Leon.1@city.ac.uk, or the supervisor of this study, Dr. Jessica Jones Nielsen, at Jessica.Jones.Nielsen.1@city.ac.uk.

Moreover, if you would like any additional support, please contact the following Latin-American organisations that offer counselling/therapy services:

- Latin American Women's Rights (LAWRS) on 02073249807.
- El Telefono de la Esperanza (the phone of hope) on 020 7733 0471.
- The Samaritans can be contacted 24 hours a day on 08457 90 90 90.

For more information on this topic:

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http://digitalcommons.pcom.edu/psychology_dissertations/77

Appendix H: Confidentiality Agreement of Translator

Translator's Confidentiality Agreement

_____ have been hired by Maria Amparo Padilla to translate the interviews conducted as part of her dissertation study to be submitted to the Postgraduate Faculty at City University of London in partial fulfilment of the requirements for the degree of Doctor in Counselling Psychology.

_____ agrees:

to maintain full confidentiality in regards to all documentation received from Maria Amparo Padilla; to make a copy of the translated interviews texts; to keep all received original documents in a safe, secure location as long as they are in my possession and return them all promptly to Maria Amparo Padilla as soon as the translation process is completed; to delete all study related files from my computer and any backup devices, not to share translated documents and study related documents with anyone, and not to discuss any information related to the study with anyone except Maria Amparo Padilla

_____ is aware of being legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if identifiable information contained in the original or translated documents and/or related files is disclosed.

_____ Translator's Name (printed)

_____ Translator's Signature

Date:

Appendix I: Interview Questions

Interview Protocol

1. Could we start with you describing in as much detail as possible your experience of having counselling/therapy with your English-speaking therapist (both positive and negative aspects if any).
2. What did you gain from this counselling experience?
 - Emotionally or practical sense, in terms of your thinking, feelings, behaviour, spiritually, mentally?.
3. Was there any particular session, or any particular incident in counselling which you saw as most significant?
4. What could your counsellor/ therapist have done differently, or additionally in order to make your experience of counselling/therapy better?
 - In terms of their action, behaviours, words, their way of being, the way they related to you? etc.
5. What do you see as the most important 'therapist actions' or 'therapist contributions' during the counselling sessions?.
6. Any cultural values that you expect your counsellor/therapist to take into account during the therapeutic process?.
7. What is your perception of English counsellors/therapists?
8. What do you think that was lacking in therapy that would have made a difference in your treatment?.

Appendix J: Analysis of transcript (Mary)

P 5

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|--|--|---|
| <ul style="list-style-type: none"> * Flexibility * Freedom of choice * Therapist Awareness. * Solution from her perspective * Problems to be handled differently * Differences in dealing with problems. * Increased awareness * Interpersonal problems * Different perspectives * Normalizing * Containment * Empathy * Unconditional positive regard * Not imposing * Culturally similar therapists as imposing problem from own perspective * Increased awareness * Autonomy * Personal responsibility for self-care * No desire for a culturally similar therapist? | <p>63. Mar: Something I found <u>interesting</u> during my therapeutic process was the fact that it</p> <p>64. was not base on a religion or religious beliefs...and I think that this was <u>important</u></p> <p>65. because independently of my beliefs, my biggest <u>problem</u> was that I did not get</p> <p>66. along with my (...). So the fact that his <u>therapeutic approach</u> was <u>impartial</u> gave me</p> <p>67. some kind of <u>freedom</u> and since this is another <u>culture</u> and here there is a <u>big difference</u></p> <p>68. in the <u>relationships between parents and children</u>, then my therapist helped me</p> <p>69. understand my <u>relationship with my (...)</u> from another <u>point of view</u>. I would say that</p> <p>70. he helped me <u>recognize</u> who was my (...) and the difficult time that I was having</p> <p>71. because of (...). The fact that <u>my therapist</u> recognized the feelings and thoughts I had towards</p> <p>72. my (...) and <u>did not put much emphasis</u> on that I had a <u>responsibility</u> with my</p> <p>73. (...) to look after (...). This is something that a <u>Latin American therapist</u> would have</p> <p>74. not told me because <u>culturally we think and act differently</u> in this respect. So, he</p> <p>75. helped me a lot to <u>reduce guilt</u>, to <u>see</u> that my responsibility was to take care of myself</p> <p>76. before taking care of (...), but I think it would have <u>not been the same</u> with a <u>Latin American therapist</u>.</p> | <ul style="list-style-type: none"> * IMPARTIAL THERAPEUTIC APPROACH * NO IMPOSITION OF RELIGIOUS ORIENTATION. * Problem from her perspective. * Awareness of Cultural Differences. * Freedom of choice. * IMPARTIAL * Cultural Differences * From her personal perspective. * Different approach to problem. * Person-centered approach. * Bilateral direction of treatment * Collaborative work * Normalizing * Containment * Unconditional positive regard * Variation * Culturally similar therapists as imposing cultural values. * Problem from Western perspective * Reduced distress * Self-care as a need for therapy. * Preference for Western therapists |
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Appendix K: Excerpt Monica

Exploratory comments, transcript, emergent themes

<p>Descriptive comments: focused on describing the content of what the participant has said, the subject of the talk within the transcript (normal text).</p> <p><i>Linguistic comments</i>: focused upon exploring the specific use of language by the participant (italic).</p> <p><u>Conceptual comments</u>: focused on engaging at a more interrogative and conceptual level (underlined).</p>		
Exploratory comments	Original transcript	Emergent themes
<p>Counselling experience impacting spirituality (156)</p> <p><u>Experience of therapy as producing internal conflict?</u> (157)</p> <p><u>Questioning relationship with god due to feelings of rejection and anger?</u> (156-157).</p> <p>Emotional disturbance. <i>I was angry against god (157) everything was going wrong (158)</i></p> <p><u>Transcending feelings of rejection and anger to religious beliefs?</u></p> <p><u>Therapeutic experience as provoking an existential change?</u> (156-158)</p> <p><i>There was not a god (158). Why her?. Disbelieve about the possibility of experiencing such difficulties and nobody supports her. So confused (159). The truth (159). Feeling of confusion and depression. Combination of becoming confuse and depressed exacerbating depression?</i></p> <p><u>Being in a dark place moving to a darker place?</u></p> <p><u>Before her therapy god was positive force in her life? Rejection of god adds another difficulty in her life?</u></p> <p>Psychological state questioning religious beliefs (160-161)</p> <p><i>I felt very depressed (160)</i></p> <p><i>I isolated myself (162) Becoming lonelier?. Bottled up her feelings. Avoiding others? (162)</i></p> <p><i>She did not want to upset her family. Mother as the most trusted? (162). Even though she is in a dark place she still cares and protects other? Projection?</i></p> <p><u>What would have happened if she had told to her family?</u></p> <p>She did not have anyone in London (164)</p> <p><u>Inability to share with family as extending to inability to share with anybody/therapist?</u> (162-164)</p> <p>Why to reach out? (162-164)</p>	<p>156. Also, I have to say that this experience affected me spiritually because at that</p> <p>157. time I walked away from god, I was angry against god, I felt that everything was</p> <p>158. going wrong, I felt that there was not a god. That how could I be experiencing such a</p> <p>159. difficult time and not having anyone to support me, I was so confused. The truth is</p> <p>160. that this depressed me a lot more, I felt very depressed and this led me to go against</p> <p>161. my belief in God</p> <p>• R: I understand</p> <p>162. Mo: I also isolated myself, I did not tell anything to my mother or anybody from</p> <p>163. family as I felt it was best not to upset them or worry them. Also, I did not have</p> <p>164. anyone here or any motivation to make friends or to talk to anyone.....</p> <p>• I understand</p> <p>165. Mo: I also knew I had</p>	<p>Angry against god (156-158)</p> <p>Unhelpful counselling experience as changing religious believes/lost faith in God (156-161)</p> <p>Lack of support aroused feelings of anxiety (159)</p> <p>Exacerbation of depression (160-161)</p> <p>Lost faith/hope? (161)</p> <p>Stigma? (162-163)</p> <p>Lack of appropriate support increased psychological risk/self-blame, confusion and isolation (162-170)</p> <p>Loss of motivation (164)</p> <p>Increased depression (165-166)</p>

<p>Loss of motivation (164) Increased depression as reducing inner ability (164)</p> <p>Lack of motivation as leading to disconnection from the outside world (164). <u>Getting into a shell? Depression interfering on interpersonal skills? Things are getting worse? (164)</u></p> <p><u>I had to find to find a job. Awareness of having to be proactive in order to get better or help herself? (165). Awareness of needing support but frustration of not getting what she needed (165-166). I did not know how or where to start (165). Is that an excuse or explanation? Being put in a difficult position? Need for guidance? Questioning self? (167). Made me feel that I was the one who was wrong? (167). Has she created a problem in her head or was it real, the world?</u></p> <p>Becoming silent. Avoiding confrontation? Creating a problem for self in her head? Did she had a real problem in her head? <u>What is reality? Was she questioning whether to be in therapy or not? Resistance? (168-169). She isolated herself. Protecting self from the outside world? (170). The only significant was that there was not nothing meaningful (171). There was a barrier, more harming that not having anything?</u></p> <p>Therapeutic experience as unhelpful? (171). <u>The truth (172). Realisation of not being able to express herself (172-173).</u></p> <p>Lack of language as preventing self-expression and communication (172-173).</p> <p>The therapeutic experience would have been better if the therapist made more effort to provide help (174-175)</p> <p>Language barrier meant needs could not be met with appropriate support (174). <u>Lack of connection with therapist? Cultural differences interfering in process? (175-179)</u></p>	<p>to find a job, but equally did not know how or where to start,</p> <p>166.especially regarding how low my mood was. The fact of not receiving appropriate</p> <p>167.support made me feel that I was the one who was wrong. All these things increased</p> <p>168.my uncertainty and my thoughts that it was best to stay quiet and that things were</p> <p>169.only happening in my head.....</p> <p>170. I did not want to see anybody...</p> <p>171.I did not have the opportunity to experience</p> <p>172.something meaningful. Instead I found it as a barrier, the truth is that you cannot get</p> <p>173.something when you cannot even express yourself properly</p> <p>174.Mo: I think it would have been good if the therapist had put more effort to help me, or</p> <p>175.at least to help me get the support that I needed.....</p> <p>176.....</p> <p>179.My therapist could have tried to some techniques to facilitate my process, but she did</p> <p>180.not even show any interest in conveying to the translator that the process was.....</p>	<p>Unmet needs lead to self-blame and increased depression and uncertainty (165-166)</p> <p>Perception of self as depressed? (166)</p> <p>Lack of support led to self-questioning (167)</p> <p>Self-blame (167)</p> <p>Self-doubt (167-169)</p> <p>Isolation/Increased depression (170)</p> <p>Unhelpful counselling experience (171-173)</p> <p>Language as a barrier (172-173)</p> <p>Perception of therapist as careless (174-179)</p> <p>Need for a different approach/ technique (179-180)</p>
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Appendix L: Super-ordinate and Sub-ordinate Themes Anne

Super-ordinate theme	Sub-ordinate Theme	Key words	Page-Line
<i>Emotional expressiveness</i>	Freedom of expression	I felt free to express myself His attitudes helped me a lot to trust him Told him honestly how I was feeling	(1. 2) (3. 31-32) (8. 117)
<i>English Proficiency</i>	Language not a barrier	I express myself better in English While in English we both knew what I was trying to say	(16. 266) (17. 283)
<i>Thoughts and Emotions lost in translation</i>	Sayings losing emotional meaning during translation	At times I found a bit difficult to express through certain "dichos" Sayings lose some valuable meaning when translated	(1. 7-8) (1. 7-10)
<i>Cultural awareness</i>	Different cultural perspectives of problem	Helped me to understand and be more aware of how from a cultural perspective I saw things differently How could I analyse what was happening to me from a different point of view	(3. 32-36) (4. 51-52)
<i>Adaptation Attitudes/ Trust</i>	Projection	In his eyes I could see that I had already acquired many customs that one attributes to the English	(3. 37-38)
<i>Cultural awareness/ identity</i>	Honesty	He never sweetened the truth; did not create false expectations.	(13. 221-225)
<i>Respect for the other's culture</i>	Knowledge and integration through cultural identification	Helped me to understand my life and my culture from another point of view .	(3. 32-33)
<i>Culturally competent</i>	Cultural awareness and reciprocity	We both knew where we were standing .	(16. 257) (16. 254-263)
<i>Cultural identification</i>	Perception of therapist as culturally competent	He had sufficient professional curiosity so to see himself through my eyes	(16. 263-265)
<i>Preference for Western therapists</i>	Cultural enlightenment	Helped me to clarify where I stand in my country and in this country I do not know if it is something (Country) or Latino American where people do not say the truth as it comes, one tries like manipulating the truth, like sweetening the situation a little bit.	(14. 225-227) (6. 78)
<i>Fostering familial relationships</i>	Mistrust towards Latino Americans		(6. 81-82)
	Family relationships	The topic about my relationships, especially those that are closest ermm was the most interventionist part	(6. 82-83)
	Mirroring therapeutic relationship for establishing other relationships	He was a very good mirror, he was a very good guide to reflect on my relationships. He made an effort to call those important people, for example (relative) my (relative) by their names.	(6. 84-85)
<i>Family unity</i>	Symbolic interactions as fostering interpersonal/familial relationships	He made an effort to introject in therapy as if he knew the people around me and remembered certain characteristics that I attributed to those people Remembered certain characteristics that I attributed to those people	(6. 83-88)
<i>Fostering relational (working relationships)</i>	Relationship with others	Similarly to my affective relationships, he made the same effort with people from my work, and any other significant relationship	(6. 90-91)
<i>Affirmation of</i>			(5. 59-

<i>religious beliefs</i>	Exploring and reinforcing religious beliefs	Would enquire about my religious views and also empathized with this part of me, I could talk openly about my religion; he knew my religion	(15. 240-252)
<i>Religious/spiritual healing</i>	Acceptance and respect for religious beliefs	He appealed to the mystical part of Latino America; life as pseudo-catholic He gave space to my spirituality...issues affecting in a spirituality level...valued my religion	(15. 240-244) (5. 63-68)
<i>Cultural awareness/sensitivity</i>	Religious/spiritual coping and direction	It was about my beliefs, what I needed; rather than anything that had to do with him or his beliefs Spiritual pain Explored how to spiritually accompany a person from another culture...with this therapeutic intervention he helped me to grow spiritually	(5. 69-72)
	Openness and respect for the other's culture	Both of us made an effort to understand the other's culture and not to take things for granted Respectful for my Latino costumes	(6. 73-77) (2. 21-22) (16. 263)
<i>Knowledge and respect for cultural differences</i>	Perception of therapist as knowledgeable and understanding of the other's culture	He was not stranger to the Latino American culture He appealed to my mestizo side... reminded me that I was a product of many races, neither Spanish nor Indian... that I was creole; how much I was fighting this within myself	4-6) (15. 245-252)
<i>Cultural awareness</i>	Affirmation of racial identity	I could talk freely about the English, he never made me feel as I was offending him But equally he brought his cultural background on the table	(15. 254-255) (15. 256-257)
<i>Increased self-awareness about adaptation processes</i>	Perception of therapist as open to cultural exploration	Helped me to realised until what extent I belong to this country I had already acclimatised to the English culture...how different I was to the person who came a few years ago . He helped me to be more aware about the changes and process that I was living here in London.	(3. 37) (3. 39-40) (3. 41-42)
<i>Acculturation/adaptation to host culture</i>	Self-identification with host culture	Helped me to be more aware about the changes and process that I was living here in London.	(16. 266-267)
	Cultural adaptation and affiliation	Personally I feel more identified with the English customs . I had also realised that we (citizens) are not that different from the English. There is also a certain level of discretion both in English and (Citizens)	(16. 268-270) (17. 290)
	Self-identification with English people and culture	I also identify a lot with the English I think that from the whole of Latino America, we are the less Latino Americans in many senses	(17. 271-272) (17. 291-292)
<i>Acculturation</i>	Adaptation to host culture	I realised how much I have both adapted and I identified with this culture	(17. 293-294)
<i>Holistic approach</i>	Eclectic approach Psychosomatic impact of emotions	One must connect mind, body and spirit The triad: physical, emotional and spiritual dimensions	(4. 47-48) (8. 124-126) (9. 131-132) (8. 126)

Appendix M: Major and Super-ordinate Themes for All the Participants

Master Themes	Super-ordinate Themes	Quote location Participant initial + Page number
<i>Emotional Expressiveness</i>	<i>The Language of Emotion</i>	<ul style="list-style-type: none"> • Carolina: 6-7. 52-53; 12.104-109; 12.102-105; 15.131-133; 16. 145-148; 17. 149-150 • Anne: 1. 2; 3. 31-32; 8. 117; 16. 266; 17. 283 • Chava: 8. 107-109; 8. 100-102; 9. 129-130; 12.172-179; 17.243-245; 16. 240; 16. 241-246; 17. 244-249; 18. 257-259 • Monica: 25.219-220; 25.220-222; 28.239-240; 25.218-220; 3. 25-29; 19.172-173; 2. 14-17; 1, 3-4; 2. 21-22; 3. 35-37; 4. 37-40; 20. 180-182; 6. 54-57; 8. 78- 79; 8. 77- 78; 3. 25-31 • Lili: 5. 66-70; 3. 29-30; 6. 85-101; 12. 198-203; • Mary: 6,7. 92-96; 13. 188-190; 12.172-178; 14. 212; 14. 217-219; 17. 260-265; 14. 228 • Camila: 12.173-175; 7. 95-98; 7. 100-102; 12. 169-173; 12. 164-166 • Sonia: 21. 249-250; 20. 237-245; 11. 128-136; 20. 236-237 • Luz: 6. 77-80; 4. 41-42; 5. 63; 5. 65-67; 1. 2-5; 3. 42-44 • Marysela: 3. 35-38; 4. 40; 3. 39-44
	<i>Dichos (sayings)</i>	<ul style="list-style-type: none"> • Carolina: (2. 15); (16, 151-155); (6, 52-57); (12. 107-109); (8. 67); (19, 173-177); (10. 89) • Anne: (1. 7-8); (1. 7-10); (3. 37-38); (5. 72); (5. 63); (13. 221-225); (4. 51-52) • Monica: 3. 32-33; (3. 33-34); (16. 145); (2. 16-17); (2. 17-18); (3. 34-36); (9. 94-95); (28. 245) • Chava: (4. 49-56); (5. 54-57); (7. 98-102) • Mary: (14. 219-227); (15. 226-233); (3. 33); (3. 36); (2. 26); (11. 159); (16. 243); (17. 253-254); (7. 99-101); (12. 185); (12. 180); (6. 87) • Sonia: (23. 274-275) ; (23. 276-277); (8. 91-92); (16. 191-197); (15. 185-188) • Lili: (1. 6-13); (2. 12-13); (2. 17-24); (3. 26-29); (3. 31-33); (3. 44-45); (4. 50-60); (5. 68-71), (6. 77-79) • Marysela: 4. 40-43; 4. 43-47; (4. 52-53); (4. 44) • Luz: (1. 10); (3. 27-29) • Camila: (3. 42); (3. 42-43); (6. 86-87); (13. 184); (13. 182-187); (6. 78-79); (14. 198-201)

Cultural Competence or Encapsulation	Family Centeredness (familism)	<ul style="list-style-type: none"> • Carolina:(16. 139); (7. 56-57); (16. 140); (16. 141-142) • Anne: (6. 78); (6. 78-88); (6. 83-88) • Lili: (6. 84-85); (5. 61-66) • Mary: (6. 88-91); (5. 67-69); (2. 20-21) • Monica: (30. 255-261); (13. 126) • Chava: (14. 203-213); (13. 183-192); (13. 191-198) • Camila: 10. 147-152); (15. 209-212) • Sonia: (12. 138-140) • Luz: 14. 176-180); (14. 178-180) • Mary:)... (6. 71-75)
	Religious/Spiritual healing	<ul style="list-style-type: none"> • Carolina: (15. 134-137); (15. 138-139); (8. 66-69) • Anne: (15. 240-252); (15. 240-244) • Anne: (6. 73-77); (5. 59-67); (5. 69-72); (5. 63-68) • Marysela: (6. 76-79); (3. 31-32) • Monica: (29. 249-252); (17. 157-161) • Chava: (5. 52-57) • Sonia: 6. 140-142) • Luz: (2. 14-16) • Chava: (15. 214-217) • Lili: (12. 177-179) • Mary: (6. 86-88); (5. 63-65); (16. 234-236) • Marysela (16. 213-217).
	Acculturation and assimilation issues	<ul style="list-style-type: none"> • Anne: (16. 142-144); (17. 152-153); (15. 134-139); (15. 136-140); (19. 170) (2. 21-22); (16. 263); (1. 4-6); (15. 245-252); (15. 254-255); (15. 255-260); (3. 37-40); (3. 40-42); (16. 271-272); (17. 289-290); (17. 291-292); (17. 293-294) • Chava: (15. 220-221); (11. 146-149); (8. 110-114); (18. 263-266); (15. 217-225); (15. 222-223); (8. 109-113); (8. 111-117) ; (14. 198-207); (15. 223-225); (8. 107) • Monica: (13. 121-122); (13. 123-127); (28. 240-241); (29. 253-254); (23. 199-201) • Lili: (11. 157-163); (10. 143-145); (10. 150); (14. 211-213); (7. 91-95); (10. 139-152); (10. 147-149); (11. 163-168) • Mary: (13. 200-203); (16. 237-249); (17. 250-255); (13. 190- 200); (14. 212-216); (13. 187-1189) • Camila: (6. 86-94); (15. 202-204); (12. 168-175); (16. 218-222); (7. 100-107); (10. 136-142); (14. 193-201); (3. 30-40); (4. 53-55); (4. 52-63); (11. 154-157) • Sonia: (24. 279-282); (16. 189-193); (26. 312-313); (25. 290-296); (24. 282-289); (20. 227) • Luz: (13. 167-174) (2. 22-26); (4. 50-51); (7. 88-91) • Marysela: (6. 77-84); (6. 77-84)

The Healing Presence	Therapist as Interpersonal	<ul style="list-style-type: none"> • Camila: (6. 49-50); (6. 46-47) • Anne: (2. 29-30); (4. 48) • Marysela: (4. 48-49); (5. 61) • Lili: (8. 117-118) • Mary: (1. 9-11); Robotic (4. 62) • Anne: A place where no one judges you (2. 26-28); (5. 63-64); (8. 118-120) • Lili: (6. 83) • Marysela: (5. 56); (3. 30-31) • Anne: (2. 27); (2. 26-27); (3. 42-46); (9. 147) • Marysela: (4.53) • Carolina: (14. 123-124); (6. 52-53) • Anne: (9. 145-153); (9. 134-138) • Mary: (5. 78-82); (5. 71-91) • Marysela: (5. 58-60) • Lili: (11. 169-173) • Mary: (14. 212-216)
	Therapists as Impersonal	<ul style="list-style-type: none"> • Monica: (9. 83-93) (28. 246-247); (28. 242-244); (12. 113-115) ;(25. 219-220); (28. 244-245); (11. 107-110); (6. 57-59) • Camila: (13. 182-187); (14. 193-201); (15. 205-208); (5. 72-78); (6. 83-84); (10. 136-142); (14. 193-201); (19. 171); (5. 68-69); (6. 85-86) • Sonia: (3. 28-32); (22. 259); (23. 269-273); (22. 259-261); (15. 177-180); (16. 189-193) • Luz: (2. 22-26); (6. 76); (4. 57-60); (11. 144-149); (3. 27-29); (7. 89-90) • Chava: (12. 173-176); (4. 44-45); (8. 105); (11. 159-160); (1. 10-12); (11. 146-149); (12. 166-168); (7. 89-95); (10. 138-145); (1. 10-14); (10. 135-137)
Cultural Formulation or Liberation	Culturally concordant therapists	<ul style="list-style-type: none"> • Monica: (6. 63-67); (5. 47-48); (7. 65-67); (15. 139-141); (21. 185-190); (22. 191-192).;(31. 267-271). (32. 271-274); (32. 273-281); (33. 279-283); (33. 282-283); (33. 283-287) • Mary: (17. 256-259); (5. 73-77); (14. 199-212) • Camila: (13. 176-178); (1. 10-14); (9. 136-139); (11. 157-158); (13. 176-179); (17. 223); (17. 224-229); (17. 226-232) • Sonia: (25. 297-302); (25. 302-306); (26. 314-315) • Luz: (14. 182-185); (10. 123-127); (14. 182-185); (14. 186-190) • Marysela: (3. 39-40); (7. 85-87)
	Culturally discordant therapists	<ul style="list-style-type: none"> • Carolina: 19. 169-171) • Anne: 14. 228-230); (16. 266-270); (16. 271-276); (16.277-282); (17-283-288); • Chava: (3. 36-38)(16. 226-230); (16. 229-230); (16. 231-234); (16. 238-242); (18-259-263) • Lili: (12. 184-197); (13. 190-203); (14. 214-216).

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