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Culture and the therapeutic relationship: Perspectives from Chinese clients

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Culture and the therapeutic relationship: Perspectives from Chinese clients

Abstract

Chinese people in the UK and USA underutilise mental health services and, when they do seek help, may find that therapy does not meet their needs. In response to calls in the literature for naturalistic studies of therapy with people of Chinese background, this study used a qualitative, multiple case approach to examine clients' individual experiences in depth and detail. Semi-structured interviews were conducted with eight Chinese clients. The aim was to investigate how culture might play a role in the therapeutic relationship. Qualitative analysis yielded four key themes concerning clients' and therapists' awareness of culture and how this impacted on their working relationship: "cultural encapsulation", "cultural formulation", "cultural liberation" and "culture is not important". Although participants' perceptions of therapy showed similarities to those reported by clients of European-American descent, culture entered into the therapeutic relationship in complex and diverse ways. The findings have implications for delivering culturally sensitive therapies.

Culture and the therapeutic relationship: Perspectives from Chinese clients

Chinese people in the UK underutilise mental health services (National Institute for Mental Health in England, 2003) and have been described as an "invisible population" (Department of Health, 1993). A similar picture exists in the USA, where Asian Americans[1] are under-represented in counselling and therapy services, and, once they do seek help, tend to terminate prematurely (Atkinson, Morten, & Sue, 1998; U.S. Department of Health and Human Services, 2001). Obstacles to seeking help may include language barriers and a lack of awareness of services, as well as perceptions of therapy as an unfamiliar or undesirable means of resolving mental health problems (Li & Logan, 2000; Li, Logan, Yee, & Ng, 1999; Nagayama Hall, 2001). Indeed, within Chinese culture, the stigma of mental health problems and the concepts of shame and "losing face" may make it particularly difficult to seek help (Li et al., 1999; Lin, Tseng, & Yeh, 1995; Uba, 1994). Those who do seek help may find that therapy does not appropriately meet their needs.

Differences in values and belief systems of Eastern and Western cultures are frequently cited as one reason that Chinese clients may terminate therapy prematurely. Chinese cultural values include an emphasis on collectivism, the centrality of the family, filial piety, hierarchical relationships, academic achievement, humility, and emotional self-control (Kim, Atkinson, & Yang, 1999; D.W. Sue & Sue, 2003). Such values are likely to play a role in Chinese clients' experience of self and identity, how they make sense of their problems, and what they expect from therapy. However, it is also important to recognise that clients will vary in the degree to which they adhere to the values and norms of their indigenous culture. Indeed, there is great heterogeneity within any ethnic group, and factors such as immigration history, language skills, and degree of acculturation need to be taken into account (Kim, Ng, & Ahn, 2005; S. Sue, 1998).

The need for therapies to be culturally "sensitive" or "responsive" has been recognised for many years (Zane, Nagayama Hall, Sue, Young, & Nunez, 2004). Nagayama Hall (2001) argues that there is a scientific and ethical imperative for developing culturally sensitive therapy, which "involves the tailoring of psychotherapy to specific cultural contexts" (p.502). Various models of culturally sensitive therapy have been debated, some applicable across cultural groups and some developed for specific groups. However, there is a dearth of empirical research on the efficacy of different therapeutic approaches with different cultural groups and what makes a therapy culturally sensitive.

The "cultural competence" (S. Sue, 1998) of the therapist is one aspect of delivering services that are culturally sensitive. Sue proposes that cultural competence comprises several characteristics or skills, perhaps the most obvious one being a good knowledge and understanding of the cultural group(s) with which the therapist works. However, he proposes that culture-specific expertise is necessary but not sufficient. A critical skill is knowing when to generalise and when to individualise: that is, the therapist must be able to recognise when and how cultural values or cultural group characteristics may be relevant to the client's problems, but also to see the client as an individual (i.e., to avoid stereotyping). Cultural competence stands in contrast to "cultural encapsulation" (Wrenn, 1962, cited in Pedersen, Draguns, Lonner, & Trimble, 2002), a term referring to the unintentional ethnocentrism that can occur when therapists are unaware of how their own culture shapes their interpretations of, and responses to, what clients bring to therapy.

There is some evidence that when clients see therapists of the same ethnic or linguistic background, treatment outcomes may be better, at least in terms of drop-out rate and number of sessions attended (S. Sue, 1998; S. Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Similarly, clients who utilise ethnic-specific mental health services (typically employing bilingual staff and aiming to respond to clients' cultural needs) also tend to stay in therapy

longer (S. Sue, 1998). However, as S. Sue (1998) suggests, “the importance of ethnic match may heavily depend on the acculturation level, ethnic-cultural identity, or ethnicity of clients” (p.442). Furthermore, studies of ethnic match tell us little about what it is that may lead to better outcomes: ethnicity is essentially a demographic variable, which in itself does not explain what processes occur to make therapy more acceptable or beneficial.

Several studies have focused on identifying therapeutic processes or strategies that are effective for Asian Americans. A range of variables has been investigated, including counselling style (Atkinson & Matsushita, 1991), session goals (Kim, Li, & Liang, 2002), counsellor emphasis on client expression (Kim et al., 2002), and counsellor self-disclosure (Kim, Hill, Gelso, Goates, Asay, & Harbin, 2003). For example, Kim et al. (2002) examined clients’ reactions to two types of session goals: in one condition European American counsellors focused on immediate resolution of clients’ problems, and in the other the attainment of insight through exploration. At the end of the session, clients in the “immediate resolution” condition perceived a stronger working alliance with the counsellor. Kim et al. link this finding to S. Sue and Zane’s (1987) suggestion that Asian American clients may have “the need for attaining some type of meaningful gain early in therapy” (p.42). Given a lack of experience with, and misgivings about, a Western style of therapy, perceiving concrete gains in a first session may be particularly important. This also may be analogous to the act of “gift-giving” in Chinese culture, the “gift” here being an immediate benefit from the therapeutic encounter (S. Sue & Zane, 1987).

Although these studies provide insight into how Asian Americans perceive various counselling strategies, the studies use methodological approaches that limit their external validity. One paradigm, typically used in earlier research, is the audiovisual analogue; that is, participants (Asian American students) listen to, or view, simulated counselling sessions and rate them on variables such as preference for counselling style or therapist credibility. A

second paradigm, used in more recent research, is to study a single session of counselling with "volunteer" Asian American clients (students who are not seeking help); this usually involves an experimental manipulation, e.g., comparing two conditions in which the therapists are trained to use different strategies. Although this second paradigm is an improvement over earlier analogue designs, the studies are limited in that they do not use real clients, they examine only a single therapy session, and they involve somewhat artificial situations in which therapists are instructed to use particular strategies.

Thus, there is a need for research examining naturally occurring therapy with clients of Chinese background. This requires alternative methodological approaches, which can complement the more tightly controlled experimental designs typically used. Indeed, S. Sue (1999) argues that the field has been limited by the priority researchers give to internal validity, and he calls for a broader range of methodological approaches, including qualitative and ethnographic methods. A central strength of qualitative approaches is that they allow researchers to study, in depth and detail, the complexity of individuals' experiences within natural settings (Barker, Pistrang, & Elliott, 2002).

The present study aimed to investigate how culture may play a role in the therapeutic relationship for Chinese clients, using a qualitative, phenomenological approach (Smith & Osborn, 2003). We were interested in studying a small number of individuals who were currently or recently in therapy, in order to obtain a detailed account of their experiences. This type of multiple case approach allows an understanding of each unique case, as well as the commonalities across cases. Through the use of a semi-structured interview, we aimed to elicit participants' perceptions of their therapy, from their own perspective and in their own words.

The study focused on clients' perceptions of what was helpful or unhelpful in their working relationship with the therapist. Because the concept of the therapeutic relationship is

pan-theoretical and central to many theories of therapeutic change (Bachelor & Horvath, 1999; Horvath, 2005), it seemed a useful framework for guiding the interviews. However, we were careful not to impose an a priori model on the data collection or analysis. We therefore adopted an exploratory, discovery-oriented approach (Barker et al., 2002) in which we attempted to be open to participants' accounts of their experiences of therapy.

Method

Participants

Inclusion and Exclusion Criteria. Our aim was to recruit English-speaking Chinese individuals who had recent experience of therapy or counselling. Inclusion criteria were: (1) age 18-65; (2) able to converse comfortably in English; (3) therapy was either ongoing or had ended within the last year; and (4) help had been sought for emotional or psychological difficulties such as depression or relationship problems, as opposed to seeking career or financial advice. People with dependency problems (substance misuse or gambling) or psychosis were excluded.

Recruitment Strategies. We initially planned to recruit participants through the British National Health Service (NHS), but this proved unsuccessful. (Inquiries made to several NHS psychologists indicated that Chinese clients were very rare, despite the services being located in London boroughs with a substantial Chinese population.) We then contacted voluntary organisations within the Chinese community in London to explore the potential for recruitment, but staff members anticipated difficulties due to the stigma of mental illness and also to a lack of proficiency in English of people in contact with the organisations. In order to broaden the recruitment strategy and minimise language-based recruitment problems, we additionally advertised the study within a university community. The final avenues of recruitment thus comprised: (1) advertising the study in a Chinese, health-related charitable

organisation that provided a therapeutic service to the Chinese community); (2) placing advertisements on two campuses of the University of London; and (3) contacting an internet group for Chinese students that existed at one of the campuses.

Characteristics of participants. Twelve people expressed an interest in participating. Three did not meet the eligibility criteria and a fourth chose not to participate. Of the final sample of eight participants (see Table 1), three were recruited from the Chinese organisation described above and five from the university setting (three via advertisements and two via the internet group).

Insert Table 1 about here

The sample comprised four women and four men, ranging in age from 19 to 37 (average age: 27). Apart from one who was not working, all were either students or in professional occupations. Two described their ethnicity as Hong Kong Chinese, one as Mainland Chinese, one as Taiwanese, one as Malay Chinese and the remaining three simply as "Chinese". Six were first generation Chinese, one second generation and one third generation Chinese. The mean score on the Asian Values Scale (see below) was 3.72 (s.d. 0.99), indicating moderate adherence to traditional Chinese values.

The three participants recruited via the Chinese organisation had expressly sought help from a Chinese therapist; all had seen the same therapist. The other five had seen non-Chinese therapists. The therapists' orientations were varied: the Chinese therapist practiced cognitive-behavioural therapy and the others used a range of approaches, including psychodynamic, cognitive-behavioural and person-centred therapy. Four participants were no longer in therapy; the average length of time since finishing was eighteen weeks. Of the remaining four, one was still in therapy, another was having a "break" from therapy, and two

others had infrequent telephone contact with their therapists. The average number of sessions attended by the group as a whole was nineteen.

Background of researchers

JJ is a second-generation, British-born Chinese woman raised and educated in London, England. She comes from a Hakka Chinese-speaking family from Hong Kong, but is not fluent in any Chinese dialect. At the time of conducting the study, she was in her mid-twenties and was a doctoral student in clinical psychology. NP is a White woman of European descent, who was born and raised in the USA but has lived in the UK for many years. She is a clinical psychologist with an interest in therapeutic relationships and expertise in qualitative research methods. Neither researcher had strong preconceptions about how culture impacted on therapy.

Asian Values Scale (AVS: Kim et al., 1999)

The AVS is a 36-item questionnaire measuring adherence to Asian cultural values. Each item is rated on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree); items are averaged to give an overall score, with higher scores indicating greater adherence to Asian values. Normative data yielded a mean of 4.28 (s.d. 0.56) for first-generation Asian American students (Kim et al., 1999). The authors report adequate internal consistency and test-retest reliability, and also give evidence of convergent and divergent validity.

Interview

A semi-structured interview schedule covered four broad areas: (1) a brief history of how and why the participant had sought help and their expectations for therapy; (2) the quality of the relationship with the therapist, e.g., what it was like to talk to the therapist and how the relationship had developed; (3) helpful and unhelpful aspects of therapy, e.g., things the therapist had said or done that the participant found useful or problematic; and (4) cultural issues, i.e., whether and how cultural values held by the participant or the therapist entered

into the therapeutic process. In this latter section, questions were asked about specific cultural issues (e.g., stigma, cultural matching of therapist and client) if they had not already been spontaneously mentioned by the participant. The interview schedule was used flexibly to allow participants to tell their "story". After the first few interviews, the phrasing of some questions was modified in order to elicit more elaborated accounts. All interviews were conducted by JJ and lasted approximately one hour. They were audiotaped and later transcribed verbatim for analysis.

Qualitative Analysis

The transcripts of the interviews were analysed thematically, using the method of interpretative phenomenological analysis (IPA: Smith & Osborn, 2003). IPA aims to explore in detail participants' perceptions or experiences of their personal world; however, it recognises that, in making sense of another's world, the researcher inevitably engages in "a process of interpretative activity" (Smith & Osborn, 2003, p.51).

The first stage of analysis involved close readings of each transcript in order to identify ideas and meanings being expressed; tentative labels were generated to capture the essence of ideas expressed by each participant. Next, similar ideas within each transcript were clustered into themes. This was an iterative process: related ideas were grouped together and the initial labels for ideas were refined and checked against the transcript. At both this and the previous stage, attention was paid not only to the explicit, or manifest, content of what was said, but also to implicit, or latent, meanings. A list of themes for each participant was produced, and excerpts of the transcript illustrating each theme were documented. Once each transcript had been analysed in this way, the themes were compared across transcripts in order to produce an integrated set of themes for the sample as a whole. Again, this was an iterative process that involved examining similarities and differences in themes for each participant, making connections between themes, re-reading the transcripts, and further

refining the theme labels. In order to provide an organising structure, the themes were clustered into broad "domains" representing different aspects of the phenomenon (Barker et al., 2002).

The analysis was conducted primarily by JJ, but "credibility checks" were undertaken, in accordance with methodological canons of good practice in qualitative research (Elliott, Fischer, & Rennie, 1999). In the early stages, NP independently analysed several transcripts and, through discussion with JJ, consensus was reached on preliminary theme labels. At the stage of comparing and integrating themes across transcripts, JJ and NP discussed ways of clustering the data, leading to further modifications in theme labels. Once an initial, consolidated list of themes and domains was produced, consultation with a third researcher (experienced in qualitative methods, but not involved in the project) led to further modifications. Finally, NP audited all the documentation to check that each theme was backed up by excerpts from participants' accounts and that the final set of themes represented a good fit to the data.

Results

Participants' experiences of therapy were varied, but a number of salient themes emerged across their accounts. The analysis yielded ten themes, organised into three domains (see Table 2). The first two domains, "Attitudes to therapy" and "Qualities of the therapist", provide contextual background and are therefore presented briefly. The third domain, "Culture and the therapeutic relationship", focuses specifically on the role of culture and so is given greater emphasis. Each of the themes is presented in turn and illustrated by excerpts from the interviews. Ellipses (…) indicate omitted material, edited for brevity. The source of each quotation is indicated by the participant code number given in Table 1.

Insert Table 2 about here

Domain 1: Attitudes to therapy

This domain concerned participants' expectations about therapy and how they thought it could be useful, their views about expressing emotions and seeking help, and how they saw their role as a client. Because of the retrospective nature of the interviews, the themes reflect a mixture of their views before starting therapy and those formed as a result of their experience of therapy.

*Theme 1.1: A spirit of inquiry***.** All participants described approaching therapy with an open mind and a sense of curiosity, but with considerable uncertainty about what it could offer.

> "I just wanted to have a *try* for whether, to see whether I could get help there ... I feel it's a little *interesting.*..I don't know whether they can help me …I want to show my curiosity." (P4)

This spirit of inquiry was also expressed in participants' views of the function of therapy once they had experienced it. Their descriptions emphasised therapy as a process of self-discovery, helping them to "fit the jigsaw together" and to find coherence in their narratives.

> "It [the therapy] was really opening new ways for me to see my life… I think he was just showing me the bigger picture…because as I spent time unravelling the whole problem with my counsellor, I had a better understanding of myself, my character, my principles and beliefs and also of my, how my past has shaped me." (P6)

> "I would say that talking is a process when you are re-arranging your thoughts... like a fragmentation, defragmentation, I mean, of your brain, you know, if you compare it with your computer system (laughs)... you put it in order." (P5)

Theme 1.2: Stigma as a flawed belief. All participants expressed, either explicitly or implicitly, discomfort with the traditional Chinese cultural view that expressing emotions and seeking help is a sign of weakness. They seemed to view this stigma as a flawed belief: having emotional responses was recognised as normal, and the expression of emotions as

helpful. This attitude seemed to be central in reducing the potentially obstructive influence of stigma on seeking help.

> "I just want to expression to somebody... I think it is important to talk about my feelings" (P1)

Some described having fought against cultural and family taboos to be able to express their "right" to talk about their emotions. In such cases, they concealed from their parents that they were in therapy, or, if they did disclose, they met with parental disapproval.

> "[My parents] actually don't allow any kind of talk about emotions in the household, not even happiness…they just didn't approve of any kind of emotions…but human beings are emotional creatures after all, so that's how I started therapy... [When I sought help] I said to them 'I'm so depressed, I don't know what to do', and that upset my father a great deal." (P8)

> "...if they found out then I wouldn't be able to see a counsellor, so I had to go counselling secretly." (P2)

Theme 1.3: Taking responsibility. Regardless of participants' views of whether their therapy had been successful, all accounts were notable in the way participants "owned" their problem and emphasised their responsibility in the therapeutic process.

> "I know she [the therapist] just going to listen, the matter is *me*, *I* am going to sort out... I think she might be give me some ideas, some advice. That's all." (P1)

Participants who were dissatisfied or disappointed with aspects of their therapy tended to take considerable responsibility for this (although they also recognised the role of the therapist, as indicated in later themes):

> "...because I wasn't prepared to go the next step." (P2)

> "... my feet became very heavy and that's a bad faith... that's one of my failures... I always start something, then give up half-way..." (P5)

Domain 2: Qualities of the therapist

This cluster of themes concerned participants' perceptions of what made a good therapist and the characteristics of their therapists that they perceived as helpful or unhelpful.

Theme 2.1: The universal therapist. All participants valued therapist qualities that are commonly considered essential to a good therapeutic relationship, regardless of theoretical orientation. These included being non-judgmental, a good listener who was able to understand the client's internal world, and someone who could be trusted.

> "It's good to be able to speak to... someone who is not judgmental, who is there to listen..." (P6)

> "... the trust is the most important thing I think – if you don't have the trust it doesn't matter how good he or she is..." (P5)

Conversely, disappointments with therapists were associated with the lack of such qualities. For example, one participant felt that her therapist could not empathise sufficiently for them to agree on the overall goal of therapy:

> "I didn't actually feel she understood where I was coming from or what I wanted to achieve" (P3).

Theme 2.2: An authoritative guide. For some participants, the therapist was also seen as a teacher or guide. They referred to therapy as a learning experience in which they saw themselves as students being guided by a knowledgeable professional.

> "She would guide me to think in a way, from a more objective perspective... I feel it's like doing a degree really, in psychotherapy, you are doing a degree on your own psychology and she is the teacher who guides you and you are the student who learns." (P8)

> "I posed an attitude to see her as a teacher more than a therapist and I learn something." (P5)

A sense of authority on the part of the therapist, and deference on the part of the client, was also expressed.

> "I found he could give me right indication… command, control and understanding the whole psychological problem so he could tell me what I could or should do" (P7)

Theme 2.3: Being a person. Knowing something about their therapist in a more personal way seemed especially important for two participants. One described how she had found it easier to "open up" with a therapist who had an "informal" approach and had talked a bit about herself (in contrast to another therapist whom she had seen previously).

> "She talked about where she's from, what she's doing and how she's become a counsellor and where she studied." (P2)

Linked to this was the importance of also being seen "as a person" by the therapist.

> "... she would actually see me as a person who is talking to her instead of someone who come to her with problems that she has to deal with." (P2)

Conversely, for another participant, the therapist's formality seemed to be a deterrent to forming a therapeutic bond, and she was considering terminating therapy.

> "I thought she was very professional in the sense that I know *nothing* about her… getting to know your counsellor on a sort of more personal basis, I think that's quite important, for *me*…I think I would have felt warmer towards her...I found it very cold, which is probably why I backed out of it." (P3)

Domain 3: Culture and the therapeutic relationship

The final, and central, domain concerned aspects of the participants' accounts specifically relating to the role of culture in the therapeutic relationship. Some participants made explicit links between cultural issues and their interactions with their therapist, while others expressed these links more implicitly. Their accounts were varied and were captured by four distinct themes, each of which represented the accounts of a quarter of the participants.

Theme 3.1: Cultural encapsulation. For two participants, the process of therapy had clearly been hampered by a perceived lack of cultural knowledge and empathy from their non-Chinese therapist. Their descriptions resonated with the concept of "cultural encapsulation" (see Introduction): the therapist seemed to lack an understanding of the cultural nuances and context of the clients' problems.

Participant 4 had sought therapy because she was having a stressful time trying to balance having a boyfriend and studying. She referred to her parents having high expectations for her academically, and her dilemma seemed in part to stem from two competing, highly-prized values in Chinese culture: that of obligation to relationship roles and academic

achievement. She felt that her therapist had been unable fundamentally to understand her difficulties, which eventually led to her terminating therapy.

> "I think understanding, at first that is the most important thing…the reason why I stopped…I think gradually, that she couldn't, she can't understand me…it seems she couldn't understand what I was saying…I tell her every , *every* aspect about the difficulties I confront, the *pressure* I endure and what I was worried so much…I think even my culture or myself, she didn't understand any of them." (P4)

Suggestions made by the therapist were perceived by Participant 4 as showing a lack of understanding about the importance of academic achievement in Chinese culture:

> "... she just suggested me don't worry too much about study... because I'm a student in university I should, you know, there are more funs, I should be enjoying myself and take part in more activities...." (P4)

Such suggestions led to this participant feeling misunderstood and consequently annoyed:

> "... you can't describe it, but you can *feel* it if somebody can't understand, then you feel, feel a little annoyed." (P4)

This lack of cultural empathy seemed to break what could have otherwise been a strong therapeutic alliance:

> "… she couldn't understand me, but she did hear with all her *attention*, with her *heart*, I can see that…she wanted to help me. I think it's a kind of warmth." (P4)

Participant 4 went on to reflect explicitly on the importance of the therapist having some background knowledge and understanding of Chinese culture:

> "…if a counsellor wants to help a foreign student, at least she should have some experience about…have some *knowledge* about China, about their culture…I think about my counsellor she maybe she knows *nothing* about China…she should have some understanding about Asian culture, about their values, their tradition …how the people there live and get along with each other… I think she didn't understand *anything* about Chinese culture."

An account from another participant (P3), who was considering terminating therapy, suggested a more latent theme of "cultural encapsulation". Participant 3 had sought help for relationship problems, including her relationship with her mother; she had hoped that therapy would help to "open up communication channels between my mum and myself". However, at one point her therapist had suggested a course of action that felt impossible to undertake:

> "... she sort of said to me that you need to take control back off your mother, and you need to talk about these things to her... [but] these are the things why I am coming to therapy, because I can't talk to her... I didn't actually think that [the therapist] fully understood why I *couldn't* approach my mother about things like that." (P3)

Participant 3 described being "quite taken aback" by the therapist's suggestion, which in the context of Chinese cultural values – i.e., filial piety and subordination to parental figures – seemed inappropriate. Although she did not make explicit reference to these values, she described her parents as "not incredibly westernised", which would make "taking control" an uncomfortable course of action; she, too, may have had an internalised sense of filial piety. Her account suggested that the therapist had not fully recognised these cultural nuances.

In the above accounts, both participants hinted at, but did not verbalise explicitly, the cultural values that came into play in the therapeutic interactions described. Participant 4 expressed an awareness that the therapist had transgressed elements of her value system, but she was unable to articulate exactly what these values were. Participant 3 made no explicit associations between her dissatisfaction with therapy and (possibly internalised) Chinese values – perhaps because she saw herself as not particularly traditional in her perspective (she was third-generation Chinese and had a relatively low AVS score – see Table 1). These excerpts thus seem to point to the possible cultural encapsulation not only of the therapists but also of the clients.

Theme 3.2: Cultural formulation. Two participants reported particular benefits from seeing a therapist from their own cultural background. Their accounts emphasised that the therapist had been able to recognise and make sense of how cultural values played a role in their problems. This facet of the therapist as a "cultural formulator" was felt to be extremely beneficial, especially in aiding a deeper understanding of distress that seemed to have arisen when value systems were in conflict.

Participant 2 had sought therapy to help her resolve difficulties in her relationship with her parents. She described how the therapist was able to normalise some of her

dilemmas, as well as make explicit some latent cultural values. This seemed to enable her to take a meta-position on her situation, leading to a reduced sense of blame, anger and guilt:

> " [My therapist] basically helped me understand my culture more…the depression I was in because of my actual cultural situation… before I felt guilty about going against [my parents]… I should actually try and live out their dreams and expectations…now I understand *why* my parents do these things and why I can now not feel guilty about feeling angry at them…[friends and a previous non-Chinese therapist] can only see it from a very British background and give me their points which is more like 'this is wrong' and then I would feel even more angry at my parents, but seeing [a Chinese therapist] helped me as she wasn't actually shocked, so that made me more understanding than angry about it." (P2)

This participant contrasted the help she had received from her Chinese therapist with that from non-Chinese friends and a previous non-Chinese therapist. Their reactions and advice seemed to pathologise her situation and increase the intensity of the anger she was feeling, thus having a kind of "negative reframing" effect. This left her feeling less able to understand and contain her distress. For this participant, the Chinese therapist's knowledge of cultural values was indispensable: "She knows and can pass on knowledge as well... instead of just sitting there and listening" (P2).

It was also clear from the account of Participant 2 that her Chinese therapist had a good grasp of British cultural values and was able to integrate knowledge of both cultures. This was vital, as the participant's distress stemmed from a clash of cultural values relating to a transition to adulthood. The sense of being "caught between two worlds" (P2) was common to other accounts, displaying, in a way, an *intra*personal and an *inter*personal cultural conflict existing through differences in internalised belief systems.

In a similar way, another participant (P5) also made extensive references to how the Chinese therapist's knowledge of cultural values had been extremely important and helpful to him. Despite this, however, Participant 5 chose to end therapy prematurely because of what seemed to be a rupture in the therapeutic alliance. He referred to a session when he had felt that his therapist had acted dismissively towards him:

> "... [I felt] not hurt but a bit angry, I come to you [the therapist]... you supposed to listen to me, show your empathy, something like that... I just need some emotional support." (P5)

Thus, a match between client and therapist in terms of cultural background does not necessarily ensure a sound therapeutic alliance.

Theme 3.3: Cultural liberation. For two participants, seeing a non-Chinese therapist was perceived as extremely beneficial: they felt they had been able to talk about their emotions and problems in a way that would not have been possible with a Chinese therapist. The predominant theme in their accounts was of therapy providing a sense of freedom from the constraints of Chinese culture.

Participant 8 felt that the traditional Chinese taboo on expressing feelings would have made it very difficult to talk about his feelings with a Chinese therapist. He also speculated that he would feel cautious about discussing any thoughts or behaviour that did not conform to traditional Chinese values. In contrast, talking to a Western therapist allowed him to explore issues openly:

> "I actually prefer that she is not Chinese because I feel that in Chinese families that there is always this taboo view - you don't really discuss your feelings... I think it is for the best for my therapist being a Westerner, well she is like a white sheet of paper that I feel comfortable starting with…If it's a Chinese [therapist]…I would actually feel uncomfortable because I then I know for sure they are thinking that to obey your parents no matter what…then that's *good* behaviour for Chinese people, then I would feel uncomfortable to talk about my parents and myself with such therapists…The benefit is that I feel open, well 'let's explore', I don't hold back any secrets really…but somehow if it's a Chinese I will feel 'oh my gosh shall I tell him this, shall I tell her that.'" (P8)

Participant 8 also described feeling that he had a kind of "emotional disability" due to his cultural inheritance (the suppression of emotions being valued in Chinese culture). When he started therapy, he expected his therapist to pick up on indirect cues (as he had been taught to do) and he struggled to express his feelings directly.

> "It [Chinese culture] disables you in terms of communication because, from a very young age, you are taught to read adult signals, their facial expressions, their body language to guess what they are trying to tell you and that is bad, that was the same

> when I started therapy. I just didn't know how to say what I wanted to say…..I would get really frustrated because I would hate the therapist for not being able to read my mind. But then she told me that 'nobody can read anybody's mind -- you have to express it'…" (P8)

For him, therapy was a process of overcoming this disability -- learning to recognise and express his emotions:

> "When I first learnt to name the feelings I had with my therapist she said 'Wow, you are learning', and I actually felt good that I was able to say it…it really disables you if you are born in that part of the world, as a Chinese." (P8)

Another participant (P6) also talked about the stigmatised nature of expressing emotions, but extended this to the inflections attached to the vocabulary of emotional experience itself:

> "It was actually good that I had counselling sessions in English…and this is something I would like to highlight, 'cause I feel I have a better emotional vocabulary in English, because Chinese culture doesn't encourage emotional openness, certainly not among men…it was much easier for me to talk about emotions in English. English is just a *friendlier* language for me to be expressive." (P6)

Participant 6 went on to describe how, although it felt possible to express his emotions in Chinese, the cultural tradition of not doing so made it difficult for him to even think about his emotional world. In effect, emotions seemed to constitute a foreign land:

> "There is the vocabulary but I would say that a lot of people don't say that sort of vocabulary as we are just not encouraged to talk about our emotions. (Interviewer: "Do you mean that people don't ask how you are feeling?") And we don't ask ourselves how we are feeling too." (P6)

Theme 3.4: Culture is not important. For two participants – one of whom had seen a Chinese therapist and one a non-Chinese therapist -- culture did not seem important to the experience of therapy. Their accounts tended to emphasise the value of therapy as a place to be heard and understood: as long as this could happen, the cultural background of the therapist did not matter.

Participant 1 had sought therapy for help with depression and anxiety, linked to domestic violence; she wanted someone whom she could trust in order to talk over her

difficulties. She had chosen to see a Chinese therapist because she felt that her own command of English was not sufficient for expressing herself fully:

> "... because my English is not very good I asked [my keyworker at Women's Aid] to look and find a Chinese counsellor to me... more easy to talk and expression myself..." (P1)

When asked in the interview if she felt she could equally be helped by a Westerner with a firm grasp of the Chinese language, she replied: "That's fine if this person can speaking Chinese, that's fine."

For Participant 7, who had seen a non-Chinese therapist for help with "emotional pressures", culture also did not seem to play a role in the therapeutic process. Indeed, he expressed surprise when the interviewer asked if cultural values had played any part in his decision-making about seeking help or in his experience of therapy. Like Participant 1, he emphasised the importance of being able to communicate, which he saw as an issue of language rather than of culture:

> "Well I don't think [cultural background] is very important, just as long as I can communicate with them, that is the most important. If I cannot express myself clearly then I have to find Chinese counsellor to help me, but that isn't necessarily important, right?" (P7)

Discussion

The accounts of participants in this study suggest that culture can play a role in the therapeutic relationship in diverse ways for different clients. For some, the therapist's ability – or inability – to understand the cultural context and nuances of their difficulties was of critical importance; for others, being able to explore their difficulties in an environment free of cultural constraints was fundamental; for yet others, culture seemed to have little importance. Despite this diversity of experiences, however, there was an underlying, central thread common to all the participants' accounts: what they valued in therapy was having a safe place to explore their problems, with someone who they felt understood them and who was able to help them make sense of their difficulties. In this way, their experiences and

views of therapy converge with those reported by clients of European-American descent (Bachelor & Horvath, 1999). However, culture entered into their experiences through subtle processes in the therapeutic relationship.

The need for therapists to have an awareness of different cultural values and cultural group characteristics is clearly a sine qua non of delivering culturally sensitive therapies (S. Sue, 1998). What was highlighted in participants' accounts, however, was not simply the therapist's cultural knowledge, but the therapist's skill in understanding the client's unique dilemmas and distress within the context of cultural values. Such "cultural formulations" seemed to enable the clients themselves to gain greater awareness of the cultural inflections of their difficulties and consequently to reduce their sense of self-blame, anger and distress. In this way, a process akin to what is sometimes referred to as "containment" (Bateman & Holmes, 1995) by the therapist seemed to occur. This appeared to be of particular benefit to clients struggling with issues where the values of Western and Chinese culture were in conflict, for example, independent vs. interdependent self-construals (Markus & Kitayama, 1991). Crucially, by having a familiarity with both Chinese and British values, the therapist was able to go beyond a level of simply acknowledging similarities and differences. It appeared they were able to take this process a stage further and incorporate their knowledge to develop a more sophisticated "cultural formulation" of the clients' dilemmas. This type of understanding from the therapist was, for some clients, essential in helping them to come to terms with their presenting problems.

In contrast to the theme of "cultural formulation", the theme of "cultural encapsulation" demonstrated the difficulties that can arise when the therapist fails to understand or explore the cultural context of clients' problems. Although misunderstandings by therapists are common and to some extent inevitable (Bachelor & Horvath, 1999), serious or repeated misunderstandings can lead to a rupture in the relationship and an impasse in

therapy (Safran, Crocker, McMain & Murray, 1990). In the present study, two participants' accounts illustrated how the therapist's lack of attention to cultural context led to a deep sense of feeling misunderstood, which ultimately adversely affected the therapeutic process. The misunderstandings in these two cases may also reflect clinicians' tendency to conceptualise problems mainly in terms of intrapsychic factors (Haynes & O'Brien, 2000); in failing to understand the role of social – in this case, cultural – factors, clinicians may make interventions that are perceived as inappropriate and unhelpful by their clients.

At first glance, the themes of "cultural formulation" (reflecting the accounts of two participants who saw a Chinese therapist) and "cultural encapsulation" (reflecting the accounts of two participants who saw a non-Chinese therapist) might suggest that the cultural or ethnic matching of client and therapist is important. However, the psychological process that seemed essential in all cases was the "empathising activity" (Jenkins, 1999) of the therapist. Entering into the experiential world of another person, who is inevitably different from oneself, is a fundamental activity of therapists regardless of theoretical orientation (Bohart & Greenberg, 1999), and is arguably an essential prerequisite for "cultural" or "ethnocultural" empathy (Ridley & Lingle, 1996; Wang et al., 2003). Although it may be easier for therapists to fully understand their clients' experiences when they share a common cultural background, such matching does not automatically ensure understanding or a good therapeutic alliance. Indeed, of the two participants who benefited from their Chinese therapist's "cultural formulation" of their problems, one also described a rupture in the relationship, leading to his terminating therapy.

The assumption that a shared cultural background between client and therapist is inevitably helpful was also challenged by the accounts of two participants who experienced a sense of freedom in seeing a non-Chinese therapist. For these participants, therapy provided a safe place to learn to express their feelings and to explore their emotional world, a process

which they perceived as incongruent with their Chinese cultural heritage. Thus, they described therapy as a kind of "cultural liberation" from social norms experienced as constricting. In addition to cultural factors, linguistic factors also played a role in their experience of therapy, in that the medium of the English language allowed them greater facility of emotional expression.

Qualities of the therapist valued by all the participants in this study were those that are commonly considered essential to a good therapeutic relationship, e.g., being non-judgmental, a good listener, and someone who can be trusted (Bachelor & Horvath, 1999). This finding is consistent with the idea that such facilitative therapist attitudes and behaviours are universally applicable. There were variations, however, in our participants' views of other therapist characteristics that they found helpful or unhelpful. Several placed particular value on the therapist's expertise and sense of authority, viewing the client-therapist relationship as akin to that of pupil and teacher. Although this may not be unique to our sample – indeed, there is ample evidence that clients vary in their preferences for various therapist stances such as level of directiveness (Bachelor & Horvath, 1999) – there did seem to be a cultural nuance to their views. Framing therapy within the culturally valued context of learning and scholarly pursuit may have served to normalise it and counteract the stigma of getting help, especially given the socio-historical context of a meritocratic structure in China. (Most of the participants were either students or teachers themselves, making the educational context even more familiar.) Viewing the therapist as an authoritative expert also may have embedded the interaction within a culturally familiar social role hierarchy, thus making it more comfortable (Lin et al., 1995; S. Sue, 1990). However, some participants also emphasised the value of an informal approach in which therapists revealed something of themselves as people. This resonates with Lin et al.'s (1995) suggestion that for Chinese clients it may be especially

important that the therapist is seen as both an expert and a friend, and that establishing a "pseudo-kin" or "own friend" relationship may facilitate therapeutic work.

The findings of this study need to be considered in the context of the particular characteristics of the clients who participated. The sample was self-selected, relatively young and well-educated. They described approaching therapy with an open-minded, curious attitude; indicated discomfort with the traditional Chinese view of seeking help and expressing emotions as a weakness; and emphasised their own responsibility in the therapeutic process. All of these attributes may have meant that our participants were more open to working within Western models of psychological therapy. However, the sample as a whole was also characterised by a moderate adherence to traditional Chinese values (as indicated by the Asian Values Scale).

Several other methodological issues have a bearing on the findings and have implications for future research. First, in conducting the interviews, we became aware of how difficult it can be for clients to take a "meta-position" on their cultural value system and verbalise tacit assumptions. (In this way, the notion of "cultural encapsulation" seems potentially applicable not only to therapists but to clients as well.) Conducting the interviews and the qualitative analysis therefore required careful attention to implicit and latent meanings, and the themes identified inevitably reflect a degree of interpretation on the part of the researchers. Second, we obtained only a "snapshot" of these clients' experiences of therapy; interviews with clients on several occasions during the course of therapy would be a valuable way forward for future studies. Third, because our study utilised an in-depth approach with a small number of participants, we were unable to examine possible associations between the role of culture in the therapeutic process and such variables as the client's degree of adherence to Chinese values or the type of problem for which they sought help. Future studies examining such associations should measure not only clients' level of

"enculturation" (the degree to which they have retained the norms of their indigenous culture) but also "acculturation" (the degree to which they have adapted to the norms of European-American culture), as both may play a role in their expectations for, and experiences of, therapy (Kim et al., 2005).

Although tempered by the above limitations, this study illustrates how cultural issues can enter into therapy in subtle and diverse ways. The qualitative, multiple case study approach allowed us to access individuals' unique experiences in depth and detail, and within the context of naturally occurring therapy. Such an approach complements the large-N, more tightly controlled designs typically used in studies of Asian American clients. Qualitative studies are valuable in generating understandings and explanations that potentially can be applied beyond the study that generated them (Willig, 2001). The central themes identified in the present study thus may provide a useful heuristic to guide future investigations. In particular, the potential importance of "cultural formulation" – helping clients to achieve an integrated understanding of their problems from both their own cultural perspective and that of the dominant culture – deserves further investigation, not only with Chinese clients but with clients from other cultural backgrounds.

For clinicians, being "culturally competent" is a complex task involving both specific and generic skills (Lo & Fung, 2003). As the accounts of our participants suggest, it is not merely a matter of knowledge of a particular culture or of utilising particular therapeutic strategies. What seems essential is for the therapist to endeavour to understand the unique individual, and to make sense of his or her distress, within the context of possible cultural influences (as well as other influences). As Jenkins (1997) argues, empathy may be a fundamental process in this activity. Indeed, there is some evidence to suggest that therapists' sensitivity to cultural and racial issues is associated with their capacity for empathy (Burkard & Knox, 2004; Wang et al., 2003). The varied experiences of participants in the present study

underline the importance of paying attention to the individual and his or her context. It is crucial for therapists to be open and curious about cultural influences – both their own cultural values and those of their clients – so that they can anticipate and recognise how and when these enter into the process of therapy.

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Footnote

[1]The term ‘Asian American’ is used in the US literature to describe individuals whose families originate from the continent of Asia (not individuals of Indian descent, as is commonly used in British and European classification systems). Research samples in US studies typically comprise a majority of Chinese participants, with Japanese and Filipino participants included but less represented (S. Sue, Nakamura, Chung, & Yee-Bradbury, 1994).

Table 1.Participant characteristics

ID	Gender	Age	Generation	Educational attainment	Occupation	Presenting problem	AVS score[a]	Recruitment source	Therapist background
1	F	26	First	Secondary school	Not working	Depression and anxiety	5.03	Chinese organisation	Chinese
2	F	19	Second	Secondary school	Student	Problems with parents	3.67	Chinese organisation	Chinese[b]
3	F	35	Third	MA	Student	Relationship problems	2.75	University	Non-Chinese
4	F	26	First	BA	Student	Studying and relationship problems	4.56	University	Non-Chinese
5	M	27	First	Post-graduate diploma	Interpreter	Emotional problems	3.53	Chinese organisation	Chinese
6	M	22	First	Secondary	Student	Perfectionism	3.11	University	Non-Chinese

				school				internet group	
7	M	37	First	Doctorate	Professor	“Emotional pressures”	4.81	University internet group	Non-Chinese
8	M	35	First	MA	Teacher	Relationship problems	2.33	University	Non-Chinese

[a]The Asian Values Scale uses a 7-point Likert scale, with higher scores indicating greater adherence to Asian cultural values.

[b]Participant 2 had also previously seen a non-Chinese therapist

Table 2: Domains and themes

Domains	Themes
1. Attitudes to therapy	1.1 A spirit of inquiry
	1.2 Stigma as a flawed belief
	1.3 Taking responsibility
2. Qualities of the therapist	2.1 The universal therapist
	2.2 An authoritative guide
	2.3 Being a person
3. Culture and the therapeutic relationship	3.1 Cultural encapsulation
	3.2 Cultural formulation
	3.3. Cultural liberation
	3.4 Culture is not important