Experiences of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

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Introduction to the Portfolio

With the rise of globalisation in the last century, cultural competence in healthcare has gained more attention and importance (Kirmayer, 2012; Purnell, 2002). In culturally diverse societies, the dominant culture shapes the health care practices and dictates "what sorts of problems are recognized and what kinds of social or cultural differences are viewed as worthy of attention" (Kirmayer, 2012, p. 149). Conventionally, in the multicultural psychotherapeutic relationship, only the client is perceived as the person who is diverse or different but in reality, "both client and therapist are different from and to each other" (Christodoulidi & Lago, 2013, p. 116). As Ridley et al. (2021) postulate, cultural competence is not only about therapists working effectively with culturally different clients and tailoring treatment to the client's needs but is also relevant to being reflexive about cultural biases on their clinical judgments as well as about cultural values and beliefs that may shape clients' psychological presentations. However, difference should not be reduced to only ethnicity or cultural identity. Acknowledging other vital and intersecting identities and appreciating the subjective experience of the client in the psychotherapeutic relationship are of paramount importance for the humanistic ethic, which is at the core of counselling psychology practice (Cooper, 2009; Bramesfeld et al., 2019, Ramarajan, 2014).

Reflecting on my identity as a counselling psychologist as well as a Turkish woman was instrumental when conceptualising the research project and the portfolio. I am a Turkish woman who came to the UK as an international student to pursue a training in counselling psychology. Early on in my training, multicultural therapy was something that I was interested in since I was always mindful, and at times self-conscious, about the differences I was bringing to the therapeutic space in terms of language and cultural background. Later on in my training, I came to realise that negotiation of differences between the therapist and the client was inherent in the therapeutic relationship since no single person is identical, and even the differences in age or gender need careful attention.

Initially, my research interest was around exploring the subjective experience of therapy for Turkish men. To my knowledge, research has mainly focused on Turkish

immigrant women and their psychological presentations and treatment. I had hoped to bring attention to the 'other' gender and the intersecting identities of ethnicity, culture, and gender in the psychotherapeutic relationship. However, despite contacting various gatekeepers and allowing four months for recruitment, I wasn't able to recruit any participants for this study. Therefore, I decided to change the focus of my research and directed my attention to student mental health and the growing public concern and scholarly interest regarding the student population supported my decision (Brown, 2018; Duffy et al., 2019; Hernández-Torrano et al., 2020).

This portfolio compromises of three pieces of work that illustrate different but related aspects of multicultural psychotherapy practice. The portfolio demonstrates my personal and professional interest in culture, intersectional identities, and inter-personal differences at both micro (related to individuals and therapeutic dyad) and macro levels (related to society, social institutions, and health care systems). First piece of work is a doctoral research project, which explores Turkish international students' experiences of accessing and undergoing therapy in the UK. The second piece is a clinical case study where integrative approach was provided to a service user in a primary care mental health setting within the National Health Service (NHS). It demonstrates multicultural psychotherapy practice that takes place between a minority therapist-mainstream patient dyad. The final piece is a publishable paper that will be submitted to *Culture & Psychology* to disseminate the research findings.

Preface

PART A: Doctoral Research

The first section compromises the doctoral research, which aimed to explore Turkish international students' experiences of accessing and undergoing psychological therapy in the UK. This research project had a dual focus. First and foremost, this research explored experience of service provision to international students. Participants shared their experiences of accessing and engaging in therapy from a student's perspective. However, they were also from a minority culture and engaged in therapy in their non-native language. Hence, the second focus of this research was to explore clients' experiences of therapy with a therapist from a non-Turkish background.

This research project has provided me the opportunity to think critically about the theories and paradigms of psychotherapy and to explore sociocultural influences that shape Turkish international students' experience of accessing and engaging in therapy. Eight semi-structured interviews were conducted with a sample of Turkish women who had engaged in psychological therapy whilst studying at a higher education institution in the UK. Their data was examined and interpreted using Reflexive Thematic Analysis and seven themes and seven sub-themes were generated. The findings are considered in relation to the existing literature and cultural theory of collectivism and individualism, while appreciating the existence of intersecting identities and the individual human subjectivity. This section ends with implications and suggestions for clinical practice and future research. The research project illustrates my interests and values as a reflexive scientist-practitioner.

PART B: Client Study

In the second section, I present a combined case study and process report based on my clinical work with a service user in a primary care service at NHS. The primary therapeutic intervention offered at the service was Cognitive Behavioural Therapy (CBT). The service user was assessed by a CBT practitioner who gave the preliminary diagnosis of low mood. However, I worked with the counselling team,

which offered time-limited psychodynamic and integrative therapies. I was able to work with the service user using an integrative model. This approach sat well with my personal stance as a pluralistic practitioner and a counselling psychologist as the model aims to combine psychodynamic ideas and techniques with evidence-based interventions from other therapeutic schools in relation to the specific needs of the client (Stricker & Gold, 2019). This case demonstrates my work with a White-British male client (a 'mainstream patient') as a Turkish minority therapist (with a difference in language, cultural and personal values, age, and gender). This client study demonstrates key aspects of my development as a pluralistic and reflexive counselling psychologist.

PART C: Publishable Paper

The final piece of work included in this portfolio is a publishable paper which reports the findings from my research project. I intend to have this paper published in *Culture & Psychology* Journal (please see Appendix A for Culture & Psychology Journal Author guidelines). I chose this journal as it promotes creating understanding of the human psychology through the exploration of identity, social conduct, and intra- and intersubjective experiences. It also encourages dissemination of qualitative research and aims to advance basic knowledge of the self in its historical and cultural contexts.

I believe the aims and objective of the journal sits well with my personal and professional values as well as my research aims and objectives. Also, their editorial board consists of scholars from different countries and various disciplines, which represents journal's multidisciplinary and multicultural approach. I hope the publication of my research findings will reach a global community of practitioners who work with Turkish international students and improve service users' experience.

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PART A: Doctoral Research

Experiences of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

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Supervised by Dr Aylish O'Driscoll

Abstract

There is a global rise in the occurrence and severity of mental health problems and help-seeking behaviours among students in higher education. Despite experiencing similar levels of psychological distress, international students experience and present with different symptoms of mental health concerns and don't seek help as much as their domestic counterparts. Overall, qualitative research concerning students' therapy experience in the UK is limited and the international student mental health literature has mainly focused on Asian students. According to the researcher's knowledge, there is no research investigating the help-seeking experience of Turkish students who are abroad for their studies. This paper presents findings from a qualitative study that explored the experience of accessing and undergoing psychological therapy of Turkish international students. Data were collected using semi-structured interviews with eight Turkish women who had engaged in psychological therapy whilst studying in the UK. Reflexive Thematic Analysis from a critical realist perspective was applied in the research process, which resulted in seven themes: deviation from the normal, pulling in two directions, feeling (un)invited, unmet expectations, managing the differences, benefits from therapy, and the nice therapist. Some of the themes consisted of sub-themes which described different aspects of participants' experiences. The findings were centred around the cultural and/or language influences on the experience of seeking professional help and engaging in therapy as an international student. It is hoped that the findings will inform and motivate service providers to develop multiculturally competent psychological therapy practices and accessible service provisions attuned to Turkish international students' needs.

Chapter 1: Introduction

1.1 Cultural Competence in Healthcare

With growing diversity and multicultural populations in the Western societies (e.g., Australia, Canada, United Kingdom (UK), United States (US)), culturally competent health care is advocated, if not mandated, to meet the different needs of racial and ethnic minority groups (Kirmayer, 2012; Schulman et al., 1999; Sue et al., 2009). However, there is controversy surrounding the notion of cultural competence, as there is a lack of consensus on its definition, rationale, empirical evidence, and effectiveness (Sue et al., 2009).

Some scholars define cultural competence as a therapeutic skill to improve the quality of cross-cultural relationships or to facilitate therapeutic change (Ridley et al., 2001). Ridley et al. (2021) suggest that not all professions aim for therapeutic change. The authors propose that multicultural competence should refer to developing better cross-cultural relationship, whereas multicultural counselling competence (MCC) should be defined as effective cross-cultural relationship for therapeutic change.

Ivers et al. (2016) advocate that MCC is a therapeutic skill that is applicable to working with all clients from different cultures, and it promotes delivering effective service provision when a client's cultural background differs from the counsellor. This assumption should be approached with caution as MCC should not be limited to only when counsellor and client are different in cultural terms. Both the therapist's and the client's cultural values and beliefs are present in the therapeutic encounter (Ridley et al., 2021).

As Barden et al. postulate, clinicians are required "to be knowledgeable of cultural values, aware of their own cultural background and personal biases, and able to integrate culturally relevant and appropriate interventions in their work with all clients" (2017, p. 203). McRae and Johnson (1991) stresses the importance of developing knowledge through acquiring facts about culture and gathering

information about particular social and political history to have an understanding of the socio-political experiences of a racial or ethnic minority group. Furthermore, one also needs to acknowledge the impact of the dominant culture on the conventional health care systems and what is considered as worthy of attention (Kirmayer, 2012). On that note, Ridley et al. (2021) give emphasis to reflexive practice, in which clinicians are aware of the cultural and instutional biases that may impact their clinical decisions and of the cultural values and beliefs that outline clients' psychological presentations.

1.2 Mental Health Understanding in the Western World

Considering the significance of reflexivity in multicultural counselling competent practice, one should be knowledgeable of cultural and instutional influences on mental health understanding and the dominant paradigm of psychology in the Western societies. Bhugra and Bhui (2014) postulate that states of distress are given different meanings in different cultures. Similarly, Good and Good (1982) argue that understanding of illness and the experience of distress are grounded in one's culture. However, as Lijtmaer conveys, dominant paradigm of mental health is based on the assumption that psychopathology is a 'universal phenomenon' and despite the variance in their modes of expression, "anxiety, depression, defence mechanisms, and dreams, are all present in all human beings of different cultures" (2008, p. 2)

Mental health theory and practice have mostly focused on Eurocentric notions and culture grounded in the Cartesian understanding of the human condition (Gopalkrishnan, 2018). Cartesian dualism, which is still at the basis of our thinking in psychology, separates the mind from the biological factors and reduces the body to mechanistic or organic processes (Duncan, 2000; Tschacher & Haken, 2007). Correspondingly, Western approaches to mental health have links with the ideas of positivism and reductionism (Fernando, 1988; Mehta, 2011; Thibaut, 2018). Cottone (2007) argues that the scientific paradigm culturally and institutionally informs the clinical practice in Western mental health which focuses on the individual and assessing their nonphysical traits and characteristics; linearly defines the cause; and

perceives change as a result of one doing something to the other individual to change the targeted trait or characteristic.

It has been long debated that the 'medical model' in current bio-medical practice of psychiatry pathologizes the human experience (emotional distress, problems of living, relationship issues, and social suffering) and perceives it as a 'mental disorder', which can be treated by medication (Boyle, 2014; Mills & Fernando, 2014; Whitaker, 2010). On the other hand, there are different frameworks in psychology to understand human nature and distress (including, organic-medical, psychological, systemic-relational, and social constructivism paradigms) (Cottone, 2017). For instance, the discipline of Counselling Psychology emerged as a critique to the positivist medical paradigm, adopted the humanistic approach and sought to understand a person's inner world and how they construct reality (Brennan et al., 2007; Strawbridge & Woolfe, 2010).

However, despite the growing diversity in approaches to mental health and emergence of different schools of psychology, "how psychology is applied is largely product of individualistic cultures" (Kim et al., 2001, p. 570). It is argued that psychotherapy itself is a cultural phenomenon and that Western values are inherent in psychological practice (Bernal & Scharron-Del-Rio, 2001; Corey, 2016). In the next section, I will introduce the cultural theory of collectivism and individualism and discuss the Turkish culture, before presenting a review of literature and empirical findings relevant to the research topic in the following chapter.

1.3 Individualism and Collectivism

Culture is a complex and multifaceted structure and may be better understood by interpreting it through different dimensions (Clark, 1987). As Triandis (1995) suggests, cultural variances in behavioural patterns, norms, attitudes, and personality factors may be better explained by locating where one culture or nation sits along these dimensions. In fact, Hofstede's (1980, 1983, 1991) four dimensions (Power Distance, Uncertainty Avoidance, Masculinity/Femininity, Individualism/Collectivism) have been used by many scholars to explore and

compare different cultural groups (Kagitcibasi & Berry, 1989). However, since psychotherapy practices are critiqued on the basis of individualistic values, I will only focus on the Individualism/Collectivism dimension and try to locate Turkish culture's position.

Individualism is defined as a social pattern consisting of "loosely linked individuals who view themselves as independent of collectives", whereas *collectivism* stands for "closely linked individuals who see themselves as parts of one or more collectives (family, co-workers, tribe, nation) (Triandis, 1995, p. 2). Furthermore, individualistic people are motivated by their own preferences, needs, rights and prioritise personal goals over the goals of others, whereas collectivistic people are primarily motivated by the group norms and duties dictated by the collective; show tendency to prioritise the goals of the collective over their own personal goals; and value interdependence among members of the collective (Kim et al., 1994; Triandis, 1995). In short, collectivistic societies value emotional interdependence, solidarity, cooperation, and conformity over individualistic notions of self-reliance, independence, autonomy, and personal achievement (Skillman, 1999; Tse & Roger, 2014). However, it should be noted that, at the individual level, variances in the individualism/collectivism dimension may be observed. That is, one may be more allocentric in an individualistic culture and believe, feel, and act similar to collectivistic people (or the visa versa, be more idiocentric in a collectivistic society and believe, feel, act very much like an individualistic person) (Triandis, 1995).

1.4 Turkish Culture

Turkey is a country that is located in both Europe and Asia. Historically, Turkey has hosted a multitude of cultures (e.g., Hittite, Greek, Roman, Ottoman) and currently, Turkey consists of people from different cultures (including, ethnic Turks, Kurds, Armenians, Greeks, Sephardic Jews, Circassians, and others) (Sunar & Okman Fisek, 2005). Despite the sociocultural mix, Turkey has been categorised as a collectivistic culture (Hofstede, 1980) and referred to as a 'culture of relatedness' (Kagitcibasi, 1985).

On the other hand, Triandis (1995) postulate that major changes in the environment, including social events may impact the culture and how the social pattern of collectivism/individualism operates. Goregenli (1995) recommended “more complex analyses […] to describe the complex social structure of cultures experiencing a process of rapid social change, such as Turkey” as her study findings showed that Turkish people mostly demonstrated allocentric tendencies and interdependence but that they also displayed individualistic tendencies on some dimensions (i.e., susceptibility to social influence and feeling of involvement in others’ lives). Kagitcibasi (2007) suggested that the collectivistic values coupled with modernisation and Westernisation movements influenced family and intergenerational relationships in Turkey. As Sunar and Okman Fisek (2005) postulate, Turkey has been experiencing rapid and ongoing social and economic transformation, which is transforming from a traditional, rural, agricultural, and patriarchal society to an increasingly modern, urban, industrial, and egalitarian one. Mocan-Aydin’s (2000) study supported these findings, which concluded that Turkish people display some individualistic values and attitudes whilst mainly preserving collectivistic cultural orientations. Another study reported that urban Turkish people perceived themselves as neither strongly collectivistic nor individualistic (Anamur, 1998). As Gergen et al. (1996) suggest, Turkish culture is better understood if characteristics of culture are perceived on a spectrum, rather than as mutually exclusive polarities.

More recently, scholarly attention has been directed towards the impact of globalisation and the generational differences in value orientations. Marcus et al. (2016) demonstrated that millennials in Turkey were significantly more self-enhancing, more self-transcending, and less conservative than Gen Xers and Boomers (i.e., older generations). Authors concluded that moving toward more individualistic and self-enhancing values over time is a “part of a larger global trend, spurred on perhaps by the homogenizing forces of globalisation” (p. 70).

Overall, considering the global trend in growing tendency for individualism and self-enhancing values coupled with sociocultural transformation in Turkey, Turkish collectivistic culture holds a unique place for scientific investigation.

Chapter 2: Literature Review

This chapter consists of an overview of the relevant empirical findings relevant to the research topic and a critical review of the literature. Firstly, I will give an overview of mental health understandings across different cultures and discuss treatment preferences comparing individualistic and collectivistic cultures. As the literature on Turkish mental health practices is limited, I will also draw on empirical findings from other collectivistic cultures. Secondly, cultural, and linguistic differences in the context of cross-cultural therapy will be explored. I will then turn the discussion to student mental health literature, before presenting a review of published studies considered to be most relevant to my research study. I will conclude the chapter by presenting the research rationale and research questions.

2.1 Mental Health Understandings Across Cultures

In non-Western cultures, individuals and healthcare systems may not make the distinction between issues of the body and the mind or perceive mental health management from a positivistic scientific perspective (Duan & Li, 2022). Different cultures may answer the question about the nature and treatment of mental disorders differently (Matthews, 2017). Hence, acknowledging the differing approaches to mental health treatment across different cultures be helpful in accounting for variance in the symptomatology of psychological distress across different parts of the world, including high levels of psychosomatic symptoms in certain cultures (Bhugra et al., 2021; Dreher et al., 2017).

For instance, the ancient Indian healthcare approach, i.e., the Ayurvedic system, has a more holistic understanding of health and takes into account “organic or physiological factors; social factors and personality factors” when classifying and managing mental and physical disorders (Ventriglio & Bhugra, 2015, p. 369). Biswas et al.’s (2016) study showed that service users in India were much more likely to present with somatic symptoms such as pain, sleep, and appetite whereas Americans presented with more cognitive-based symptoms, such as a negative view

of the future, which indicates that the difference in epistemological basis of health between two cultures is reflected in people's lived experiences of mental health.

Another example is the practice of Traditional Chinese Medicine, which is based on the notion of the mind-body connection and aimed at enhancing self-awareness and promoting the unification of the mind and body to strengthen both physical and mental health (Kraus, 2015). Traditional or alternative forms of healing that are not grounded in Western understanding of illness and treatment methods, target repairing the unity of the emotional, mental, and physical bodies and helping people cope with the disease, distress, disability, and recovery or prepare them for pain and suffering (Waldram, 2000).

Furthermore, scholars suggest that cultural beliefs about the aetiology of illness may also influence how one experiences and manages distress (Hechanova & Waelde, 2017). For instance, the traditional Chinese understanding of the cause of illness is the lack of balance of emotions (Haque, 2010). Hence, Southeast Asian people may feel reluctant to talk about their difficulties thinking that "talking about painful issues can stir up painful feelings" and prefer to cope by helping others or staying busy (Hechanova & Waelde, 2017, p. 33). In the Turkish folk culture, illness is believed to be caused by spiritual beings or due to fate or transgression of religious taboos and distress management involves magico-religious therapeutic practices (Carkoglu & Toprak, 2007; Ozturk & Goksel, 1964). However, research concerning the urban Turkish population indicate a difference in cultural beliefs about the causes of psychological problems as well as treatment preferences. Studies report that Turkish people in urban settings perceive social problems and weakness of personality as the cause of depression (Bilir & Artvinli, 2021; Ozmen et al., 2004). Consequently, mental health support involves families and other members of the community as well as delivery of professional care in community-based settings as opposed to the magico-religious practices in Turkish rural settings (Bilir, 2018; Bilir & Artvinli, 2021; Ozmen et al., 2004). Differences between rural and urban Turkish people in their perceptions of illness and treatment preferences may support the literature findings on the variance in collectivism/individualism values in Turkish society (Anamur, 1998; Gergen et al., 1996).

2.1.1 Cultural differences in mental health treatment

Tribe (2005) suggests that Western approaches to health emphasise individual pathology and intrapsychic experience in therapeutic practices. The western healthcare system is based on individualistic values, which promote independence and autonomy (O'Hagan, 2004; Tse & Ng, 2014). Hence, the theory of psychotherapy in the Western world is grounded in individualism and the psychological subject is "decontextualized and self-possessive, alone responsible for itself and its thoughts, emotions, and behaviours" (Ingle, 2021, p. 926). McCarthy, notes that a client with an individualistic value orientation may perceive that the cause of the problem lies within themselves; engage in a therapeutic relationship that is brief in duration; or "want the counsellor to assume the role of counsellor or adviser" (2005, p. 110). It has been suggested that people in western individualistic cultures seek psychological support with the expectations of accomplishing personal needs and goals and report a preference for high level of directness, explicitness, and verbal expressiveness (Gao et al., 1996).

Studies show that the application of a Western type of psychotherapy in the collectivistic context has its limitations as the constructs of the self and others differ between the two kinds of cultures (Chadda & Deb, 2013). As an example, non-Western practices in China are generally not in the form of conventional talking therapies and usually involve instruction, training, or teaching by a guru or a healer, which involves respect and acceptance of authority (Hofstede, 1980; Kraus, 2015; Kwan, 2009; Laungani, 2005). Poyrazli (2003) notes that the influence of the value given to the authority figures in collectivism is observed by clients' strong preference for guidance, probing, and provision of structure from their therapist. Collectivistic individuals are also more likely to expect immediate therapeutic gains, such as symptom relief rather than promoting insight and trying to understand the core conflicts or underlying causes of their problems (Kim et al., 2001). Gao et al. (1996) people from collectivistic cultures prefer indirect, implicit, and nuanced communication and non-verbal expression, which is related to protecting one's perceived respect in the community and preserving existing relationships and group harmony. Hence, collectivistic individuals may prefer focusing on strengthening

personal composure and social functioning within the therapeutic setting (Burleson & Morteson, 2003; Chang, 2001; Kim et al., 2009).

Another difference observed in collectivistic societies is the emphasis given to interdependence and family involvement in one's care (Murthy, 2014; Stanhope, 2002). For example, in India family is regarded as the key source in the care of someone with mental health needs, which aligns with the emotional interdependence and cooperation ideas valued in collectivistic cultures (Avasthi, 2010). Studies have shown that among Asians (e.g., Chinese, Korean, Japanese), coping behaviours and problem-solving strategies are often group-oriented and interpersonally based (Kuo et al., 2006). In fact, acknowledging the value of relationships and the role of the family has been regarded as a key factor for psychological change in collectivistic societies (Chadda & Deb, 2013; Wong & Piran, 1995; Rathod et al., 2019; Williams & Levitt, 2008).

2.1.2 Cultural differences in therapeutic relationship

As previously described, there is contradictory empirical evidence on cultural (counselling) competence, including its effectiveness (Sue et al., 2009). Some findings suggest ethnic matching for effective treatment for minority ethnic or racial groups. Fluckiger et al.'s (2013) study indicated that ethnic or race-related differences between the therapist and client adversely impact alliance building and the therapeutic relationship. Clients displayed vigilance towards the signs of differences or disapproval. The findings indicated that clients felt threatened by differences and felt apprehensive about their therapist's judgement (Williams & Levitt, 2008). Concern about the differences interfered with the therapeutic work and diminished open communication and trust towards the therapist (Williams & Levitt, 2008). Similarly, other studies found that an ethnocultural mismatch between therapist and client may lead to low client satisfaction (Chang & Yoon, 2011; Chu et al., 2022) and increased risk for premature termination (Anderson et al., 2019; Owen et al., 2012; Owen et al., 2017).

On the other hand, there is empirical evidence that suggest ethnic matching is not necessary for effective service provision for ethnic and racial minority client populations. Research has shown that therapist factors can positively impact the therapeutic relationship and lead to MCC. For example, research indicates that clients perceive their therapist as more credible if cultural differences are addressed in therapy, which has been conveyed to generate a positive therapy experience for both the client and the therapist (Day-Vines et al., 2007; Knox et al., 2003). Having a humanistic approach and attempting to access the client's view are regarded as ways to demonstrate cultural curiosity and open-mindedness (Dyche & Zayas, 1995; Falicov, 2014; Jenks, 2011). Clients tend to have more faith in the therapeutic relationship and therapeutic process when their therapist acknowledges the difference, communicates their understanding, and demonstrates unconditional positive regard (Gonzalez et al., 1995; Tsang et al., 2011; Williams & Levitt, 2008). Zhang and Dixon's (2001) findings suggest that therapists who display cultural competence by greeting the client in their native language or expressing interest in getting to know the client's culture more were perceived more favourably. In fact, in multicultural therapeutic encounters, effective work is believed to be possible when the therapist engages in reflective practice and feels competent and confident to work with diversity and difference (Christodoulidi & Lago, 2013; Edge & Lemetyinen, 2019).

However, Kanakam's (2022) findings indicate that therapists working cross-culturally may feel restricted by time constraints in providing cultural adaptations or hesitate to address cultural differences due to fears of making incorrect assumptions about a client's culture or saying something offensive. Hence, having cultural curiosity as well as knowledge about cultural groups and socio-political contexts and being mindful of the impact of culture seem necessary for clinicians to feel confident enough to create cultural dialogues and deliver effective therapy for each client (Beagan, 2018; Benuto et al., 2018; Christodoulidi & Lago, 2010; Lopez et al, 2020; Naz et al., 2019).

2.1.3 Linguistic differences in therapeutic relationship

Every language is associated with a culture, and language provides meaning to the physical and social world we experience (Schrauf et al., 2003). In fact, one's self-identity and account for their emotional experience may be influenced by both cultural and linguistic factors (Schrauf, 2003). Wierzbicka (1994) argues that attitudes toward feelings and emotions and how they are verbally and non-verbally expressed vary across cultures. Therapists count on language to build therapeutic relationships and rapport as well as to comprehend the mental world of the client (Schouler-Ocak, 2020).

Language is central to all therapeutic relationships due to the "evocative power of words to engender emotional states and cognitive associations" (Espin, 2013, p. 202). However, language requires more attention in intercultural therapy as therapists work with multilingual clients, who may speak a different first language than their therapist. de Courtivron (2003) suggests that no matter how fluent one is in a second language, their first language is the language for emotions. Studies show that communicating in a non-native language involves additional cognitive processes (McFarlane et al., 2020). People speaking in their non-native language are believed to engage more in active thinking and improved reasoning with reduced emotionality in their account in therapy (Bialet et al., 2020; Hayakawa et al., 2017; Keysar et al., 2012; Lehtonen et al., 2018).

The content and emotional tone of what is discussed in therapy may be influenced by the language used in the counselling process (Bowker & Richards, 2004). Javier (1989; 2007) argues that clients who speak multiple languages can mobilise and shift their language as a coping mechanism in anxiety-provoking situations. Espin's (1999) study with immigrant women in the USA found that clients found it easier to talk about some topics in English, conversations related to the feeling of shame. The second language may allow the client to communicate things that are inexpressible in their first language either because the second language has more vocabulary to express the emotions and cognitions or it provides more freedom and is not associated with forbidden things in their mother tongue and native culture (Dewaele, 2016; Espin, 2013).

Furthermore, as Morina et al. (2010) postulate, many words may lose some meaning and for very culturally specific words, meaning may be completely lost in translation. If the therapist has a different contextual understanding of the word used by the client, misunderstandings are more likely to occur (Liamputtong, 2006). For example, when the clinician and patient have different mother tongues an overt misunderstanding or a lack of concordance between the two sides is more likely to occur (Magnusson et al., 2009). Some scholars point out that negotiating differences over language and working on cross-cultural misunderstandings bring reparative opportunities for collaboration for therapist and client, and therefore can generate therapeutic change and shared understanding (Anderson, 2007; Sametband & Strong, 2013; Strong & Sutherland, 2007).

On the other hand, anxiety and apprehension related to the use of a foreign language (i.e., foreign language anxiety) are associated with feelings of low self-efficacy and increased cognitive load (Bialet et al., 2020; Hayes & Linn, 1994; Li et al., 2018; MackIntrye & Gardner, 1994). For instance, Yoon & Jepsen's (2008) study demonstrated that Asian international students were concerned about making grammatical mistakes in front of their therapists. Overall, in the therapeutic relationship, clients may encounter challenges in terms of expressing themselves in their non-native language and fear of being judged by their therapist regarding their language proficiency (Ang & Liamputtonng, 2008; Hundley & Lambie, 2007; Willis-O'Connor et al., 2016).

2.2 Student Mental Health

Public concern and scholarly interest in student mental health have been rising in recent years (Brown, 2018; Duffy et al., 2019; Hernández-Torrano et al., 2020). Studies suggest a global rise in the occurrence and severity of mental health problems and help-seeking behaviours amongst students in higher education (HE) (Auerbach et al., 2018; Evans et al., 2018; Lipson et al., 2019). A World Health Organization (WHO) initiative screened a sample of first-year university students across Australia, Belgium, Germany, Mexico, Northern Ireland, South Africa, Spain,

and the United States (US) and found that 38.4% met the criteria for at least one mental disorder (Auerbach et al., 2019).

Past research in the UK revealed that the incidence rate of symptoms of a psychological disorder amongst university students was similar to the age-matched general population levels (~17%) (Macaskill, 2013). However, recent studies convey that the psychological well-being of students in tertiary education has deteriorated (Lipson et al., 2019). In the UK, survey results indicated that nearly half of the student population experienced a mental disorder ranging from mild to severe levels (Gorczynski et al., 2017; Thorley, 2017), It's been suggested that between the years 2006 and 2016, the rate of first-year students disclosing a mental health problem to their higher education provider in the UK has quintupled (University and Colleges Admissions Service (UCAS), 2020).

There are different explanations in the literature as to why there is an increasing prevalence of mental health problems among individuals in higher education. Firstly, chronic stress has been associated with the emergence and aggravation of symptoms of mental health problems (Davis et al., 2017; Rosiek et al., 2016). It has been shown that the younger generations report higher levels of stress compared to older generations (American Psychological Association, 2018).

In fact, starting university and undergoing different life changes are perceived as stressful and challenging for many students (Harris, 2019). Research shows that individuals aged between 13-25 undergo a neurodevelopmental stage, i.e., "transitional age brain", that makes them more sensitive to stress (Chung, 2017). The expectation of independent study and self-directed learning, leading to a heightened sense of academic responsibility and achievement as well as the need for time management across multiple demands, is associated with increased levels of stress and anxiety among university students (Lowe & Cook, 2003; Yorke & Longden, 2008; Yorke, 2000). Furthermore, high workload, fear of not achieving enough learning, insufficient feedback from and poor relationship with university staff are listed as challenges that contribute to the stress students encounter during their studies (Labrague et al., 2017; Porru et al., 2022; Stallman & Hurst, 2016).

Other studies have illustrated the unique stressors students encounter that may increase their psychological distress upon their entry to university, such as leaving the family home and moving into shared accommodation, managing domestic responsibilities on their own, or working part-time to support themselves financially (Alsubaie et al., 2019; Peltz et al., 2020; Student Minds, 2014). More, establishing new friendships or experiencing pressure to fit in as well as lacking peer support can be challenging and may exacerbate the stress levels for individuals in tertiary education (Beiter et al., 2015; Denovan & Macaskill, 2013; Mulder & Cashin, 2015; Thorley, 2017).

On the other hand, there is growing research evidence conveying the impact of the Covid-19 pandemic on student well-being, including heightened levels of stress, and triggered or exacerbated symptoms of mental health problems (Kohls et al., 2020; Stathopoulou et al., 2020; Van de Velde et al., 2020). For example, Defeyter et al. (2021), investigating mental well-being in UK Higher Education during Covid-19, reported that food or housing insecurity resulted in a decrease in mental health. A UK-based study found that social isolation, changes in the learning experience, and reduced access to support services and means of coping brought on by the Covid-19 pandemic had a negative impact on the aspects of student life, which disrupted student well-being (Appleby et al., 2022).

Furthermore, the growing attendance of students from non-privileged backgrounds in HE institutions and the specific challenges they are faced with are perceived as contributors to the increased prevalence of psychological problems in the UK (Broglia et al., 2017; Holm-Hadulla & Koutsoukou-Argyraki, 2015; Sarmento, 2015). Researchers suggest that culture itself may induce the development of mental disorders, influence illness symptomatology, or make certain categories of people more susceptible to psychological distress (Bhugra et al., 2021). With more students coming from different demographic and cultural backgrounds, it is reported that university counselling centres are seeing students with more complex and diverse needs (Holm-Hadulla & Koutsoukou-Argyraki, 2015). For example, there is research suggesting that women studying male-dominated subjects are more likely to face “stereotype threat”, meaning that these students might be more predisposed to conform to gender stereotypes and experience poor mental health (Bell et al., 2003).

Similarly, ethnic minority groups are more likely to experience higher levels of psychological distress due to minority-related stressors, including the pressure to reject group stereotypes (Aronson et al., 2013; Shahid et al., 2018). The literature suggests that marginalised identity groups, including women, sexual minorities, and racial and ethnic groups underrepresented in the field of study, are more likely to feel pressure to work harder (in order to combat negative stereotypes) and experience stress and burnout, which make them more vulnerable to psychological problems (Acker et al., 2022; Roberts et al., 2020).

Moreover, the campus climate and prejudice or discrimination minority students encounter at university are believed to have a negative impact on their mental well-being (Christopher et al., 2009; Sue et al., 2017). To illustrate, Greer and Chwalisz's (2007) study compared minority status stress at two different US universities and found that African American students at a white-dominated university experienced higher levels of distress compared to their counterparts at a Historically Black university.

2.2.1 International student mental health

Research has indicated that what international students encounter may be different from their native counterparts (Ammigand et al., 2019; Huang et al., 2020; Minutillo et al., 2020). In fact, international students have been regarded as the "overlooked minority" in the student mental health literature (Chen et al., 2020). Hence, international students' mental health has gained more attention in the literature in recent years (Cao et al., 2021) and researchers have started considering this population as a vulnerable group with distinct mental health concerns (Mori, 2000).

It has been reported that international students are at a higher risk for developing psychological problems (Grez Buchling, 2012; Huang et al., 2020; Koo et al., 2021a). For example, a German study showed that, when compared to their native counterparts, major depressive disorder, somatoform disorder, and anxiety disorder along with heightened levels of depressive, somatic and anxiety symptoms were more prevalent among international university students (Grez Buchling, 2012). In

fact, research suggests that international students show a greater tendency to turn psychological stress into physical health concerns, which may be disregarded or unnoticed by mental health professionals (Ruckert, 2015). Other studies have also found that international students who seek help from professional services most commonly presented with depressive symptoms (Kawamoto et al., 2018; Yi et al., 2003). Shadowen et al. (2019) demonstrated that out of a sample of 490 international students in the US, 45.3% met or went above the cut-off score for clinically significant depressive symptoms and 24.7% for anxiety symptoms. Moreover, 27.2% of Asian international students were found to meet the cut-off score for moderate to severe anxiety symptomatology compared to their non-Asian counterparts with only 13.3%.

Research shows that international students encounter similar life events and stressors as other students, especially local minorities, in HE intuitions. For instance, one of the many challenges that international students face is stereotypes, which may also bring forth racial discrimination and poor mental health (Wu et al., 2015; Xiong et al., 2022). UK Council for International Student Affairs' (UKCISA, 2018) findings conveyed that for some students, moving abroad can lead to new identity development, meaning that individuals may be identified as an ethnic minority for the first time in their lives and find themselves facing the discrimination that comes with it. Duru and Poyrazli's (2011) study showed that Turkish international students with higher levels of perceived discrimination had higher levels of adjustment difficulties. In a similar vein, Shadowen et al.'s (2019) study demonstrated that perceived discrimination among international students at a US university was associated with higher levels of depressive symptoms.

In addition, the literature suggests that international students experience a set of unique stressors related to being a foreigner and studying abroad (Alharbi & Smith, 2018). Research indicates that international students undergo acculturative and adjustment stress due to moving to and living in a foreign country for their studies and therefore, are more likely to have psychological problems (Bastien et al., 2018; Koo et al., 2021b). In fact, study findings suggest that up to 20% of international students are at risk of developing psychological problems due to acculturation-related problems (Zhang & Goodson, 2011).

According to Tseng and Newton (2002), international students may encounter problems in four different areas: general living, academic life, social and cultural life, and personal and psychological functioning. Firstly, students may face practical issues due to moving to a foreign country, such as adapting to the weather, living arrangements, and food (Tseng & Newton, 2002). Also, students have to adjust to the new academic culture and educational system, which may be very different from what they are accustomed to (Koo et al., 2021b; Lee & Ciftci, 2014; Mori, 2000; Ruckert, 2015; Wu et al., 2015).

Students who are non-native speakers of the host country's language may have problems with language proficiency in their academic and personal lives (Depreeuw, 2013; Kim, 2011; Koo, 2021). For instance, language proficiency was found to be a mediator factor in acculturative stress (Jackson et al., 2013). Yildirim's (2015) study exploring Turkish international students in the US indicated that low levels of language-related difficulties predicted decreased adjustment stress. Research shows that having difficulties with the language may restrict one to express themselves and hinder social interactions (Chan, 2013; Depreeuw, 2013), leading to isolation, loneliness, and various psychological problems (Alharbi & Smith, 2018).

Similarly, it has been reported that international students are at a higher risk of developing psychological problems due to the cross-cultural adjustment process, e.g., experiencing cultural shock (Forbes-Mewett & Sawyer, 2019; Ward et al., 2001; Wu et al., 2015). Several studies convey that there is an inverse relationship between acculturative stress and the degree of cultural difference, meaning that the severity of acculturative stress may depend on how much one's culture of origin differs from the host culture (Weihua & Shu, 2011; Wu et al., 2015). International students coming from collectivistic value systems, generally associated with Eastern/Asian cultures, reported more acculturative stress than their European international students from individualistic cultures (Candel, 2021; Ma et al., 2020). However, Yeh and Inose (2003) attribute the difference in acculturative stress among European and Chinese international students to the fact that Europeans encounter racism or discrimination less compared to students from other parts of the world. Similarly, a recent study exploring Turkish international students' adaptation in

Hungary and US reported that students studying in Hungary experienced less cultural distance and a more positive cross-cultural adaptation process due to the shared historical background between Turks and Hungarians, positive political attitude towards Turkey, and experience of cultural similarities in their relations and daily lives as opposed to what students in the US encountered (Erturk & Nguyen Luu, 2022).

Priteto-Welch (2016) reported that collectivistic individuals who are struggling to adjust to the individualistic values in the host country are more likely to experience depression. For instance, humility (associated with collectivistic cultural norms) was found to be a predictor of depressive symptoms among Chinese international students in the US (Wong et al. 2014). Moreover, culturally adopted (maladaptive) coping mechanisms have been associated with the variance observed in stress levels among international students (Anjalin et al., 2017; Jackson et al., 2013; Smith & Khawaja, 2011). Khajawa and Dempsey (2008) have found denial, substance use, self-blame, venting, and behavioural disengagement as dysfunctional coping strategies that predicted psychological distress among international students. Moreover, emotional suppression has been identified as a preferred coping mechanism for Asian international students dealing with acculturative stressors, increasing their vulnerability to mood disorders (Wei et al., 2008).

Researchers convey that financial difficulties in the host country or financial dependency on the families may also increase stress levels or the likelihood of developing psychological problems for students living abroad (Koo et al., 2021b; Ruckert, 2015). For instance, for Taiwanese international students, high socio-economic status (SES) predicted better cross-cultural interactions, which was associated with higher overseas life satisfaction (Chen et al., 2021). Poyrazli and Grahame's (2007) focus group study with 15 international students, including German, Korean, Indian, Chinese, Turkish, and Mexican, found that many students found it challenging to manage the cost of tuition and living expenses, which was one of the barriers to their adjustment and led to increased stress.

Other research findings suggest that international students face feelings of loneliness and homesickness and heavy pressure from the self and others to do well

academically, which have been associated with higher levels of anxiety and depression amongst international students (Depreeuw, 2013; Koo & Nyunt, 2022; Mukminin, 2019). Besides, international students are more likely to go through these life events and difficulties in isolation as they are away from their friends and family, especially if they lack social or institutional support in the host country (Can et al., 2021; Praharso et al., 2017; Ruckert, 2015). In fact, living away from loved ones and experiencing difficulties may exacerbate stress levels and psychological distress as some students may keep their problems to themselves in order to not worry people back home (Wei et al., 2012).

2.2.2 Implications of poor student mental health

Mental health problems are regarded as the major contributor to the deterioration of general well-being (Vigo et al., 2016). In fact, mental disorders have been associated with various physical conditions, including diabetes, cardiovascular diseases, and cancer (Stein et al., 2019) as well as heightened risk for suicidal behaviour and early mortality (Planna-Ripoll et al., 2019). On the other hand, mental health problems are also linked with poor functioning (Goldman-Mellor et al., 2014; Ricky & O'Donnell Siobhan, 2017), such as difficulties in social relationships and poor economic outcomes in later life (Hernández-Torrano et al., 2020).

It has been conveyed in the literature that the peak onset period for mental health disorders coincides with the time for tertiary education (Ahrnsbrak et al., 2017; Ibrahim et al., 2013). Although it is not possible to make any causal inferences, a UK-based study showed that the prevalence of common mental disorders among young adults is higher for individuals in higher education compared to those who are not (Lewis et al., 2021). Moreover, the National Health and Nutrition Examination Survey reported that adults with a university education were more likely to use antidepressant medication compared with those with a high school education (Brody et al., 2020). Hence, the student mental health literature has also investigated the student-specific consequences of psychological problems.

It has been reported that untreated mental health problems experienced by students create or exacerbate difficulties in their academic lives (Hunt & Eisenberg, 2010). Students with severe mental distress are more likely to report low academic self-efficacy and delayed study progress than students with few or moderate symptoms of mental distress (Groton et al., 2019). Research shows that students with low levels of psychological well-being are more likely to have difficulties with motivation and concentration concerning their academic work (Eisenberg et al., 2009). In fact, psychological distress during tertiary education has been linked with poor educational outcomes, including a heightened risk of university dropout (Lipson & Eisenberg, 2018) and low academic engagement and academic success (Antaramian, 2015).

2.2.3 Mental health service use among students

Earlier studies suggest that students who suffer from psychological distress or have mental health problems don't often report their symptoms and seek professional help (Eisenberg et al., 2007; Rosenthal & Wilson, 2008). Research shows that only one-third of American students with a diagnosed mental health problem receive professional treatment (Eisenberg et al., 2011; Henshaw & Freedoam-Doan, 2009). In fact, nearly 70% of university students in the US who have symptoms of psychological problems, reported not being formerly diagnosed with a mental health disorder (American College Health Association, 2019).

However, recent studies illustrate that more students have been engaging with mental health services. For example, The American College Health Association (ACHA, 2019) reported that there has been a steady increase in the number of students utilising on-campus care for mental health problems in the US. Their research showed that 21.3% of the students stated that they had received psychological services at their university counselling centre. Besides, ACHA's (2019) findings indicated that between 2010 and 2019, students accessing external support for mental health increased nearly 1.5 times. Specifically, in 2019, 42.6% of all students are accessing mental health support off campus.

Similarly, HUMEN's (2022) study amongst 7200 UK university students revealed that 57% have accessed university services (i.e., counselling services, helplines, self-help resources, and well-being groups) for mental health. Data showed that 31% of women and 60% of non-binary people who accessed services received a mental health diagnosis, whereas only 19% of male students were diagnosed with a mental health condition. Interestingly, it was reported that among men who were struggling with their psychological well-being, 73% sought help from university services.

However, some scholars believe that many students still "suffer in silence" as not all individuals who show symptoms of psychological distress get a diagnosis or treatment (Tugade et al., 2021). In fact, the World Mental Health International College Student Initiative findings demonstrated that amongst 13,984 first-year students in eight different countries, only 24.6% reported that they would definitely seek treatment in case of a future emotional problem (Ebert et al., 2019).

Studies suggest that despite the recent rise in help-seeking behaviour among university students, more than half of the student population globally has unmet needs as many students still don't approach services (Broglia et al., 2021; Cullinan et al., 2019; Eisenberg et al., 2012; Lipson et al., 2015). There is a large body of literature investigating the factors that prevent students from accessing appropriate mental health services and engaging in treatment (Batchelor et al., 2020).

Stigma and negative help-seeking attitudes were linked to lower help-seeking behaviours (Chandrasekara, 2015; Gulliver et al., 2010; Kearns et al. 2015). A qualitative study conducted in the UK conveyed that students were reluctant to access mental health support as they felt "afraid of the stigma attached to mental health difficulties and feared that it would be seen as a sign of weakness" (Quinn et al., 2009, p. 410). Furthermore, studies show that in general, men who conform to masculinity norms and experience self-stigma more were more likely to have unfavourable attitudes toward help-seeking and therefore, less prone to use mental health services (Sagar-Ouriaghli et al., 2020; Vogel et al., 2011).

Despite the studies showing that university counselling in the UK has been beneficial in helping students with their mental health-related problems (Biasi et al., 2017),

many students are reluctant to engage in professional services due to the perceived ineffectiveness of treatment (Ebert et al., 2019). Having negative perceptions about mental health services has been identified as a barrier to help-seeking (OfS, 2019). Both the London School of Economics (LSE) and the University of Chester students shared that they felt discouraged to engage in university counselling services due to reports of long waiting times and because of not wanting to use the limited number of sessions available to them early on in their studies (LSE Students' Union, 2019; Chester Students' Union, 2018).

Another common barrier to seeking professional help for mental health problems is the lack of knowledge about mental health issues and sources of help (Almanasef, 2021; Gulliver et al., 2018). A UK-based survey showed that 34% of students were not aware of services for mental health problems at their college or university (NUS-USI, 2017). Empirical evidence indicates that students with low mental health literacy were more reluctant to seek help for mental health problems (Rafal et al., 2018; Ratnayake & Hyde, 2019). Lu et al.'s (2014) findings suggest that not knowing symptoms of psychological distress or thinking that their level of distress is not serious enough to receive treatment withheld students from accessing support. Wang et al. (2012) reported that international students were more likely to be unaware of having a mental illness. Being unaware of or lacking appropriate knowledge about the services and support available for psychological distress acted as a barrier to help-seeking for both international and domestic students (Thomson et al., 2015). Furthermore, it was found that Chinese and Malaysian international students were reluctant to access services due to lacking knowledge about the NHS system, counselling, and confidentiality (The University of Nottingham, 2011).

Some students didn't access services for mental health treatment as they perceived their symptoms as a typical reaction to university stress (Bilican, 2013; Eisenberg et al., 2007). Also, students with a heightened risk for suicide were shown to not access treatment as they reported no perceived need for treatment (Czyz et al., 2013). Broglia et al. (2017) propose that students in the UK are more likely to delay accessing services until they experienced severe needs or observed a negative impact on their academic performance.

On the contrary, research on what aids students to seek help for psychological problems and engage in treatment is limited. Several studies have shown that having prior experience with therapy or knowing someone else who has previously accessed professional help contributes to having a positive attitude toward mental health services (Disabato et al., 2018; Rickwood et al., 2005; Vogel et al., 2007). Scholars suggest that knowledge from direct experience or by learning from others' accounts may increase one's mental health literacy and positively impact their future help-seeking intentions (Coppens et al., 2013; Gulliver et al., 2010). However, research indicates that even for students who have positive attitudes towards professional help-seeking and treatment for psychological problems, they are more likely to approach friends, family, or university staff than seeking formal type of support (Bilican, 2013; Goodwin et al., 2016; Hughes et al., 2018).

Studies that investigated international students' help-seeking attitudes and behaviours found both similarities and differences compared to their local counterparts. Firstly, negative attitudes towards psychological difficulties or therapy services are a major obstacle to help-seeking among international students from cultural backgrounds with a strong stigma attached to mental health (Ruckert, 2015). Research demonstrates that international students have a much higher threshold for engaging in university counselling (Depreeuw, 2013). For instance, Asian international students were found to use mental health services less than domestic and other international students due to culture-related factors, including stigma and fear of losing respect (Young, 2017; Xiong & Yang, 2021).

International students also experience unique barriers to receiving support for mental health needs. The most significant obstacle is the language barrier, which may negatively impact international students and make them feel more reluctant to seek help in the first place (Hwang et al., 2014). Research shows that international students may experience negative attitudes toward engaging in services in the host country due to having concerns about the counselling process arising from language barriers (Chalungsooth & Schneller, 2011; Willis-O'Connor et al., 2016). Hwang et al. (2014) suggest that language-related challenges around communicating distress may lead international students to delay help-seeking until their condition becomes very severe.

Also, research has demonstrated that cultural differences in coping with psychological distress may also explain international students' reluctance towards engaging with mental health services (Salaheddin & Mason, 2016). For instance, Chinese people report a higher degree of self-reliance and not wanting to seek help from others (Shi et al., 2020). There is evidence that international students may access other sources of support or engage more in alternative coping strategies for dealing with psychological distress, such as using religious or spiritual coping or seeking help from friends and family (Gulliver et al., 2010; Maciagowska, 2018; Mundia & Shahrill, 2018; Neighbors et al., 1998; Yelpaze & Ceylan, 2020).

2.2.4 Support offered to students in the UK

It has been reported by a number of UK HE institutions that well-being support offered to all students includes group sessions or workshops covering a range of different topics, campaigns and awareness training, peer-to-peer support, and self-help through digital resources (Department of Education (DoE), 2021). Some of the specific mental health services offered by HE institutions are face-to-face counselling, psychological therapies, online support, and specialist trauma, emergency, or out-of-hours support offered by partnership external organisations (DoE, 2021). HE institutions are also known to collaborate or partner with local GPs or mental health practitioners, specialist services, local A&E departments, and their Psych Liaison Teams, and Increasing Access to Psychological Therapies (IAPT) services (DoE, 2021; Williams et al., 2019). However, as the waiting times for on-campus support get longer and concerns around student mental health increase, more and more students are campaigning for better service provision for psychological support (Office for Students, 2019).

Similar to the problems identified with the on-campus support, the general population, including students, encounter problems after referral to NHS mental health services. The most significant concern is the long waiting times to start treatment (Docherty & Thornicroft, 2015; Thorley, 2017). Service user data shows that 54% of people who have been referred to specialist mental health services wait for up to three months to start treatment and 12% report wait for more than a year (MIND, 2013).

On the other hand, Doran suggests that support offered by university-based or other mental health professionals focuses on resolving difficulties through one-to-one medication treatment and/or talking therapy and that “there is little or no focus on social or organisational structures or barriers within which students are expected to fit” (2009, p. 4). In the NHS England Long Term Plan published in 2019, student mental health is incorporated “within its wider approach to services for people aged 18–25, with a commitment to deliver an integrated approach across health, social care, education, and the voluntary sector” and to work closely with universities to improve access to mental health services (Callender et al., 2021). It was conveyed in Doran’s (2009) report that a more holistic and systemic approach needed to be taken when thinking about supporting university students with their mental health. In fact, a survey among HE providers concluded that there was an identified need to evaluate the effectiveness of services, understand students’ expectations for and experiences of support, and investigate barriers to help-seeking in order to improve the support provided to students (Pollard et al., 2021).

2.3 Research into Therapy Experiences of University Students

As illustrated above, there is existing research on student mental health and their help-seeking attitudes and behaviours. However, literature on university students’ therapy experiences, including of international students, is very limited and it mostly consists of quantitative studies (outcome measure or randomised-controlled trials) investigating the effectiveness of psychological therapy. For example, Kanetsuki et al. (2008) measured the effectiveness of delivering Cognitive Behavioural Therapy (CBT) to Japanese university students for anger management and concluded that compared to the control group, participants in the treatment group showed greater improvement and reported decreased trait anger. Similarly, Galante and her colleagues (2018) measured the effectiveness of mindfulness-based intervention on 616 university students and compared self-reported psychological distress scores to the control group who received mental health support only. The findings indicated that university students mindfulness skills for students intervention was significantly effective in reducing psychological distress. Another example, Cerutti et al.’s (2022) study among Italian university students conveyed that participants in the in-treatment group, compared to a waiting-list comparison group, reported reduced psychopathological symptoms, and improved psychological adjustment. These

studies indicate that psychological intervention for university students begot positive therapy outcomes and reduction in psychological distress.

On the other hand, Biasi et al. (2020) investigated the variables associated with therapy effectiveness and positive therapy outcome predictors amongst university These findings suggest that client factors have an impact on therapy effectiveness. Zeren et al.'s (2020) study investigated mode of therapy (face-to-face vs. online) as a variable for therapy effectiveness among Turkish university students. No significant correlation between mode of delivery and subjective well-being scores was found, indicating that online counselling can be as effective as in-person therapy. However, authors demonstrated that positive and negative affect scores from pre-test to post-test showed significant improvement for only the students in the face-to-face counselling group, suggesting that long-term improvement due to counselling may be different for students receiving psychological intervention via different medium.

A study by Keum et al. (2022) explored therapist's perspectives on therapist and counselling centre factors. It was demonstrated that therapists found it more effective when they 'met where students were at', spent more time on fostering working alliance and rapport, provided overt attention to client's identity in cultural context and to cultural humility, openness, and curiosity. On a similar note, Bektas (2008) recommends training in multicultural competency, awareness of international students' potential difficulties, and cultural sensitivity to improve counselling provision to international students at Turkish universities. On the other hand, literature suggests that counsellor's cultural background or native language may influence counselling provision. As Li et al. (2018) convey, international counselling students have been shown to experience foreign language anxiety, which impacted counsellors' perceptions of their self-efficacy in counselling situations (Li et al., 2018). The authors discuss that foreign language anxiety may impede international counselling students' acculturation into the mainstream culture. Therefore, it is possible that therapist's mother tongue may act as a therapist-related factor for effectiveness of therapy offered to university students, including to international students from different cultural contexts, speaking different native languages than the counsellor.

Overall, there are studies in the literature investigating therapy effectiveness or counselling provision related therapist factors. However, such studies don't provide information on clients' subjective experiences of engaging in therapy or generate an understanding on what is most helpful/unhelpful from the perspective of the client. In this section, I will review a selection of published papers that explored the experiences of therapy for university students as this was the specific area I was interested to study.

2.3.1 Literature review strategy

A comprehensive literature search was undertaken in order to access relevant existing research. I used searched for qualitative studies in different databases, which were CityLibrary Search, APA PsychINFO and Wiley Online Library. The following criteria was used to identify potential articles.

Selection criteria. Research articles, review articles, unpublished Doctoral theses (the decision to include unpublished doctoral theses was due to the limited number of published papers available in the literature)

Publication date. 2000-2020

Key words used. 'university Student', 'international student', 'psychological therapy', 'psychotherapy', 'counselling', 'experiences', 'reflections', and 'qualitative research' (the keywords were used in various combinations)

Criteria for considering studies for literature review. I included qualitative studies that explored the experiences of therapy for university students. No criteria were given to the type of treatment or psychotherapy model. The database searches yielded 233 articles in total, and 10 studies were included in this review.

.2.3.2 Reasons for engaging in therapy

Qualitative methods have been used to explore model-specific therapy experiences for university students and researchers have investigated therapy process from the clients' point of view. Bernhardsdottir et al. (2014) explored the reasons for undergoing cognitive behavioural group therapy (CBGT) among nineteen female university students at an Icelandic university. Interpretive content analysis was used for data analysis, which resulted in four themes. Findings from this study illustrated that university students engaged in CBGT to gain knowledge about themselves, develop positive outlook in life, and feel self-confident and in control. This study emphasised that students engaged in CBGT for various reasons, which were centred around developing insight, changing their thinking, and promoting self-reliance. Participants' subjective experiences highlighted that individualistic values and goals influenced their decision to initiate therapy, but there was no mention of any specific reason for engaging in group therapy. It would be interesting to conduct a similar study among students from other cultures (i.e, collectivistic) and investigate whether group-related reasons or collectivistic values influence their decision to engage in group therapy.

A study by Gericke et al. (2021) yielded similar findings, concerning the reasons for undergoing therapy. Nine university students (three male and six female first-year students) at a South African university were interviewed to explore their experiences of using an Internet-based CBT intervention. They analysed the interview data by using thematic analysis outlined by Braun and Clarke (2006) and took an inductive data-driven approach with the assistance of Atlas-ti software. Echoing Bernhardsdottir et al.'s (2014) findings, this study emphasised that students gained self-awareness which they perceived as necessary for change. The findings highlighted that ability to reflect and develop introspection were perceived as helpful by students. Also, this study reported that students benefitted from the flexibility and autonomy provided by the delivery method. These findings corresponded to the existing literature which argue that cultural values shape mental health understanding and treatment (Hechanova & Waelde, 2017). However, due to the nature of qualitative investigation, the transferability of findings is limited, and similar studies

are needed to understand diverse groups' experiences, including students from other universities, age groups, and cultural backgrounds.

2.3.3 Changed attitudes towards help-seeking

Story et al. (2019) conducted semi-structured interviews with eleven university students who accessed psychological therapy about their experience around mental health leave. The thematic analysis revealed that all students experienced increased stress and symptoms prior to taking leave and starting therapy. The findings also emphasised that participants experienced obstacles accessing or embracing therapy. For example, some students experienced difficulty in determining the severity of their problems and where to go for support. This conveyed that lack of mental health literacy (about symptoms and severity of psychological distress) hindered help-seeking. The findings emphasised a shift in students' attitudes towards seeking help through therapy, as students reported that they no longer felt ashamed or afraid to ask for help. Students reported benefitting from developing new plans, skills, and perspectives to deal with academic problems. The findings conveyed that skill-based intervention and high level of directiveness by the therapist was perceived as beneficial. This study generated knowledge about what students experienced around receiving psychological help and the importance positive therapy experience for developing positive attitudes for future help-seeking. However, the study recruited participants from only one American college and interviewed students who successfully returned to their studies after their leave. Hence, students with different demographics or the ones who have not returned to college after taking a mental health leave may have different experiences regarding undergoing therapy and its benefits. No other published papers qualitatively investigating the impact of undergoing therapy on attitudes towards help-seeking. It would be useful to explore students' subjective experiences concerning change in attitudes towards therapy, including for students from different cultures or who engaged in different types of therapy.

2.3.4 Therapy relationship experiences

Batchelor et al.'s (2020) study on student perspectives on mental health support and services revealed information about what university students experienced within

NHS mental health services. The participants were asked to rate the care they received from the NHS on a five-point Likert scale. Out of 120 participants, 40 answered two open-ended qualitative questions: ‘Is there anything particularly good about your care?’ and ‘Is there anything that could be improved?’. The content analysis revealed that students made positive comments about the qualities of the NHS staff but also indicated their wish to receive more compassionate and person-centred care. Findings emphasised what students perceive as indicators of good therapeutic relationship between therapist and client. The survey was amongst students across the UK, but most of the participants were home students and given the nature of qualitative inquiry the findings are not transferable to international students. It would be interesting to explore international students’ experiences with the NHS staff and inquire what they value in therapeutic relationship.

Quinn et al. (2009) explored how students experienced support received from university services and the NHS. Authors conducted in-depth interviews with twelve students. The interview data was analysed ‘through the identification of key themes and issues’, but no analytic framework was mentioned. Findings indicated that most of the students were reluctant about receiving support from university counselling services, but the ones who did seek help valued the support. Students who accessed NHS services often felt dismissed by their GPs, which echoed Batchelor et al.’s (2020) findings on person-centred and compassionate care. This study findings emphasised the negative aspects of their experiences of psychological support from the NHS. However, no demographic information concerning the interview participants was mentioned and therefore, it is not possible to comment on the characteristics of the sample group.

A mixed-methods study by Wenzler and Keeley (2022) utilised thematic analysis by Braun and Clarke (2006) to code and analyse data from 453 university students at an urban university. Participants were asked to respond to a question about why they discontinued their mental health treatment. As the aim of this research was not to explore students’ experiences in-detail, the qualitative findings were restricted in scope and depth. However, it did reveal information about the mental health service

experience for those participants that discontinued treatment. The authors reported that participants' negative experiences with mental health services were related to 'bad experiences with clinician', which included feeling not listened to, not having a trusting relationship, and not feeling comfortable with their therapist to talk about difficult experiences. Findings emphasised that bad therapeutic relationship students experienced with their therapist contributed to early termination of therapy. However, most of the participants were White/Caucasian first-year female students. The authors indicated the need for future research to further understand why college students seek mental health care and explore why they choose to continue or discontinue mental health services. Also, it would be interesting to explore the same experience among male students or students from minority groups to generate more knowledge on early termination of therapy and therapeutic relationship based on their subjective experiences.

2.3.5 Cross-cultural therapy experiences

The literature review recovered only three qualitative studies that explored cross-cultural therapy experiences amongst university students. Olaniyan and Hayes (2022) interviewed forty-eight racial and ethnic minority students in two British universities. The authors indicated that their study was guided by the principles of constructivist grounded theory and reflexive thematic analysis. The interview data was then analysed by using the NVivo-12 qualitative analysis software. The findings showed that students were apprehensive about ethnic matching as they feared loss of objectivity in the therapeutic relationship. Participants expressed that their therapists would be attached to similar cultural values and possess preconceived ideas about cultural or religious values, which meant that therapists would not be able to stay impartial towards them and what they are sharing. It was noted that participants felt apprehensive about potential conflicts or judgement associated with their culture being brought into the session and they feared conflict or judgment from a therapist of the same ethnic background. These findings emphasised that cultural

matching may be unhelpful if clients feel that cultural judgments are being enacted in the therapeutic relationship. It appeared that ethnic matching hindered feelings of safety and non-judgement. The authors reported establishing a good therapeutic alliance through having things in common with therapist was important for the participants, but it didn't necessitate ethnic matching. Another finding was around the capacity to engage culturally, which was important for the therapeutic relationship. However, the authors pointed out that ethnic matched service had limited value if they were unable to engage with the students as unique individuals, not with the stereotype or culturally specific preconceptions. Overall, the study results yielded useful information for services to create an understanding of students' experiences of having ethnic match.

Liu et al. (2020) investigated East Asian international students' experience of counselling using an interpretative phenomenological approach (IPA). Five students from mainland China and four students from South Korea from Midwestern universities in the USA were interviewed about their counselling experiences. Out of nine, 4 participants were male. The findings conveyed that students valued their counsellors' empathy, listening skills, and collaborative attitude. It was also demonstrated that mismatched expectations were associated with medical model of psychotherapy. They expected to receive "professional" suggestions or medications to "treat" their problems. This was contrary to the existing literature on traditional East Asian/holistic approaches to mental health understanding and treatment (Kraus, 2015; Waldram, 2000) and this study's findings convey that international students from China and South Korea don't hold the 'traditional' values towards well-being.

Furthermore, findings also emphasised that East Asian international students attributed their psychological distress to medical reasons and preferred the medical model, which echoed Hechanove & Waelde's (2017) findings on Southeast Asians' reluctance to talk about painful issues and preference for emotional avoidance. Liu et al. (2020) reported that students emphasised lack of multicultural competence

that negatively contributed to the counselling experience. Participants expressed that their therapist's lack of knowledge about sociocultural context or social norms made them feel that they were not understood by their therapist. This finding supported McRae and Johnson's (1991) view on the importance of having information about particular social and political history and understanding minority client's socio-political experiences for MCC.

It is also worth to mention Wilk's (2016) doctoral research project, which qualitatively explored therapeutic relationship in the context of cross-cultural therapy. Braun and Clarke's (2006) framework for thematic analysis was used to interpret the interview data from five international students at a UK university. Only one participant was a male student, and he was Mexican. Four other participants were female students; two Chinese, one Kuwaiti, and one Portuguese. The study sample was diverse in age, nationality, subject of study at university, and length of time spent in England. Hence, the focus of investigation based on participants' international student identity. Students reported challenges of cultural and language barriers. Participants expressed that engaging in therapy in English created additional difficulties in being able to express themselves whilst experiencing distress in other areas of their life. Some participants reported experiencing cultural barriers due to having differing perspectives and worldviews with their therapists about psychological distress. The findings showed that students appreciated acceptance and non-judgement from counsellors and regarded that as the key facilitator for positive therapeutic alliance and engagement within therapy. The author suggested that the counselling space was perceived as a space for mutual learning of diversity that not only benefitted the students but also the counsellors. Similar studies with homogenous samples may give more in-depth information about culture specific experiences for international students.

2.4 Research Rationale

The UK is the country with the second most international students in the world and the number of international students enrolled to HE institutions has been rapidly growing since 2016 (Erudera, 2022). Studies indicate that student mental health services are not ready for the number of students seeking help but also not in a position to effectively respond to the diversified student population and accommodate their needs and preferences (Arthur, 2008, 2017; Okorocha, 2010a, 2010b).

As outlined earlier, many international students experience unique barriers to help-seeking, including the influence of culture (e.g., Bilican, 2013; Hughes et al., 2018; Rafal et al., 2018; Xiong & Yang, 2021; Yelpaze & Ceylan, 2020). The international student-focused research has mainly adopted quantitative approaches and studied help seeking attitudes, perspectives on psychological support, and barriers to access to mental health services for international students (Broglia et al., 2021; Pendse & Inman, 2017). On the other hand, students' experience of therapy hasn't received much scholar attention to this date. There remains a gap in creating an understanding of the challenges as well as helpful and unhelpful experiences international students who decide to seek help and engage with mental health services encounter. As a matter of fact, the Office for Students (2022) advocates for research on international student experiences and calls for evidence to promote accessibility and effectiveness of support services.

Also, the international-student focused research has mainly focused on students coming from Southeast Asian and East Asian countries and investigated the influence of the collectivistic culture orientation and its interplay with the dominant Eurocentric practices in the host countries. However, to the researcher's knowledge, there is no qualitative investigations on Turkish international students. According to UNESCO (2021), 3420 students from Turkey are enrolled in a British HE institution. Turkish people display individualistic values and attitudes whilst mainly preserving

collectivistic cultural orientations (Mocan-Aydin, 2000). Hence, Turkish international students represent a unique cultural group with potentially different needs and experiences than their other international counterparts (Erturk & Nguyen, 2021). Identifying and responding to the needs of Turkish international students are necessary for multicultural competent counselling practice (Tatar & Horencyzk, 2000). To address Turkish international students' needs, service providers and clinicians need know and understand the students and should develop knowledge of Turkish culture and norms from students' perspectives. It is hoped that acquiring information about Turkish culture will prompt cultural curiosity and prompt culturally competent service provision (Jacob & Greggo, 2001; Yoon & Portman, 2004).

In order to understand the experience of accessing and undergoing psychological therapy of the chosen group of Turkish international students in the UK, the following research questions were used to guide this project:

1) What are the experiences of Turkish international students accessing psychological help in the UK?
2) What are the experiences of Turkish international students undergoing psychological therapy in the UK?

Chapter 3: Methodology and Methods

This chapter starts with giving an outline on how the research questions were developed. It also describes the research aims and research design, which is followed by the discussion of the analytical process and Reflexive Thematic Analysis (RTA) framework. There is also a consideration given to critical realism and its influence on the methodology. Secondly, this chapter presents the research strategy, procedures and analysis and addresses ethical or procedural issues that were debated during the research process to ensure good quality and rigour. The chapter ends with a reflexivity section and discusses the meaning and influence of the researcher's stance and subjectivity on the research process.

3.1 The Counselling Psychologist Researcher

Henton and Kasket (2017) suggest that counselling psychologists need to think more thoroughly about their approach towards research and towards their own research practice. Similarly, Cooper (2009) debates the necessity of 'ethics in action', which is to integrate the counselling psychology values into research activity. On that note, prior to presenting the theoretical positioning and methodology of the research, I wanted to note my role as a scientist-practitioner as well as explore my values as a counselling psychologist to explain how these were demonstrated in my research project.

One of the roles of a counselling psychologist is to produce knowledge that would advance the field and to translate research into practice "to make a difference, and to help." (Henton & Kasket, 2017, p. 7). Not only generating new knowledge, but the counselling psychologist's research activity is also expected to produce useful and practical knowledge for the wider professional arena (Henton & Kasket, 2017). Hence, my research questions were rooted in the objective to produce new knowledge about Turkish international students, which would be then transferred into clinical practice and used by various professionals within the field.

On the other hand, the field of counselling psychology acknowledges the inevitability of subjectivity and intersubjectivity as well as appreciates the uniqueness of each individual (Bugental, 1964; Kasket, 2013). Some scholars suggest that humanistic philosophy and values that sit at the core of counselling psychology translate to client-centredness in therapy and to methodological pluralism in research (Henton & Kasket, 2017). Similarly, Cooper and McLeod (2011) advocate for a pluralistic approach in professional practice, which is the conceptualising of problems and selection of appropriate methods tailored to the individual needs of the client.

In my clinical practice, I work collaboratively with the client and try to understand what would be best suited for their unique needs. This means that I put the client at the centre and assess their needs as opposed to prioritising the therapy model. Then, I either integrate or bring together different models or techniques that I feel confident and competent utilising with the client.

I took a similar approach when developing my research proposal. Pluralism in research means acknowledging that there may be various ways to address a research question (McAteer, 2010). Kasket (2013) points out that a counselling psychologist stays open-minded and considers different research approaches available that may all be valid to answer the research question in their own distinct way and chooses the methodology that she regards as the most fitting for the research objectives. Setting my research objectives aided me to develop the research questions, which was followed by the decision for the qualitative research approach and critical realism as a philosophical stance. Then, my sense of confidence and competency as well as the utility of the analytical strategy helped me to determine the methodology.

3.2 Research Aims and Questions

Research questions that guided my study are as follows:

1) What are the experiences of Turkish international students accessing psychological therapy in the UK?

2) What are the experiences of Turkish international students undergoing psychological therapy in the UK?

One of the research questions was born out of my personal experiences around undergoing therapy in the UK as part of the DPsych training. It was the first time I ever engaged in therapy, and I had two sets of therapy and two different therapists. I thought this would be a good opportunity to utilise my personal experience as a starting point for generating a research question, which was about Turkish people's therapy experiences. I was curious to know more about how Turkish people experienced therapy in English and with a therapist from a different culture. I felt like there were some cultural aspects to my experiences which I found difficult to explore with either of my therapists. It was also difficult to describe some of my experiences as some of the feelings didn't have an exact translation in English. On the other hand, upon exploring the literature, I was also interested to explore what motivates Turkish students to seek professional help and engage in psychological therapy as well as what they experience during their search for a therapist. Considering the literature on barriers to help-seeking and call for more explorative studies on international students' experiences, I was curious to explore what Turkish students experienced whilst seeking help and what they found helpful or unhelpful during the process. However, I was cautious to not make any assumptions based on my personal experiences or existing evidence and literature, and to incidentally affect the research (see Reflexivity section).

Also, when I was having conversations with my colleagues on placement or my peers on the course, I realised that I received lots of questions about Turkish people and the Turkish culture. The questions were mostly about perception of mental health and stigma amongst Turkish people, the Turkish language, norms, and the socio-economic situation in Turkey. Although my research didn't address these topics, having these considerations made me realise that professionals in the field of psychology would benefit from gaining insight into this population and their experiences of therapy.

The research aims were centred around exploring Turkish international students' journey with therapy (i.e., their experiences of accessing as well as undergoing psychological therapy). Through exploring what Turkish international students experience, I aimed to not only produce useful knowledge that would inform professionals within the field of psychology and student mental health but also to give participants a chance to voice their unique experiences. Knowledge generated from the research findings was hoped to provide information about this minority client group as well as to promote cultural curiosity that is associated with cultural counselling competence for therapists working with this student population.

3.3 Qualitative Approach

The choice of methodology for this research project began with a debate on the research approach. Considering the humanistic values and appreciation of the inevitability of subjectivity, this study rejected a positive approach, which is predominantly adopted by quantitative researchers. According to Bhaskar et al. (1998), positivism limits 'reality' to what can be empirically known. Positivists claim that 'truth' or 'reality' exists independently of the observer (Kirk & Miller, 1986). Hence, studying phenomena involves empirical measurement, experimental designs, generalisable findings, and high-quality standards of validity and reliability (Cohen, Manion, & Morrison, 2007; Hammersley, 2013). Firstly, my research objective was to explore what individuals experienced through their therapy journey and not to generalise the findings to a wider population. Secondly, as the positivist approach is based on "deduction from existing systems of thought", generating new knowledge outside the pre-existing theoretical frames becomes nearly impossible (Willig, 2008, p. 4). As discussed in the first chapter, there is limited information available about Turkish students that live abroad or in the UK, including about their well-being, and a lack of knowledge about their experience of therapy in the UK. A quantitative approach didn't sit well with my objective to explore a shared experience that wasn't investigated before. I also acknowledged that a quantitative approach would not be appropriate to prioritise the subjectivity and uniqueness of each individual.

Given my position as a counselling psychologist researcher as well as considering the gaps in the literature and the study objectives, a qualitative approach was deemed more suitable. In accordance with Midgley's (2004) framework for psychotherapy research, this research acknowledged the intersubjective nature of undergoing therapy whilst contributing to a knowledge base targeted at informing and improving the service provision for Turkish international students.

In qualitative research, one attempts to generate insight into the human experience and embraces the researcher's role in interpreting what the participants say about their experiences (Austin & Sutton, 2014). As Rogers and Willig (2017, p. 11) say, "there is no simple and direct relationship between 'the world' and people's experiences of it, let alone our accounts of those experiences, or indeed interpretations of those accounts". Hence, recognising and exploring the theoretical underpinnings of the project and identifying methodology accordingly are necessary for a reflexive qualitative approach in research.

3.4 Theoretical Positioning

Theoretical assumptions determine how the researcher understands the data and interprets the findings (Byrne, 2022). Willig (2021) discusses that a researcher not only contemplates what questions to ask and the knowledge which can be acquired, she also debates how these questions can be answered and how the knowledge can be accessed. After deciding on my research aims and questions, I decided to investigate which epistemological and ontological assumptions were embedded in my research.

Firstly, I was acknowledging that there was a shared experience. Each participant shared a common experience of accessing and undergoing psychological therapy in the UK as a Turkish international student. Secondly, I was appreciating that each participant had their own subjective experience of initiating and engaging in therapy. They not only accessed therapy through different services and engaged in different types of therapy with different kinds of therapist at different lengths, but they also experienced and reported it through their own unique perspective. Hence, I arrived at

the conclusion that I assumed that there was a 'real' experience of accessing and undergoing therapy as a Turkish international student, yet no absolute knowledge could be generated about it since it was subjectively experienced as well as based on participants' subjective accounts. Also, I took the perspective that my socio-cultural position and experience as a Turkish international student in the UK coupled with my identity as a counselling psychologist had an influence on my understanding of the participants' experience, which added another layer of (inter)subjectivity.

Therefore, considering my aim to generate knowledge about what individuals in this study experienced and find patterns in their experiences to tell something about the reality of accessing and undergoing psychological therapy in the UK. The research aligned with a critical realist (CR) position and the questions that I wanted to address with this research embraced the assumption that the real world can only be accessed through the subjective lens of the subject.

3.5 Critical Realism

CR advocates that it is impossible to reduce the nature of reality to our knowledge of it (Fletcher, 2017). It considers the limitations of accessing reality and acknowledges that it would be impossible for the researcher to generate true knowledge about the world. It postulates that the real world can only be accessed by the subjective lens of the knower, including both the researcher and the research participant (Willig, 2012). Hence, we can only know the world subjectively, but this doesn't allow us to generate true knowledge about the world. This prompts the researcher to be more critical and reflexive about the knowledge that they generate and provide a richer conceptualisation of the mechanisms at work in the social world (Ackroyd & Karlsson, 2014). Also, critical realists' position on subjectivity corresponds with the philosophical basis of counselling psychology, which emphasises exploring client's subjective realities and meanings and accepting their subjective world as meaningful and valid (Strawbridge, 2016; Strawbridge & Woolfe, 2003).

CR was developed as a critique to positivism and constructivism as both are assumed to reduce "reality to human knowledge, whether that knowledge acts as

lens or container for reality" (Fletcher, 2017, p. 182). In other words, CR views ontology independent of epistemology and divides reality into three levels: empirical, actual, real (Fletcher, 2017). At the empirical level, the events are experienced and observed and understood by human experience and interpretation. The human filter is also construed by language, culture, and discourse (Maxwell, 2012). As Braun and Clarke (2022, p. 170) note, "you cannot identify a simple 'additive' distortion to reality that these provide" yet reality can only be captured through how humans represent it. At the actual level, events occur irrespective of the human experience and what is real may be different to what we perceive or interpret at the empirical level. The causal mechanisms inherent in objects or structures exist at the real level. The real that exists at this level is noted as the causal forces behind the events that occur at the empirical level.

There is no existing research on Turkish international students' experiences with therapy within the mental health literature. Therefore, there is a lack of information about the events that occur. I was convinced that a CR position offered a way to explore what events are experienced by Turkish international students whilst they access and undergo psychological therapy in the UK. On that note, this study aimed to explore the experience of accessing and undergoing therapy through the lens of the research participants and generate knowledge based on the interpretations of their subjective accounts. This research was guided by epistemological relativism, which suggests that what is experienced or perceived and sought to be known are shaped by personal and contextual factors (Lawson, 2003). Hence, deciding on the epistemological and ontological framework aided me to choose the appropriate method for analysis for this study.

3.6 Reflexive Thematic Analysis

The quest to find the right methodology for this project was driven by my study aims and research questions coupled with the CR position. Thematic Analysis (TA) is not theory-driven and allows freedom for the researcher (Braun & Clarke, 2022). Braun and Clarke (2021) note that TA is a broad concept for data analysis that consists of various different methods and procedures. What is common between different

methods of thematic analyses is the shared “interest in patterns of meaning, developed through processes of coding” (Braun & Clarke, 2022, p. 4). I was convinced that TA was well-suited for prioritising my research aims and questions, values, and worldview. Conducting a critical realist TA aided me to explore, interpret, and report the events experienced and perceived by the participants, which provided insight into research participants’ experiences whilst illustrating repeated patterns across the data set. Furthermore, Braun and Clarke (2022) postulate that TA is widely used in counselling and psychotherapy research. Also, based on my literature review, I concluded that most of the existing qualitative research in the relevant literature utilised TA, which reported useful findings for clinical practice.

For this research, I chose a reflexive approach to TA as this framework acknowledges and utilises the subjectivity of the researcher, which was in line with the critical realist position and counselling psychologist philosophy (Braun & Clarke, 2019). Braun and Clarke (2022) indicate that Reflexive Thematic Analysis (RTA) is not prescriptive, and the method of analysis is based on the researcher’s ‘analytic story’ and interpretation. That is, analysis is shaped by the researcher’s values, skills, knowledge, and interaction with the dataset and knowledge generation is based on contextualised truths (i.e., participants’ subjective experiences and meaning-making coupled with their social and cultural context) and interpreted realities of research participants.

3.7 Interpretation

Willig (2017) stresses the necessity to give more attention to interpretation in the field of qualitative research. She points out that the role of the researcher and the work of interpretation should be acknowledged, rather than distancing self from the research data and performing qualitative research whilst implicitly adhering to the positivistic epistemologies. Within the context of a critical realist position, which suggests that reality can only be captured partially and that it is always influenced by how the knower interprets it, the notion of interpretation became more critical to explore and clarify before commencing RTA. Given the research rationale and aims,

exploring the events and understanding them through human interpretation was grounded in the CR approach and different levels of reality.

Braun and Clarke (2022) suggest that analysis is akin to telling a story; talking about the patterns as well as communicating why those patterns are important in relation to your research questions. The authors indicate that the story is always contextualised, meaning that how you interpret the data is tied to the wider context of the data as well as the subjectivity of the researcher. As long as the interpretation is justifiable, the authors propose that it can go beyond the data; interpretation can reveal a new dimension that is not available at face value. Willig and Rogers (2008) propose that the researcher can find the right balance in how far to go with the interpretation if she refrains from imposing meaning on the phenomenon or attempting to fit it to a particular theoretical formulation.

Furthermore, Ricoeur's (1996) theory of hermeneutics addresses the interrelationship between the interpreter and the interpretation. He states that empathic interpretation offers a bottom-up approach to generating meaning, which is focused on the manifest content. Willig (2017) says that an empathic attitude in interpretation results in understanding how the phenomenon is experienced and manifested. She explains that empathic interpretation asks the researcher to focus on the "characteristics of an account, making connections between its various attributes and noticing patterns" (Willig, 2017, p. 3). On the other hand, Ricoeur (1996) postulates that hermeneutics of suspicion are concerned with revealing the meaning behind what is presented. It is a top-down approach and tries to understand why the phenomenon occurs; looks at the underlying processes and brings in explanation using pre-existing theories (Willig, 2017).

Subsequently, the term 'hermeneutic cycle' captures the interrelatedness between suspicious and empathic approaches to understanding (Schmidt, 2006). The pre-existing knowledge and presumptions the interpreter has are necessary for an understanding to be generated about the new or unknown aspects of the phenomenon (Willig, 2017). Willig (2017) conveys that forming new information about a phenomenon is linked with combining empathic and suspicious approaches

to interpretation. She states that, depending on one's position and theoretical approach, a researcher can locate herself along the continuum.

Again, regarding the lack of knowledge in the literature about Turkish international students' therapy experience and my research aims centred around creating an understanding of what these students experience, I decided to follow an inductive approach to data coding and interpretation. This was so that I could stay close to the data, rather than incidentally basing the analysis on my own personal and subjective experiences. I was curious to explore participants' experiences whilst interpreting the data based on my understanding of the manifested content.

After my initial engagement with the data and reflecting on my insider position as well as my scholarly knowledge, I realised that I needed to do more critical interpretation and foster my suspicious understanding of the data. The suspicious interpretation was also aided by the therapy model I practiced at the time. I was on a psychodynamic placement and was using interpretation and making inferences in my clinical practice. I was applying the same level interpretation to my research participants' data and using my psychological knowledge (by importing theory and existing concepts) to uncover hidden meanings, make connections and find patterns by bringing my own explanations to why the manifested content may be occurring.

Hence, I positioned myself on the 'conceptually interpretative' end of the spectrum (Braun & Clarke, 2022). The task was trying to stay with what the participants' expressed in their accounts whilst "going deeper into a more theoretically- and contextually-informed analytic mode" so that I can make better sense of the data (Braun & Clarke, 2022, p. 208-209). This was also in line with my critical realist position; capturing a part of the reality even if it is out of participants' awareness but at an observable level to the researcher.

3.8 Consideration of Interpretive Phenomenological Analysis

Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) was initially considered for this study. One of the reasons why I considered IPA for this

research was because of the critical realist position that is inherent in the methodology itself. Also, IPA has a similar approach to answering research questions as it is phenomenological and interpretative. IPA aims to understand individuals' experiences and make sense of the data in the context of participants' personal and social worlds (Smith et al., 2009). An IPA researcher focuses on exploring the lived-experiences of their research participants and examining their meaning-making activities by providing "a critical and conceptual commentary" (Willig, 2021, p. 19). IPA is utilised to understand the data from an idiographic perspective; every case is analysed individually and within the individual's context working to describe patterns within and across interviews (Braun & Clarke, 2013; Terry & Hayfield, 2021).

I used IPA for analysing the pilot interview. This was because I initially planned to use IPA for the broader study, and my experience with IPA for the pilot interview led me to reconsider my decision. Firstly, IPA allowed me to analyse the individual's experience in depth, interpreting verbal and non-verbal communication in their particular context. However, the analysis resulted in many different themes specific to the individual's unique experience and account. IPA is more interested in understanding the quality and texture of each individual's lived-experience, which requires a more phenomenological approach to knowledge production (Willig, 2021). As I started to recruit participants and interview them, I realised that the sample wasn't homogenous enough to produce coherent themes across interviews. The pilot analysis indicated that IPA wasn't suitable for this study, and this eventually impacted my decision to apply RTA.

IPA builds up codes and themes from a single case and therefore, has an idiographic approach that focuses on the individual and emphasises the unique personal experience of human nature. As opposed to analysing individual versions of a common experience with IPA, RTA was less idiographic and allowed interpretation of a shared experience. With RTA, the focus was on identifying repeated patterns across the data set. Understanding the repeated patterns in Turkish international students' experience of therapy took precedence over gaining insight into each individuals' experience in the quest for generating knowledge to inform clinicians and improve service provision.

3.9 Methods

3.9.1 Ethics

Following an application outlining my proposed research (please see Appendix 1), ethics clearance of this study was obtained from the City, University of London Psychology Research Ethics Committee. Recruitment commenced after the ethics clearance was received. The research followed British Psychological Society's (BPS, 2021a)'Code of Human Research Ethics', 'Ethics Guidelines for Internet-Mediated Research' (BPS, 2021b), 'Code of Ethics and Conduct' (BPS, 2018), and 'Data Protection Regulation: Guidance for Researchers' (BPS, 2018) as well as adhered to City University London's (n.d.) 'Framework for Good Practice in Research'. Given that research was carried out during the COVID-19 pandemic, 'Ethics Best Practice Guidance on Conducting Research with Human Participants During Covid-19' (BPS, 2020) was also followed closely.

3.9.2 Sensitive research

In line with the Code of Human Research Ethics (BPS, 2021) careful consideration was given to ethical problems and potential risks that may be linked with the research topic and research group. The study was deemed a low-risk project. However, talking about mental health and therapy experience may have been sensitive to and potentially distressing for people (Decker et al., 2011). Ethical problems associated with risk were assessed and addressed before, during, and after data collection.

Firstly, participants were informed about their right to withdraw and refuse to answer any particular research questions (please see Appendix 2 for Informed Consent). A Distress Protocol (please see Appendix 3) was developed for managing potential risks and the possibility of difficult issues resurfacing during data collection. It was anticipated that the participants may become emotive during the interview

considering the research topic. The researcher was mindful about staying open, empathic, and containing during data collection. The protocol was developed to assess and manage responsively if a situation was to occur, by asking the participants if they wanted to continue. Participants were informed that should they feel uncomfortable answering any of the questions, they could let the researcher know and that the interview or the recording could be stopped depending on their preference. None of the participants indicated signs of distress, refused to answer any of the interview questions, or requested to have the recording stopped. Finally, participants were also informed about emergency contact details to manage risk and potential distress after the data collection (please see Appendix 4 for Debrief Sheet).

3.9.3 Informed consent

People who responded to the research advertisement were sent an information sheet outlining the research aims and procedure. People who demonstrated interest were scheduled for a brief screening call on Zoom (please see Appendix 5 for Screening Guide). Following the screening call, individuals who fit the research criteria and agreed to participate in the study were then sent an informed consent sheet and asked to electronically sign it prior to attending the interview. All of the participants were asked to email the electronically signed and completed consent sheets before their scheduled interview appointments. Participants were made aware of their right to withdraw from the study during or up-to one month after the interview. Participants were also explained that they would be able to refuse to answer any interview questions if they wanted to. None of the participants declined to answer any questions or chose to withdraw from the study. After the completion of the interview, participants were debriefed, which involved reiteration of the aims of the research project, gaining insight on participants' experience of the interview, and signposting to appropriate psychological support if it was deemed appropriate. However, none of the participants expressed or indicated sign of distress that necessitated signposting. Following the completion of the interview, participants were emailed the debrief sheet, which outlined their rights and provided emergency contact details.

3.9.4 Confidentiality and anonymity

All standard precautions were taken to ensure confidentiality and anonymity of the participants. Interviews were conducted online, on an end-to-end encrypted video conferencing platform called Zoom. All the participants were asked to join the video interview from a private space.

Each online interview was recorded using Zoom's encrypted cloud recording function. A separate audio recording was kept using an encrypted recording device, to prevent any data loss due to potential technical issues. Following completion, each online interview data was automatically transcribed and uploaded to the cloud by Zoom. The video recording of each interview was deleted immediately after from the cloud and the audio recording and interview transcript were uploaded to City's encrypted cloud platform, OneDrive. The audio recordings from the recording device were deleted afterwards. Each Zoom-generated transcript was then reviewed and edited for accuracy by the researcher.

Each interviewee was asked to choose a pseudonym for themselves for reporting purposes. All other identifying details (including their names, the name of their therapist or service provider, and universities) that would compromise anonymity in the interview data (transcripts) were altered by the researcher. The genders and ages reported below are real. Participants were made aware of the handling of their data as per the Informed Consent and Debrief forms. Demographic information questionnaires that contained personal information were stored separately to all the other paperwork. All personal data was processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). The email addresses were deleted for participants who wished not to receive the research findings. The researcher only kept the email addresses of the participants who gave their consent to receive the research findings; their personal data will be deleted once the study is completed and findings are disseminated.

The paper documents (e.g., printed transcripts, list of codes, thematic maps) used for the purposes of data coding and analysis were digitalised, and the paper copies were destroyed. All the digital documents (e.g., electronically signed consent sheet, demographic information sheet) were stored in a password-protected computer. Personal data and interview recordings will be deleted at completion of the research project and all other data will stored in a password-protected computer and destroyed after 10 years in accordance with City University's guidelines.

3.9.5 Language

The language of the research, including of the researcher and participants, may have a significant influence on research conceptualisation, data collection, analysis, and dissemination of data (Van Nes et al., 2010). Language not only offers a medium for verbal communication but also for representation of social or cultural context (Welch & Piekari, 2006). Hence, good qualitative research, especially when it involves cultural or linguistic diversity or ethnic minority, requires the researcher to be reflexive about the language differences due to translation or different dialects, social or cultural backgrounds (Lee, 2017; Nasri et al., 2020; Van Nes et al., 2010).

This research was conducted as part of the portfolio requirements to meet the criteria for the Degree of Professional Doctorate in Counselling Psychology in the UK. Therefore, representation and dissemination of the data was targeted for an English-speaking audience. Research was conducted in English from the beginning to end. However, collection and analysis of data in Turkish could have been a possibility, as the researcher was a native Turkish-speaker and in the position to conduct the interviews and later the analysis in participants' native language without the need of a translator. Conducting the interviews in participants' native language may have enhanced trust and collaboration between the researcher and participant, prompted openness and more 'authentic' or 'rich' responses, and increased data accuracy (Welch & Piekari, 2006).

The decision to utilise English during data collection was based on a number of factors. Firstly, all the research participants were international students at a British

higher education institution, which required them to have a certain level of language competency in English. Also, they engaged in therapy in the UK and in English. For the interviews, it seemed appropriate to use English as this was the language used in therapy. The therapy process itself may have prompted the acquisition of psychology-informed vocabulary or novel ways to express and communicate their experiences, describe their problems, and develop an understanding in the English language (McMullen, 1985).

Secondly, many scholars consider translation as an interpretive act and suggest that the translated data may fail to have the same meaning or decreased effectiveness in representing the respondents' accounts (McKenna, 2022; Van Nes et al., 2010). Therefore, translation and language interpretation may result in reconstruction of meaning instead of its discovery (Temple & Young, 2004). Collecting data in English and not having to resort to translation also seemed appropriate to help democratise the research process and reduce power difference in the study (Karnieli-Miller, et al., 2009). Participants were allowed to express themselves in the language which the data was analysed and reported in and hence, they were involved in the data interpretation process. This was considered an effective way for the researcher to share power with the participants (Green & Johns, 2019). Using participants' original voices and grounding the analysis and interpretation in their first-person accounts seemed more fitting to enhance the rigour of this qualitative study (Das, 2010; Mangen, 1999; Raheim et al., 2016).

On the other hand, the researcher also acknowledged that using non-native language may have hindered participants from communicating the cultural context or subtle nuances (Welch & Piekari, 2006). "Cultural integrity cannot be achieved without […] without an in-depth knowledge and understanding of the sociocultural and political dynamics of a particular research setting" (Pelzang & Hutchinson, 2018, p. 1). On that note, mutual cultural background between the researcher and participants seemed instrumental in promoting cultural integrity as the researcher had an in-depth knowledge and understanding of the cultural dynamics and language nuances. Moreover, at the beginning of the interview, participants were encouraged to use Turkish words or phrases if and when they thought it was necessary for them to feel more comfortable or more at ease in articulating their

thoughts and experiences (Baillie et al., 2000). However, only two of the eight participants used one or two Turkish idioms each during their interviews and a simultaneous translation from Turkish to English was mutually agreed on.

3.9.6 Sampling strategy

Purposive sampling was used to select research participants for this project (Patton, 1990). This sampling method enables the researcher to identify and select individuals that are experienced with the area of study (Creswell & Clark, 2017). Campbell et al. (2020) note that purposive sampling sits well with the qualitative research paradigm as participants can be chosen based on shared experience or characteristics. This appeared to be the most suitable sampling strategy as the research objective wasn't centred around generalisability of findings by controlling potential selection bias but on exploring in particular Turkish international students' experience (Palinkas et al., 2015).

With purposive sampling and the attempt to recruit a homogenous sample in terms of participant characteristic and experience, the researcher aimed to increase the depth of the understanding rather than the breadth of it (Palinkas et al., 2015). However, the inclusion criteria were kept broad due to two different reasons. Firstly, there was no information available to estimate the size of the potential sample pool (i.e., no information about how many Turkish international students in the UK seek help from mental health services). Secondly, there was time pressure to recruit participants and complete the research on time. In short, the sampling strategy was focused on ensuring that all the participants were Turkish and university students and shared the experience of accessing and undergoing therapy in common. Variables such as gender, age, year and topic of study, type and length of therapy, and type of mental health service may have influenced participants' experiences concerning the area of research and led to heterogeneity in the experience.

Inclusion and exclusion criteria. The first criterion was that participants were over the age of 18. The second criterion was for the participants to identify as Turkish. The third criterion was for them to have completed a course of psychological therapy at

least three months prior to data collection so that they could have sufficient time to process the experience. Also, participants who had therapy more than five years prior to data collection were excluded. This was because each participant gave a retrospective account of their journey of accessing and undergoing therapy and the researcher aimed to limit various issues related to the recall process and memory retention due to the passage of prolonged time following the experience (Amin & Malik, 2014; Sandelowski, 1999). The fourth criterion was for the participants to have received therapy whilst being an international student in the UK and to have engaged in the therapy process in English. Additionally, participants who no longer resided in the UK were not included in this study due to the possible procedural and ethical complexities concerning recruitment of participants from outside the UK (Bhattacharya, 2018). The researcher checked with the participants during the screening call to ensure that they had access to the internet and could participate in the online interview in a private space.

3.9.7 Recruitment

Research advertisements were sent to university wellbeing or counselling centres and student union officers in the UK, and they were asked to put it on their noticeboards or share on their online platforms. The research advertisement was also shared in relevant student or Turkish people groups on Facebook (please see Appendix 6 for Research Advertisement). A total of ten volunteers registered initial interest and eight were deemed suitable after screening. One was excluded due to not currently residing in the UK and the other due to having completed therapy more than five years ago. All the other eight volunteers agreed to participate.

After interviewing with eight participants, it was decided to end the recruitment process. Despite the lack of consensus on sample size in thematic analysis, the researcher's decision was informed by Braun and Clarke's (2013; 2022) guidelines for thematic analysis for small-scaled projects. As opposed to collecting information until no new information is gathered, the researcher stopped the recruitment when it was deemed that the data was rich enough to produce deep and quality analysis (Fugard & Potts, 2015).

3.9.8 Participants

Demographic information was collected prior to the interview (please see *Table 1*). The Demographic Information Sheet (please see Appendix 7) inquired about participants' area of study and current year or year of graduation as well as details about the therapy(ies) that they have taken in and outside the UK. The participant sample of this study were four undergraduate degree students, one PhD student, and three postgraduate course alumni. All participants identified as women and were aged between 21 and 34 years. Six participants self-disclosed that they lived and/or studied in London. There was variation in the service setting as well as the psychotherapy model and therapy length.

Pseudonym	**Age**	**Area and Level of study**	**Year engaged in therapy in the UK**	**Service Setting**	**Therapy Model**	**Therapy Length (session number)**	**First time therapy experience (y/n)**
Semra	27	Psychology related post graduate course, graduated	2019	NHS talking therapies (self-referral)	CBT	8	yes
Deniz	25	Neuroscience related post graduate	2021	NHS talking therapies (referral	CBT	8	no

		course, graduated		by university counselling service)			
Oyku	21	Social sciences related undergrad course, year 3	2021	low-cost counselling (self-referral)	CBT	10	yes
Mina	21	Psychology related undergrad course, year 3	2021	Private (self-referral)	Psycho-dynamic psychotherapy	52	yes
Irem	21	Psychology related undergrad course, year 3	2021	low-cost counselling (self-referral)	Guided self-help	13	yes
Sanem	21	Psychology, year 3	2021	low-cost counselling (self-referral)	Existential psychotherapy	36	yes
Asli	27	Psychology related post graduate course, graduated	2021	low-cost counselling (self-referral)	Counselling	8	yes

Merve	34	Psychology related PhD, year 3	2019-2020	University counselling service (self-referral)	Counselling	4	yes

Table 1. Summary of participant demographic information

3.9.9 Data collection

Pilot interview. As I had no prior experience of interviewing in a qualitative research project, I conducted a pilot interview with a family member who met study criteria. This was so that I could practice my interviewing technique as a researcher and address potential practical issues (Van Teijlingen & Hundley, 2002; Majid, Othman, Mohamad, Lim, & Yusof, 2017) and refine the interview schedule (Castillo-Montoya, 2016). After reflecting on the pilot interview transcript with my supervisor, I became aware of my choice of words (which may have communicated agreement or disagreement such as 'but', 'great', 'makes sense') along with my tendency to paraphrase and summarise, which may have influenced what participants shared with me and therefore, guided the interview content. Through this, I recognised the need to refrain from using conjunction words that would imply disagreement or rejection as well as to be more confident and actively seek information that is relevant to my research questions (e.g., "Can you tell me more about this?"). The interview schedule remained unchanged.

Interviews. All communication was by email. Before the interviews, each participant had emailed me the signed consent sheet. When we met on Zoom, they were reminded of their rights as a voluntary research participant. I also confirmed their consent for the interview to be recorded. They were made aware that the recording was done by using Zoom's internal recording function as well as with an external audio recording device.

I used a semi-structured interview guide (please see Appendix 8), which included open-ended questions, follow-up questions, and prompts. The interview started with open-ended questions centred around the experience of being a Turkish international student in the UK. This was to warm-up the participants to the interview and prompt them to think about their experiences as a Turkish international student. Some of the questions were influenced by the existing literature exploring the impact of receiving counselling on student well-being. In addition, the interview schedule was flexible. After conducting the first two interviews, I noticed that participants spontaneously started talking about their relationship with their therapist when they were asked about their therapy experience. Hence, I amended the interview guide and changed the order of the questions respectively. Also, participants usually covered several topics when presented with a single question. I remained flexible and asked follow-up questions to be able to elaborate more on the topics that they had already talked about in the interview. The flexibility of the interview structure and open-ended questions allowed me to focus on the participant's own framework of meanings rather than imposing predefined ideas or assumptions (Britten, 1995).

The average interview length was sixty minutes. In all interviews, the same interview schedule was utilised. However, one interview was on the shorter side (39 minutes) as the participant was concise in her account. One interview was on the longer side (1 hour 24 minutes) as the participant spoke about a wide range of topics. Upon completion of the interview, each participant was debriefed and then emailed the debriefing sheet. When I asked in the debrief about participants' interview experience, most of them reported that they enjoyed participating in it and reiterated their interest in receiving the research findings. The summary of the findings are planned to be shared in a one-pager format and emailed to the participants who opted in receiving the study findings when completing the informed consent sheet). They did not report any concern or regret regarding their decision to have participated in the study.

3.9.10 Analysis

Braun and Clarke (2022) describe RTA as a six-phase process. They suggest that this is only a guideline and involves moving between the phases, rather than following each phase step-by-step or approaching the analytic process as a linear and unidirectional framework. Hence, in my research I endeavoured to engage fully with each phase as well as to remain flexible and extend analysis in several directions at the same time (i.e., going back and forth between different phases when necessary).

Phase 1: Familiarising self with the dataset. The familiarisation process for me started when I listened to the interview recordings to review and correct the transcriptions for accuracy. Then, I read and re-read each interview transcript whilst listening to the recordings. During that process, I took preliminary notes about each transcript, including initial thoughts, ideas, and reflections. I had to be mindful about taking notes that were linked to the data itself and what the participant talked about and noticing what my reflections were, including my thoughts, feelings, and sensations about what the participant 'meant' or what their experience is about.

Phase 2: Coding. This phase is about capturing the line-by-line and specific meanings or concepts from the dataset and developing analytically meaningful descriptions, i.e., code labels. I looked at both the surface level and implicit meanings whilst coding each interview and utilised empathic and suspicious approaches to interpretation (please see Appendix 9 for a representative example). When I was satisfied with the amount and depth of the coding, I collated all the code labels in a coding manual (please see Appendix 10 for a representative example) and compiled the relevant extracts from the interview data for each code. There was a long list of code labels at this stage, which I assumed was due to the wide range of topics and experiences participants talked about.

Phase 3: Generating initial themes. The aim in this phase is to develop a shared patterned meaning across the dataset. I clustered the codes that I felt were able to address the research questions when put together. I identified the candidate themes based around the data as well as my knowledge, insights, and the research aims and questions. Again, there were quite a number of initial themes at this stage and some of them didn't reflect the aspects of a shared experience (please see Appendix

11 for an illustrative example). However, I decided to keep them and review it at the next phase so that I didn't discard any themes that would be later conceptualised as internally coherent, consistent, and distinctive.

Phase 4: Developing and reviewing themes. This phase is about assessing the overall analysis and seeing whether the candidate themes fit the data. I identified the themes that could be combined together or separated. Also, I let go of the themes that didn't really fit with the full data set or address the research questions. The task was to think about the central organising concept and its scope whilst focusing on the most important patterns in the dataset in relation to the research questions (please see Appendix 12 for an illustrative example).

Phase 5: Refining, defining, and naming themes. This is the fine-tuning phase of the analysis. I revised all the themes to make sure that they were built around a strong core meaning which was related to the process of accessing and undergoing therapy and all fit into the analytic story I was telling about Turkish international students' experiences. Here, I also wrote a short descriptive paragraph of each theme and then decided on a name for each theme. I revised some of the names after meeting with my supervisor as well as after re-visiting the coding manual and reviewing the relevant data extracts.

Phase 6: Writing up. The task is to build an analytic narrative and tell a coherent and persuasive story to the reader. My findings and interpretation of the data are reported in the analysis and discussion chapters. After my interpretation and discussions with my supervisor, I revisited Phase 4 and 5 to be able to generate a more in-depth analysis and tell a coherent and interesting story.

3.9.11 Quality and rigour

Korstjens and Moser (2018) argue that quality criteria used in quantitative research do not apply to qualitative studies. Hence, rather than judging generalisability, internal validity, reliability, or objectivity, the quality of qualitative research should be evaluated regarding in relation to its' trustworthiness (Korstjens & Moser, 2018). As

Lincoln and Guba (1985) suggest, good qualitative research is credible, transferable, dependable, confirmable, and reflexive. This advice was embraced throughout the research process.

Following Lincoln and Guba (1985) as well as Sim and Sharp's (1998) recommendations, trustworthiness in this research was attempted through prolonged engagement with the data and research methodology; provision of thick description; delivery of an audit trail; and diary keeping. My in-depth engagement with the topic and literature whilst conducting the interviews and analysis served as prolonged engagement. Thick description was provided in this chapter as I described the research process and gave information about the participants. Steps taken throughout the research process were recorded transparently for audit trail purposes. Besides, taking notes in my research diary and having discussions with others prompted a reflexivity during the research process.

It could be argued that conducting good qualitative research is the same thing as conducting a good RTA. Hence, I followed the 15-point checklist for good RTA developed by Braun and Clarke (2022). To provide a better idea about how I met each criterion, I summarised my response to each check-list item corresponding to different stages of the research process in Table 2.

Process	No.	Criteria	Response
Transcription	1	The data have been transcribed to an appropriate level of detail; all transcripts have been checked against the original recordings for 'accuracy'	*All transcripts transcribed to an appropriate level of detail and checked against recordings, as demonstrated in Appendix 9*
Coding and theme development	2	Each data item has been given thorough and repeated attention in the coding process	*All transcripts were reviewed multiple times to generate coding. Sample of coded data available in Appendix 9*

	3	The coding process has been thorough, inclusive, and comprehensive; themes have not been developed from a few vivid examples (an anecdotal approach)	*The coding process was thorough, inclusive, and comprehensive since the whole dataset was used to generate codes and develop themes. Each theme was developed from numerous codes collated from each participants' account. Sample of coded data available in Appendix 11*
	4	All relevant extracts for each theme have been collated	*A coding manual was created to collate all the relevant extracts for each theme. Sample of coding manual available in Appendix 10*
	5	Candidate themes have been checked against coded data and back to the original dataset	*The coding manual was used to do the checks. For additional context of extracts where creating themes, I referred back to the transcripts. Candidate themes were also discussed in supervision and revised accordingly.*
	6	Themes are internally coherent, consistent, and distinctive; each theme contains a well-defined central organising concept; any subthemes share the central organising concept of the theme	*The themes were discussed in research supervision and each theme was described in detail in the written report to evidence internal coherence, consistency, and distinctiveness.*
	7	Data have been analysed-interpreted, made sense	*As evident from the results, data was described in detail to provide depth*

Analysis and interpretation – in the written report		of- rather than just summarised, described, or paraphrased	*and interpreted to create analytical categories.*
	8	Analysis and data match each other- the extracts evidence the analytic claims	*As is evident from the results and data extracts, analysis and interpretation closely match the data set.*
	9	Analysis tells a convincing and well- organised story about the data and topic; analysis addresses the research question	*Analysis and interpretation were developed to tell a story to the reader and provide a rationale as to why the story mattered.*
	10	An appropriate balance between analytical narrative and data extracts is provided	*Illustrative data extracts have been used within the results section.*
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly (including returning to earlier phases or redoing the analysis if need be)	*Enough time was allocated to conduct the analysis (five months specifically devoted to it) and to discuss it with others to ensure a reflexive and good quality research.*
Written report	12	The specific approach to thematic analysis, and the particulars of the approach, including theoretical positions and assumptions, are clearly explicated	*As stated in the methods section.*

	13	There is good fit between what was claimed, and what was done - i.e., the described method and reported analysis are consistent	*As evidence in the Methodology and Results chapters.*
	14	The language and concepts used in the report are consistent with the ontological and epistemological positions of the analysis	*Appropriate language and concepts were used in the report. Critical realist position was evidenced by the methods selected and approach to interpretation, along with how the analytic story was told.*
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'	*First-person narrative was used to evidence the ownership of interpretation. Themes were reported as being developed by the researcher, rather than conceptualising it as 'emerging' from the dataset.*

Table 2. Response to the 15-point Checklist developed by Braun and Clarke (2022, p. 269)

3.9.12 Dissemination of findings

As I first started thinking about my research topic, prepared my proposal, and sought ethics approval, I envisioned publishing my work in the form of a journal article and am still planning to do this. For that reason, I sought participants' informed consent to disseminate the research findings. I also acknowledged that research participants were a potential audience for this research. When considering disseminating the findings, I was mindful about maintaining confidentiality as well as using their data and portraying them in way that was honest, respectful, and sensitive (DeCarlo et al., 2020; Kaiser, 2009; Mootz et al., 2019). Some participants also gave their consent for me to retain their contact details as they were interested in receiving the research findings. After the completion of the project, a document with a lay summary of the themes and key recommendations for mental health professionals will be sent to participants (please see Appendix 13). Informing participants about the research outcome and letting them know what happened to their interview data seemed important. Scholars suggest that it is a way to honour and respect the participants (DeCarlo et al., 2020; Kaiser, 2009). It is advocated that allowing the participants to have an understanding of the research in which they partook may be enjoyable and intrinsically valuable for them (Appadurai, 2006). Disseminating and communicating the findings with research participants can be empowering as they can appreciate their role in knowledge enhancement the social value of their experiences (Chambers, 2007; Tribunal, 1996).

On the other hand, as I worked on my analysis and discussed the possible clinical implications of my research findings with my supervisor, I decided that a way to disseminate directly to clinicians working with this population would be in line with the utilitarian perspective. Hence, a short document which discussed the rationale for the study and presented a summary of the themes and key recommendations for clinical practice was created (please see Appendix 14). This was in line with the trending effort to translate research into practice (Edwards, 2015). Also, dissemination of findings with relevant services seemed to accompany the effort to honour the participants and make their participation more meaningful.

3.10 Reflexivity

In this section, I will discuss both personal and methodological reflexivity as an insider and outsider scientist-practitioner.

Firstly, I came to the UK as an international Turkish student. As it was a requirement for my doctoral training, I also underwent psychological therapy in the UK. I often found myself distressed because of the social and political events happening in Turkey. I felt the need to explore how these events impacted me in my personal therapy. However, I also sensed that I had to educate my therapist on what was happening in Turkey, including recent social and political changes. Personally, I found this frustrating at times as I felt like I was talking to someone who had little information about where I was coming from. At first, I was surprised to hear in the interviews that participants mostly had neutral or positive position towards their therapist who lacked knowledge about recent or ongoing events in Turkey. I noted this surprise in my reflexivity journal (see Appendix 15 for Example of Memos). Being able to write about it and share my reaction with my supervisor helped me to realise I felt alone in my experience. I believe being aware of the difference between my experience as a Turkish person in therapy versus what study participants experienced helped me to collect and analyse research data focusing on participants' perspective rather than on my personal and subjective experiences and assumptions. At first it was difficult for me to navigate my multiple roles as a researcher. Despite considering myself as an insider researcher at the start of my research project, I realised that I was more of an outsider. Hence, I had to be reflexive and let go of my subjectivity by staying curious to what the participants communicated to me in their interviews. This made me curious and more open to what my participants experienced that were different to my own experiences in therapy and made me reflect on my own frustrations rather than projecting on their accounts.

On the other hand, following some discussions with my colleagues and a supervisor, I realised that my insider perspective in the research project allowed me to stress the

importance of social and cultural context in my interpretation of the findings. During the analysis stage, I conceptualised social/political context as something separate to the culture and in supervision, I had to defend my decision, which was very surprising to me as I felt misunderstood. Before that, I didn't even think that culture and social context could be explored under the same umbrella. Especially in the recent years, people in Turkey have experienced many significant political, social, and/or economic events. For me, both as a trainee counselling psychologist and a client in therapy, being curious to and having open and honest conversations about culture and its influences weren't enough. My supervisor pointed out that social and cultural context may have been conceptualised as a single concept if it were analysed by someone else. This conversation happened because I had many preliminary themes and was looking to bring together some themes. Her comments made me question the probes I used during the interviews, which perhaps may have directed the participants to talk about social context and culture separately. Yet, when doing the analysis, I observed that some participants talked about social context or culture as separate notions during the interviews when I had not used the probes. This suggested to me that, social context and culture were perceived separately as part of their shared experience of therapy journey. On that note, sharing an experiential base and knowledge of the collective experiences Turkish people have recently been going through may have allowed me to have an insider perspective as a researcher and to pay better attention to subtle differences in conceptualisation of social context and cultural influences. Hence, I felt confident in my decision to underscore the difference between culture and social context in my analysis and communication of the research findings.

Similarly, I believe my insider status as an English as a foreign language (EFL) speaker fostered more in-depth discussions with the participants both on the notion of language in therapy and their use of English as a non-native speaker. Also, participants indicated in their accounts that they didn't express all the things they wanted to say in therapy due to language barriers (see Analysis section). Research has shown that Turkish EFL students experience increased Foreign Language

Speaking Anxiety (including communication apprehension and fear of negative evaluation) when they communicate with a native speaker (Cagatay, 2015). If participants had been interviewed in English by a native speaker, what they shared in their accounts may have been influenced by their anxiety, perhaps begot less ‘openness’ or ‘honesty’. In line with the evidence in the literature, sharing knowledge of the Turkish language (although not the language of the research) and experience of speaking a foreign language allowed me to position myself as an insider researcher and the participants to be more open or honest about their experiences (Asselin, 2003; Kanuha, 2000).

However, after reflecting with my supervisor, I became aware of the impact of my outsider status as a counselling psychologist researcher and a representative of the profession. I believe, there was a limitation to how much participants shared their evaluation of the effectiveness of therapy and therefore, their openness or honesty about their experiences was restricted. As I was conducting the analysis, I realised that there was a difference in how participants talked about accessing therapy and engaging in therapy. It appeared that they shared the negative aspects of their experiences of accessing therapy more readily. However, participants accounts of their experiences of undergoing therapy were more positive. Participants may have felt reserved about sharing their negative experiences concerning their therapy experience. Also, when participants shared something negative about the experience of engaging in therapy, they mostly commented on factors that were independent of their therapists. This made me wonder whether my identity as a counselling psychologist had an impact on the above-mentioned difference. I remained mindful about my influence on the content of the interview data whilst conducting the analysis. It was a learning experience for me as a researcher, to be able to reflect on my experiences during the interview phase and data collection. In future research projects, I will be more mindful about my outsider status, both a researcher and a representative of the profession, from the very start of the research project and especially, during the interview stage. On the other hand, I did feel that I had a good rapport with each participant and believe that they were open and honest during the interviews. However, bringing it to the attention during the

interview that I was a representative of the profession and asking them to reflect how this was experienced in the interview would allowed interesting discussions.

Also, I enjoyed interviewing with the participants as I was very interested in what they shared with me. It was interesting for me to hear about the similarities and differences between our experiences. Given that my subjective position will inevitably influence my interpretation, I was mindful of my own presumptions, insight, and knowledge as well as of the perceived similarities. For the differences, I was mindful to stay empathic and pay close attention to what the participant was saying as well as to stay curious. As mentioned earlier, I am aware of my dual role as a researcher and a counselling psychologist. Despite allowing me to be empathic and curious, my own identity as a counselling psychologist may have impacted the rapport I developed with the participant and the material that was brought up. Despite becoming more aware of my use of probes after conducting the pilot interview, I acknowledge the potential impact I have as a counselling psychologist researcher. Although I adopted an inductive approach to analysis, I was also mindful about my engagement with the data being expanded by my counselling psychologist thinking and bringing psychological knowledge into interpretation, especially when doing latent coding and finding myself thinking about what is beyond the participants' awareness or account. As I was keeping a reflexive journal during the analysis, I realised that I was bothered by some of the comments participants had made about their therapist or the therapy process. For example, when I was reading participants' accounts about their expectations of therapy and not being content with the things that were covered or achieved in therapy, I remember feeling frustrated. This was the therapist side of me, potentially, getting triggered by the feeling of not being a good enough therapist – something that I struggled with during my training and have addressed in personal therapy. However, I regarded this as something that was a part of their subjective therapy experience, and this led me to engage with the data reflexively and critique my potential influence on analysis as well as fostered empathic interpretation as I strived for staying with what participants presented.

On another note, there was variation amongst the participants regarding the type of service as well as the type and length of therapy they experienced. I was initially concerned about having a broad inclusion criteria. I was also concerned about not being able to recruit any male participants, but I didn't want to amend my exclusion criteria based on gender, as I didn't have any rationale to only focus on female students. It was equally important for me to explore and generate an understanding of how male Turkish students experienced accessing and undergoing psychological therapy. However, due to circumstantial constraints, which are addressed in the discussion chapter, my dataset consisted of female participants only. I may have experienced differences in the rapport due to perceived similarities or differences if I had male participants in this study and this would have prompted other ways to reflect on my influence as a female researcher.

Chapter 4: Analysis

This chapter illustrates my attempt at organising the rich data that was generated by the RTA approach to the interview material. The research questions which guided my analysis were: (i) what are the experiences of Turkish international students accessing psychological therapy in the UK? and (ii) what are the experiences of Turkish international students undergoing psychological therapy in the UK? The aim of analysis was to access Turkish international students' experiences and gain a better understanding through their point of view.

4.1 Overview of Themes

Pertinent aspects of participants' experiences of accessing and undergoing psychological therapy are captured in different themes through RTA approach and the findings are organised following a chronological order. This seemed like the most logical and meaningful manner to conceptualise the themes and build a coherent story of the data, in order to (i) address the two separate yet interlinked research questions and (ii) reflect my understanding of participants' experiences of accessing and undergoing psychological therapy as a process that consists of a beginning, middle and end. The 'beginning' of the process provides a story of participants' experiences prior to help-seeking as well as the process of initiating formal psychological support and accessing mental health services. The 'middle' reflects participants' experiences around the processes concerning clinical decision making and waiting times as well as engaging in therapy with a therapist from a different culture and in their non-native language. The 'end' captures participants' reflections on the impact of receiving psychological care and engaging in therapy as well as a retrospective evaluation of their experiences.

The analysis resulted in a total of seven themes, three of which contain sub-themes (please *Figure 1* for the Thematic Map). The corresponding sub-themes conveys a more in depth and refined account of participants' experiences. I acknowledge that my interpretation and analysis of the interview data yielded a high number of themes. The interview data was wide in scope and rich in content, which illustrated many

different aspects to participants' experiences of accessing and undergoing psychological therapy. I felt it was best represented this way as each theme captured something different from the data, either a particular concept or a particular aspect related to the process accessing and undergoing therapy. Despite the large number of themes, I decided to keep all seven of the themes as there was coherence and consistency between all of them. There is no specific guidance on the number of themes considering the RTA approach. However, Braun and Clarke (2006) suggests that themes must have internal homogeneity (coherence and consistency) as well as external heterogeneity (distinction between themes). Hence, careful consideration was given whilst reducing down different aspects of experience through my analytic process and all the themes that felt relevant and significant to the participants' experiences are presented below. A detailed narrative of each of these themes is outlined below, with illustrative quotes from interviews to convey the interpretative approach of the analysis.

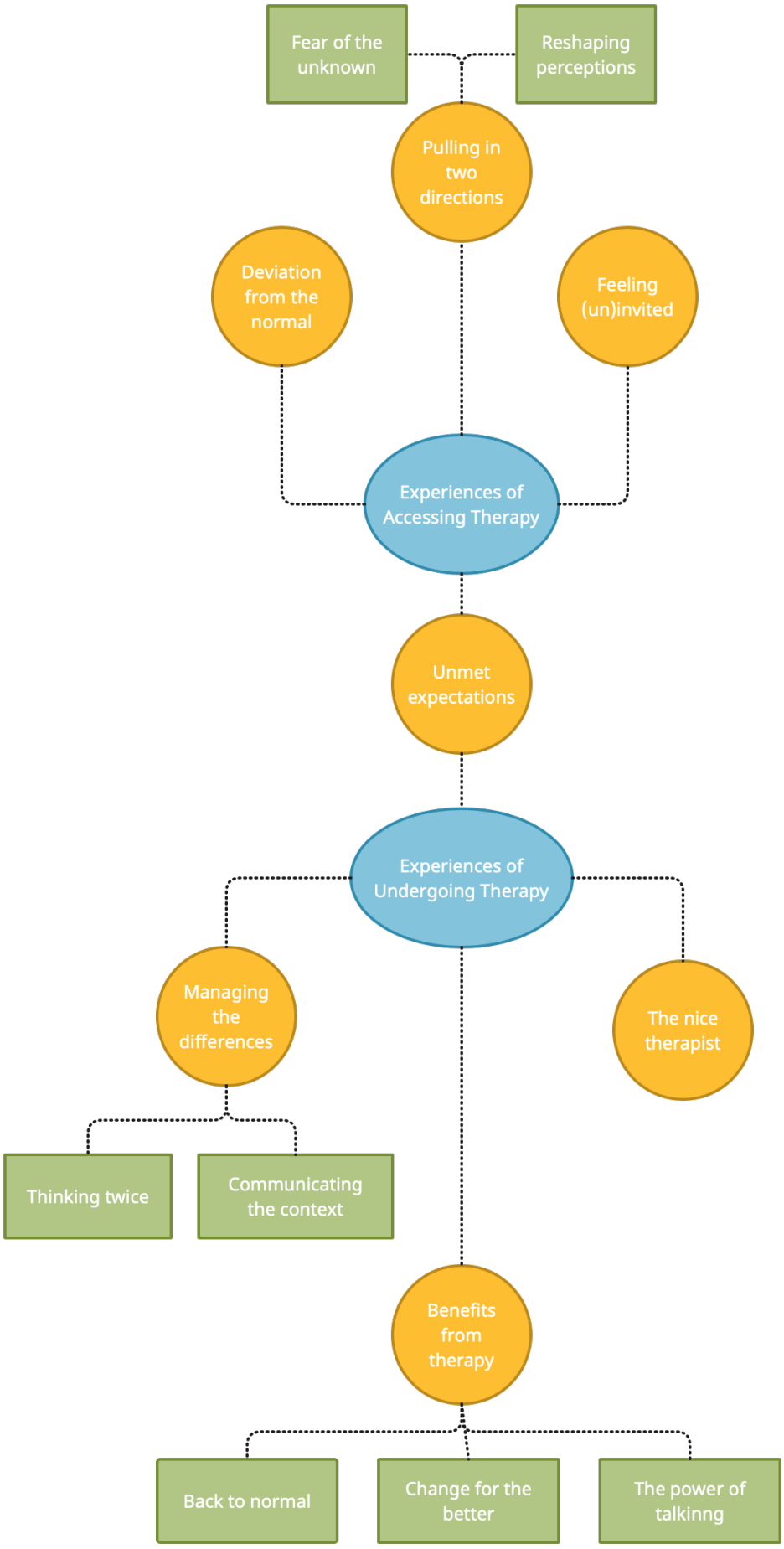

Figure 1. Thematic Map

4.2 Theme: Deviation from the Normal

This theme captures what participants experienced prior to their decision to seek psychological support and access therapy. Participants talked about various reasons for their deteriorated psychological health after starting their studies in the UK. They emphasised the impact of their experiences as an international student on their mental health;

> *"During that period, it was, it had turned from want to need. So, I think being an international student had an effect on that." (Oyku, p. 13, L257-261)*

> *"When I start PhD, I felt so lonely and I was struggling […] when someone is alone, this is my thinking, overthinking maybe or negative thought or something." (Merve, p. 6, L112-119)*

However, what stood out from the data was that most participants' symptoms were viewed by them as a deviation from the normal. It seemed that they had a 'realisation' and became aware of their distress. Some participants used words such as 'not normal' and 'not feel like me' to exemplify this point;

> *"[…] then I realised I don't normally… usually, I'm positive person, but I realised I wasn't positive at all […] And then I thought I should seek therapy." (Merve, p. 6, L112-119)*

> *"I remember crying about an assignment on the street and when that happened, I was just like 'I'm way too stressed, this amount of stress is not normal'." (Oyku, p. 12, L232-234)*

> *"When I think back on it now, it doesn't feel like me in the sense that, like, it was so far from how I normally see myself, even in my lowest moments." (Sanem, p. 9, L179-184)*

Participants spoke of a departure from the way that they would normally think, feel, behave, or interact. In other words, they emphasised a feeling of abnormality, which negatively impacted their overall functioning, including their personal and academic lives;

> *"I mean, of course, stress and losing sleep, but also, I started to procrastinate. I would write an essay in like eight hours and do nothing for the rest of the week." (Deniz, p. 8, L150-152)*

> *"While studying or interacting with a friend there's always this worst scenario in my head and I wasn't feeling that [..] I wasn't living in that moment, which also was affecting my friends next to me and also, I wasn't doing the things that I was supposed to be doing." (Semra, p. 11, L217-221)*

For most of the participants, the strong sense of abnormality constituted an emergency itself and indicated a breaking point. Semra conveyed the heightened levels of her psychological distress when using the words 'very' and 'too';

> *"I was very terrified of a thought, and I was like shaking […] and I realized that I am too afraid to stay alone because of my thoughts are very, you know, panicky" (Semra, p. 13, L257-260)*

In most cases, participants' distress seemed to be exacerbated due to the stressors associated with being a student or studying abroad. However, what stood out from their account was a feeling of defeat. Semra demonstrated her sense of overwhelm and helplessness with the word 'conquer' and perhaps feeling 'alone' added to that feeling;

> *"I decided to get help because, you know, I'm here alone in this country as a student, but my thoughts are conquering me." (Semra, p. 13, L260-262)*

Evident in most participants' accounts was feeling concerned about themselves. Irem spoke about an 'abnormal' experience, which indicated an out of body feeling

and perhaps this not only impaired her sense of control in her ‘body’ but also in herself;

> *“I didn't feel like I was in my body, but I was watching myself from somewhere else when I was thinking about it, and I was like, ‘that’s concerning’. I was kind of concerned about this.” (Irem, p. 10, L202-205)*

It seemed that they experienced a strong urge to fix things or alter the situation to go back to normal and perhaps regain the control of their lives by restoring the equilibrium as quickly as possible;

> *“I don't like it so, like, I need something that can help me calm down.” (Oyku, p. 12, L232-234)*

> *“It was just really terrifying, and I directly called the NHS hotline to get a therapy appointment.” (Semra, p. 13, L257-262)*

4.3 Theme: Pulling in Two Directions

This theme captures participants’ ambivalence about getting professional help and towards starting therapy. Many participants noted a pressing problem or a need that had to be dealt with immediately. Yet, in their accounts, they discussed their reluctance to undergo therapy. For many, this seemed to be due to the fact that the concept of therapy was unfamiliar to them, and they lacked the knowledge about what therapy entails. For a few, the lack of awareness or knowledge about available support for their mental health needs contributed to this. Also, apprehension about making an independent decision about themselves along with the need to get others’ input and guidance was emphasised. Participants underscored the benefits of getting support and encouragement from other people, which perhaps helped them to develop more positive attitudes towards help-seeking as well as to acquire the necessary information about psychological therapy and mental health services.

4.3.1 Sub-theme: Fear of the unknown

This sub-theme relates to the unknown aspects of the therapy process, including accessing services and undergoing therapy. It appeared that not knowing what therapy actually involved as well as the perceived uncertainty around the process of seeking help resulted in trepidation about accessing mental health services.

Participants suggested that despite making and executing the decision to start therapy, accessing services had been mentally and emotionally challenging. It appeared that the notion of engaging in therapy and meeting with a stranger to talk about personal things was very foreign to them at first;

> *"Deciding to pursue a therapy, that was not easy at first, because I don't know what I'm going to, I didn't know what I'm going to experience." (Semra, p. 33-34, L679-680)*

> *"It was still a bit unpredictable about who it [therapist] will be [..]" (Irem, p. 19, L401)*

Merve commented that she was in doubt whether she contacted the right university service and indicated that lack of information about services available for mental health support triggered uncertainty and perhaps a sense of hesitancy;

> *"I wasn't sure I emailed the right person or the right service" (Merve, p. 9, L183)*

Some participants suggested a sense of overwhelm, perhaps because of the number of options available online and feeling unable to manage the process on their own. Asli indicated a level of anxiety related to the uncertainty around who her therapist was going to be, which was a decision she had to make by herself. It seemed like not having any support or guidance during the process of seeking help was unhelpful for the participants;

> *"[…] because there are so many psychologists out there, it's difficult to find a fit, so I think initially you feel a bit overwhelmed trying to find somebody." (Asli, p. 10, L204-205)*

Asli's account conveyed a feeling of unease or uncertainty about choosing a therapist on her own. These feelings were emphasised when using phrases 'not too sure' and 'this is good' whilst Asli engaged in positive self-talk. It seemed that Asli attempted to persevere with the uncertainty around who her therapist was going to be;

> *"[…] when choosing that therapist, you know, I wasn't too sure, but at the end of the day, I was like 'this is good, you're having some sort of support'. If it works out with the therapist, great. If it doesn't work out, great." (Asli, p. 13, L245-250)*

Despite acknowledging the benefits of getting professional help, trepidation about receiving psychological support appeared in participants' accounts. Deniz conveyed her uncertainty about engaging in psychological therapy when using the words 'hope', 'meh' and 'chance';

> *"So, I think it would be nice to hear from someone who actually knows what they're doing. […] I didn't have many hopes, but I just thought 'meh, I can try my chance'." (Deniz, p. 9, L182-184)*

Mina reiterated the emotional strain of not knowing what to expect in therapy and discussed feeling nervous excitement about accessing psychological care. She used words such as 'intrigued', 'daunting', 'anxious' and 'stressful' to perhaps emphasise the mixed feelings she had about starting therapy;

> *"I was intrigued by it, but I think it was also a bit daunting to kind of just wait for a session and then, like, not know what to expect, I think that was stressful before starting […] I wasn't necessarily the only person who was anxious about starting therapy" (Mina, p. 8, L165-173)*

Mina went on to discuss what the service providers can do to improve Turkish students' experience around accessing therapy, which echoed what other participants spoke about. It appeared that lacking information about what therapy is and how it works contributed to the sense of reluctance;

> *"I think just maybe, making it […] more well-known or more understood, I guess, like why people go to therapy and stuff like that" (Mina, p. 17, L354-356)*

Merve spoke of the ways in which universities could make it easier for students to access therapy, highlighting that feeling informed about available services for psychological support was important;

> *"Maybe they can send an email or […] 'if you need more help, we will refer to other service or something like that', maybe [to] make it easier or manageable." (Merve, p. 24, L481-488)*

After accessing the service, participants felt more positive about their decision to get professional help. Taking the first step was 'daunting', yet there was a shift when they initiated the process, perhaps because the influence of the unknown lessened;

> *"I do remember when I took the initial interview [assessment]. I think it was when they want to assign me to someone, I just remember sitting in front of the laptop, and kind of feeling good that I was doing this because I feel that I would have put it off" (Sanem, p. 8, L171-173)*

> *"I think once I kind of made the decision to start, I felt a bit better in terms of that anxiety and stress" (Mina, p. 10, L191-192)*

> *"Starting therapy because it wasn't something I had any experience with, so I was a bit nervous to actually start it. But after I started, I just felt more comfortable." (Oyku, p. 26, L529-530)*

4.3.2 Sub-theme: Reshaping perceptions

Participants emphasised the need for encouragement from others regarding starting therapy, in order to normalise getting help for psychological problems and perhaps to develop positive attitudes towards mental health services. For most of the participants seeing their friends in therapy or others openly talking about receiving psychological support was encouraging and it made them feel less apprehensive about accessing mental health services. Mina emphasised the sense of 'comfort' associated when she realised that seeking psychological care from professional services was a common experience;

> *"I think if my friends weren't also thinking of starting therapy or if they hadn't said, like 'Oh, I've been to a few sessions, and it's actually helped me a lot', I might not have been as prone to start going to therapy, I think that kind of, not persuaded me, but made me more comfortable with my decision." (Mina, p. 7, L137-140)*

Also, Mina mentioned the relationship between the Turkish culture and people's reluctance to seek psychological help, which perhaps underscored the importance of collective acceptance and promotion of positive attitudes towards help-seeking;

> *"If my friends hadn't done it, I probably wouldn't have started, I think it made… I know it's accessible, but I think, culturally Turkish people tend not to take that step, and they tend not to look up a therapist" (Mina, p. 17, L351-353)*

Many of the participants spoke about their decision to start therapy with other people, perhaps as a way to validate their decision or get encouragement to start therapy. For many, it seemed that discussing accessing therapy with a family member or friend was important to manage their reluctance. It may be the case that feeling supported by others and receiving guidance, rather than making an independent decision, was more comforting;

“I talked to my parents, and I was like ‘should I get therapy?’. I kind of asked them, but it was more like, kind of demanding as well, and they were supportive.” (Oyku, p. 12-13, L247-251)

“I spoke to my mom about it, more so about, this specific therapist. Because, I guess, she knew the kind of things that I was thinking when I wanted to start therapy. So, I talked to her about what the therapist had said in the initial [session], like the discussion and then kind of came to the conclusion to start.” (Mina, p. 6, L122-125)

“So, I do have a friend who's a psychologist. I did have a discussion with her about potential options.” (Asli, p. 10, L191-192)

For some, they felt uncertain whether therapy would be helpful, and this contributed to the ambivalence about accessing therapy. However, Irem emphasised that apart from normalising getting psychological help, her friends provided reassurance about the usefulness of therapy. This also suggested that Irem preferred to make a decision based on others’ opinions and ‘their experiences’ and perhaps, after reaching a group consensus;

“I knew that my friends were getting support so, I just saw, like, I could ask them if that could be helpful for my situation. And they all agreed that it could help, I just need to give it a try and see how that goes. So, it was like an idea influenced by their experience.” (Irem, p. 11, L227-230)

4.4 Theme: Feeling (Un)invited

Most of the participants described their lack of involvement in the process of accessing therapy, including the waiting experience, therapist allocation, choice of therapy model and number of sessions. Regarding waiting times and type of therapy offered, participants described their wish to be kept informed during the process or provided with a justification for what was decided by the service provider. Also, participants emphasised their preference to be included in the decision-making

process regarding their care, such as discussing the choice of therapy model, number of sessions, or therapist allocation with the service provider. However, some of the participants who sought psychological help felt included and informed and described their experience as caring and collaborative.

The wish to be kept informed about or involved during the process of accessing therapy was a strong feature in all the interviews. Semra described her experience of accessing therapy very positively and this was exemplified with words such as ‘smooth’ and ‘easy’. Receiving adequate information and being informed about the whole process helped the participants feel content about reaching out for professional help;

> *“It was pretty smooth when I called them, and it was easy to reach. They explained me everything a lot, so I don't remember anything unhelpful” (Semra, p. 16, L321-322)*

Most of the participants reflected on not knowing when they would access therapy after they were referred to the service. Some of the participants were surprised to have their first therapy appointment scheduled shortly after contacting the service;

> *“I knew I was on the waiting list, I just didn't know when, I didn't ask when. I was actually surprised that they came back to me two weeks later.” (Asli, p. 12, L233-235)*

Yet, prolonged waiting time coupled with the lack of communication and ‘clarity’ from the service provider made some participants feel left in the dark and neglected. Words such as ‘forget’ and ‘valid’ emphasised this feeling;

“Instead of radio silence for two months, they could’ve just sent […] ‘There are maybe 30 people before we get to you’ […] ‘Okay, we are going to get you help, so, be okay’ or like […] ‘We didn’t forget you, you are valid.’” (Deniz, p. 29, L590-595)

Oyku emphasised that lacking information about the waiting times diminished the sense of clarity around the process of accessing mental health services and perhaps exacerbated the reluctance participants experienced about receiving psychological help;

“My friends struggled finding mental health help through NHS and other places, so I think being more clear about the process and the time it's going to take and actually working on that to reduce the periods is crucial.” (Oyku, p. 30, L616-619)

On the contrary, other participants described their waiting experience positively. Semra described being informed about the waiting times and having a set appointment date made the waiting experience more manageable;

“Knowing that I have an appointment in two weeks, was a relief for me, I can say that it helped a little bit too […] because it's better than nothing. I mean, waiting without a date in your hand is much more difficult.” (Semra, p. 15, L308-310)

Not only finding it beneficial to feel included in the process to cope with the uncertainty around the waiting times, but participants also reflected on being informed about the clinical decisions made on their behalf. Oyku emphasised her wish to have received justification from the service provider regarding therapist allocation. It seemed like participants felt powerless during the process and perhaps, they wished to get a reasoning for decisions made on their behalf to feel more included;

“I think I would have liked, like, […] “She's studying this or she's doing this stuff, so we thought she would be good for you’, like, there was no

justification. I feel like I would have appreciated that in the moment." (Oyku, p. 16, L322-326)

Oyku later mentioned that despite the therapy model offered to her was not matching her needs, having given justification, and being informed about the decision-making process was reassuring. It appeared that participants valued getting information from the service provider to be able to 'trust' them with the decision and perhaps, feel that they can rely on professionals with their psychological care;

"But at the time, I also felt like they were assigning CBT to everyone […] they were like 'We think for your situation specifically CBT is going to help' and I trusted them because they were professionals." (Oyku, p. 23, L461-468)

Sense of involvement in the process when accessing psychological therapy was also related to receiving personalised care and support. Participants voiced their wish for the service provider to invite them into the decision-making process and ask about their preference regarding therapist allocation and therapy model. Irem emphasised that having greater choice and control over how she received her mental health care would have bettered her overall experience. Perhaps, this would have reduced the feeling of powerlessness and increased collaboration;

"Maybe they could inform us about […] 'There's a therapist who do this kind of therapy and there's a therapist with this kind of therapy, do you have any preference?'" (Irem, p. 18-19, L397-399)

"It could be better to be able to […] think different kinds of therapies and try and get my idea about which one I could." (Irem, p. 19, L405-407)

She went on to discuss her discontent with the decision-making process. Therapist allocation was based on the perceived similarities between the therapist and client and lacked collaboration to better understand the service user at an individual level. Irem indicated that she wasn't invited in the process and that her preferences were

disregarded. It seemed that lack of collaboration meant that the decision was more likely to be based on cultural stereotypes or misconceptions and this perhaps, reduced the feeling of trust towards professionals and formal type of psychological care;

> *"Understanding that person at a more unique level, at a more personal level rather than seeing that person as a community, I think, it would be more helpful for everyone." (Irem, p. 35, L758-760)*

> *"During the pre-assessment if these could be mentioned, or like these could be, I don't know, underlined, maybe that, like, if that person is comfortable with this much of cultural thing or […] trying to investigate it a little bit could be helpful." (Irem, p. 35, 773-775)*

On the contrary, for the participants who accessed therapy through a private therapist, they felt more empowered to shape and manage their own mental health care. It appeared that Mina indicated that she chose her therapist based on her own preferences and perceived needs;

> *"I found an online website where therapists near me were listed and then I read through and looked at the pictures and see, trying to see like which one I thought was most welcoming or was most relevant to what I thought I wanted out of therapy." (Mina, p. 5, L103-106)*

Asli mentioned choosing her therapist based on her own judgement. It appeared that she was more comfortable trusting her own judgment when deciding on how and from whom she was receiving psychological care. This suggested that some participants only relied on themselves when making the decisions about the care they received;

> *"I had the option of emailing them or calling them, speaking to whoever it was that I wanted to." (Asli, p. 22, L445-446)*

“I started looking at low-cost counselling and I actually just went with my intuition, just picked someone.” (Asli, p. 9, L185-186)

4.5 Theme: Managing the Differences

This theme relates to participants' experience of engaging in therapy with a non-Turkish therapist and in their non-native language. The theme captures how participants, and their therapists managed the difference they experienced in their therapeutic relationship due to language and cultural factors.

4.5.1 Sub-theme: Thinking twice

Participants noticed that using English in therapy had an impact on what they spoke about or how much they shared with their therapist. Many participants indicated that despite being fluent in English, they had to go through an additional thought process due to engaging in therapy in their non-native language. One of the participants emphasised feeling a struggle in therapy due to experiencing language differences with her therapist. She exemplified her struggle with words such as ‘challenge’, ‘trying’ and ‘consuming’;

“It was a really big challenge, because in my head, I'm understanding him, also I'm thinking of the answer and also I'm trying to translate it in my head and also filtering what I'm going to say, or what I'm not going to say, it was consuming.” (Semra, p. 20, L400-402)

Some participants felt like they were unable to get the meaning across at times, as they couldn’t find the right English word for their Turkish thoughts. Deniz mentioned that despite wanting to share things with her therapist, she remained silent from time to time or just laughed (‘ehehe’) as she couldn’t think of a meaningful way to express herself in English;

“Sometimes things get lost in translation, you just have to say something in Turkish and then just say “ehehe”.” (Deniz, p. 30, L605-606)

Most of the participants spoke of their concern about sounding wrong and not being understood by their therapist due to the language differences;

“I couldn't translate in my head, even though I know, I speak English fluently. I couldn't explain it to the therapist and the therapist didn't get it.” (Semra, p. 19, L372-374)

Some participant emphasised that they felt self-conscious about their language use or proficiency, which exacerbated their doubts about sharing their thoughts. They discussed how this impacted what they shared with their therapist or how they expressed themselves. It seemed that this disconnect made the clients doubt themselves, which impact their thinking and talking in a ‘vicious cycle’;

“I just always found myself searching for words. And then I guess, when you search for words, you tend to maybe overthink a little bit more, as in your thinking, ‘Oh, I won’t explain it properly’, and then you kind of think, ‘What am I trying to explain?’ […] translating that can sometimes make you overthink or maybe not mention something because you're second guessing yourself at times.” (Mina, p. 19, L405-410)

“I'm not speaking in my own language. So, when I see his face and he looks like he's not getting anything […] I started to speak worse when I see his expressions because time to time, I wasn't speaking very well.” (Semra, p. 23-24, L467-471)

Many participants discussed that trying to think and speak in English, led them to think more about what they were going to say to their therapist and how they were going to present themselves;

> *“I would have preferred to make, say stuff in more of a comical way, but in my head, I was like, ‘No. Should I really translate this to English and then make that joke?’” (Oyku, p. 20, L412-413)*

One thing that stood out from participants’ accounts was that thinking twice before sharing or deciding to hold back certain ideas to be able to rule out any misunderstandings meant that some things weren’t discussed and therefore, not explored further or worked on in therapy. Semra emphasised that she wasn’t able to fully express herself and was pessimistic about the prospect of her therapist empathising and developing a comprehensive understanding of her;

> *“Not being able to tell everything…Basically, it also made me discouraged, because what am I doing here if I cannot tell everything and if I cannot tell everything we cannot solve it […] if I'm filtering things out, how are we going to solve them if he cannot know what they are, or if I cannot express myself.” (Semra, p. 21, L420-425)*

On the contrary, some participants shared that they weren’t concerned about being misunderstood by their therapist despite facing language-related challenges. One participant reflected on feeling comfortable about making mistakes when speaking in English. It seemed that experiencing unconditional positive regard from the therapist and not fearing judgment related to use of language strengthened the therapeutic relationship and perhaps enabled shared understanding;

> *“I often just translated things directly to English and we would laugh because it sounds ridiculous. So, it was also nice, she would try to understand what I’m saying, and she would tell how to say it in English, or the slang of it sometimes.” (Deniz, p. 30, L611-613)*

Participants emphasised feeling confident that their therapist would understand them and communicate their understanding back in the face of having a language barrier. It appeared that some participants had a more trusting relationship towards their therapists, or their therapists were better able to communicate empathy and non-judgemental attitude. This was exemplified by words ‘sure’, ‘understand’, and ‘get it’;

“Even if I couldn't explain the word or I don't know the exact word or something, I could explain it in some way. And then, I'm sure my therapist understood at that time because I could understand from her reply to me.” (Merve, p. 13, L264-266)

“After a while I was like, ‘Let me just say whatever I think. Just do the translations, she'll get what I’m saying in the end after all.’” (Oyku, p. 20, L413-415)

4.5.2 Sub-theme: Communicating the context

Apart from language-related challenges, many participants discussed feeling worried about their therapist interpreting things differently due to cultural differences or lack of knowledge about the social context. Participants felt that their therapist wouldn’t be able to have a comprehensive understanding of what they were trying to share. However, worrying whether their therapist was able to understand the cultural nuances or contextual significance of what they shared didn’t prevent participants from expressing themselves. Perhaps language related challenges were perceived as a personal failing or shortcoming, whereas cultural differences or context related challenges were not;

“I didn't feel that I could always convey it in the way that I wanted to, or I meant to. I would try to explain it, but it would not always really, it could be some things just can't be explained. Like, it's just a collectivist thing, it's a learned thing.” (Sanem, p. 14, L296-299)

“I think she doesn't understand some of the cultural aspects of things at times. For example, if I talk about like my parents’ views on something or like the way I grew up or something, it's sometimes difficult to explain that, in a Turkish culture that's normal […] nuances of the culture are kind of difficult to explain and I think sometimes what you're trying to say isn't understood” (Mina, p. 12, 254-258)

Also, some participants sought to be understood by their therapist concerning the influence of the social context, including the impact of current political and economic events in Turkey. It appeared that apart from culture, social context related to their Turkish identity needed to be addressed, explored, and understood;

> *"Being Turkish and being here. There is still a huge influence of what's happening in Turkey […] serious things are happening in the country and it's almost impossible to not be impacted and, I think, therefore it's important to seek help, speak up and also feel understood in that aspect" (Sanem, p. 26-27, L544-550)*

> *"The main thing that they should know is the economic and the ideological, political situation in Turkey, which is, I think causing a lot of people anxiety. So, I think assigning a therapist that has no clue about what's going on could make people feel like their therapists won't understand them, because it's a bit hard to talk about that kind of stuff." (Oyku, p. 30, L601-604)*

It appeared that participants were concerned about how much their therapists understood the context. Yet, as Semra highlighted, most of the participants attempted to 'translate' the cultural meanings;

> *"Some of the things were so difficult to explain because it had cultural context. Even though I tried try to translate them, maybe the psychologist or therapist is not going to get it." (Semra, p.19, L382-384)*

Asli spoke about the importance of acknowledging and exploring the cultural difference in therapy. It appeared that participants appreciated the therapeutic relationship if the therapist was curious about their culture and endeavoured to understand the differences;

> *"I would like the therapist to ask and acknowledge, you know, ask me what the differences are, if any for them to be able to understand me more." (Asli, p. 22, L434-435)*

Subsequently, Deniz discussed feeling invited by her therapist to talk more about her culture and the social context related to her difficulties. It seemed that Deniz and her therapist's generated a shared understanding by collaboration and open-mindedness;

> *"She was like 'Oh, please explain this, the education system or this thing in Turkey in more detail. Even, if I get another Turkish student, you can, I can help them more'." (Deniz, p. 18, L355-356)*

Deniz went on to talk about how despite the cultural dissimilarities, her therapist's attempts to understand her and her culture at an individual level made her feel accepted and understood. It appeared that therapist expressing her interest in getting to understand the client in the context of their culture as well as the uniqueness of their experience was perceived favourably;

> *"It shows her interest in the whole therapy thing, in her job and in me as well. You know, she just didn't dismiss me as another case." (Deniz, p. 18, L363-364)*

4.6 Theme: Benefits from Therapy

This theme reflects what participants experienced as the benefits of undergoing therapy. It captures what participants discussed about the positive aspects of having received therapy or achieving good therapy outcomes. Most of the participants spoke about the symptom reduction they experienced as a result of having psychological therapy. They also discussed observing an improvement in other aspects of their lives and functioning. Some of the improvements they experienced were not anticipated when they first started seeing their therapist. Another benefit of undergoing therapy was a changed attitude towards help-seeking as well as developing a positive view on being vulnerable and talking about emotions.

4.6.1 Sub-theme: Back to normal

Most of the participants engaged in psychological therapy as a result of unmanageable psychological distress, which was coupled with a sense of urgency and concern. This sub-theme captures a wide range of experiences relating to improved functioning and going back to a sense of 'normal'.

Participants reflected on the therapy outcomes and discussed what they experienced as a result of therapy. Most of the participants indicated that therapy helped reduce stress and improve symptoms related to psychological problems. Asli discussed undergoing a period of distress prior to starting therapy and pointed out that therapy 'helped' her to feel 'de-stressed';

> *"I think it definitely helped. Therapy was de-stressing." (Asli, p. 20, L408)*

Similarly, many participants discussed improved functioning. There was a positive change in terms of what they experienced as abnormal or out-of-character prior to starting therapy. Some participants spoke about better sleep, reduced procrastination, and improved social life, which they had identified as symptoms of their deteriorated mental health previously in their accounts;

> *"Rather than sleeping just for 10 hours in five days, I started to sleep like three to five hours, every day. So, it kind of helped." (Deniz, p. 27, L531-532)*

> *"I got the skills that prevented me from procrastinating." (Oyku, p. 24, L489-490)*

> *"My relationship with my boyfriend got better because I am no longer talking about whether if I have cancer or not." (Semra, p. 31, L629-630)*

The intensity of the problems they experienced prior to therapy was exemplified with the repetition of the word 'too much'. However, as Deniz emphasised, after undergoing therapy many participants developed a sense of control over their psychological health as they felt able to 'stop' before spiralling out;

“Gained knowledge of how can I stop myself from thinking too much, and too much stress and too much anxiety.” (Deniz, p. 20, L404-405)

What stood out from participants’ accounts was that after ending therapy the sense of urgency regarding their psychological health was relieved. Hence, participants not only reflected on the symptom improvement but also emphasised that they no longer felt concerned about their psychological well-being;

“I definitely saw the benefits, not only to improve and kind of, helped me get off that phase I was in last year.” (Sanem, p. 19, L406-407)

“I wouldn't say my stress was fully gone, but that moments, where I can just physically feel the stress, were gone. That was really helpful […] I didn't experience any of that outer body experience I had.” (Irem, p. 31, L680-683)

In fact, participants discussed learning ways to ‘manage’ their psychological problems. It appeared that they didn’t feel overwhelmed with their issues any longer and felt empowered to be able to cope;

“I’m a lot better, like, managing anxiety and stress.” (Mina, p. 16, L332)

“Now, I’m a lot less stressed when there's a stressing situation. I can separate the stress and I actually focus on finding solutions instead of focusing on the stress.” (Oyku, p. 28, L569-570)

“I cannot say that I'm hundred percent over my anxiety etc. It's still with me, but I think it's more manageable right now” (Semra, p. 29, L576-577)

4.6.2 Sub-theme: Change for the better

Participants discussed experiencing improvement in various different areas. This sub-theme considers the positive changes participants experienced, which were

related to their improved well-being, insight and sense of self, and ways of relating with others. What is different from the above-mentioned theme, *Back to normal*, is that this theme captures the improvement in areas which participants had not identified as symptoms or reasons for coming into therapy.

Many participants emphasised developing introspection and gaining a better understanding of themselves, including their emotions. It seemed that participants noticed the mind-body connection, and this was exemplified when Oyku used the words ‘emotions’, ‘thoughts’ and ‘stressors’ together;

> *“I could look at what was going through my mind, like my emotions, my feelings, my thoughts, my stressors. Because I could see that I became able to work on those as well. Before that I was ignorant.” (Oyku, p. 25, L510-512)*

> *“[Therapy] changed and impact[ed] my way of thinking about a lot of things and just awareness of myself and my thoughts and my feelings and why I might be feeling those this way.” (Sanem, p, 19, L408-410)*

Most of the participants discussed an increased sense of self-worth and confidence after undergoing therapy. This was perhaps because they became more empathic towards their own emotions and developed self-compassion;

> *“I found more confidence, I build more self-confidence through that [therapy], I think it's really helped my self-esteem and self-confidence” (Irem, p. 27, L580-581)*

> *“I’ve become a lot more confident in knowing what I want or understanding if I feel a certain way then it's okay to express that or change that.” (Mina, p. 15, L313-315)*

They also spoke of developing their ability to prioritise their own needs and wishes and establishing boundaries with other people. Perhaps, as a consequence of therapy, individualistic values were cherished and normalised;

“I prioritise myself and my emotions and my physical well-being […] I just kind of draw the line at where I’m comfortable as long as its respectful obviously” (Sanem, p. 22, L468-471)

“I realised more so like the value in taking care of myself as well. I think, before I might have been a little bit of a people pleaser and not that I don't like helping people now, but I also understand that my self-worth as well.” (Mina, p. 14, L291-293)

Moreover, some participants talked about a change in their value systems and suggested that ‘appreciating’ different things was ‘advantageous’ for their well-being in general. It seemed that strengthening relationships and perhaps, resorting more to their personal and social resources for distress management had a positive impact on their well-being;

“I started valuing friendships a lot more” (Mina, p. 16, L337)

“I started to see the value of what we have and appreciate it a little and take more advantage of it and so it's just gave me a perspective, where I can be more energetic, be more positive, be more well minded.” (Irem, p. 27, L584-586)

4.6.3 Sub-theme: The power of talking

Participants discussed their struggles with opening up and talking about their emotions in therapy. They emphasised that this was not encouraged within the Turkish culture, including in their families and within the wider community. However, one of the benefits of therapy was changing their attitudes towards talking about emotions and being vulnerable with someone. Talking about themselves or their feelings and being vulnerable with others were considered as unfamiliar experiences for many participants;

> *"I think, as Turkish society we like talking […] we actually talk in surface. We are not going deep inside, we don't understand actually what cause it, why we feel that way, what is actually the root of that feeling and the emotions." (Merve, p. 20, L407-410)*

> *"I'm a bit influenced by the Turkish thing of like, not really speaking about one's feelings." (Sanem, p. 18, 381-382)*

Many participants shared that it wasn't easy for them to let their guard down and talk about their feelings. For some participants, this struggle was one of the things they focused on in therapy;

> *"One of the things I talked about in therapy was finding it hard to talk about my emotions, like, the whole therapy process itself for me, trying to, like, me working at it. So that was difficult." (Oyku, p. 27, L538-540)*

Subsequently, Mina reflected on her therapist's encouragement to help her talk more about their emotions. Despite it being challenging, many participants reflected on the benefits of talking and exploring feelings;

> *"That's kind of what my therapist realised and then started talking to me more, interacting with me more to get me to open up. I think that's when it started becoming more beneficial." (Mina, p. 18, L372-374)*

Many participants commented on the positive impact of talking and being listened to. This was exemplified when Asli used the word 'cathartic' when explaining her experience of talking therapy;

> *"What I enjoyed was the fact that somebody was giving their undivided attention right, really trying to understand me listening to me and also how cathartic that experience is. Just talking and talking and talking." (Asli, p. 14, L281-283)*

Participants discussed that opening up in therapy helped them to gain a new insight into the benefits of talking. Some of the participants discussed seeing the benefits of talking and sharing, which was related to gaining a greater understanding of themselves. Developing self-knowledge and being able to talk about unfamiliar topics were experienced as a revelation and this was exemplified with the word 'actually' and 'realised' which have connotation for a sense of surprise and a new understanding, respectively.

> *"I was talking a lot about things, and actually opening up about things. So, I realised through that like, "Oh, this is bothering me, like this and that's bothering me." (Mina, p. 14, L285-286)*

Asli emphasised that talking in therapy helped her to face certain emotions and let herself experience and explore those feelings in the therapeutic space. It appeared that feeling safe enough in the therapeutic relationship helped participants to be more open about their emotions and benefit from sharing it with someone;

> *"I'd say it was a hard experience, in the sense that it was quite heavy for me. Just a lot of crying, build-up of emotions and it was surprising because I didn't expect it would be so powerful at times" (Asli, p. 18, L354-355)*

Participants reflected on their realisation regarding asking for help from others. They discussed feeling reassured after therapy that it was safe and comforting to talk with other people;

> *"That realization to say, 'You can also get that help'. That was something, being able to express myself was something which I'm not able to do in my outside life." (Asli, p. 18, L370-371)*

> *"I can open up and because I had that safe space right, I could create more safe spaces for myself and my personal life or I could talk about my emotions as well." (Oyku, p. 27, L541-542)*

Subsequently, most of the participants spoke of the new perspectives they gained regarding the therapeutic process. Rather than finding a cure, participants perhaps realised the benefits of talking therapy, including finding alternative coping mechanisms and increased insight;

> *"I really enjoyed getting therapy and I got CBT, so it really allowed me to find mechanisms to help me cope with my problems." (Oyku, p. 23, L460-461)*

> *"I realized the reason of my behaviours or I'm doing less right now." (Semra, p. 29, L577-578)*

> *"It's that learning opportunity, that understanding of yourself." (Asli, p. 19, 386)*

Some participants discussed their new understanding about reasons for undergoing therapy. Rather than starting therapy out of an urgent need, they suggested that they were now enthusiastic about undergoing talking therapy in the future to focus on the underlying causes. It appeared that they started valuing exploring emotions and talking, rather than repressing things;

> *"I believe I need to continue having therapy because other than the specific health issue, I'm an anxious person […] we kind of resolved it [health anxiety] with those sessions, but I think I should continue." (Semra, p. 31, L621-624)*

> *"I realized that I need longer and effective therapy. Because this thought is inside me for years and years […] So, it made me realise, I really need it, and it needs to be talked." (Merve, p. 19-20, L393-396)*

4.7 Theme: The Nice Therapist

This theme conceptualises how participants experienced their therapists' way of being as well as the therapeutic relationship. A key feature in all participants' accounts was that they all commented positively on the working relationship and

therapeutic alliance as well as appreciated their therapists' personality, attitude, and professional competence. It appeared that the 'nice' aspects of the therapist and the relationship dynamic helped the participants experience trust, safety, and comfort, which yielded positive therapy outcomes.

Many participants shared their content with their therapists' professionalism and perceived competency in their area of training. Perhaps this promoted trust and respect for their therapist;

> *"The therapist was very qualified." (Semra, p. 31, L631)*

> *"I really appreciated her in her area of training." (Sanem, p. 11, L238)*

Merve commented on her first impression of her therapist. She emphasised that observing her therapist as a 'positive', 'nice', and 'calm' person made her feel 'good' about committing to therapy. It seemed that apart from their professional competency, therapists' demeanour and first impression on the client were important to establish a level of trust;

> *"If I got, you know, the good impression, I can continue […] when my therapist came, she was so positive and then, nice and calm person and I'm saying, "Okay, she looks good", I felt good." (Merve, p. 11, L220-225)*

This was echoed in Irem's account. It appeared that the first impression she got from the clinician promoted trust toward the efficacy of therapy;

> *"When doing the pre assessment, I just remember thinking that what I could get from here can be really helpful for me […] all that procedure really made me believe that therapy will work for a better." (Irem, p. 16, L344-346)*

Some participants highlighted that sharing a similarity, such as age, interests, or worldview, positively contributed to their relationship. It appeared that finding a common ground with their therapist was perceived positively. Perhaps, participants

felt that their therapist was better able to relate to them when they shared things in common;

> *“I liked that she was quite young. Like, if she could relate to like my day-to-day problems and my like exam stress of like that, because, like she was going through that stuff probably as well, so that was like an enjoyable aspect.” (Oyku, p. 19-20, L394-396)*

> *“I felt closer to her, in that sense, because of also her views and my views being very similar on other topics other than psychology, such as, I like energy and like Karma and chakras and like we were very similar” (Sanem, p. 13, L275-277)*

Deniz and Irem both expressed they found talking to her therapist similar to talking with a friend. It appeared that as therapy progressed, the therapist was perceived more like a friend, rather than a stranger, and this perhaps improved the therapeutic alliance;

> *“It was very similar to my own...it was just like talking to my...friends but with someone actually with a degree on it.” (Deniz, p. 20, L397-399)*

> *“It was just like it was talking to a therapist and a friend, at the same time topics were discussed, so I think it was particularly helpful for me.” (Irem, p. 23, L493-494)*

Many participants reflected on feeling safe and cared for in relation to how they experienced their therapist. It appeared that therapist’s non-judgemental and non-threatening attitude and level of openness contributed to the positive therapy experience;

> *“I don't feel any challenge with my therapist. She was good.” (Merve, p. 12, L229-240)*

“She was quite open, easy to talk to.” (Asli, p. 13, L262)

“I liked her like demeanour. Liked her personality, she wasn't threatening.” (Oyku, p. 19-20, L396-397)

Merve spoke about feeling listened to and contained in the therapeutic relationship. It appeared that therapist’s attempt to normalise Merve’s feelings and empathise with her were therapeutically beneficial and perhaps, encouraged her to feel trust towards her therapist and the efficacy of therapy;

“Someone for me, I mean, listens me, […] understood me. When I shared the things at that time, she said, she gave me some examples [from other people’s experiences] that makes me feel better.” (Merve, p. 12, L229-231)

4.8 Theme: Unmet Expectations

Many participants described a gap between their expectations and their actual experiences concerning psychological care and access to therapy. Experiences not matching these expectations often brought a sense of disappointment or at other times impelled participants to find alternative ways to manage.

Many participants mentioned reaching a breaking point and therefore, required urgent response when they sought psychological care. Some participants tried contacting the university counselling service or their GP to access therapy but did not receive immediate attention. The sense of disappointment was highlighted by two of the participants;

“I needed to talk to someone at that moment. And I did call them, and no one picked up and there was like a queue of a lot of people in front of me too and it was just a horrible experience. Basically, like, they're either very understaffed or they just don't care” (Sanem, p. 24, L519-522)

> *“So, a patient in your system ask for psychiatrist, ask for help, and then you just send a letter, that’s it. It is, I think it's a bit, you know, ignoring people” (Merve, p. 18, L364-366)*

Some participants had acknowledged the fact that they couldn’t get urgent care and attention from university services or the NHS and found an alternative that would match their needs and expectations;

> *“I went onto their [university counselling service’s] website and just looked what they offered and then I realized that it took them quite a while to, I think it was like a six week wait time or something like that, and I didn't really want to wait for that, I was kind of more interested in starting sooner, so I decided not to.” (Mina, p.8, L152-155)*

Oyku reflected on the urgency to access psychological care as she felt waiting ‘too long’ would severely impact her studies. She mentioned trying to access NHS for mental health care would be a ‘luxury’. In other words, she didn’t have any time to waste on waiting;

> *“[…] with NHS, it was quite difficult to, like, the waiting periods were too long and stuff like that and I needed a quick solution because my exams were coming up. And I wasn’t studying, so I didn't have the luxury to wait like two months, three months for therapists.” (Oyku, p. 15, L296-299)*

Deniz, who was on the waiting list for a couple of months, mentioned that she had low expectations to start with and that she resorted to her own coping strategies in the meantime, which in turn made her feel ‘okay’. It appeared that she lowered her expectations and repressed the memory of contacting the service in order to avoid any disappointments;

> *“I kind of knew that it would take a while, so I was not disappointed, but I wasn’t expecting much.” (Deniz, p. 12-13, L247-248)*

“I actually forgot about that, until I get the e-mail […] me and my friend, we would regularly go for walks and just roam around, got each other, relax. So, it was okay.” (Deniz, p.11, L224-226)

Also, some participants expressed their unmet needs regarding the therapeutic process. A sense of not having had enough therapy was evident in some of the participants’ accounts. In her account, Deniz repeated multiple times that she was offered ‘eight’ sessions. Her dissatisfaction with the number of sessions was exemplified with the word ‘just’ which indicated a sense of insufficiency;

“I think, it was just like eight sessions.” (Deniz, p. 24, L487)

She also emphasised that therapy duration was the reason for not having an ‘impactful’ therapy experience. Even though she and her therapist found ways to manage the differences in culture and social context (as discussed in *Managing the differences)*, Deniz indicated that time-limitation got in the way of an effective therapy experience;

“I think, it was just like eight sessions. Also, like I said, most of them were just, you know, not wasted but lost time in a sense that I had to explain stuff about the system in Turkey. So, it was, you can think of more of maybe five and a, maybe at most five sessions. So, it was not that impactful. But impact in the small senses.” (Deniz, p. 24, L487-490)

Merve also reflected on similar experiences about the brief nature of therapy she received at the university counselling service. She emphasised that having time-restriction led her to not explore certain topics in detail or at a slower pace, which negatively impacted her therapy experience in general;

“We should choose one topic and then continue with that, there's no time to continue or something. We just talked general with her and, yeah. I mean in, in personal life there's something urgent, we need to intervene, or we need to leave for a while and then continue later.” (Merve, p. 23, L458-461)

However, Covid-19 pandemic and the restrictions put in place also caused a disruption in Merve's therapy experience. In fact, she conveyed that having to end therapy did more harm than good on her psychological health;

> *"And, I think, the interrupted therapy after four weeks also not good for mental health. You're going through something and then it stops, and then you are there. It isn't, it is not good, I mean, it is like the playing with your feelings and emotions." (Merve, p. 19, L374-376)*

> *"I don't think there is a good impact on me, there is negative impact. It's just four weeks therapy, it's nothing." (Merve, p. 18, L353-354)*

Most of the participants discussed finding therapy more effective and feeling that their needs were met further when their therapist was more directive or 'attentive'. It seemed that participants preferred receiving guidance or probing from their therapists;

> *"I quite liked the, like, after I had talked about something she would give her input, but not like direct me towards something, she would more so talk to me about or help me talk through things. (Mina, p. 10, L211-213)*

> *"I'm just doing the talking and I'm doing this on my own, which I know is like the whole process, but when you want like a fix you kind of want the other person to be a bit more responsive." (Oyku, p. 17, L340-342)*

The following chapter provides a discussion of these findings in relation to the relevant literature. Also, the project will be evaluated in terms of its contributions to the field and implications for future research will be explored.

Chapter 5: Discussion

The aim of this research project was to gain an understanding of Turkish international students' experience of accessing and undergoing psychological therapy in the UK. The findings emphasise each key aspects of the experience of accessing and undergoing psychological therapy as identified by the participants. In the first part of this chapter, I seek to examine the key findings with reference to the project aims and research questions with links to the existing literature. However, the ideas developed in relation to the shared knowledge of the field are tentative as the critical realist position adopted in this project contests reaching definitive conclusions and rather claims that one could make sense of participants' experiences in numerous ways. In the second part, I summarise the applicability of the findings to counselling psychology and consider the recommendations and limitations of the present study.

5.1 Discussion of Findings

In relation to the themes discussed in the previous chapter, much of the processes emphasised by the participants were linked to their wide range of experiences connected to their multiple identities. That is, their experiences do have unique aspects in relation to their identity, language, and culture as Turkish international (female) students, but the experiences they reflect on must not be reduced to only one of the many identities they possess. Some of the processes they experienced and emphasised in their accounts could be conceptualised as in relation to their experiences as a woman; a young adult; a university student; an international student; a foreigner; a Turkish person; a Turkish woman; a person with collectivistic culture orientation (and the list goes on).

"The definition of who one is can be complex and multifaceted" and therefore, it is important to acknowledge the multiple identities one holds as they provide the lenses through which one gives meaning to the world (Ramarajan, 2014, p. 590). In line with the research aims to promote multicultural competence in clinical practice, one needs to appreciate intersectionality and recognise "how various identities converge,

intersect, and mutually influence one another to create unique subjective experiences" (Bramesfeld et al., 2019, p. 16). In this sense, whilst making connections with the shared knowledge within the field of international student mental health, I also evaluated other studies in relation to the particular research findings.

The research questions were:

1) What are the experiences of Turkish international students accessing psychological therapy in the UK?

2) What are the experiences of Turkish international students undergoing psychological therapy in the UK?

5.1.1 Deviation from the normal

This theme illustrates participants' emphasis on the intensity of the sense of abnormality they experienced, which constituted an emergency in itself and indicated a breaking point. Most of the participants discussed the impact of being a student and studying abroad on their mental health, which in some cases heightened their psychological distress and contributed to a strong sense of helplessness as well as feelings of concern about themselves. It seemed that participants didn't notice the symptoms of their deteriorated psychological health until things reached a breaking point and this was coupled with a sudden realisation that they no longer thought, felt, or acted as their 'normal' selves. Participants emphasised that the signs of 'abnormality' begot a strong urge to promptly fix the situation or find a solution to ease the 'deviation from the normal'. This sense of urgency coupled with a lack of self-control and a feeling of powerlessness was a strong contributor to their decision to seek professional help.

Existing literature suggests that not knowing about the symptoms of psychological distress or not regarding them as severe enough to receive professional help prevents students from accessing mental health services (Lu et al., 2014). It seemed

that the participants didn't notice the early signs of their psychological distress and hence, delayed help-seeking until their symptoms exceeded the 'normal'. This reflected Bilican's (2013) findings showing that denial of psychological difficulties was one of the most common barriers to professional help-seeking among university students in Turkey. Also, participants' lack of awareness of their distress until the situation became critical is in correlation with the literature findings demonstrating the association between low mental health literacy and delay in accessing support (Rafal et al., 2018; Ratnayake & Hyde, 2019; Wang et al., 2012). However, it should be noted that the term 'critical' refers to their subjective experience, and that none were critically mentally unwell in the sense of being admitted to a hospital.

Deniz and Semra discussed their worrisome academic problems due to experiencing intense psychological distress, which is consistent with the literature (Broglia et al., 2017). Participants avoided seeking support until their needs became very severe and they started to observe the impact of their deteriorated mental health on their academic performance. This also echoed Depreeuw's (2013) findings which conveyed that international students have a much higher threshold for engaging in university counselling. However, participants also talked about their impaired relationships with friends and significant others as an alarming sign of their 'abnormal' state. This hasn't been identified in the relevant literature, but it reflects Vogt et al.'s (2019) findings, which reported that relationship impairment facilitated treatment-seeking for post-traumatic stress disorder and depression for female military veterans and hindered it for their male counterparts. In terms of the gender difference, it appears that negative effects of limited social support may be greater for women than men.

As participants reflected on being a student and living abroad as contributors to their deteriorated psychological health, they also emphasised a sense of loneliness. Feeling alone and being away from loved ones perhaps led them to experience difficulties with isolation and resulted in the absence of their preferred sources of support and coping strategies. It is possible that feeling lonely promoted a greater need for self-control and self-management, which was also reported as a preferred coping strategy among other international student groups (Shi et al., 2020). However, literature shows that students with collectivistic cultural orientations are

more inclined towards seeking help and support from friends and family rather than engaging in formal sources of support in the face of adversity (Mundia & Shahrill, 2018; Yelpaze & Ceylan, 2020). Among university students in Turkey, friends (59%) and family (45.6%) were the most frequently reported sources of help for personal problems in times of need (Cebi & Demir, 2020). The difference between current study findings and existing evidence in the literature may be related to the international student experience and living abroad.

Hitting a breaking point and feeling no longer able to cope with problems reflect an experience of crisis. It seems that participants' preferred strategies were not sufficient and/or available because they were studying away whilst they experienced difficulties, which led to an unmanageable amount of distress and feeling not in control. Research findings suggest that people can experience a crisis as a feeling, e.g., powerlessness, depression, and despair (Bristol MIND, 2004), and most of the participants reflected on similar feelings in the context of experiencing concerning and unmanageable mental health symptoms. Coping strategies that were familiar and formerly successful no longer served the participants due to contextual factors. Previous studies have shown that the efficacy of coping strategies can diminish when the external resources required are not available or adequate (Oakland & Ostell, 1996).

5.1.2 Pulling in two directions

This theme considers participants' ambivalence towards seeking help and accessing services. Participants discussed their lack of information regarding available support and services as well as not knowing about what therapy entails and feeling overwhelmed with having many options with no guidance or support. Participants were apprehensive about seeking help and making a decision on their own and therefore, found it helpful to get input, support, or encouragement from family and friends regarding their decisions around help-seeking and accessing mental health services.

5.1.2.1 Fear of the unknown

This sub-theme relates to the unknown aspects of the therapy process as participants emphasised not knowing what therapy actually involved and what services were available for psychological support. Some participants discussed feeling overwhelmed with the options available online. Also, this sub-theme reflects the need for support and guidance from others to make a confident decision when dealing with the unknown and to overcome their ambivalence towards help-seeking.

Studies have shown that one of the common barriers to help-seeking is poor knowledge and awareness of existing services available for students (Almanasef, 2021). Participants discussed getting information about mental health services from friends and using second-hand knowledge in order to lessen the unknown aspects related to help-seeking and cope with the uncertainty and reluctance they experienced prior to engaging in therapy. Echoing literature findings on collectivistic values related to cooperation and knowledge-sharing (Skillman, 1999), participants resorted to others' knowledge and experience to cope with stressors related to help-seeking.

Asli indicated that she felt overwhelmed by the number of therapists available online. Perhaps, this complicated the help-seeking process and added to the unknown aspect of mental health support. Information overload whilst in a state of crisis (as discussed in the first theme) may have made it more challenging to manage and overcome the uncertainty, which exacerbated fearful feelings and anxiety around getting professional help. A similar finding was reported by Westberg et al. (2020), which demonstrated that help-seeking was hindered for young people in Sweden when they attempted to access mental health care through multiple contacts and felt lost as they dealt with numerous sources for formal psychological support.

Mina conveyed that she was experiencing mixed feelings about engaging in therapy due to 'not knowing what to expect'. Participants discussed being unacquainted with therapy and lacking information about what therapy entails, which resulted in feeling apprehensive about the therapy process. This echoes the above-discussed literature findings, which suggest that low mental health literacy, including a lack of knowledge

about professional help and negative beliefs about psychological therapy, contributes to reluctance toward help-seeking (Gulliver et al., 2010). Participants' ambivalence towards accessing mental health services and engaging in therapy was lessened after they acquired information about the therapeutic process and/or initiated the process, which is in line with study findings showing that prior experience with therapy or knowing someone who has accessed professional support promotes positive attitudes towards help-seeking (Disabato et al., 2018; Rickwood et al., 2005; Vogel et al., 2007).

5.1.2.2 Reshaping perceptions

This sub-theme reflected participants' need for encouragement from friends and family regarding professional help-seeking. They also sought others' involvement in the decision-making process for accessing mental health services. It seemed that participants developed more positive attitudes towards help-seeking and accessing professional support when others shared their experiences about or provided guidance for getting psychological care. This sub-theme emphasised participants' diminished hesitancy about engaging in psychological therapy when they felt well-supported during the process of accessing services.

Mina suggested that Turkish culture had an impact on people's reluctance towards professional help-seeking. This echoed Ruckert's (2015) findings on international students, which showed that reluctance towards accessing psychological care was associated with a strong stigma attached to mental illness in their native cultures. Aci et al.'s (2020) study reported that Turkish people held negative beliefs towards people with mental disorders and that the social stigma around mental health was high. It seemed like participants needed encouragement from others to normalise their experience and reduce internalised stigma related to having psychological problems and getting professional help. Furthermore, perceived public stigma has been found to correlate with internalised stigma within a sample of adults with experience of recent mental health service use (Bradstreet et al., 2018). Participants emphasised that having friends who held positive attitudes towards therapy aided their decision to access mental health services. Perhaps, it helped them to

recalibrate their perception of public stigma towards mental health and reduce their internalised stigma about receiving psychological care.

Participants also discussed consulting other people regarding their decision to engage in psychological therapy. It seemed like deciding on their own was daunting and they sought others' support and encouragement. Asli and Irem shared that they sought their friend's guidance, whereas both Oyku and Mina shared their decision about getting psychological help with their parents and invited them to be a part of the decision-making process. Overall, involving friends and family in the process and seeking their support and guidance appeared to be helpful to reduce their ambivalence and feel confident in their decision to get professional help. Kuo et al.'s (2006) findings show that people from collectivistic cultural orientations prefer interpersonally based coping behaviours and problem-solving strategies. It appeared that participants struggled with accessing services due to stigma but found it beneficial to get help and support from other people to cope with the stress-inducing process of help-seeking. This also mirrored Avashti's (2010) study, which reported that collectivistic individuals benefit from including family in their mental health care planning as this aligns with their cultural values of emotional interdependence and cooperation. Rather than making an autonomous decision, participants seemed to benefit from a collective decision.

5.1.3 Feeling (un)invited

It appeared that receiving adequate information during the process of accessing services and initiating psychological care helped to diminish the ambivalence participants experienced about professional help-seeking. Lack of communication during the process and clarity about what it entailed seemed to make participants feel excluded and neglected. In their systematic review, Carbonell et al. (2020) identified structural barriers in mental health systems that demonstrated a sense of abandonment in individuals who sought to access psychological care experienced. Furthermore, failure to communicate with patients and families has been associated with perceived caring neglect and diminished patient well-being and resulted in treatment dissatisfaction (Reader & Gillespie, 2013).

Sense of neglect was exacerbated when the process of accessing psychological care involved long or obscure waiting times. Deniz discussed feeling forgotten as she didn't receive any communication during the waiting period and lacked information about how long she needed to wait. As Stanley Budner (1962) postulates, ambiguous situations can be perceived as sources of threat and therefore, can be anxiety inducing. Furthermore, high levels of missing information is associated with greater perceived uncertainty (Lawrence et al., 2022). Research findings show that motivated forgetting can be functional for emotion regulation and avoidance of unpleasant emotions (e.g., anxiety) (Norby, 2015). On the contrary, Semra emphasised feeling better able to cope with the long waiting time when the service provided her sufficient information regarding the process, which perhaps lessened the uncertainty and the associated unpleasant emotions related to accessing mental health services. This echoes Hicks's (2014) findings demonstrating the benefits of ongoing information sharing as a way to help patients deal with the ambiguous aspects of their care provision and diminish unpleasant emotions stemming from uncertainty.

Oyku emphasised her wish to have received justification from the service provider regarding therapist allocation. Irem spoke about wanting to have more options regarding therapy models and having a say in therapist allocation. Participants suggested a sense of powerlessness stemming from a lack of collaboration. Quinn et al. (2009) reported that students who tried accessing mental health care from the NHS experienced a sense of dismissal and recommended increasing collaboration between the patient and service provider during clinical decision-making. Also, the wish for collaboration could be understood from a cultural aspect as research has shown a strong preference for solidarity and cooperation in collectivistic cultures (Tse & Roger, 2014).

On the other hand, some participants preferred to make their own decisions and therefore, accessed therapists in private practice. It appeared that self-reliance and presumably, most importantly, whether or not they could afford this influenced their choice and experience of accessing psychological therapy. This may be regarded as a collectivistic value participants held, which led them to get professional help

without worrying others or making it public to avoid potential loss of respect (Shi et al., 2020; Wei et al., 2012). Perhaps, it could also be regarded as an act of individualism, which promotes independence and autonomy (O'Hagan, 2004). If this is the case, it echoes Mocan-Aydin's (2000) findings on Turkish culture, suggesting that Turkish people hold a collectivistic cultural orientation while also displaying individualistic values and attitudes.

Irem reflected on her dissatisfaction with not being able to share her preferences regarding therapist allocation (*"Understanding that person at a more unique level, at a more personal level rather than seeing that person as a community")* and suggested that she didn't benefit from therapy as much due to the cultural mismatch between her and her therapist. It seemed that lack of collaboration during therapist allocation process led to ineffective clinical decision-making, which was perhaps based on service providers' cultural stereotypes or misconceptions. This emphasised that not including participants in psychological care planning diminished the sense of personalised care as well as resulted in a failed attempt at culturally sensitive service provision. This correlated with Olaniyan and Haynes' (2022) findings, which indicated that ethnic or cultural matching had limited value when students' individual needs and unique experiences weren't taken into consideration by the service provider.

5.1.4 Managing the differences

Participants described their experiences of engaging in therapy with a non-Turkish therapist and in their non-native language. The theme considers how participants, and their therapists managed the cultural and language-related differences they encountered in their therapeutic relationship.

5.1.4.1 Thinking twice

Participants reflected on engaging in therapy in English and with a non-Turkish-speaking therapist. It appeared that using English in therapy begot additional thought processes. Whilst trying to translate their Turkish thoughts into English, some

participants found it difficult to express themselves. Participants regarded this as experiencing a language barrier. Some participants felt self-conscious about their language proficiency or grammar, which had a filtering effect on what they shared with their therapists.

Participants suggested that engaging in therapy in their non-native language was challenging as it required extra effort to communicate with their therapists. This echoed McFarlane et al.'s (2020) findings, which concluded that communicating in a non-native language requires additional cognitive processes. Participants reflected on various cognitive processes that were related to using two different languages whilst communicating with their therapist: "*I'm understanding him, also I'm thinking of the answer and also I'm trying to translate it in my head and also filtering what I'm going to say."* It appeared that this intensified participants' cognitive load and made them more conscious of their thoughts (Bialet et al., 2020).

On the other hand, studies have found that increased brain activity due to high cognitive load is associated with active thinking and reasoning functions (Bialet et al., 2020). This may be one of the reasons why participants decided not to express certain thoughts. Semra suggested that the additional thought process also included deciding what to express to her therapist. It is possible that increased cognitive activity and heightened reasoning led participants to think more critically and carefully before they spoke as they tried to negotiate two languages in therapy. This aligns with previous findings by Keysar et al. (2012), which demonstrated that foreign language use was associated with increased cognition and emotional distance compared to native tongue use. Similarly, despite not being explicitly discussed in participants' accounts, increased reasoning due to foreign language usage may also have given rise to diminished emotionality (Hayakawa et al., 2017). It appears that the emotionality and the impact of the language used need further investigation to identify whether this is also relevant to the Turkish international student population.

Other than thinking more carefully, using English also meant that participants had to negotiate two languages whilst communicating with their therapists. Deniz emphasised that the language barrier resulted in her not being able to find meaningful ways to express herself in English. It appeared that participants dealt

with the language barrier by remaining silent and not expressing what they wanted to share with their therapist. This was perhaps because they felt embarrassed about not making sense to their therapists (Hundley & Lambie, 2007; Willis-O'Connor et al., 2016) and experienced low self-efficacy regarding their abilities to express themselves (Li et al., 2018; MackIntrye & Gardner, 1994). Participants also spoke about feeling self-conscious about their language use or proficiency, which exacerbated their fears of being misunderstood or judged by their therapists. Similarly, Yoon and Jepsen's (2008) study indicated that Asian international students experienced self-doubt and were concerned about making grammatical mistakes when speaking to their therapists. Remaining silent may be perceived as avoidance behaviour since people with low self-confidence and negative beliefs about their capability to do a particular task are more likely to shy away from challenging situations or avoid expressing themselves out of shame, embarrassment, or fears of judgement (Moroz & Dunkley, 2015; Pabro-Maquidato, 2021; Jex et al., 2001).

However, thinking twice before sharing or deciding to hold back certain ideas to avoid misunderstandings meant that participants didn't discuss everything openly and that perhaps some important topics weren't fully explored or worked on in therapy. Semra emphasised that she wasn't able to fully express herself and experienced doubt about the efficacy of the therapeutic work as she was sceptical about her therapist's capacity to develop a comprehensive understanding of her. This aligns with Martinez's (2021) findings on the nurse-patient relationship, which conveyed that patients' limited language skills in English as a foreign speaker diminish effective communication, negatively impact perceived empathy and understanding, and hinder therapeutic alliance.

Some participants indicated that they and their therapists were better able to manage language-related differences. Despite experiencing a language barrier in communicating with her therapist, Deniz suggested that she didn't fear being misjudged by her therapist as she felt comfortable making language-related mistakes or not being able to get the meaning across. It seemed that she experienced a safe therapeutic relationship and perhaps any language-related challenges or misunderstandings allowed reparative opportunities for the therapeutic relationship and increased collaboration that facilitated therapeutic change or shared

understanding (Anderson, 2007; Sametband & Strong, 2013; Strong & Sutherland, 2007). Merve and Oyku indicated that they trusted their therapists' ability to understand them irrespective of language differences or potential misunderstandings. This may be explained by relevant study findings suggesting that empathy and a non-judgemental attitude in therapeutic relationships promote trust, which is also related to trusting the therapist's capacity to understand and the effectiveness of treatment despite linguistic dissonance (Ackerman & Hilsenroth, 2003; Cousin et al., 2012).

5.1.4.2 Communicating the context

Research on cross-cultural therapy emphasises therapist-related factors that generate a positive therapy experience when cultural differences are encountered, such as open communication, cultural curiosity, and unconditional positive regard (Dyche & Zayas, 1995; Falicov, 2014; Jenks, 2011; Tsang et al., 2011). These findings were echoed in this study since participants conveyed that they appreciated the therapeutic relationship and trusted their therapist more if the therapist was curious about their culture and social context in Turkey and endeavoured to understand the differences. Deniz emphasised feeling appreciated and valued when the therapist was not only curious about her culture but also attempted to understand Deniz's subjective experience of culture and social context. This was consistent with Olaniyan and Hayes' (2022) findings, which concluded that therapists' capacity to engage culturally was crucial for the therapeutic relationship, but it also necessitated engaging with clients at an individual level and taking into consideration their subjective reality.

It seemed that participants engaging in therapy with a non-Turkish therapist felt it necessary to create a shared understanding of the cultural nuances and contextual influences. Asli valued the importance of acknowledging and exploring cultural differences in therapy. Also, participants highlighted the importance of communicating the impact of the social context and current political and economic events in Turkey on their psychology, such as financial strain of studying abroad due to the downward trajectory in Turkey's economy. Participants discussed their

attempts to convey the cultural nuances or explain the relevance of their social context in Turkey, which is both related to their upbringing and their current situation. They didn't feel discouraged to speak about the differences. In fact, they helped their therapist to gain a better understanding. This finding wasn't previously identified in the student mental health literature.

Participants not only encountered and tried to manage the language-related differences in the therapeutic relationship, but they also spoke about their experiences related to culture and social context. Evidence in the existing literature suggests that when clients are apprehensive about their therapists' disapproval, ethnic or cultural differences in the therapeutic relationship negatively impacts the working alliance (Fluckiger et al., 2013; Williams & Levitt, 2008). Contrary to these findings, participants in my study didn't express any fears about being judged for cultural differences by their therapists. As discussed earlier, participants reported feeling apprehensive about language differences and feared being judged or misunderstood by their therapists due to using non-native language. Perhaps they perceived language-related misunderstandings as a result of their personal shortcoming due to their lack of language proficiency. However, this wasn't the case for managing differences related to culture or social context. It appeared that participants' perceived misunderstandings related cultural or contextual differences as a limitation of the service provider, if not the therapist.

5.1.5. Benefits from therapy

This theme captures what participants experienced as the benefits of undergoing therapy, which included achieving good therapy outcomes and developing positive attitudes towards help-seeking and talking about emotions. Most of the participants spoke about symptom reduction, which diminished the sense of urgency and lack of control they experienced before engaging in therapy. Participants also discussed an improvement in other aspects of their lives and functioning and a new perspective on the impact of talking.

5.1.5.1 Back to normal

Most of the participants sought psychological help due to experiencing unmanageable levels of psychological distress, a sense of urgency, and worry regarding the severity of their symptoms. This sub-theme is related to the sense of 'normality' participants gained, which was due to symptom relief and improved functioning.

Participants reported gaining back the sense of control and learning new ways to cope with psychological distress before it reached 'abnormal' levels as a result of therapy. It seemed that experiencing symptom reduction meant that they no longer described a state of crisis. This was consistent with Yelpaze and Ceyhan's (2019) study on Turkish university students' perceptions of psychological help-seeking, which conveyed that students expected to obtain solutions for difficult situations and a sense of relief through psychological help.

Improved functioning appeared to be also related to their personal and academic lives as they emphasised that their 'out-of-character' ways of being and relating with others were no longer an issue. The sense of relief may be related to starting to experience improvement in their 'problematic' or 'unusual' areas, which perhaps motivated them to seek professional help in the first place. This echoes previous research findings, which suggest that university students in the UK approach to services at higher severity levels (Broglia et al., 2017) and that collectivistic individuals seek for symptom relief in counselling (Kim et al., 2001).

It seemed that one of the immediate gains of therapy was feeling empowered and no longer feeling overwhelmed with their level of psychological distress. In fact, Kim et al.'s (2001) findings conveyed that having immediate gains in therapy was expected and valued more among collectivistic individuals as they sought goal-oriented help. This echoed the findings in the literature, which suggest that strengthening personal composure and social functioning are more likely to be preferred by collectivistic individuals as therapy goals (Burleson & Morteson, 2003; Chang, 2001; Kim et al., 2009). Furthermore, it appeared that getting out of a crisis and gaining new tools enabled participants in my study to re-engage in their preferred coping mechanism,

which was self-management and solving problems through individual efforts. These findings aligned with existing evidence in the literature, which reported that Chinese people show preference for self-management (Shi et al., 2020) and demonstrated 'keep-to-self' attitudes among students at Turkish universities (Yelpaze & Ceyhan, 2019).

5.1.5.2 Change for the better

This sub-theme captures the positive changes participants experienced, which participants had not identified as symptoms or reasons for coming into therapy. Apart from a reduction in symptoms and improved functioning (as discussed under *Back to normal*), participants also observed changes concerning their self-concept, values, and relationships. It appeared that participants developed insight after undergoing therapy and experienced changes that improved their general well-being, which also shed light on the interplay between cultural orientation, therapy preferences, and therapy outcomes.

Many participants discussed becoming more introspective and generating an understanding of the interplay between their thoughts, feelings, and sensations. Also, participants highlighted a developed sense of self-worth and improved confidence after undergoing therapy. It seems that engaging in therapy promoted a Euro-centric understanding of psychology and internalisation of Western values, which 'emphasises self-understanding, self-identity, self-actualization, freedom, individual happiness, and so on" (Hicks, 2019, p. 72). It appeared that after engaging in therapy, participants in my study became more empathic towards their own emotions and developed self-compassion. Participants also emphasised improved relationships through being better at prioritising themselves and setting boundaries with others. What participants described may be perceived as contrary to collectivistic values as evidence shows that in collectivistic cultures, the self is primarily based on social embeddedness and interdependence and that others' needs are prioritised over the individual's goals and preferences (Xiao, 2021). However, in their accounts, participants in my study reflected on these changes positively and underscored the beneficial impact on their well-being. Perhaps, this

may be because therapy aided participants to adopt individualistic values and normalised independence, autonomy, and personal achievement. Embracing these values may have made it easier for them to navigate in a Western individualistic society. As scholars indicate that acculturative stress is experienced by international students due to mismatch in cultural norms and expectations, it is possible that having psychological therapy in the UK fostered positive attitudes towards individualistic values (Mesoudi et al., 2016; Schwartz et al., 2006). Perhaps, this may promoted acculturation to individualistic values such as independence and autonomy and therefore, facilitate adaptation to the individualistic culture in the UK.

On the other hand, participants spoke about appreciating the value of their friendship as well as finding happiness within and using their personal resources. It appeared that strengthened relationships and social connectedness were a feature of the changes that participants experienced. This is in line with collectivistic value orientations and the benefit of solidarity and interconnectedness as a social resource for psychological well-being. However, the findings also suggested that participants started valuing personal resources more for distress management, which may be understood both as an individualistic preference (i.e., independence and self-reliance) and as a collectivistic coping strategy (i.e., self-control and self-management) (Shi et al., 2020; Skillman, 1999; Tse & Roger, 2014). Both cases are equally possible based on the premise that Turkish culture consists of both individualistic and collectivistic values (Mocan-Aydin, 2000) and perhaps, one can surmised that one of the benefits of therapy is to foster the values that are functional in client's current context.

5.1.5.3 The power of talking

This sub-theme captures the change in participants' perceptions around opening up and discussing feelings as well as attitudes towards professional help. Despite it being an unfamiliar and difficult experience, most of the participants saw the benefits of talking and exploring feelings in the therapeutic setting. It appeared that observing the positive impact of talking on their well-being motivated the participants to be more open about discussing their feelings and being vulnerable with others.

Developing positive attitudes towards therapy and experiencing the benefits of talking therapy also encouraged the participants to explore the underlying causes of their psychological distress or to further their insight around their problems. It seemed that realising 'the power of talking' had a positive impact on future help-seeking attitudes as participants in my study expressed their interest in engaging in long-term therapy in the future.

Participants reflected on the cultural inhibitions on opening up and talking about emotions with others. Both Merve and Sanem emphasised that Turkish culture didn't promote talking explicitly about feelings. It appeared that the therapy space was the first-time participants were experiencing this. This correlated with Gao et al.'s (1996) findings that demonstrate particular communication style in collectivistic societies, in which indirect and implicit communication is valued to protect group harmony, existing relationships, and one's perceived respect. In certain cultures, rather than the expression of feelings and emotional vulnerability, repression and intentional forgetting are valued and promoted (Ots, 1990; Parker, et al., 2001).

Participants indicated that they worked on expressing their feelings and allowing themselves to be emotionally vulnerable in therapy, which later proved its benefits. Participants conveyed that opening up in therapy helped them to gain insight into the benefits of talking and expressing emotions. Talking can be culturally perceived as a way for asking something to others to get an answer or a solution, rather than expressing distress and uneasiness (Busiol, 2016). As findings show, this might be particularly 'true' for Turkish international students.

Being emotionally vulnerable and revealing personal struggles to someone may be hindered when one is concerned about others' responses and feels powerless (Timmers et al., 1998). Mina described her therapist's encouragement for her to express herself and explore emotions in therapy. Perhaps, the unfamiliar experience of self-expression coupled with their therapists' non-judgemental attitude in the safe therapeutic space helped the participants to feel less concerned about showing vulnerability. Jacob et al. (2020) have shown that 'feeling comfortable and listened to' positively impacts the therapy experience. Having a positive experience and seeing its benefits may have aided the participants to develop positive attitudes

towards talking as a way for self-expression and perhaps engaging in therapy for insight development. This correlates with Story et al.'s (2019) findings, which concluded that after engaging in therapy, students no longer experienced shame or fear about asking for help. Participants in my study conveyed a shift in their attitudes towards help-seeking and discussing feelings with others. They highlighted having new insight into being vulnerable and expressing their personal struggles and feelings, which seemed to encourage participants to express themselves and to start thinking about underlying causes. It appeared that this shift in participants' perspective aligned with Western ideas about help-seeking, which are centred around generating an understanding of the core conflicts or underlying reasons for problems (Kim et al., 2001).

5.1.6 The nice therapist

This theme captured the therapist-related factors that had a positive impact on the therapeutic relationship and participants' overall therapy experience. Participants discussed therapist's personality, attitude, and perceived professional competence, which promoted feelings of trust, safety, and comfort in the therapeutic relationship and confidence in quality of the service provision.

Many participants expressed feeling trust and respect towards their therapists based on their therapist's perceived competence and professionalism. Higher therapist-perceived competence is associated with positive treatment responses to psychological problems (Espeleta et al., 2022). This echoed Yelpaze and Ceyhan's (2019) findings, demonstrating that Turkish university students who held positive views about the competence of therapists regarded them as experts, believed that they should be trusted, and were confident that an expert view will be beneficial in solving one's problems. Similarly, Wenzler and Keeley (2022) confirmed the importance of trust in the therapeutic relationship as their findings indicated lacking trust in therapists was a strong indicator of therapy dropout among students. It is possible that developing trust and respect is especially important for Turkish international students to perceive their therapist as a credible source of help.

Merve expressed her positive first impression of her therapist, which encouraged her to commit to therapy and feel trust towards the efficacy of therapy. Laungani (2002, p. 108) postulates that the first interview where the therapist and client encounter for the first time "often sets the scene or creates a 'template' for all subsequent counselling sessions." The first session is believed to give the clinician a chance to convey their genuineness and person-centred approach, which influences the expectations both the therapist and the client bring to the start of therapy (Lambert, 1992). It appeared that experiencing their therapist as positive and calm set the stage for positive outcomes. This echoed Jacob et al's (2022) findings on students' therapy experiences, which suggested that they received kind and person-centred care from their clinicians and that this was helpful.

Participants expressed their liking of their therapists, which has been identified as a contributor to working alliance (Wieselquist et al., 1999). Also, participants highlighted being listened to and cared about as indicators of the therapist's trustworthiness and competence, which begot positive attitudes towards the efficacy of therapy and belief in the therapeutic process (Crits-Christoph et al., 2019; Horvath & Greenberg, 1989; Wilks, 2016). This was correlated with Jacob et al.'s (2020) findings that reported 'feeling comfortable and listened to' contributes to a positive therapy experience. Liu et al. (2020) showed that East Asian international students' experience of therapy was perceived positively when counsellors conveyed empathy and their listening skills. This was echoed in this study as participants suggested that the therapist's non-judgemental and non-threatening attitude and level of openness contributed to the positive therapy experience.

Some participants discussed sharing similar ages, interests, or worldviews with their therapist positively contributed to their therapeutic relationship. It seemed that having a common ground was perceived positively by the participants. This may be because participants felt that their therapist was better able to relate to them if they had things in common. Laungani (2002. P.108) suggests that 'each client tends to perceive the counsellor in his/her own idiosyncratic ways' and that based on a wide variety of factors, including age or approach, a client can see the counsellor as a friend. Perhaps, participants who perceived a similarity between themselves and the therapist looked upon them as a friend. As it is more acceptable to talk to a friend

rather than a stranger or a professional about personal struggles in Turkish culture (Bilican, 2013; Cosan, 2015), finding a common ground and connecting with the therapist at a personal level may have facilitated the therapeutic relationship and perhaps, improved the therapy outcomes (Lambert & Barley, 2001).

5.1.7 Unmet expectations

This theme captures participants' experiences that did not match their expectations. It appeared that unmatched expectations brought a sense of disappointment. Also, some participants discussed finding alternative ways to manage or deal with the sense of disappointment.

As most of the participants sought help because of an urgent need or a sense of crisis, it appeared that they required an urgent response. However, not getting immediate attention or response resulted in a sense of disappointment, coupled with losing trust towards mental health care providers. Quinn et al.'s (2009) findings correlated with the sense of disappointment participants experienced as the authors reported that UK-based students felt dismissed by their service providers and dissatisfied with the (lack of) options available for mental health support. The sense of disappointment was echoed by Punton et al. (2022) as they postulated that 'too long' waiting time for highly vulnerable clients or individuals with immediate care needs often experienced a feeling of abandonment.

It seemed that participants dealt with the disappointment by relying on alternative forms of support. Some participants sought psychological care from private therapists or private mental health services. Perhaps, they felt that they had to rely on themselves in order to find a service that would match their needs. In fact, there is evidence in the literature showing that excessive waits in public services result in greater demand for private intervention for access to support sooner (Mind, 2013; Wooster, 2018). Also, participants suggested that they resorted to their familiar coping strategies. Deniz expressed that she lowered her expectations prior to help-seeking and subsequently, repressed the memory of contacting the service in order to avoid any disappointment. She also mentioned using her friends as a source of

support. As above-discussed, repression and forgetting have been identified as a common coping mechanism in collectivistic cultures (Ots, 1990; Parker, et al., 2001). Punton et al.'s (2022) research findings indicated that young people on long waiting lists may rely on alternative methods of support, such as seeking alternative interventions, developing coping mechanisms, and relying on social support.

On the other hand, some participants reflected on not having had enough therapy. Deniz emphasised that the therapy duration wasn't enough to match her needs. It appeared that this was partly because of the extra time and effort needed to spend on creating a shared understanding regarding cultural differences. Merve emphasised that time-limited therapy resulted in not being able to explore certain topics in-depth and a lack of opportunity to go at a slower pace. It seemed that unmatched needs due to the brief nature of therapy negatively impacted well-being and led to dissatisfaction. Population studies on prediction of treatment length show that on average, clients expect five or less sessions (Pekarik, 1991; Swift & Callahan, 2011). Also, a Canadian study on university students' treatment satisfaction concluded that brief therapy (1-3 sessions) was not only preferrable but sufficient for many clients (Warner, 1996). On the contrary, Surette and Shier's (2017) study assessing the applicability of the common factors model to students accessing university-based counselling concluded that longer the duration of the therapy process, the more alleviation of symptoms of psychological distress clients experienced.

Furthermore, Morris (2011) demonstrated that students in Singapore (which is a collectivistic society) preferred longer-term counselling. The contradictory findings in the literature may be due to client factors. Perhaps, building trust toward a professional to be able to disclose personal information took more time for individuals coming from collectivistic cultures, in which self-expression is not common (Busiol, 2016), which this may be particularly 'true' for Turkish international students. It may be that collectivistic clients require more time to adjust to the therapeutic process and for relationship building, whereas individualistic clients rather require a high level of directness, explicitness, and therapy brief in duration (Gao et al., 1996; McCarthy, 2005).

5.2 Evaluation of the Current Study

5.2.1 Strengths and limitations

This was an exploratory study that investigated the experience of accessing and undergoing psychological therapy for Turkish international students in the UK based on the accounts of eight voluntary participants. My understanding and interpretation of the data were shaped by my own perspective as an insider and outsider researcher as well as a counselling psychologist. It is possible that another researcher or the reader may take a different point of view.

In their accounts, participants reflected on the limitations of using a second language when expressing their thoughts and feelings to their therapists. It is possible that conducting the interviews in English may have hindered their level of expressiveness. Welch & Piekari (2006) suggest that use of native language not only prompts 'authentic' or 'rich' responses but also, contributes to the trust and collaboration established between the researcher-participant dyad. Firstly, I would argue that the data collected was rich enough to do an in-depth qualitative investigation. This was supported by the number of meaningful themes conceptualised during the analysis phase. Secondly, I believe all the research participants engaged very well with the interview, demonstrated openness and collaboration when answering the questions and reflecting on their experiences. As discussed in the methodology chapter, I privileged my counselling psychologist role, which may have allowed a more trusting relationship and diminished their sense of reservedness. Furthermore, my position as an insider researcher who speaks English as a second language may have diminished participants' fear around being judged or misunderstood due to the language barrier and their level of language proficiency. This was evident when some participants used Turkish words and we agreed on the English translation together in the interview. It appeared that they did not limit what they wanted to share with me due to language constraints. However, it would have been useful to explore the impact of using English in the interview and have a specific question asking for participants' reflection of the interview process to ascertain my thoughts on the choice of language used in the study.

The international student participants were recruited as a purposive sample, where their Turkish identity and the course of psychological therapy they engaged with in the UK were the key elements that met the inclusion criteria for this research project. Also, the sample size was small, and the analysis was based on the accounts of eight students. Hence, the study participants' experiences weren't intended to serve as a representative sample of all Turkish international students in the UK.

Furthermore, all the participants were female. This echoed the existing evidence in the literature, which suggest that men often express less emotion than women do and are less likely to express weakness and seek professional help than their female counterparts (Wendt & Shafer, 2016). It is possible that the number of male Turkish international students who sought help was lower than their female counterparts and that they were also less likely to volunteer to participate in a research study to share discuss their therapy experiences. This study wasn't intended to explore the gender differences of therapy experiences of Turkish international students nor to generalise findings to the male population.

On the other hand, a flexible recruitment strategy was implemented, which meant that participants included in this study were from diverse demographic backgrounds, including age, level and area of study, university attended, and city of residence. The sample was also heterogeneous in other aspects, i.e., past therapy experience, therapy type and duration, service provider, and therapist-related factors. In their accounts, participants conveyed a breadth of experiences related to accessing and engaging in therapy as Turkish international students. With a more homogenous sample, it is possible to generate deeper interpretations. By limiting the number of factors that may be impacting the topic of investigation (i.e., experience of accessing and undergoing therapy), it is more probable to find more shared patterns between the participants' accounts and interpret on a deeper (suspicious) level.

Despite these limitations, I believe the themes generated from the participants' accounts provide an insight into what Turkish international students experience.

Considering the exploratory aims of this study, I believe the heterogeneity of the sample does not take away from the validity of the present study. I hope that the study findings will provide insight into Turkish international students' preferences and expectations for help-seeking and therapy practices. appropriate practices for psychological care for Turkish international students with similar experiences. I will develop some recommendations below.

5.2.2 Suggestions for future research

Given the call for research on the impact of under-utilisation of services, early termination, and ineffective therapy experiences in student mental health in particular (Office for Students, 2022), it is important to bring detailed information about what Turkish international students think and need in relation to mental health care provision. More research can focus on generating information for service providers and clinicians about the needs of under-studied student groups and promote better suited and effective practices in order to improve access to mental health services and generate better therapy outcomes. Qualitative research that explores these processes from a client's point of view and reflects on the subjective experience is believed to provide valuable information for service providers to better able to support these students. It seems important to conduct more qualitative studies specifically targeting ethnic minority student groups and other international student populations to generate more information about their experiences of therapy and to inform service providers about what is regarded as important and helpful for them, in terms of cross-cultural therapy provision. It seems important to investigate the impact of English use in therapy for non-native speaker student populations and larger sample quantitative research could be used to generate generalisable findings that would be helpful to understand the limits of English use in therapy and whether students would benefit more from engaging in therapy in their native language.

During the interviews, participants discussed other interesting topics, which were not directly related to the research questions but still relevant to my research. A variety of issues relating to contributors to poor mental health (i.e., living and studying

abroad, experiencing heavy demands from university, Turkish economy and economic burden of studying abroad) arose during the interviews. These topics seemed to be relevant to Turkish international students and their mental health and could be explored in future research.

Regarding the different coping strategies and forms of support discussed by most of the participants (self-control and self-management, getting support from friends and family, avoidance strategies such as forgetting), it is seems an important area for further research to explore these preferences and look at culture-specific strategies to improve student mental health. This may include qualitative studies exploring attitudes towards or larger sample quantitative studies investigating the efficacy of self-help support resources or computer-based interventions among Turkish international students.

Further, research focused on the factors which promote mental health literacy, such as demystifying psychological therapy and psychoeducation on symptom of psychological distress or common reasons for psychological help-seeking and aims of formal type of support) among Turkish international students would make a valuable investigation.

In relation to intercultural therapy experiences, exploring factors that allow better therapeutic alliance for Turkish international students (such as therapist's cultural curiosity, knowledge about the social context, perceived competence, and trust) may reveal interesting and valuable findings. A specific focus on the second-language effect or an in-depth exploration of engaging in therapy with a non-Turkish therapist may be an area for future research. Again, doing larger sample studies may yield more generalisable findings. However, randomised controlled trial may also be valuable as a way to understand the causal relationship between different therapist- and client-related factors impacting the therapeutic relationship and treatment effectiveness for Turkish international students.

Scholars interested in this topic could also focus on participatory action research. It appears to be important to invite research participants to become more involved in the collaborative process of exploring the research phenomenon; not only understanding the collective experiences but also, actively translating research findings into social change (Cornish et al., 2023). Reflecting on the challenges I faced when recruiting for my initial research project (concerning Turkish men in therapy in the UK) or limitations brought with the heterogeneity of the current study sample group, participatory action research could be considered to elect 'team members' from the community of interest and involve them in the recruitment strategy process and utilise their expertise and connections during recruitment. This would also amplify research participants role in (practical) knowledge generation (Schneider, 2012).

5.2.3 Applications for clinical practice

The findings of this study provide an emergent understanding of the factors affecting Turkish international students' experience of accessing and undergoing psychological therapy in the UK. There are implications for service providers and clinicians who offer psychological support to Turkish international students. From the perspective of counselling psychology, the findings of this study have the potential to support service providers to develop more effective ways of supporting these students and interacting with them in therapeutic practice.

It is hoped that understanding the challenges Turkish international students face whilst accessing mental health services may generate more effective systems of support and diminish barriers to help seeking. Promoting mental health literacy and delivering psychoeducation about early signs of psychological distress may be useful in avoiding crisis situations or the need for immediate attention and care. Also, community-based support strategies (e.g., mental health first aid, peer-support groups, or drop-in sessions) as well as opportunities for students to strengthen

existing relationships or build new ones with peers and university staff may maintain and reinforce already helpful coping strategies.

Providing guidance and support during the process of accessing services, such as informing them about the waiting times and signposting to online resources in the meantime, as well as delivering psychoeducation to demystify psychological therapies, may encourage students to seek professional help early on. Following the current study findings, providing clear information about what each therapy model is and in which ways it will match client's needs seems to promote trust towards organisations and people offering formal type of support. Discussing the therapy types and therapist options at assessment appears to be more effective for developing trust and positive attitudes towards formal type of support. Staff diversity appeared to be not of major importance as participants of my study revealed that matching on ethnic or cultural similarities is not effective unless the client is involved in the therapist allocation process. Turkish international students seem to benefit more from engaging in therapy who shows cultural curiosity. On that note, therapists' attempts to create a share understanding as well as collaborating with the client to increase therapist's knowledge about cultural nuances and contextual factors related to students' experiences are strongly encouraged.

A trusting and confiding relationship in therapeutic work appears to be important for Turkish students as the current study findings showed that they often feel judged or misunderstood due to engaging in therapy in their second language. For example, asking about the Turkish jargon and trying it together to find a way to translate certain emotions or ideas to English in meaningful way. Also, allocating more time on building therapeutic alliance and guiding the client to express their thoughts and feelings about what is happening in the room may help them to feel safer in the therapeutic relationship and to be more open and honest. This may be possible through asking the client about how they find working with a non-Turkish therapist or reflecting on what the client has found difficult to explain the therapist due to cultural differences.

Current study findings convey a need for multicultural counselling competence training provision for clinicians within mental health services and for students on counselling programmes. Counselling psychologists value giving attention to diversity and sociocultural context, person-environment interaction, and systemic influences irrespective of their country of practice or training (Goodyear et al., 2016). However, in relation to the study findings, it is of paramount importance to promote reflective practice and foster more open dialogue around the influence of culture, sociocultural context, language, and all other differences that are observed and experienced between the therapist-client dyad. Also, it has been observed that in the global context, counselling psychologist, although one of the core values of the profession, give less endorsement to preventive interventions (Goodyear et al., 2016). As the study findings demonstrate, some client groups, especially individuals from collectivistic cultures and non-Western perceptions of well-being, may benefit more from preventive interventions. Hence, it appears to be important for clinicians to take into consideration the unique needs of individuals from different backgrounds and to adjust service provision and counselling approaches accordingly.

5.3 Conclusion

This study aimed to explore Turkish international students' experiences of accessing and undergoing psychological therapy from a critical realist position though RTA and in the context of cultural theory on individualism and collectivism. The findings show that Turkish international students' experiences are similar to other student populations or cross-cultural therapy clients in some ways but also, different in other ways.

The findings convey that Turkish international students seek professional help when they experience severe levels of psychological distress and expect to find a sense of relief. The findings suggest that students experience ambivalence towards seeking help and accessing services and found it helpful to get input, support, and encouragement from family and friends to start engaging in therapy. The findings

convey that ongoing information sharing is regarded as helpful for students to deal with the ambiguous aspects of their care provision. Some recommendations are drawn from the implications, which overall support alternative methods of support, including informal psychological care, and prevention strategies, such as promoting culturally valued coping strategies (self-help resources or peer support groups).

A number of considerations arise as part of the findings of this research, including creating safe and collaborative therapeutic space to alleviate language-related challenges and work through misunderstanding that may arise from sociocultural differences between the client and therapist. The findings specifically suggest that not only culture, but also social context (including political and economic situation in Turkey) are addressed and explored as part of cross-cultural therapy provision. This is also followed by a preference for longer-term therapy to build therapeutic alliance and allow extra time to create a shared understanding on the differences with the therapist.

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Appendices

Appendix 1. Ethics Application

Ethics ETH2122-1106: Ms Elif Mertan (Low risk)

Date Created 20 Feb 2022
Date Submitted 22 Feb 2022
Date of last resubmission 02 Apr 2022

Date forwarded to committee 14 Mar 2022
Academic Staff Ms Elif Mertan
Student ID 190037697
Category Doctoral Researcher
Supervisor Dr Aylish O'Driscoll
Project Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

School School of Health & Psychological Sciences

Department Psychology

Current status Approved after amendments made

Ethics application

Risks

R1) Does the project have funding?

No

R2) Does the project involve human participants?

Yes

R3) Will the researcher be located outside of the UK during the conduct of the research?

No

R4) Will any part of the project be carried out under the auspices of an external organisation, involve collaboration between institutions, or involve data collection at an external organisation?
No

R5) Does your project involve access to, or use of, terrorist or extremist material that could be classified as security sensitive?
No

R6) Does the project involve the use of live animals?

No

R7) Does the project involve the use of animal tissue?

No

R8) Does the project involve accessing obscene materials?

No

R9) Does the project involve access to confidential business data (e.g. commercially sensitive data, trade secrets, minutes of internal meetings)?
No

R10) Does the project involve access to personal data (e.g. personnel or student records) not in the public domain?
No

R11) Does the project involve deviation from standard or routine clinical practice, outside of current guidelines?
No

R12) Will the project involve the potential for adverse impact on employment, social or financial standing?
No

R13) Will the project involve the potential for psychological distress, anxiety, humiliation or pain greater than that of normal life for the participant?
No

R15) Will the project involve research into illegal or criminal activity where there is a risk that the researcher will be placed in physical danger or in legal jeopardy?
No

R16) Will the project specifically recruit individuals who may be involved in illegal or criminal activity?
No

R17) Will the project involve engaging individuals who may be involved in terrorism, radicalisation, extremism or violent activity and other activity that falls within the Counter- Terrorism and Security Act (2015)?
No

Applicant & research team

T1) Principal Applicant Name
Ms Elif Mertan

T2) Co-Applicant(s) at City

T3) External Co-Applicant(s)

T4) Supervisor(s)

Dr Aylish O'Driscoll

T5) Do any of the investigators have direct personal involvement in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest? No

T6) Will any of the investigators receive any personal benefits or incentives, including payment above normal salary, from undertaking the research or from the results of the research above those normally associated with scholarly activity?
No

T7) List anyone else involved in the project.

Project details

P1) Project title

Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

P1.1) Short project title

P2) Provide a lay summary of the background and aims of the research, including the research questions (max 400 words).
Well-being of students, including their mental health, is a prevailing research topic. Recent studies suggest a global rise in the occurrence and severity of mental health problems and help-seeking behaviours amongst students in higher education (HE) (Auerbach et al., 2018; Evans et al., 2018; Lipson et al., 2019). Between 2006 and 2016, the rate of first-year students disclosing a mental health problem to their HE provider has quintupled (NICE, 2020). A 2016 YouGov poll showed that 26.5% of students in the UK experienced mental health difficulties (NICE, 2020). Wallace's (2012) study findings show that counselling has a positive impact on academic outcomes and overall wellbeing for students in British HE institutions. However, there is a limited number of qualitative studies investigating the experience of accessing mental health services and undergoing psychological therapy for students in the UK.

There is evidence in the literature suggesting that students who move abroad for their studies might encounter a unique set of stressors, impacting their mental health (Prieto-Welch, 2016). For example, research findings show that international students coming from collectivistic cultural orientations demonstrate heightened levels of adjustment stress than their individualistic culture counterparts, making them more vulnerable to psychological distress (Hansen et al., 2018; Ma et al., 2020). Research has shown that despite experiencing similar levels of psychological distress, international students don't seek help as much as their domestic counterparts (Hyun et al, 2010).

There is increased research interest on Asian international students' mental health and their help- seeking practices. For Asian international students, language barriers and cultural norms about help- seeking for mental health problems have been linked with under-reporting of psychological distress and under-utilisation of professional help (Russell et al., 2008; Young, 2017). It was found that Chinese students delayed accessing therapy until they were in crises and that both Chinese and Malaysian students under-utilised mental health support services (The University of Nottingham, 2011). However, other groups of international students, including students from other collectivistic cultures, have been overlooked in the literature.

According to UNESCO (2021), 3420 students from Turkey were enrolled in a British HE institution. There is research concerning the psychological well-being of Turkish students in Turkey, including help-seeking attitudes and behaviour for mental health issues (e.g., Bilican, 2013; Sivis-Cetinkaya, 2013; Kaya et al., 2017). However, there is no research investigating the experience of accessing services and undergoing therapy for mental health needs of Turkish students who are abroad for their studies.

This study aims to explore the experience of accessing and undergoing psychological therapy of Turkish international students in the UK. It is hoped that the findings will inform and motivate service providers to develop psychological therapy practices and accessible service provision attuned to Turkish international students' needs.

This study will address the following research questions:
1) What is the experience of Turkish international students accessing psychological help in the UK?

2) What is the experience of Turkish international students undergoing psychological therapy in the UK?

P4) Provide a summary and brief explanation of the research design, method, and data analysis.
This research adopts a qualitative approach and aims to generate insight into how individuals experienced accessing and having therapy using Thematic Analysis (TA). Clarke and Braun's (2014) six-step thematic analysis method will be used. The researcher will conduct semi-structured 1-1.5 hour-long interviews to gather data from each participant and their experiences will be interpreted using an inductive approach. Research volunteers will be contacted for a screening call. Interviews will take place online, via Zoom.

P4.1) If relevant, please upload your research protocol.
P5) What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?
The research is designed to comply with the principles and procedures set out in the Code of Human Research Ethics (BPS, 2021), Ethics Guidelines for Internet-mediated Research (BPS, 2021), and in City's guidelines.

1) Valid consent

-Participants will receive an information sheet detailing the requirements and research aims, and an online interview guide

-They will be briefed about their privacy, right to withdraw and limits to confidentiality prior to participation

- Individual, written informed consent will be sought from all participants and they will be required to submit the electronically signed informed consent form at least one day prior to the interview. Should they fail to submit the signed informed consent form before the interview, they will be required to electronically sign the form before starting the interview

-Participants will be asked to reach out to the researcher via email should they have any questions prior to the interview

-Participants will be given the opportunity to ask questions before, during, and after the interview

-The researcher recognises that consent is an ongoing process and participants will be informed of their right to withdraw from the study before and during the interview, and/or one month after the data collection.

2) Confidentiality
-The research will be compliant with GDPR and Data Protection Act 2018

-All names and identifying information will be changed to protect confidentiality. Participants will be asked to choose a pseudonym after completing the interview for the purposes of publication and dissemination of findings

-All the recordings and transcribed data will be encrypted. Zoom-recordings will be immediately downloaded onto a computer, only the audio file will be kept and transferred to City OneDrive until the end of the study, and the video will be deleted immediately

-A separate audio recording will be kept using an encrypted digital recorder -Audio recordings will be deleted until the end of the study (after viva)

-Research data will be stored in a password-protected computer and destroyed after 10 years in accordance with City University's guidelines

-Participants will be advised that the research will be written up as a thesis and that sections of the interview (anonymous quotes) may be reproduced in print

3) Psychological impact of the interview
-Participants' needs will take precedence over the research process
-Screening call will be used to discuss the potential psychological impact on the participant

-The potential psychological impact of having an in-depth interview on the experience of accessing and undergoing therapy will be acknowledged. Participants will be debriefed about the research and given the opportunity to ask questions

-Should distress arise during or after the research, they will be signposted to organisations that may be able to offer help and support

-Participants will be provided with a debrief sheet after the interview and will be advised to contact the services recommended on the sheet should they feel distressed

4) Online interviews
-Interviews will be conducted online

-Given the online format, should a participant experiences distress the researcher will follow the distress protocol

-The researcher has experience in delivering online therapy and in dealing with clients who show distress

5) Interpretation of the data
-The researcher will be committed to reflexivity throughout the research and will keep a reflexivity log

-The researcher is aware of her role as a researcher and a counselling psychologist. Thus, when eliciting sensitive material in interviews the researcher will endeavour to only discuss topics that the participant is feeling comfortable sharing.

6) Safeguarding the researcher
-For any unanticipated distress, the researcher will use personal therapy and research supervision

P6) Project start date

The start date will be the date of approval.

P7) Anticipated project end date

30 Sept 2022

P8) Where will the research take place?

Online platforms (i.e. Zoom)

P10) Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee?
No

Human participants: information and participation

The options for the following question are one or more of:
'Under 18'; 'Adults at risk'; 'Individuals aged 16 and over potentially without the capacity to consent'; 'None of the above'.

H1) Will persons from any of the following groups be participating in the project?

None of the above

H2) How many participants will be recruited?

10

H3) Explain how the sample size has been determined.

10 participants will be recruited for this research. The sample size has been determined by taking into consideration the recent guideline for thematic analysis (Braun & Clarke, 2013).

H4) What is the age group of the participants? Lower Upper
18

H5) Please specify inclusion and exclusion criteria.

-Aged 18 or older
-Identifies as Turkish
-Resides in the UK
-Had received therapy in English whilst being an international student in the UK
-Able to participate in an online interview (has access to the Internet and private space)

-Has had therapy in the last 5 years and finished it at least 3 months ago

Inclusion and exclusion criteria are based on the aims of the research, investigating the experience of accessing and undergoing psychological therapy of Turkish international students. People who had therapy more than 5 years ago will be excluded due to potential memory issues (they may not be able to remember the details of how they felt before or during therapy). Participants who finished therapy in less than 3 months will be excluded since they might still need time to process their experience and see the impact of therapy on their life.

H6) What are the potential risks and burdens for research participants and how will you minimise them?
1) Risk of pre-existing psychological vulnerability

Participants will be contacted via phone for screening purposes and will be asked whether they see themselves fit to participate in the research where it may be potentially psychologically distressing to talk about their experience. Participants who agree that they are fit to participate will be recruited.

2)Risk of distress during and/or after the interview

All participants will be offered a debrief. The researcher is aware that discussing their experience may have a psychological impact on the participant. Participants will be signposted to organisations that may be able to offer help and support should there be any visible signs of distress during and/or after the interview (i.e. start to cry). The researcher will use the distress protocol. All participants will be made aware of their right to withdraw during and/or up-to one month after the interview.

H7) Will you specifically recruit pregnant women, women in labour, or women who have had a recent stillbirth or miscarriage (within the last 12 months)?
No

H8) Will you directly recruit any staff and/or students at City?

None of the above

H8.1) If you intend to contact staff/students directly for recruitment purpose, please upload a letter of approval from the respective School(s)/Department(s).

H9) How are participants to be identified, approached and recruited, and by whom?

Individuals will be recruited via the purposeful sampling technique. The researcher will put the research advertisement on student noticeboards at universities in London. The research advertisement will also be shared in student groups on Facebook.

The research advertisement will outline the research motivation and aims and give information about the interview process. People who respond to the research advertisement (via email) will be sent an information sheet. They will be then asked for a convenient time to participate in a brief call over Zoom for screening purposes.

H10) Please upload your participant information sheets and consent form, or if they are online (e.g. on Qualtrics) paste the link below.
H11) If appropriate, please upload a copy of the advertisement, including recruitment emails, flyers or letter.

H12) Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained.
1) People who respond to the research advertisement will be sent (email) an information sheet outlining the research aims and procedure.

2) People who are interested in participating in the research will be contacted via Zoom for a brief screening call.

3) Potential participants who fit the research criteria and agree to participate in the study will be sent a consent form outlining their rights and confirming their voluntary participation

4)Participants will be encouraged to reach out before the interview if they have any questions

5)Participants will be asked to send the digitally signed consent form via email at least one day prior to the interview. Should they fail to send the signed consent form before the interview, they will be asked to electronically sign it before the interview starts

H13) Are there any pressures that may make it difficult for participants to refuse to take part in the project?
No

H14) Is any part of the research being conducted with participants outside the UK?

No

Human participants: method

The options for the following question are one or more of:
'Invasive procedures (for example medical or surgical)'; 'Intrusive procedures (for example psychological or social)'; 'Potentially harmful procedures of any kind'; 'Drugs, placebos, or other substances administered to participants'; 'None of the above'.

M1) Will any of the following methods be involved in the project:

None of the above

M2) Does the project involve any deceptive research practices?

No

M3) Is there a possibility for over-research of participants?

No

M4) Please upload copies of any questionnaires, topic guides for interviews or focus groups, or equivalent research materials.
M5) Will participants be provided with the findings or outcomes of the project?
Yes

M5.1) Explain how this information will be provided.

The participants who have asked to receive the study findings will be contacted via email after the completion of the project and the research results provided will include a lay summary of research outcomes and the themes generated.

M6) If the research is intended to benefit the participants, third parties or the local community, please give details.
The research aims to provide an understanding of the experience of accessing and undergoing psychological therapy of Turkish international students. It is aimed to generate an understanding of what the participants experience and the commanlities and differences in their experience. It is hoped that the findings will inform the service providers about what Turkish international students experience when they access and undergo psychological therapy in the UK.

M7) Are you offering any incentives for participating?

No

M8) Does the research involve clinical trial or clinical intervention testing that does not require Health Research Authority or MHRA approval?
No

M9) Will the project involve the collection of human tissue or other biological samples that does not fall under the Human Tissue Act (2004) that does not require Health Research Authority Research Ethics Service approval?
No

M10) Will the project involve potentially sensitive topics, such as participants' sexual behaviour, their legal or political behaviour, their experience of violence?
No

M11) Will the project involve activities that may lead to 'labelling' either by the researcher (e.g. categorisation) or by the participant (e.g. 'I'm stupid', 'I'm not normal')?
No

Data

D1) Indicate which of the following you will be using to collect your data.

Interviews
Audio/digital recording interviewees or events

D2) How will the the privacy of the participants be protected?

De-identified samples or data

D3) Will the research involve use of direct quotes?

Yes

D5) Where/how do you intend to store your data?

Password protected computer files
Storage on encrypted device (e.g. laptop, hard drive, USB

D6) Will personal data collected be shared with other organisations?

No

D7) Will the data be accessed by people other than the named researcher, supervisors or examiners?
No

D8) Is the data intended or required (e.g. by funding body) to be published for reuse or to be shared as part of longitudinal research or a different/wider research project now or in the future?
No

D10) How long are you intending to keep the research data generated by the study?

In line with City's guidelines, the research data will be kept for 10 years and stored on OneDrive.

D11) How long will personal data be stored or accessed after the study has ended?

All personal data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulations (GDPR). Personal data (participant email addresses for the participants who opted-in to receive the study findings) will be deleted when no longer needed (e.g. after findings are shared).

D12) How are you intending to destroy the personal data after this period?

After 10 years, a request for destruction of personal data will be logged via the Service Now website or on call 0207 040 8181.

Health & safety

HS1) Are there any health and safety risks to the researchers over and above that of their normal working life?
No

HS3) Are there hazards associated with undertaking this project where a formal risk assessment would be required?
No

Appendix 2. Informed Consent Sheet

INFORMED CONSENT

Name of principal investigator/researcher Elif Mertan

REC reference number ETH2122-151

Title of study Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

		Please tick or initial box
1	I confirm that I have read and understood the participant information dated ETH2122-1517, dated 21 Apr 2022 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw before or during the interview without giving a reason and without being penalised or disadvantaged.	
3.	I understand that I will be able to withdraw my data up to one month after the interview.	
4.	I give my consent to partake in an interview online.	
5.	I agree to the interview being audio recorded.	
6.	I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR).	
7.	I understand that direct quotes from the interview may be used for publication, provided that any identifying information is removed.	
8.	I understand that my anonymous data will be made open access (i.e., to underpin journal publication).	
9.	I agree to take part in the above study.	

I would like to be informed of the results of this study once it has been completed and understand that my contact details will be retained for this purpose	Yes/No

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

Appendix 3. Distress Protocol

Distress Protocol

1	Getting emotional or showing minimal signs of distress (e.g., cracking voice, teary eyes)	Check-in with the participant, ask if it is okay for them to continue
2	Getting severely emotional or showing visible signs of distress (e.g., start to cry, raise voice)	Pause the tape, check-in with the participant and allow to come back
3	Keep on showing visible signs of distress	Stop the interview. Let the participant know we can take a break or re-schedule.

Appendix 4. Participant Debriefing Sheet

Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

This research is targeted at learning more about Turkish international students experiences of accessing and having psychological therapy in the UK. You were asked to join this study so that we can inform service providers about the experiences and needs of Turkish international students.

If you feel or think like the research has raised concerns or triggered psychological distress, please contact your GP or get in touch a mental health support service, you can find below some recommended services and support lines:

Student Space

0809 189 5260

students@themix.org.uk

The Samaritans

116 123

jo@samaritans.org

Mind

0300 123 3393

info@mind.org.uk

Crisis Text Line

text 85258

We hope you found the study interesting. If you have any other questions please do not hesitate to contact us at the following:

Elif Mertan
Researcher
elif.mertan@city.ac.uk
07340017118

Dr. Aylish O'Driscoll
Research Supervisor
aylish.odriscoll.2@city.ac.uk
02070400266

Ethics approval code: ETH2122-151

Appendix 5. Screening Call Guide

Screening Call Schedule

The researcher will have a screening call with individuals who respond to the research advertisement (via email). The date and time of the screening phone call will be confirmed with the individual when sending the participant information sheet. Below is the screening call schedule:

1) "Do you have any questions or concerns? Now that you have a basic understanding of the study, do you think you might be interested in participating?"

2) If the caller is not interested thank them and end the call.
If the caller is interested provide the purpose/nature of the current screening.

"Before enrolling people in this study, we need to determine if you may be eligible to participate. I would now like to ask you a series of questions. It will take approximately 5-10 minutes of your time."

3) Indicate that their name and other identifying information (i.e., email address) will be recorded so that they can be contacted again. Indicate participation is voluntary and tell them that they can refuse to answer any question or withdraw at any time.

4) Explicitly obtain permission to ask the screening questions: "Do I have your permission to ask you these questions?"

5) Screening questions:

-Do you identify yourself as a Turkish?

-What is your age?

-Did you receive psychological therapy within the past five years whilst being a student in the UK?

-When did you end therapy?

-Would you be willing to talk about your experience of accessing and receiving therapy in the interview?

-Talking about your experience of accessing and receiving therapy in the interview might potentially be psychologically distressing, do you feel comfortable attending the interview?

-Do you have access to the Internet, can you participate in an online interview?
-Do you have access to a private space for 1-1.5 hours so that you can attend the online interview?

6) If the caller is potentially eligible for the study: "Based on your answers to the questions, it appears you may be eligible to participate in the research study. Would you like to set a date and time for the interview?

7) I'll be sending you a consent form. Once you read the consent form you can reach out if you have questions before participating in the interview. Please send the signed consent form to me at least a day prior to the interview. Confirm the potential subject's contact information (email address).

8) If the caller is not eligible for the study: "Unfortunately, based on your responses, you are not eligible to participate in the research study. Thank you for your time and interest. Do you have any questions?" and discuss the reasons why with the caller.

Appendix 6. Research Advertisement

Department of Psychology

School of Arts and Social Sciences
City, University of London

PARTICIPANTS NEEDED FOR
RESEARCH AROUND TURKISH INTERNATIONAL STUDENTS' EXPERIENCE OF ACCESSING AND RECEIVING PSYCHOLOGICAL THERAPY

-Are you currently studying or have studied in the UK as a Turkish international student?
-Have you accessed psychological therapy in the UK?
-Have you received therapy in English?

This is a chance for you to talk about your experience of accessing and receiving psychological therapy in the UK as an international student.

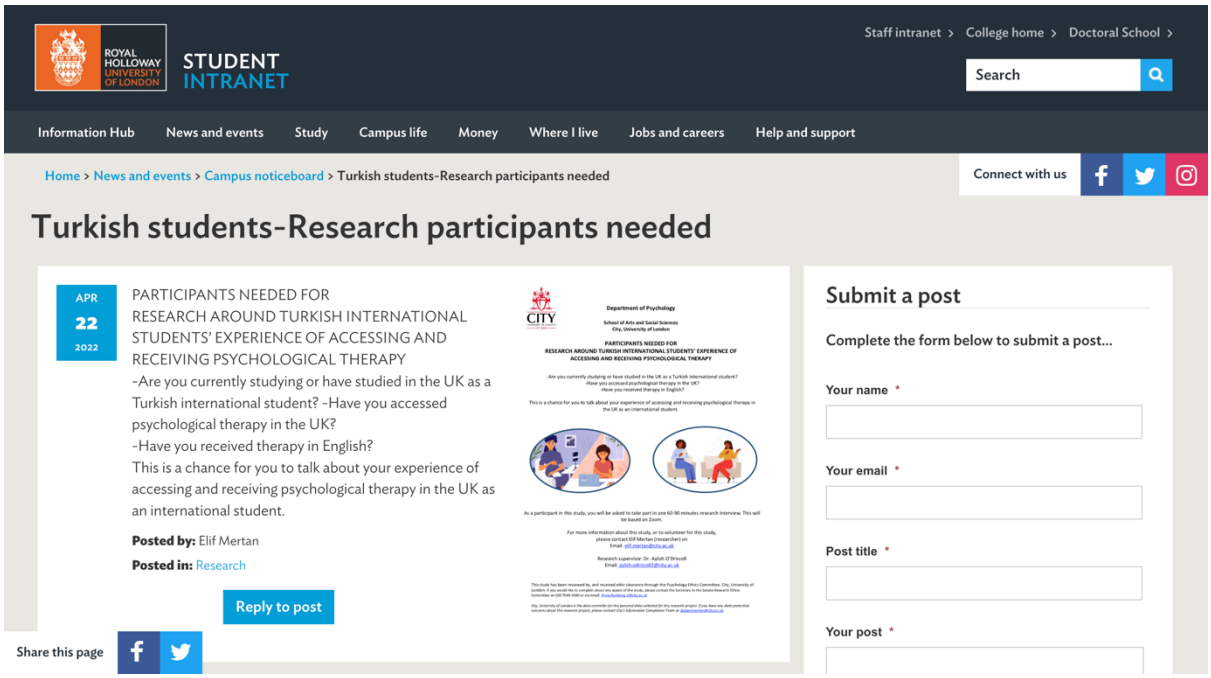
As a participant in this study, you will be asked to take part in one 60-90 minutes research interview. This will be based on Zoom.

For more information about this study, or to volunteer for this study,
please contact Elif Mertan (researcher) on
Email: elif.mertan@city.ac.uk

Research supervisor: Dr. Aylish O'Driscoll
Email: aylish.odriscoll2@city.ac.uk

This study has been reviewed by, and received ethic clearance through the Psychology Ethics Committee, City, University of London. If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.uk


ROYAL HOLLOWAY UNIVERSITY OF LONDON
STUDENT INTRANET
Staff intranet › College home › Doctoral School ›
Search
Information Hub
News and events
Study
Campus life
Money
Where I live
Jobs and careers
Help and support
Home › News and events › Campus noticeboard › Turkish students-Research participants needed
Connect with us
Turkish students-Research participants needed
APR
22
2022
PARTICIPANTS NEEDED FOR RESEARCH AROUND TURKISH INTERNATIONAL STUDENTS' EXPERIENCE OF ACCESSING AND RECEIVING PSYCHOLOGICAL THERAPY
-Are you currently studying or have studied in the UK as a Turkish international student? -Have you accessed psychological therapy in the UK?
-Have you received therapy in English?
This is a chance for you to talk about your experience of accessing and receiving psychological therapy in the UK as an international student.
Posted by: Elif Mertan
Posted in: Research
Reply to post
Department of Psychology
School of Arts and Social Sciences
City, University of London
PARTICIPANTS NEEDED FOR
RESEARCH AROUND TURKISH INTERNATIONAL STUDENTS' EXPERIENCE OF
ACCESSING AND RECEIVING PSYCHOLOGICAL THERAPY
Share this page
Submit a post
Complete the form below to submit a post...
Your name *
Your email *
Post title *
Your post *

Appendix 7. Demographic Information Sheet

Demographic Information Sheet

Gender:

Age:

Area of study and year:

If graduated, year of graduation:

<u>Therapy attended in the UK</u>

Type of therapy:

Number of sessions:

When did it take place:

Where did it take place:
(NHS, private sector, charity sector, low-cost counselling, university counselling service)

Any other experiences of therapy in the UK: Yes/No **(If yes, please complete the following)**

I.

Type of therapy:

Number of sessions:

When did it take place:

Where did it take place:
(NHS, private sector, charity sector, low-cost counselling, university counselling service)

II.

Type of therapy:

Number of sessions:

When did it take place:

Where did it take place:

Appendix 8. Interview Guide

Interview Schedule

To start with, I just wanted to get a sense of your experience as an international student in the UK. Then, I'll ask more specific questions about psychological therapy:

1) Can you tell me about your experiences of being an international student in the UK?

Prompts:
-How has it been for you to live abroad?
-How has it been for you to live away from family and friends?

-How has it been for you to live and study in a different language?

-Any challenges you faced as an international student?

-Anything you enjoy as part of your experience as an international student?

-Are there any aspects of being an international student that has been beneficial or challenging on your general health and wellbeing?

Now, I'm going to ask some specific questions about therapy:

2) What led you to seek psychological help?

Prompts:
-How were you feeling during that time?

-Can you describe the moment you decided to see a therapist?
-Did you experience anything significant which led you to seek psychological help? -Do you think being an international student in the UK was relevant to this? -What did you hope to get out of therapy?

3) Can you tell me about your experience of finding your therapist/accessing the service?

Prompts:
-after you decided to seek psychological help, what was your first step?

-how did you find your therapist?

-did you get any help from others in finding a therapist/accessing the service?

-what was helpful for you during the process of finding a therapist/accessing the service?

-what was unhelpful for you during the process of finding a therapist/accessing the service?

-were there any challenges you encountered when trying to find a therapist/access the service?

-was there a waiting list? if yes, how was it for you to be on a waiting list? how did you cope during that process?

-how did you feel during the process of finding a therapist/accessing the service?

-If they have prior experience of having therapy outside the UK: -how was it similar/different from your experience of finding a therapist/accessing the service elsewhere?

4) Can you tell me about your relationship with your therapist?

Prompts:
-what did you enjoy and challenging about your relationship with your therapist?

-How was it working with an English-speaking therapist? Do you think there was anything lost/gained due to having therapy in English?

-if your therapist was from a different cultural background, how was this experience for you? Were there any helpful and unhelpful aspects to that?

5) Can you tell me about your experience of having therapy in the UK?

Prompts:
-what were the key things you took from therapy?
-what was meaningful for you about therapy?

-were there any challenges you faced with the therapy process?

6) In which ways having therapy in the UK has impacted you?

Prompts:
-Have you noticed any changes as a result of therapy?

-on your psychological wellbeing?
-on your academic life?
-on your personal and family life?
-on how you feel about yourself as a person? e.g., self-esteem, self-confidence

7) Based on your experience, what service providers and therapists need to know about Turkish international students in the UK to provide them with a better service?

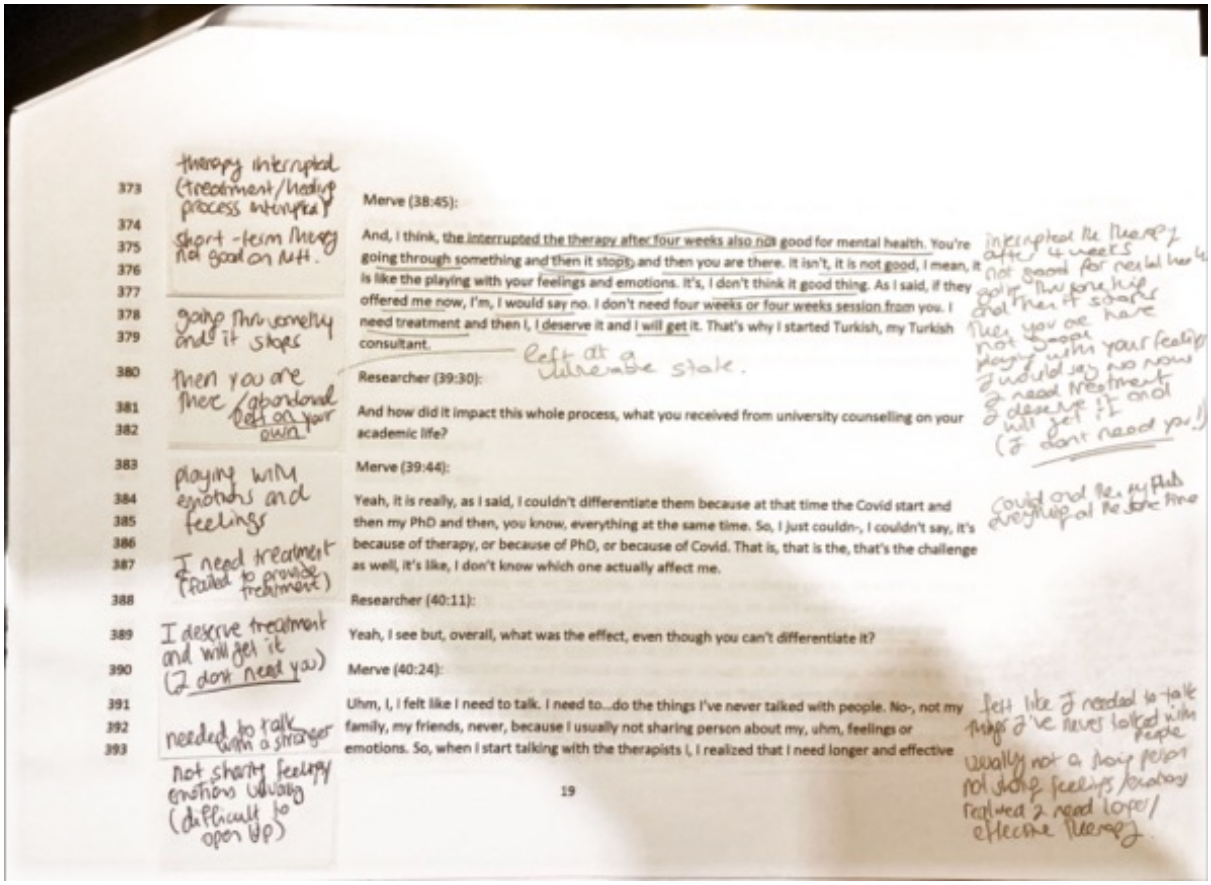
Prompts:

-Is there anything that could have done differently to improve your experience of accessing services for psychological help?

-Is there anything that could have done differently to improve your experience of undergoing therapy?

8) Is there anything else that you think may be important or useful for me to know about?

Appendix 9. Phase 2 Coding Example (Illustrative Example)



Merve (38:45):

And, I think, the interrupted the therapy after four weeks also not good for mental health. You're going through something and then it stops, and then you are there. It isn't, it is not good, I mean, it is like the playing with your feelings and emotions. It's, I don't think it good thing. As I said, if they offered me now, I'm, I would say no. I don't need four weeks or four weeks session from you. I need treatment and then I, I deserve it and I will get it. That's why I started Turkish, my Turkish consultant.

Researcher (39:30):

And how did it impact this whole process, what you received from university counselling on your academic life?

Merve (39:44):

Yeah, it is really, as I said, I couldn't differentiate them because at that time the Covid start and then my PhD and then, you know, everything at the same time. So, I just couldn-, I couldn't say, it's because of therapy, or because of PhD, or because of Covid. That is, that is the, that's the challenge as well, it's like, I don't know which one actually affect me.

Researcher (40:11):

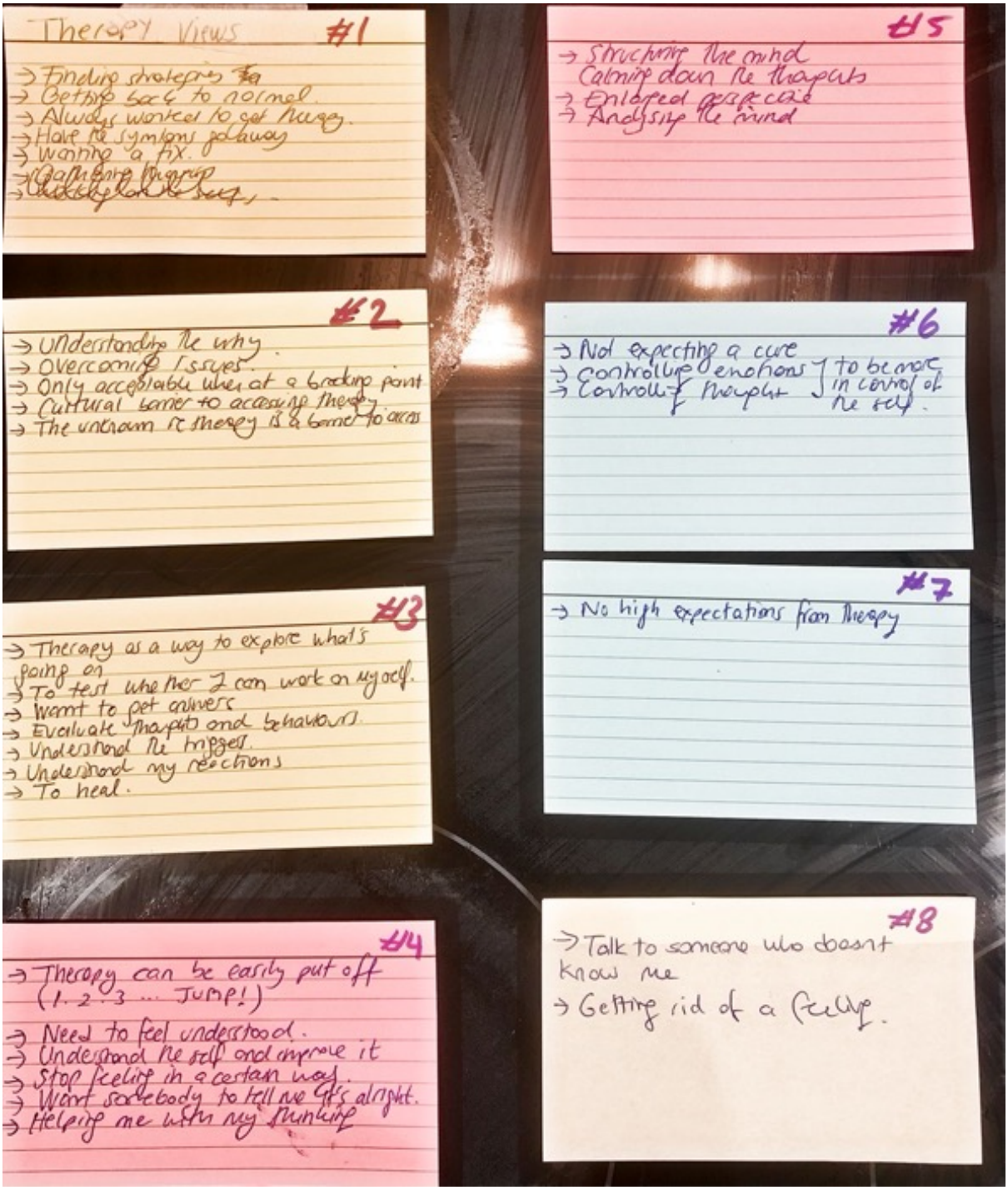
Yeah, I see but, overall, what was the effect, even though you can't differentiate it?

Merve (40:24):

Uhm, I, I felt like I need to talk. I need to...do the things I've never talked with people. No-, not my family, my friends, never, because I usually not sharing person about my, uhm, feelings or emotions. So, when I start talking with the therapists I, I realized that I need longer and effective

19

Appendix 10. Coding Manual (Illustrative Examples)



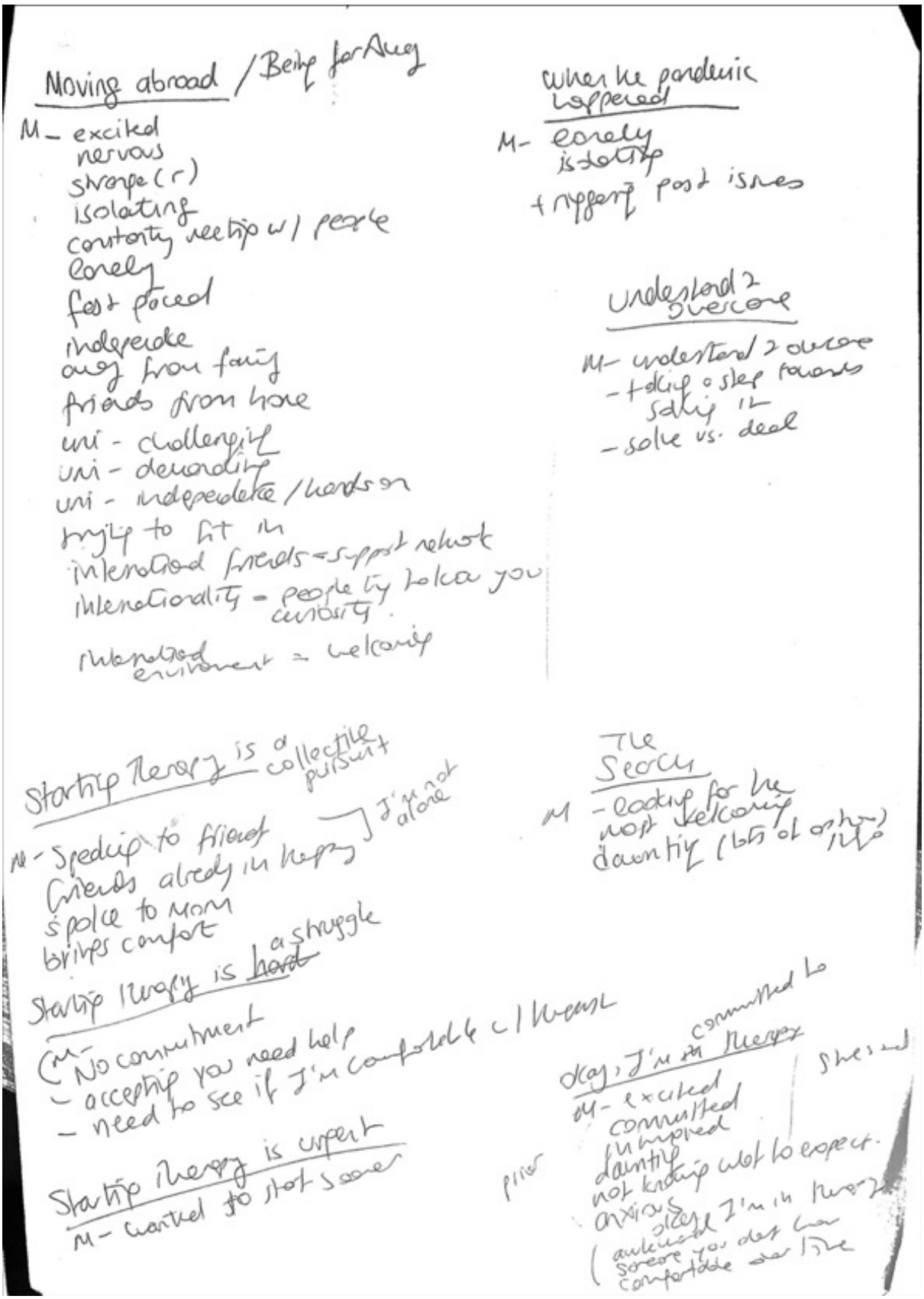
CODE LABELS

→ Made feel your problems are not important enough
→ No justification given for therapist allocation
→ Lack of clarity re the therapy process

→ Freedom to chose your therapist
→ Therapist matching your needs
→ Power in choosing your therapist
→ Information available online is daunting
→ Trying to find a therapist is overwhelming process
→ Feeling neglected by university
→ Being kept in the loop is important
→ Involvement in the decision making process / therapist allocation
→ Anonymous assessor made it easier to share everything.
→ Getting help for free / without financial pressure is encouraging
→ Receiving a generic email response from the service.
→ No sense of individualised care
→ Feeling forgotten during the waiting period
→ Left unsupported during the point of crisis
→ Surviving the crisis using personal resources
→ Services need to walk the walk.

(1)

Appendix 11. Phase 3 Initial Themes (Illustrative Examples)



Theme 4: Fear of the unknown		
Description: Codes in this theme focus on the unknown aspects of the therapy process that create a sense of reluctance towards seeking help. The codes capture the fear of the unknown lessening after starting the therapy process.		
Semra	p.10	L199-205
Oyku	p.8	L95-102
Sanem	p.7	L82-85
Merve	p.10	L105-112
Irem	p.16	L203-210
Asli	p.14	L189-209
Deniz	p.11	L200-209
Mina	p.5	L60-63

Theme 5: Reshaping perceptions		
Description: This theme is related to the need for encouragement from others regarding starting therapy and normalising for getting help for psychological problems. The codes capture the need for validation about their decision as well as the normalising they have received from their environment.		
Semra	p.14	L250-265
Oyku	p.10	L167-174
Sanem	p.7	L88-92
Merve	p.9	L89-97
Irem	p.12	L109-112
Asli	p.14	L183-185
Deniz	p.8	L156-159
Mina	p.7	L112-115

Appendix 12. Phase 4 Candidate Themes (Illustrative Example)

Appendix 13. Dissemination of Findings to Participants

Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

Dear participant,

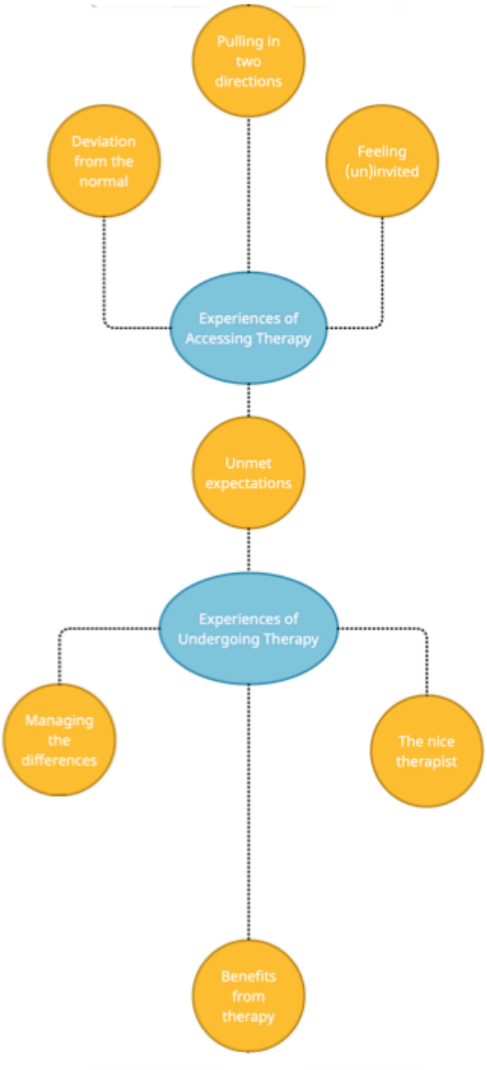
Thank you again for having participated in the research study and showing interest in receiving the research findings.

All the research data, including yours, were qualitatively analysed, which resulted in seven themes. The themes were used in order to organise the interview data and create a narrative of research participants' experiences of accessing and undergoing psychological therapy. It is hoped that these findings will inform clinicians working with Turkish international students and promote mental health service provision and psychological support that better accommodate students' needs.

Please find below an illustration detailing how each theme is connected to one another and a brief summary of each theme.

Kind regards,

Elif Mertan
(Researcher)


Pulling in two directions
Deviation from the normal
Feeling (un)invited
Experiences of Accessing Therapy
Unmet expectations
Experiences of Undergoing Therapy
Managing the differences
The nice therapist
Benefits from therapy

1. Deviation from the normal

This theme captures the sense of abnormality participants experienced, which constituted an emergency in itself and indicated a breaking point. The impact of being a student and studying abroad on mental health was emphasised. It seemed that most of the participants didn't notice the symptoms of psychological distress until things reached a breaking point. Subsequently, participants experienced a sudden realisation that they no longer thought, felt, or acted as their 'normal' selves.

2. Pulling in two directions

This theme captures participants' ambivalence towards seeking help and accessing services. Participants emphasised not having sufficient information about available support and services for psychological support. Some expressed that they lacked information about what therapy entails. Participants were apprehensive about seeking help and making a decision on their own and therefore, found it helpful to get input, support, or encouragement from family and friends regarding their decisions around help-seeking and accessing mental health services.

3. Feeling (un)invited

This theme captures participants' experiences around not receiving adequate information as they were accessing services. Lack of communication during the process and not being informed about what to expect during waiting time or decision-making process seemed to make participants feel excluded and neglected by the service provider.

4. Managing the differences

Participants described their experiences of engaging in therapy with a non-Turkish therapist and in their non-native language. It appeared that using English in therapy begot additional thought processes. Some participants felt self-conscious about their language proficiency or grammar, which limited what they shared in therapy. It seemed that having a good relationship with the therapist and feeling comfortable led participants to trust their therapists' ability to understand them irrespective of any language differences or potential misunderstandings. Participants expressed that engaging in therapy with a non-Turkish therapist made it necessary to create a shared understanding of the cultural nuances and contextual influences as well as for the therapist to be more knowledgeable about current issues (economical, political, social) in Turkey.

5. Benefits from therapy

This theme captures what participants experienced as the benefits of undergoing therapy, which included achieving good therapy outcomes and developing positive attitudes towards help-seeking and talking about emotions. Most of the participants spoke about symptom reduction, which diminished the sense of urgency and lack of control they experienced before engaging in therapy. Participants also discussed an improvement various aspects of their lives and doing better at university or having better relationships. Participants also shared having a more positive attitude towards being vulnerable and talking about emotions and indicated that they would be interested in engaging in therapy again in the future.

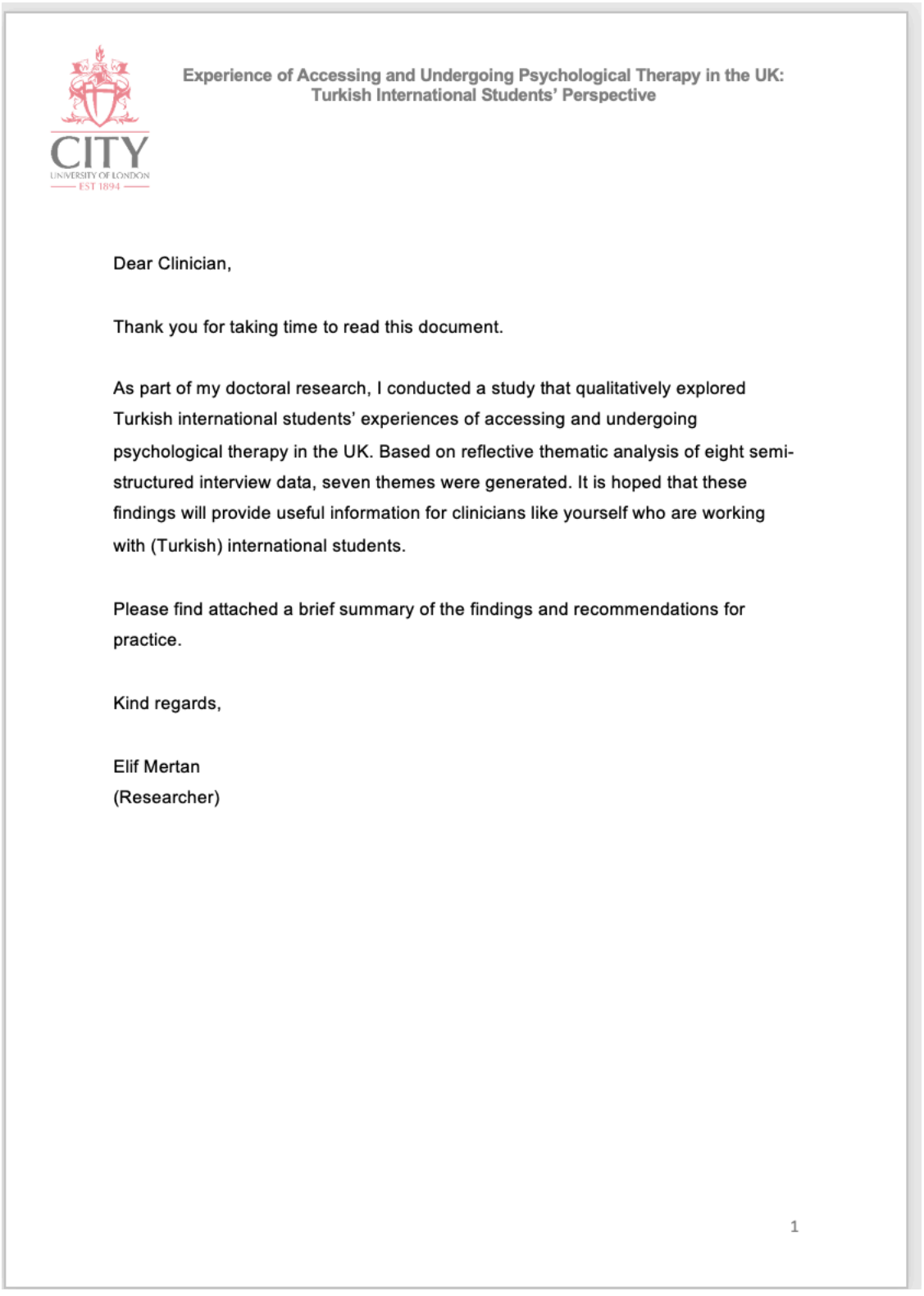
6. The nice therapist

This theme captures the therapist-related factors that had a positive impact on the therapeutic relationship and participants' overall therapy experience. Participants discussed therapist's personality, attitude, and perceived professional competence, which promoted feelings of trust, safety, and comfort in the therapeutic relationship and confidence in quality of the service provision.

7. Unmet expectations

This theme captures participants' experiences that did not match their expectations, not having immediate attention or support when they contacted the services or not having enough therapy sessions due to service constraints. It appeared that unmatched expectations brought a sense of disappointment. Also, some participants discussed finding alternative ways to manage or deal with the sense of disappointment, such as getting support from friends and family or keeping their expectations low regarding what the services could provide.

Appendix 14. Dissemination of Findings to Practitioners



Experience of Accessing and Undergoing Psychological Therapy in the UK: Turkish International Students' Perspective

Dear Clinician,

Thank you for taking time to read this document.

As part of my doctoral research, I conducted a study that qualitatively explored Turkish international students' experiences of accessing and undergoing psychological therapy in the UK. Based on reflective thematic analysis of eight semi-structured interview data, seven themes were generated. It is hoped that these findings will provide useful information for clinicians like yourself who are working with (Turkish) international students.

Please find attached a brief summary of the findings and recommendations for practice.

Kind regards,

Elif Mertan
(Researcher)

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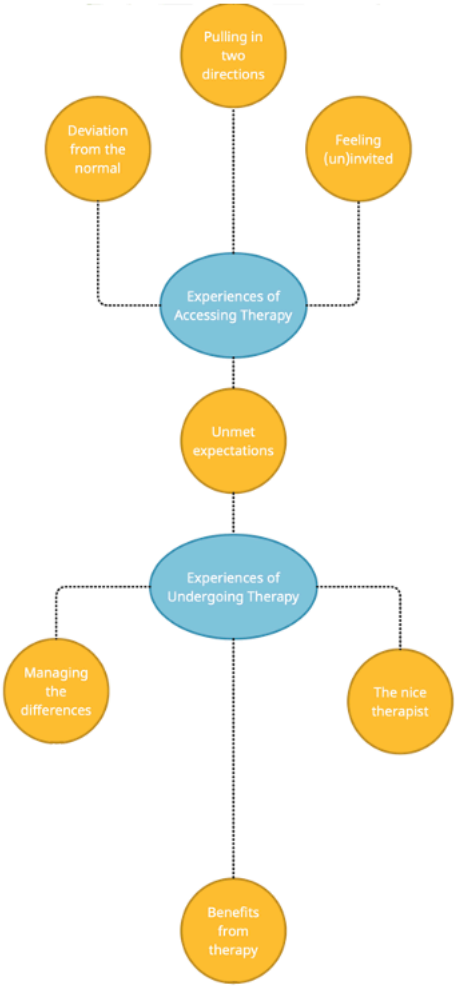
Pulling in two directions
Deviation from the normal
Feeling (un)invited
Experiences of Accessing Therapy
Unmet expectations
Experiences of Undergoing Therapy
Managing the differences
The nice therapist
Benefits from therapy

2

1. **Deviation from the normal**

This theme captures the sense of abnormality participants experienced, which constituted an emergency in itself and indicated a breaking point. The impact of being a student and studying abroad on mental health was emphasised. It seemed that most of the participants didn't notice the symptoms of psychological distress until things reached a breaking point. Subsequently, participants experienced a sudden realisation that they no longer thought, felt, or acted as their 'normal' selves.

2. **Pulling in two directions**

This theme captures participants' ambivalence towards seeking help and accessing services. Participants emphasised not having sufficient information about available support and services for psychological support. Some expressed that they lacked information about what therapy entails. Participants were apprehensive about seeking help and making a decision on their own and therefore, found it helpful to get input, support, or encouragement from family and friends regarding their decisions around help-seeking and accessing mental health services.

3. **Feeling (un)invited**

This theme captures participants' experiences around not receiving adequate information as they were accessing services. Lack of communication during the process and not being informed about what to expect during waiting time or decision-making process seemed to make participants feel excluded and neglected by the service provider.

4. Managing the differences

Participants described their experiences of engaging in therapy with a non-Turkish therapist and in their non-native language. It appeared that using English in therapy begot additional thought processes. Some participants felt self-conscious about their language proficiency or grammar, which limited what they shared in therapy. It seemed that having a good relationship with the therapist and feeling comfortable led participants to trust their therapists' ability to understand them irrespective of any language differences or potential misunderstandings. Participants expressed that engaging in therapy with a non-Turkish therapist made it necessary to create a shared understanding of the cultural nuances and contextual influences as well as for the therapist to be more knowledgeable about current issues (economical, political, social) in Turkey.

5. Benefits from therapy

This theme captures what participants experienced as the benefits of undergoing therapy, which included achieving good therapy outcomes and developing positive attitudes towards help-seeking and talking about emotions. Most of the participants spoke about symptom reduction, which diminished the sense of urgency and lack of control they experienced before engaging in therapy. Participants also discussed an improvement various aspects of their lives and doing better at university or having better relationships. Participants also shared having a more positive attitude towards being vulnerable and talking about emotions and indicated that they would be interested in engaging in therapy again in the future.

6. The nice therapist

This theme captures the therapist-related factors that had a positive impact on the therapeutic relationship and participants' overall therapy experience. Participants discussed therapist's personality, attitude, and perceived professional competence, which promoted feelings of trust, safety, and comfort in the therapeutic relationship and confidence in quality of the service provision.

7. Unmet expectations

This theme captures participants' experiences that did not match their expectations, not having immediate attention or support when they contacted the services or not having enough therapy sessions due to service constraints. It appeared that unmatched expectations brought a sense of disappointment. Also, some participants discussed finding alternative ways to manage or deal with the sense of disappointment, such as getting support from friends and family or keeping their expectations low regarding what the services could provide.

Implications of findings

The findings show that Turkish international students' experiences are similar to other student populations or cross-cultural therapy clients in some ways but also, different in other ways. It appears that Turkish international students seek professional help when they experience severe levels of psychological distress and expect to find a sense of relief. The findings suggest that students experience ambivalence towards seeking help and accessing services and found it helpful to get input, support, and encouragement from family and friends to start engaging in therapy. The findings convey that ongoing information sharing is regarded as helpful for students to deal with the ambiguous aspects of their care provision. Some recommendations are drawn from the implications, which overall support alternative methods of support, including informal psychological care, and prevention strategies, such as promoting culturally valued coping strategies (self-help resources or peer support groups).

A number of considerations arise as part of the findings of this research, including creating safe and collaborative therapeutic space to alleviate language-related challenges and work through misunderstanding that may arise from sociocultural differences between the client and therapist. The findings specifically suggest that not only culture, but also social context (including political and economic situation in Turkey) are addressed and explored as part of cross-cultural therapy provision. This is also followed by a preference for longer-term therapy to build therapeutic alliance and allow extra time to create a shared understanding on the differences with the therapist.

Some of the recommendation are:

- Promoting mental health literacy and delivering psychoeducation about early signs of psychological distress may be useful in avoiding crisis situations or the need for immediate attention and care. Also, community-based support strategies (e.g., mental health first aid, peer-support groups, or drop-in sessions) as well as opportunities for students to strengthen existing relationships or build new ones with peers and university staff may maintain and reinforce already helpful coping strategies.

- Providing guidance and support during the process of accessing services, such as informing them about the waiting times and signposting to online resources in the meantime, as well as delivering psychoeducation to demystify psychological therapies, may encourage students to seek professional help early on. Following the current study findings, providing clear information about what each therapy model is and in which ways it will match client's needs seems to promote trust towards organisations and people offering formal type of support. Discussing the therapy types and therapist options at assessment appears to be more effective for developing trust and positive attitudes towards formal type of support.

- Staff diversity appeared to be not of major importance as participants of my study revealed that matching on ethnic or cultural similarities is not effective unless the client is involved in the therapist allocation process. Turkish international students seem to benefit more from engaging in therapy who shows cultural curiosity. On that note, therapists' attempts to create a share understanding as well as collaborating with the client to increase therapist's knowledge about cultural nuances and contextual factors related to students' experiences are strongly encouraged.

- A trusting and confiding relationship in therapeutic work appears to be important for Turkish students as the current study findings showed that they often feel judged or misunderstood due to engaging in therapy in their second language. For example, asking about the Turkish jargon and trying it together to find a way to translate certain emotions or ideas to English in meaningful way. Also, allocating more time on building therapeutic alliance and guiding the client to express their thoughts and feelings about what is happening in the room may help them to feel safer in the therapeutic relationship and to be more open and honest. This may be possible through asking the client about how they find working with a non-Turkish therapist or reflecting on what the client has found difficult to explain the therapist due to cultural differences.

Appendix 15. Example of Memos

Why do I feel I'm alone in my experience?
I initially had thought my experience
of undergoing therapy would be similar
to what the participants experienced.
I noticed feeling very frustrated
after the first two interviews. ~~the~~
They were very appreciative of their
therapist and difference of culture didn't
seem important to them. This made
me question the reasons for starting
therapy. My reason was very different
than the participants. Most of them
were in need of urgent care, whereas
I had to undergo therapy as it was
a course requirement. I realized I
was at a position to be more selective
and also critical of the experience
of therapy. I was also comparing how
I present myself as a therapist
vs. how my therapist was to me as
a client.

It was very difficult for me to dog to hold my status as a researcher during the interview. What she was telling me in her account ~~was~~ she was doing with me the reason for her to start therapy. I noticed I wanted to support her, validate her feelings and be her therapist. I suppose I got a bit confused. I had to remind myself during the interview that this isn't a therapy session - but it was very difficult to take a step back and be curious to what she was doing with me from a researcher standpoint.

Feeling not dismissed by her therapist but also being understanding towards her therapist - she doesn't know anything about Turkey, but curious and asking questions to learn about Turkey. Mention of positive aspects of giving info about Turkey to her therapist but no mention of anything negative about it. Makes me wonder why this is? I felt very frustrated when my therapist asked very basic questions, things that should be common knowledge or things she could've researched online to show that she cared about where I was coming from. But for this participant, asking questions and being honest about not knowing was welcomed very positively - very surprising to me! not what I expected myself in therapy.

I was worried at the start of this interview as she had told me in the screening call that she ~~did~~ learnt English a year prior to moving to the UK for her studies. I noticed my worry was centred around not being able to get as rich data from her and her account staying at the surface level or being more descriptive, rather than reflective. However, I must confess that I was very surprised at the end of our interview. Despite needing more pauses and talking at a slower pace, she was able to reflect on very different aspects of her experience and communicate her emotions, reflections, perceptions very effectively. I do wonder if this would've been the case with a native-speaker researcher as in her account she shared that she used to feel humiliated by her English proficiency. But it was also the case that she was a very confident woman and she also told me that she doesn't care what other people think. It may be due to various factors

Julianna asked me why I didn't conceptualise social context and culture together / under one superordinate theme. I was surprised at first. The social context in Turkey is very sporote to its cultural elements. The social context that I refer to, which the participants also talked about in their accounts are centred about the sociopolitical, political, and economic changes that have been experienced in the past years. The essence of social context is therefore very different to what one considers as cultural context. I needed to defend my view and give Julianna some examples from the interviews. ~~Not~~ Putting it into context and communicating my rationale based on my own experiential knowledge (along with participants' accounts) was helpful to be able to prove my reasons. I doubt a "foreign" researcher would have shared my point of view unless they were very informed about the events happening in Turkey.