A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE AND RESEARCH WORK

Including an investigation into South Asian people's acculturation strategies and acculturative stress, and whether these factors affect their likelihood to use psychological services

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Statement of anonymity

Throughout this portfolio names have been replaced with pseudonyms and identifying information has been changed or omitted to preserve the anonymity and confidentiality of clients and research participants.
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Appendices
Introduction to the portfolio

This portfolio represents the culmination of three years of training to become a counselling psychologist. It contains a selection of academic, therapeutic and research papers written during these three years and aims to reflect my personal and professional development. Each dossier will be considered in more detail below, but first I intend to provide the reader with some background information that I hope will set my academic work, personal and professional development in context.

A long-standing curiosity

My interest in psychology and consequent pursuit of a career in counselling psychology stems from childhood (a theme which is also picked up in my final clinical paper). I was a curious child and, having a brother ten years older, I was somewhat precocious. I can remember listening with great interest to my brother's conversations with friends about relationships and dilemmas. Unsurprisingly, as a teenager I became an enthusiastic reader of the problem pages in magazines. I went to a high achieving girls' school and after some adjustment I felt settled and happy there. It became clear that the things I enjoyed most about school were socialising and talking with friends. However, it soon drifted into my awareness that there were others who did not take the same pleasure from coming to school. One such girl was particularly unhappy and this was expressed in the form of an eating disorder. Another girl always seemed to be getting into trouble with teachers and, later, the law. These differences observed in early life fuelled my desire to understand human processes and emotions.

I studied psychology at UCL and found myself captivated in certain lectures (e.g. social psychology and psychopathology), and numbed in certain others. Looking back, I can now see that I was slowly discerning my tastes towards counselling psychology. After university I worked with children with learning
difficulties in disadvantaged, inner-city schools. This was hard work, but exhilarating at the same time. I enjoyed working with children and became aware of how comfortable I felt adapting my way of being with each of them in an attempt to respond to their individual needs. It was probably during this time that I started to consider the possibility of pursuing therapeutic psychology, rather than psychology per se. I was very curious about the interplay between intra-psychic processes, interpersonal function and social and cultural factors, and how my relationship with a particular child seemed to alleviate some of their distress, if only temporarily.

I volunteered as a telephone 'counsellor' at a charity helpline for victims of crime. During my shifts I spoke to victims of rape and violent assault and I was frequently moved by peoples’ stories. It became clear to me that there was a real value in talking about distress, and at this point I decided to pursue a therapeutic training. Once I had reached this conclusion, the decision to study counselling psychology came with relative ease. The attention to the relationship, the openness to the use of different therapeutic theories, the attentiveness to personal development and the considered use of research in order to enhance practice are all factors that seduced me into training as a counselling psychologist. I cover these attractions in more depth in my final clinical paper.

*Academic dossier*

The academic dossier contains three essays, presented chronologically from each of my three years of training.

The first essay considers psychosocial conceptualisations of the development of ethnic identity, and it represents the beginnings of my formal interest in acculturation. In my first year at Surrey, I was thrilled to be a student again and I indulged myself by attending as many extra-curricular talks as possible. One of these talks was by a psychologist who had been investigating national
identity in ethnic minority children, and this subject captured me. I had always taken an interest in culture and the idea of living with different cultures, and finally I was able to name this phenomenon and link it to a theoretical framework. I came away from the talk invigorated and I think that some of this enthusiasm is evident in the essay. I have resisted the urge to rewrite or heavily edit the essay as it is indicative of my stage in training and also offers the reader an introduction into my main research interest.

The second essay explores shame from a psychodynamic perspective, and was motivated by my client work and my own experiences in personal therapy. It seemed to me that shame was an affect that was regularly felt but not often discussed in therapy. This led me to wonder if there was something inherently shaming about the analytic setting. I wanted to explore this subject further and this essay gave me the opportunity to investigate shame at a more theoretical level, giving a conceptual framework to my thinking. It is interesting that in this essay I refer to the client population as patients rather than clients, which is the term of reference I use in all my other pieces of work. I feel this not only reflects the literature I encountered on the subject matter (largely coming as it did from the psychoanalytic perspective), but also the orientation of the placement I was on at the time. I flag this up as an issue of note and recognise my personal preference for the term client.

My final essay offers an exploration into post-traumatic stress disorder and was motivated by my work with a particular client, who is duly discussed. The essay assisted me in my conceptualisation of the client’s distress. It also focussed my attention on the far-reaching negative effects of mental health difficulties, both on the individual and their family. This served as a useful reminder for me that a person’s difficulties should be explored within the context of their lives rather than as an abstract list of symptoms.
**Therapeutic practice dossier**

This dossier provides an overview of my experiences as a therapeutic practitioner. It contains descriptions of the clinical placements I have undertaken over the past three years, covering details such as context and orientation of the work, the client population and supervision. This dossier also contains my final clinical paper, which is a personal account of my personal and professional development as a counselling psychologist. In this paper I outline some of the defining moments that I believe have shaped me as a practitioner and nurtured the development of my identity as an integrative counselling psychologist.

**Research dossier**

This dossier contains my first year literature review, my second year qualitative research report and my third year quantitative research report. My research dossier focuses on the acculturation process of ethnic minority individuals.

The decision to explore ethnicity, and specifically South Asian ethnicity, came from a personal curiosity about my own cultural position. I come from a Bangladeshi background and was born and brought up in the UK. As such, I have always been interested in the subject of living with at least two different cultures. Doing the course has enabled me to delve into this subject explicitly. When I started the course, I thought that the process of acculturation was relatively simple and straightforward. Through carrying out my research I have discovered that this is far from the truth, and my research ideas have evolved alongside my development as a counselling psychologist, gradually learning more about the complexities of culture.

My literature review offers a critical examination of the current theories pertaining to acculturation and the extent to which they provide suggestions to
help those dealing with acculturative stress. One of my frustrations in carrying out this review was the fact that the models seemed restrictive. There were clear ideas about the process of acculturation but very few indications of how to deal with problems encountered during this process. This led me to investigate the therapeutic aspects of acculturation more explicitly in my second and third year research reports. As a result of this, I have decided to keep the literature review in its original form, as it illustrates how my engagement with the topic has progressed and developed over time.

In my second year research I employed a qualitative method, template analysis, to explore therapists’ perceptions of ethnic minority clients. This allowed me to look in depth at how participants made sense of their experience with ethnic minority clients rather than produce an objective statement about them. While carrying out the interviews, I was able to track my participants, gauge their responses, and challenge them where appropriate in a process that shared similarities with the therapeutic endeavour. As a researcher, I felt that my position was similar to that of an empathic therapist where my aim was to explore the participant’s world view and to adopt, as far as possible, an ‘insider’s perspective’ (Conrad, 1987). This method seemed particularly suited to the ethos of counselling psychology: It was respectful of diversity and had an interest in uncovering, as far as was humanly possible, subjective truths by recognising the powerful interplay between the participant’s phenomenological account and the researcher’s interpretation. Conducting this research offered me a huge learning experience on how to execute qualitative research and interpret the results.

In my third year research I decided to look at ethnicity from another perspective. By drawing on themes identified in my literature review and interviews, I was able to establish some hypotheses and test them out on a larger scale by means of a quantitative study. I compiled a questionnaire and distributed it to a South Asian population of non-service users. The questions were about ethnic identity, acculturation and mental health, and this time I was seeking to explore if there were any links between these factors and the
likelihood to seek different kinds of support. I enjoyed carrying out this piece of research as it felt like a culmination of my work, having explored acculturation from a theoretical position, from the therapist's perspective and finally from the perspective of an ethnic minority individual.

Having utilised three different research methodologies during my training I now feel more confident in my ability to choose a style of research appropriate to the research question.

**Final note**

I hope that this portfolio will give the reader an impression of my academic and therapeutic development as a counselling psychologist, as well as my development as a researcher within this field. I have attempted to be as honest and candid as possible in order to illustrate the genuine ebb and flow of my progression as well as present an overview of my personal development during this training.
References

ACADEMIC DOSSIER

Introduction to the academic dossier

This dossier includes three selected essays, submitted during the three years of training. The first essay considers psychosocial conceptualisations of the development of ethnic identity. The essay goes on to explore the implications for counselling psychologists working with clients for whom ethnic identity is a salient issue. The second essay investigates shame from a psychodynamic perspective. Finally, the third essay is an exploration into post-traumatic stress disorder.
Critically evaluate psychosocial conceptualisations of the development of ethnic identity. What might these implications hold for counselling psychologists working with clients for whom ethnic identity is a salient issue?

**Introduction**

Achieving a positive and coherent self-identity is a crucial part of psychological development (Erikson, 1968). Attitudes towards one's ethnicity are seminal to the attainment of self-identity. This is highlighted in those who live in societies where their group is at best poorly represented (politically, economically and in the media), and is at worst discriminated against (Phinney, 1990). The concept of ethnic identity provides a way of understanding the need to assert oneself in the face of threats to one's identity (Weinreich, 1983).

There are various models that explore the development of ethnic identity. In this essay I have chosen to look into social identity theory and acculturation to see how the issue of ethnic identity might express itself in the consultation room. I will examine the ways in which ethnic identity has been defined and conceptualized, and critically evaluate the two models. I will then focus on acculturative stress in the client and the subsequent issues for the counselling psychologist.

**Definitions of ethnic identity**

Psychologists appear to share a broad general understanding of ethnic identity. However, the fact that there is no widely agreed-on definition is indicative of confusion about the topic (Phinney, 1990). Tajfel (1981) defines it as "that part of an individual’s self-concept which derives from his knowledge

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1 The first person approach has been used in parts of this essay to convey the personal and reflective nature of the topic from the author’s perspective.
of his membership of a social group (or groups) together with the value and emotional significance attached to that membership” (p. 255). Phinney (1990) states that ethnic identity involves an individual’s self-identification as a group member, a sense of belonging to an ethnic group, attitudes towards ethnic group membership and degree of ethnic group affiliation or involvement. Others placed more stress upon the sense of shared values and attitudes (White & Burke, 1987), or feelings of commitment (Singh, 1977) for example. In this essay I have decided to work largely from Phinney’s definition as it is referred to most frequently in the literature on this subject.

Social Identity Theory

Social Identity Theory (srr) maintains that the concept of social identity is central to understanding intercultural relations. It describes a cognitive component that one is in a particular social category (e.g., British, female, student) and an affective component that represents one’s attachment to that category. Tajfel and Turner (1979) developed the idea that simply being a member of a group provides the individual with a sense of belonging that adds to a positive self-concept. srr proposes that individuals are instinctively inclined to achieve this positive self-identity and to think well of themselves, rather than negatively. This goal will prompt people to make comparisons between their own social group and others in order to achieve a distinct, positive identity. According to the theory, where comparison yields a positive identity people will try to maintain or even enhance it, and where comparison results in an inadequate social identity (neither positive nor distinct) people will try to change themselves and/or the situation in which they find themselves (Stephan & Stephan,1996). Changes can be “individualistic”, i.e. the person will strive to change themselves, or “collectivist”, i.e. individuals will strive to change along with the rest of the group.

Therefore, in the case of ethnic minority groups, if the majority group views minority group characteristics adversely, then this may lead to the minority
group developing a negative social identity (Tajfel, 1978). Identifying with a low-status group may result in low self-regard (Hogg, Abrams & Patel, 1987). Tajfel (1978) maintained that members of low-status groups seek to improve their status in a number of ways. Individuals may seek to leave their group by “passing” as members of the dominant group, but this may have negative psychological repercussions. Another solution might be to develop pride in one's own group (Cross, 1978), and reinterpret the characteristics deemed as “inferior” so that they no longer appear subordinate (Bourhis, Giles & Tajfel, 1973). Sit goes on to describe the possible difficulties in operating within two different cultures. Tajfel (1978) stated that when an individual from an ethnic minority is identifying with two different groups (i.e. the majority group and the minority group), this might be problematic for identity formation. Problems might occur when the two groups have conflicting attitudes, values and behaviours (Rosenthal & Cichello, 1986). The issue at stake here is whether an individual must choose between conflicting identities or whether they can incorporate the two cultures to establish a bicultural identity (Phinney, 1990).

This theory is quite persuasive as it takes into account both the cognitive element of identity formation and the subjective value that the individual places upon it. The notion that one makes comparisons between one's own social group and others in order to construct some sense of identity is a reasonable suggestion. Sit offers some explanation for the possible difficulties in identity formation faced by those from ethnic minority groups. The theory seems to acknowledge the strength of social reputation with regards to identity, and this idea is also picked up in other domains. For example, in educational literature it has long been recognised that reputation is a powerful predictor of performance, especially with regards to the underachievement of black boys in British schools; it has been hypothesised that black pupils were victims of institutional racism in schools and that teachers were unwilling or unable to examine the concept in relation to how they generally viewed them through a combination of negative prejudice, destructive stereotyping and low expectations (London Schools & the Black Child, 2003). This argument
highlights the importance of the majority group perception of the minority group individual, and this is also picked up in SIT, which homes in on the impact of social reputation. In addition to this, SIT explores possible “solutions” for the individual who identifies with a low-status group, and these seem fairly robust and realistic.

However, this model also has certain limitations. The social categories that are outlined in SIT are fixed and rigid. I feel they do not express the true nature of identity formation and the fluidity of concepts. Instead, SIT describes discrete categories and labels. Similarly, SIT assumes one’s attachment to a given social category is static and un-changing. In reality, I think things are very different. For example, if an individual from an ethnic minority were racially assaulted, it may have an impact on the way they viewed themselves as well as the way they perceived their group and the majority group. This would be reflected in their subsequent attachments and affiliations with these groups. SIT does not allow room for the concept that those in low-status groups might seek to improve their reputation through self-promotion and re-education. For example, there have been major drives in the last few decades to improve race-relations and increase representation of ethnic minority groups via community-led events, through teaching in schools and through the monitoring of equal opportunities in the workplace. I also feel that the notion that mere association with a group can provide a positive self-concept is too simplistic. I feel that SIT lacks consideration of the context in which these judgements are made. It is important to use a fully contextualised picture and to not look at things in isolation, although these considerations have been partly addressed in more recent work that draws on SIT (e.g. Akerlof & Kranton, 2000).
Acculturation

Acculturation concerns how ethnic minority individuals adapt to dominant culture and the associated changes in their beliefs, values and behaviour that result from contact with the new culture and its members (Berry, Trimble & Olmedo, 1986). Acculturation may be more stressful for some ethnic groups than others (Berry & Kim, 1988). In general, it is found that the greater the differences (e.g. in language or religion), the more difficult is the process of acculturation (Ward, 1996). This concept has been termed 'cultural distance'. When the cultural distance is great, behavioural changes pose a greater challenge since the amount of change required (of both groups, but more for the minority group) is greater (Padilla, 1980). According to Berry's model of acculturation there are four ways ethnic group members can associate with their host culture: individuals who see themselves as belonging exclusively to the majority group and not to the ethnic minority group have 'assimilated'. Those who see themselves as belonging exclusively to the ethnic minority group and not to the majority group have adopted the 'dissociative strategy'. Those who identify with both the ethnic minority and the majority group have assumed the 'acculturative strategy'. Finally, those who identify with neither group are 'marginalised' (Berry, Kim, Power, Young & Bujaki, 1989).

Research assessing the acculturation strategies of various immigrant groups in North America has demonstrated that the acculturative strategy (i.e. becoming bicultural) is the most psychologically adaptive pattern (Berry et al., 1989). The work of Berry and his colleagues showed that bicultural individuals experienced less acculturative stress and anxiety and manifested fewer psychological problems than those who were marginalised, dissociated or assimilated.

This model of acculturation is fairly robust as it considers both the relationship with the ethnic culture and the relationship with the dominant culture, and expresses that these two relationships may be independent. The
theory is flexible as it allows for minority group members to have strong or weak identifications with both cultures. It asserts that strong ethnic identity does not necessarily imply a weak relationship with the dominant culture, and I appreciate that this is not an exclusive relationship.

From a personal perspective, as a member of an ethnic minority group, I feel this model offers a sound explanation of the orientations in ethnic identity. It does, however, have some draw-backs. The use of fixed cultural categories and dichotomies is unhelpful and restrictive. The model assumes that cultures are independent and stable; however, I feel that they are ever-evolving. They do not have a fixed geographical location, and I felt that some recognition of the fluidity and changing nature of cultures would have been welcome. Berry's model failed to offer any explanation for the adoption of the four strategies. Some reflection of the societal aspects (e.g. differential size, power, rights and resources) involved in cultural relations would have been relevant as these factors have an important bearing on how individuals engage and consequently identify themselves. Attitudes, motives, values and abilities are all highly variable psychological characteristics of individuals and they are important factors that will impact on the individual's acculturative strategy. Therefore, if the individual's attitudes (e.g. towards their own as well as other ethnic groups) change, it is probable that their acculturative strategy could change and I felt that the model did not account for this. Over time, the minority group undergoes transformations and develops features, which are not identical to those in the original group at the time of first contact. This would imply some form of parallel phenomena whereby individuals undergo psychological changes (as a result of influences from both their own changing group and from the dominant group) and with continuing contact, further psychological changes will take place.

I would have liked to have seen some reference to the mutual influence of cultures and how this impacts on the ethnic identity of an individual. For example, in the UK the impact of Indian immigrants is such that their
influence can be seen in everything from the generation of new styles of music to additions to the English dictionary (e.g. 'chuddies' – meaning underpants!).

Berry’s model seems to presume that the individual employs one acculturative strategy; however, I feel that this is highly dependent on the context. For example, an individual at school where the dominant language is spoken may well identify themselves differently to when they find themselves at home where another language is used.

The task of understanding ethnic identity is complicated and the uniqueness that distinguishes each group makes it difficult to draw general conclusions. However, I feel that Berry et al.’s theory focuses on common elements that apply across groups, and contributes to a better understanding of ethnic identity.

**Ethnic identity in the consultation room**

People who come to a new country have to undergo a certain number of changes. These changes can be relatively easily accomplished (e.g. in ways of speaking, dressing, eating etc.) or they can be more problematic, producing ‘acculturative stress’ (Jalali, 1988). This may manifest itself in an individual as uncertainty, anxiety, depression and even psychopathology (Al-Issa & Tousignant, 1997). In fact, acculturative stress has frequently been linked to psychological problems in children and adolescents (Nguyne, 1997). Research has linked this phenomenon to suicide (Hoberman & Garfinkel, 1988), suicidal ideation (Hovey & King, 1996), conduct disorder (Apter, Bleich, Plutchik, Mendelsohn & Tyano, 1988), post-traumatic stress disorder (Bagheri, 1992) and anger and aggression (Myers, McCauley, Calderon, Mitchell, Burke & Schloredt, 1991).

To help a client facing these difficulties requires a counselling psychologist to have an understanding of the client’s sociocultural context, level of
acculturation and acculturation style. Without exposure to theories around acculturation and ethnic identity, the psychologist would be ill-equipped to help. The counselling psychologist would need to be aware of the potential differences in values and culture between the host and the traditional country. For example, the most commonly practised form of psychotherapy in Western cultures promotes individuation (Dwairy, 1998). However, Eastern cultures do not necessarily subscribe to the same beliefs. Instead, individuals in these cultures adopt a collective identity, where the individual is seen as secondary to the group. Therefore, in certain instances, Western therapy might not be suitable for an ethnic minority individual who is experiencing acculturative stress. The psychologist should be aware that Western counselling techniques may clash with the client's set of values and beliefs. Therefore they would need to adapt existing models of therapy to be more suited to the needs of an ethnically different client to help them make a smooth transition into the new culture.

It would be necessary to have an understanding of the problems facing the client as well as a grasp of majority group attitudes towards the client's ethnic group. With a clearer grasp of the client's predicament, the psychologist would able to provide more tailored help. This might be more easily achieved if the therapist and client are ethnically similar (Bland & Kraft, 1998). Indeed, Smart and Smart (1995) consider it necessary to train and recruit ethnic minority psychologists and develop ethnic minority therapeutic services. They hypothesise that therapists who are ethnically similar to their clients will have undergone the process of acculturation. These therapists will be more likely to understand their clients' problems and therefore better able to help their clients to overcome them.
Conclusion

The growing proportion of minority group members in the Western world has resulted in an increasing concern with issues of pluralism, acculturation and discrimination. As a consequence, the psychological relationship of ethnic minority group members with their own group and the notion of ‘ethnic identity’ have attracted more interest. The increasing diversity makes it essential to understand the psychological impact of such diversity (Albert, 1988). The challenge now stands for counselling psychology to modify existing psychological theories and psychotherapy models to incorporate factors such as acculturation and acculturative stress, to ease the transition into a new culture for ethnic minority clients.
References


Shame and psychoanalysis: An exploration into the concept, causes and implications from a psychodynamic perspective

Shame is a subject that is found in fields as broad-ranging as literature, the arts, the scriptures, in legends, psychoanalytic writings, and in analytic practice and supervision. It is defined by the Oxford English Dictionary as “a painful feeling of humiliation or distress caused by the consciousness of wrong or foolish behaviour” (Soanes & Stevenson, 2005, p. 1622). In this essay I will attempt to unpack this definition and look at others with the aim of exploring the origins and causes of shame. I will look at historical conceptualisations of shame, the differences between shame and guilt, and developmental perspectives on shame. I will then explore some of the positive aspects of shame and turn towards shame in the analytic situation, and finally I will present a patient who presented with issues around shame. In my conclusion I will attempt to draw together these strands and summate with a view to elucidating the complex nature of shame.

The Cinderella of unpleasant emotions

In psychoanalysis, shame has long been deemed the ‘Cinderella of unpleasant emotions’ (Rycroft, 1972, p. 14), and only in recent years has more attention been paid to this neglected affect. Pines (1987) proposed two possible explanations for this neglect. Firstly he blamed a general weakness of psychoanalytic theory regarding affects and a lack of distinction between shame and guilt. Secondly, he considered Freud’s own personality to have steered psychoanalysis away from shame. Pines suggested that psychoanalysis was Freud’s own personal creation, and as he paid more attention to guilt than shame, psychoanalysis followed in his footsteps. Pines speculated that the reason for this imbalance was because Freud was a shame-sensitive person.
who avoided dealing with the issue and who consequently turned his attention toward guilt, which has less painful self-referential qualities.

Shame is very caught up in vision. In shame we avoid the eyes of others; they are spectators of our state of distress, of our ugliness, our incompetence and loss of self-control. Freud's few references to his own visual appearance as seen in mirrors show how much he disliked what he saw. He saw an elderly ugly man and at times failed to recognise the image as his own. Therefore, it is not until recently that shame has been picked-up and re-examined in psychoanalytic literature.

**Shame versus guilt**

In order to begin to elucidate shame, it is necessary to look at guilt and the differences between shame and guilt. Levin speculated that the comparative lack of shame in the literature might be due partly to the fact that whereas 'guilt feelings bring material into the interview, shame keeps it out' (Levin, 1967, p. 274). In other words, shame is shameful. In general, guilt seems to be felt in response to harmful or prohibited actions or fantasies of such actions, which are often aggressive in nature. However, shame is often to do with failures to do what is expected. Piers and Singer define shame as a tension between the ego and the ego ideal, whereas they define guilt as a tension between the ego and the super-ego (1953). They go on to explain that whereas guilt is generated when a boundary (set by the super-ego) is transgressed, shame occurs when a goal (presented by the ego-ideal) is not being reached. Therefore according to Piers and Singer, shame indicates a real shortcoming.

The focus in guilt seems to be the other whom one has hurt, whereas the focus in shame is the self. Therefore it is possible to feel both guilty and ashamed of the same event. For example, in the bible when Peter betrayed Jesus, we might imagine that Peter's distress included both guilt and shame: guilt that he had hurt his friend, and shame at discovering that he was capable of such betrayal.
As Thrane (1979, p. 322) puts it, in guilt we say “How can I have done that!”; whereas in shame we say “How can I have done that!”. Shame may also generate guilt more directly. For example, a person might feel shame about a parent, spouse or child because of their social inadequacies or behavioural peculiarities, which could lead to a sense of guilt for having such feelings. Similarly, shame may be felt about one’s family as a whole, especially regarding class, cultural or educational background, which may in turn lead to feelings of awkwardness or rejection to one’s own kin. Therefore, it would appear that the manifestations of shame are wide-ranging, however, where do these manifestations originate?

**Developmental perspectives on shame**

Shame is commonly evoked alongside failure. The failures can range broadly from failure to achieve academically, to possess a desirable body, accent, clothes or social skills, failure to understand or respond appropriately, etc. However, it has been suggested that the failure to evoke an empathic response in an other is the most fundamental failure. Broucek (1982) argued that a sense of efficacy forms the basis for a sense of self. We might consider one of the most basic forms of efficacy is that of being able to communicate one’s needs and having them understood by the primary caregiver, i.e. the mother. This continues into adulthood whereby communications with others who display empathic understanding leave us feeling relatively free of shame and we feel a sense of continuity between our experience and the other’s. Whereas, when we anticipate or experience incomprehension or disapproval, we experience shame. We start to feel a ‘gulf between ourselves and others’ and we become strangers to each other (Mollen, 2002, p. 26).

Broucek (1982) suggests that shame may arise in the early experiences with the mother, when she is experienced as a ‘stranger’ to her infant. One way this could occur is from a mother’s changing moods and preoccupations, which may in turn affect her facial expressions and behaviour. The “still face”
experiments (Tronick, Ricks & Cohn, 1982) demonstrate this point quite effectively. In these studies three-month-old infants were filmed interacting with their mothers under two conditions; in the first, the mother was instructed to act as she normally would with her baby; and in the second she was instructed to make eye contact but not engage in facial or verbal interaction. The infants at first reacted to the still face by attempting their normal engagement with the mother, but eventually responded either by crying in distress or by slumping down, turning the head down and averting their gaze from the mother’s face. Spitz (1965) suggested that the infants who showed the second kind of response were displaying an early form of shame and that this bears similarities to an infant’s response to strangers. The fact that the infants first attempted to engage the mother using their usual behavioural repertoire and then reacted with distress when these efforts failed is perhaps significant. The shame arose when the infant encountered the mother (the emotionally significant other) as a stranger. She did not behave as expected and therefore the infant did not know how to respond to her. All of a sudden, the infant’s relational world was alarmingly unpredictable. The same thing occurs with adults when our social expectations are violated. We call it embarrassment.

Schore (1999) explores developmental and neurobiological data on facial mirroring as a major vehicle of emotional communication. He concludes that: ‘The experience of shame is associated with unfulfilled expectations and is triggered by an appraisal of a disturbance in facial recognition, the most salient channel for non-verbal communication’ (Schore, 1999, p. 65). Schore proposes that shame arises when the infant looks to the mother for facial mirroring, but instead finds a response indicating disgust or disapproval. Therefore, instead of the expected psychobiologically energised state whereby the production of endogenous opiates mediates pleasure, the infant experiences shame; a de-energised and painful state where stress biochemistry, such as corticosteroids, induce withdrawal and inhibition.
Both Freud and Erikson noted the painful sense of exposure in shame – of being seen when one does not want to, or is not ready to be seen. Erikson (1959) suggested that the child is particularly susceptible to shame at the time when he learns to stand upright and to walk. Erikson proposes that at this time of great achievement and relative independence when the child can stand on his own, he is paradoxically confronted with a sense of his helplessness and vulnerability. Another important achievement at this stage is learning to control the sphincter. Given that shame is often associated with a loss of control, it would follow that the development of shame might be associated with the anal phase of development.

Wharton (1990) talks about the need of the infant to have a sense of his own intrinsic goodness reflected back at him from the very beginning of his life. This is conveyed by his parents’ attentiveness to him and delight in him, which affirm his being. Alongside this, the infant is learning to manage the inevitable and necessary frustrations of life, at first by means of the primitive mechanisms of splitting and projection, and fantasies of omnipotence, then later coming to a truer sense of reality in terms of his own separateness and limitations (Klein, 1975). In Kohut’s writings on narcissistic patients, he describes how shame originates in a failure of the mirroring and approving response that is expected and needed by the infant, i.e. when the parents’ attentiveness and delight are absent. The early grandiose self is cut off and prevented from developing a realistic sense of self-esteem and will burden the ego with unrealistic aspirations for perfection (Kohut, 1971). When these idealistic aspirations are not met, the individual feels ashamed. This may lead you to believe that there are only negative consequences resulting from shame. However, this is not necessarily the case.

The positive aspects of shame

The biblical story of Paradise is one of the most renowned stories in Western culture which deals with shame. In the story we are told that after eating from
the Tree of Knowledge, Adam and Eve suddenly felt ashamed of their nakedness. Before this incident they had not felt ashamed of being naked. However, the fruit of knowledge gave them the capacity to ‘distinguish between I and Thou’ (Jacoby, 1993, p. 426), and therefore they became aware that they were two separate beings and that their naked bodies were different. Feeling ashamed, they stitched together garments of fig-leaves to conceal their ‘private parts’.

Taking this archetypal story, we can conclude that shame arises when one is ‘seen’ by others, and that one of its functions may be to safeguard individual intimacy. Shame can motivate us to protect our intimacy and keep for ourselves what is ‘no one else’s business’ under the cover of a symbolic loincloth. As a consequence, shame can reinforce distinctiveness and help to maintain a sense of one’s individual identity (Jacoby, 1993).

In addition to this, shame can act as a powerful inducement of social adaptation and it can serve to maintain social conformity. For example, shame can uphold the rules of ‘public decency’ that prohibit public nudity, or public confession of one’s private feelings, amongst other things. Those who ignore these rules may suffer embarrassment. A good example of this is illustrated in the channel 4 television series *Shameless*, whereby the main characters operate within a hectic world of sexual adventures and crime. The viewers are made to squirm as they observe the brazen Gallagher family drift from one catastrophe to another. However, at the same time as being put-off by their behaviour, the audience cannot help but feel envious of their audacity and I wonder if there is something liberating in being shameless.

From a developmental perspective, Schore (1999) suggests that shame helps the child to learn when it is appropriate to become subdued and withdraw within a social setting. Nathanson (1992) reiterates this point as he describes the safety-seeking emotional withdrawal of a child when he fails to evoke facial mirroring in his mother.
Some writers have deemed shame to be a reaction formation against exhibitionistic impulses (Pines, 1987). Freud said that ‘Shame, disgust and morality are like watchmen who maintain repressions, dams that direct the flow of sexual excitation into normal channels instead to reactivating earlier forms of expression’ (Freud, 1909: 45). It is proposed that indulgence in exhibitionism brings about attacks from within in the form of guilt and attacks from without in the form of castration anxiety (Nunberg, 1955). Therefore, shame can act as a defence against these impulses and anxieties.

Other authors do not posit morality as the exclusive motive behind reducing exhibitionistic excitement, but point to the ego-destructive nature of over-stimulation. They see shame as a function to protect against the loss of boundaries, which are implicit in some forms of sexual fantasy, for example, observing the sexual behaviour of others. Therefore, shame serves to ground a person who is over-stimulated by feelings of omnipotence (Pines, 1987).

**Shame and the analytic setting**

In psychoanalysis, the patient is supposed to trust a complete stranger with their most intimate and perhaps most embarrassing concerns. However, the relationship is not mutual and the analyst will tend to offer very little information about them self as part of the process. Although the analysand is free to enter into/ leave the therapeutic relationship, the analyst tends to occupy the more powerful position. The analyst has a variety of interpretations at their command, with the ability of using the patients’ weak spots to their own advantage, and although this conduct is unprofessional, it can be difficult to police in the unconscious. This however, does not mean that the patient cannot make the therapist feel worthless and manipulated at times.

In theory, the analytic situation is designed so that the patient would not feel judged, blamed or shamed, and if such feelings still arose in spite of this neutral setting, they could be identified as projections into the therapist.
However, in psychotherapy the acknowledgement of need and vulnerability might be experienced as shameful. The inability to know one's own mind and the realisation that some of one's own communications are unconscious might be mortifying for some patients. The fear that the analyst might deem the patient 'weird' or that they would not understand them could be similarly humiliating. Given these inherent difficulties, it is possible to conclude that the analytic setting itself is shame-producing. Therefore, in analysis it becomes difficult to determine whether a patient's shame-anxiety is attributed to their transferential feelings, or whether they are caused by the reality of the analytic setting.

If elements of the therapy are not handled with sensitivity, they can evoke shame and therefore distort and impede the therapeutic process. For example, the patient might not know what to expect when visiting an analyst for the first time, therefore, they would not necessarily know what behaviour was appropriate for the situation. Many analysts will give minimal cues and simply wait expectantly, the rationale for this being that the patient's anxieties and fears are allowed to surface more clearly. However, this stance is abnormal compared to how human beings behave with each other in most other settings. Hence, the patient is deprived of the normal, expected cues, and will be reacting to an abnormal situation, highly likely to evoke social anxiety and shame.

Clinical illustration

Mrs S is an extremely shame-prone patient who came to see me for therapy. Mrs S had a traumatic childhood with a father who was a violent and controlling alcoholic, and a mother who was pre-occupied, suffering with severe bouts of depression. In the therapy with Mrs S, an aspect of her shame was played out in her strong dislike of being looked at and she often became distressed with me just looking at her. She described feeling 'lonely' in the sessions and said that she wished that I would talk to her more.
Mrs S grew up in a cold and hostile world with the absence of empathy and warmth from her parents. I feel that Mrs S internalised the absence of an empathic response in the form of an unempathic internal object. This unempathic figure was subsequently projected into me, as the therapist. Mrs S feared a lack of responsiveness and understanding from me, and as a result, felt that my gaze was not one of empathy, but incomprehension. As a result, she was left feeling ‘lonely’, alienated, and ashamed both inside the sessions and outside, in her everyday life.

Conclusion

In conclusion, shame is a highly complex phenomenon, which can be associated with a fundamental kind of social inadequacy. It can manifest as a sense of not fitting in and of not being able to enter into the realms of human discourse, and taken to its extreme, this fear can be one of being cast out and facing complete and utter annihilation. Kohut (1971) talked about the importance of facial mirroring between mother and infant, and the “still face” experiments (Tronick et al., 1982) highlighted that an absence of the expected facial mirroring can be extremely disturbing to the infant, provoking primitive shame responses. However, there are some more beneficial aspects of shame. It would appear that without shame and its corresponding threshold of restraint, civilisation would be almost unthinkable. Shame adapts individuals to society’s collective norms, on the one hand, and protects the individual’s sphere of intimacy, on the other. Given that shame is a human condition that touches everyone, it is of great importance to explore this affect in psychotherapy. However, it can be extremely difficult to delineate whether a patient’s shame is transferenceal, or whether it is real, brought on by the nature of the analytic setting. I feel that if handled sensitively, shame needn’t create a barrier between analyst and analysand. Instead, the exploration of shame could help to enrich the analysis by looking at those parts of ourselves that we find difficult to look at.
References


An exploration into post-traumatic stress disorder

If one were to consider the number of people who have been exposed to war, assault, natural disasters, accidents and other major stressors it would become clear that traumatic experiences are very common. Following a traumatic event, the disturbance most frequently observed is post-traumatic stress disorder (PTSD). The incidence of PTSD in the general population worldwide is estimated at 1% (Helzer, Robins & McEvoy, 1987). However, more recent studies in the USA have estimated that PTSD affects 9% of the USA population (Breslau, Davis, Andreski & Peterson, 1991). Therefore, epidemiological studies would seem to suggest that PTSD has become a serious problem in the Western world and one that requires attention and exploration.

In this essay I will unpack the medical definition of PTSD and its diagnostic criteria. I will then offer a critique of these criteria. I will conceptualise PTSD and outline the nature of therapy from a cognitive-behavioural stance as this has been the most studied treatment modality. I will attempt to explore the nature of PTSD from the perspective of the sufferer as well as from the perspectives of those they encounter and I will explore some of the psychosocial factors relating to the genesis and maintenance of PTSD. Finally, I will try to reflect on the nature of therapy with a client presenting with PTSD and I will look at the implications of this kind of work on the therapeutic alliance.

The diagnostic criteria

The fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) outlines six criteria to be met for a diagnosis of PTSD. In brief, firstly it states that the person has been exposed to a traumatic event in which they experienced or witnessed an event that involved actual or threatened death or serious injury.
The person's response will have involved intense fear, helplessness or horror. Secondly, the traumatic event is persistently re-experienced via intrusive recollections, dreams, acting as though the event were happening again or experiencing distress in response to another event that may resemble the source of the trauma. Thirdly, the person persistently avoids stimuli associated with the trauma, for example, avoiding places, activities, thoughts or feelings. They may also feel detached and estranged from others and may experience a restricted range of affect. In addition to this they may experience a sense of a foreshortened future. Fourthly, the person experiences symptoms of increased arousal that were not present before the trauma in the form of difficulty in sleeping, irritability or outbursts of anger, difficulty concentrating, hypervigilance or an exaggerated startle response. Fifthly, the duration of the above-mentioned symptoms is more than one month, and finally the disturbance causes 'clinically significant distress' in social, occupational or other important areas of functioning (American Psychiatric Association, 1994, pp. 427-429).

The DSM diagnostic definition is important in terms of determining potentially effective ways of tackling PTSD, researching outcomes, educating practitioners and for ease of discussion amongst practitioners. Although I can see that the diagnostic criteria offer a useful tool in terms of classifying these complex difficulties, I feel that they have certain draw-backs. Through seeking to categorise peoples' struggles, the DSM misses some of the more fine-grained details of human experience. Human beings are complex creatures and their difficulties are even more nuanced and hard to box neatly away. Therefore any attempts at categorisation will miss the texture of a more individual account, which could ultimately prove obstructive for the sufferer who might not receive the best possible help. Also, the traditional psychopathological account of distress is not always helpful. This way of viewing things may be perceived as locating the difficulty within the individual and it may overlook a broader, more contextualised picture. By omitting reference to social and hegemonic factors, the diagnostic criteria can sometimes sound blaming and the individual may feel stigmatised by their diagnosis. In addition to this, the
notion of psychopathology can evoke ideas of abnormality and ‘wrongness’, which may lead to an individual feeling marginalised as a result of their difficulties. However, other individuals may feel a sense of freedom and containment in their diagnosis.

The DSM definition sometimes has an air of judgement in its descriptions of symptoms, for example, when it refers to ‘clinically significant distress’ (American Psychiatric Association, 1994, p. 429) it implies that a person’s level of distress will be assessed to ascertain its level of significance. This kind of perceived assessment may exacerbate a person’s difficulties and lead to them feeling more estranged and cut-off. However, it might also serve to reassure someone that their experiences were being taken seriously. The DSM-IV criteria can sometimes become sterile and lose focus on the person by using abstract lists of symptoms. Another difficulty with the DSM-IV criteria for PTSD is its definition of ‘trauma’. Events such as ‘ordinary’ bereavement and miscarriage do not fit in as qualifying incidents in the diagnostic definition. However, such events are frequently personally traumatic and require looking at. Therefore it is essential not to lose site of the issues that are important to individuals, and miss out on the opportunity to help in a variety of circumstances.

Given this critique of the diagnostic criteria I feel it is extremely important to explore PTSD from a human angle, although I feel that there are still some grounds to identify PTSD as a treatable disorder. Therefore, in this essay I intend to refer PTSD according to the DSM-IV criteria but I also wish to include a more personal account of this particular difficulty from the perspective of the sufferer and their family.

**A cognitive-behavioural understanding of PTSD**

Given the scope of PTSD and its often severe disruption of daily functioning, it is of utmost importance to have efficient and effective therapies. Within
psychosocial treatments for PTSD, cognitive-behavioural therapy (CBT) in its various forms has been the most studied treatment modality, with well-controlled investigations to ascertain its efficacy. Therefore, I have decided to look at PTSD and the treatment of PTSD through a cognitive-behavioural lens.

It has been hypothesised that PTSD occurs because of a person’s inability to process a traumatic experience adequately (Foa, Steketee, & Rothbaum, 1989). If these difficulties are indeed the result of inadequate emotional processing, then therapy that seeks to reduce these difficulties could be perceived as facilitating such processing. CBT espouses that the behavioural roots of PTSD lie in a conditioned fear response to the traumatic event. For example, if a woman is assaulted in her car, the car can become a conditioned stimulus or trigger that evokes a conditioned fear response. Similarly, smells, sights, or sounds experienced during the assault may become conditioned triggers of re-experiencing the trauma memory. This concept is central to current CBT that targets the conditioned fear response.

The cognitive dimension of PTSD has its roots in unhelpful meanings associated with the fear as well as a disruption in the processing of information. Therefore, according to this theory, two conditions are required in order to minimise the fear. Firstly, the memory of the fearful event must be activated, and secondly, new information must be provided which is incompatible with the existing fear so that a new memory can be formed.

Ehlers and Clark (2000) expanded on this model to suggest that PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious and current threat. They proposed that the sense of threat arises as a consequence of: (1) excessively negative appraisals of the trauma, (2) a disturbance of autobiographical memory characterised by poor contextualisation and elaboration, strong perceptual priming and strong associative memory. Ehlers and Clark go on to suggest that change in the negative appraisals and the trauma memory is prevented by a series of problematic behavioural and cognitive strategies.
Psychosocial factors relating to PTSD

Various factors are thought to be related to the likelihood of a person who has experienced trauma going on to develop PTSD. The type and intensity of the trauma (i.e. the degree of exposure, duration, extent of injury or threat to life) are thought to affect the development of PTSD. Assaultive violence is associated with the highest rates of PTSD (21%), and the sudden death of a loved one is the experience most often sited as the precipitating event among persons with PTSD (31% of PTSD cases, with a risk of 14%) (Breslau et al., 1998). Amongst former prisoners of war, the severity of trauma during captivity was the best predictor of developing PTSD (Gold et al., 2000). Trauma-related factors, such as loss of possessions, involvement in rescue efforts, and proximity to the trauma were found to be risk factors for PTSD after the September 11th 2001 terrorist attacks in New York City (Galea et al., 2002).

Several personal characteristics and demographic factors are linked to either a heightened risk of PTSD or resilience to PTSD. Recent findings in the literature highlight the association between female gender and risk of PTSD, independent of perceived threat to life and trauma severity (e.g. Holbrook, Hoyt, Stein & Sieber, 2002). Other personal characteristics that are associated with a heightened risk of PTSD include poor education, low income, minority status, history of childhood abuse (particularly sexual assault before age 16), high life stress, history of psychiatric illness, family history, antisocial personality disorder and anxiety, history of childhood adversity (e.g. early separation from parents, parental separation or divorce, and poverty), feelings of insecurity, sense of lack of personal control, and alienation from others (Helzer et al., 1987; Freedman, Brandes, Peri & Shalev, 1999). Further exploration into some of these factors, such as poor education, low income and minority status may well help to broaden the understanding of PTSD by using a more contextualised, systemic view of mental health as hinted at earlier.

Social support after trauma has been found to act as a protective factor against PTSD (Coker et al., 2002). Coker and his colleagues found that among women
who experienced interpersonal violence, higher social support was associated with a lower risk of poor mental health. Among rape victims, those who experienced supportive social reactions to the trauma had fewer physical and emotional health problems than did those who perceived social reactions to be hurtful (Coker et al., 2002). In contrast, poor social support is a risk factor for PTSD in studies of medically ill persons (e.g., after bone marrow transplantation or myocardial infarction) (Jacobsen et al., 2002).

**Therapy for clients presenting with PTSD**

Exposure therapy is one of the major techniques in CBT for the alleviation of difficulties relating to PTSD. This therapy comprises graded, repeated exposure to the trauma and to avoided objects, situations and memories associated with the trauma. Exposure therapy can be imaginal or in vivo. During imaginal exposure, the client is instructed to imagine the traumatic event and to describe it aloud with accompanying emotions. In contrast, during in vivo exposure, the client actually revisits trauma reminders in order to achieve desensitisation. Exposure procedures elicit the fear memory and constitute an opportunity for corrective information to be integrated, and thus to modify the fear. The intended result of such modification should be the reduction of the anxiety and associated avoidance. Repeated exposure to the traumatic memory is expected to result in habituation, so that a person can remember it without intense fear responses. It has been suggested that habituation within and across exposure experiments in therapy, and changes in threat appraisals are indicators that changes in the fear structure have taken place (Foa & Kozak, 1986). Various studies have indicated that fear activation and exposure in therapy produces successful outcome in PTSD clients (e.g. Fairbank, Gross & Keane, 1983).

Systematic desensitisation is another cognitive behavioural approach to tackling PTSD. Similar to imaginal exposure therapy, systematic desensitisation involves exposing the client to fearful imagery, but crucially, this is done while
the client is in a state of relaxation. The aim of this kind of work is to replace the pairing of the stimulus with a fearful response to a more relaxed response. Systematic desensitisation has been shown to be successful at reducing the symptoms of PTSD amongst war veterans (Peniston, 1986) and it has also been shown to be effective with rape victims in reducing fear, anxiety, depression and social maladjustment (Frank & Stewart, 1984).

Stress Inoculation Training (SIT) is used in CBT to improve anxiety management and thereby reduce avoidance and intrusion-related distress. SIT involves muscle relaxation exercises, breathing retraining, role-playing and guided self-dialogue around the traumatic event. The rationale for this kind of work is to directly affect the self-schemata of the individual. By teaching the person techniques for coping with stress and anxiety, it will reinforce an image of themselves as a successful coper. This increased perception of control may allow the individual to tolerate the traumatic memories for longer periods of time. In addition to this, an individual who perceives themselves as able to cope will expect to be more able to avert potential dangers. These schematic changes are likely to facilitate positive social interactions, which will in turn strengthen the well-functioning schemata.

**The experience for the client and their family**

I have worked with many clients who have experienced trauma, but only one who was given a diagnosis of PTSD. Ms M was a 32 year old who had been the victim of a violent group rape 6 years prior to starting therapy. Ms M experienced vivid flashbacks of the rape whereby she would often report feeling ‘as though it were happening all over again’. She would tell me about her sleepless nights and being woken up in a cold sweat by nightmares and how she could no longer fall asleep unless she’d had a bottle of wine. In session Ms M would become very distressed when we explored anything that might remind her of the rape, and as a result she’d become dissociated from her feelings. She seemed to be frightened of having feelings, fearing that if she
were to express one they would all spiral out of control. Ms M would talk at speed during our sessions. This seemed to be the way she avoided thinking or feeling. This was echoed in her relationships with friends and family, whereby she would often find herself ‘rambling on’ nervously in a bid to ‘shut feelings out’.

There wasn’t an area of Ms M’s life that had not been affected by the PTSD. Her flashbacks and nightmares had been relatively persistent since the rape, six years ago. She had become so anxious that she was no longer able to work and she felt unable to socialise with her friends in the way that she had done previously. Since the rape, her relationships had become characterised by over-dependency and what she described as a ‘see-saw’ effect whereby one person would always predominate.

Ms M’s relationship with her parents had become strained and even when they attempted to offer her support, she was often unable to receive it stating that ‘other people can never understand how I feel.’ Ms M sometimes described her family as ‘critical’ and ‘over-involved’, however, she could also see that she had become more irritable with them and that this seemed to sour their relationship. When Ms M did talk about the rape, she would describe with a real sense of sadness her family’s inability to inquire about trauma. When I pondered this, I imagined how difficult it might be for them to even think about something so painful happening to a loved one. Ms M talked about her parents’ sorrow when they had first heard about her rape. This made me think about a sense of grief that they might have felt having ‘lost’ their daughter to the trauma.

During the course of therapy with Ms M I gained a huge insight into the reality of living with PTSD. It seemed to me as though her difficulties were all-pervasive colouring her relationships with those in her life, as well as her relationship with me. After sessions, I would often be left feeling drained and shattered and this informed me about how life might be for Ms M, and indeed, those around her on a daily basis.
**Therapeutic considerations**

Engaging in therapy with a client who has been diagnosed with PTSD can be quite challenging. Sufferers are naturally reluctant to engage in reliving their trauma, therefore the therapist may feel uncomfortable using a therapeutic method that encourages the client to recount the trauma and therefore elicits intense emotional pain. This could potentially create a dynamic in the therapeutic relationship whereby the therapist feels they have to take care of the client, as was sometimes the case in my work with Ms M. In those instances, it required careful vigilance to ensure that any signs of such a dynamic were spotted and then tackled so as not to reinforce unhelpful ways of relating.

One of the major challenges in working with a PTSD sufferer is that the therapist may become vicariously traumatised. Research has shown that people who work with survivors of trauma may experience profound effects that can be disruptive and painful, and which can persist for months or years (McCann & Pearlman, 1990). The psychological consequences of working with trauma survivors are often referred to as 'burnout', which is a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations (Conrad & Berry, 2000). Research suggests that vicarious traumatisation is an occupational hazard, which is an unavoidable result of undertaking work with survivors of trauma (Saakvitne & Pearlman, 1995); therefore it is extremely important for therapists carrying out this kind of work to have good supervision and professional support. In a way, therapy and the therapeutic relationship can be seen as a dance whereby sometimes it might feel appropriate for the therapist to come close and share their client’s experience, while at other times, it might feel more appropriate to draw away for the sake of both the therapist and the client.
**Conclusion**

PTSD can be chronic and disabling, and it is associated with widespread difficulties and functional impairment. It affects clients and those who are close to them and its costs are similar to those of other severe mental health difficulties. Due to the nature of the difficulty, careful attention is required in therapy to ensure the client feels safe enough to talk about the trauma memory without becoming re-traumatised. In addition to this, the therapist also needs to be vigilant to ensure they are not becoming traumatised vicariously. Through careful assessment of trauma and PTSD in all clients, therapists may more readily identify individuals at risk of PTSD and in need of interventions early on. This may help to improve outcomes and potentially limit the chronic and disabling effects of PTSD. Research has shown that among the most effective psychosocial interventions are cognitive behavioural approaches that use exposure and desensitisation techniques (Fairbank, Gross & Keane, 1983). However, it is possible that other approaches, which have been less researched, may also offer useful insights towards reducing the difficulties associated with PTSD. With regards to future exploration, it seems that more research is needed in order to gain a clearer insight into why some people who have experienced trauma go on to develop PTSD, while others do not.
References


Introduction to the therapeutic practice dossier

This dossier relates to my therapeutic practice and contains brief descriptions of my clinical experiences throughout three years of training. It also includes my final clinical paper, which offers an account of my development as a counselling psychologist.

As highlighted in the statement of anonymity, all potential identifying information relating to clients has been changed or omitted in order to ensure client confidentiality.
First year placement: Employee counselling service

November 2006 - July 2007

This placement was an in-house employee counselling and trauma service provided by the occupational health department of a company. In this organisation the client population was predominantly male, mixed in terms of age and from a diversity of ethnic backgrounds. The service was made up of 18 therapeutic practitioners (psychotherapists, counsellors and counselling psychologists) and was available to all of the organisation’s employees and was well utilised. Employees could either refer themselves for counselling or be referred by their manager. Once employees were referred to the service, they were initially assessed during a telephone conversation before being assessed face-to-face by a therapist. As a trainee, I was not permitted to carry out either part of the assessment, but I had access to the assessment notes once a client had been allocated to see me for individual therapy. The counselling service was predominantly humanistic in its orientation and typically offered six sessions of individual therapy to clients.

The counselling service was confidential except when there was a perceived safety risk to the individual or others, especially regarding safety at work. The presenting issues were varied and I worked with clients experiencing relationship difficulties, bereavement, depression and anxiety.

I was encouraged to work in a person-centred way with my clients and to pay considerable attention to the provision of the ‘core conditions’. My supervisor, however, was a Gestalt psychotherapist and working with her increased my awareness of what it felt like to be present with a client. She encouraged me to observe and attend to my physiological sensations and helped me to understand how these could be used as information to enhance my understanding of the therapeutic relationship. I also had group supervision, which was an invaluable forum for me to learn and share my experiences with another trainee and supervisor. I felt like I learnt a great deal about 'being
with clients during this year and experienced my supervision (both individual and group) as excellent, not least because they were invigorating, supportive and containing.
This placement was in secondary care at an NHS psychotherapy clinic in north London. The client population was predominantly White British, but was very diverse in terms of age, financial and educational background. The service consisted of nearly 30 members including: psychiatrists, psychotherapists, analysts, trainee analysts and trainee counselling psychologists. The clinic offered individual and group psychodynamic psychotherapy for 1-2 years duration. Clients were referred by their G.P., CMHT, psychiatrist as well as other mental health care practitioners involved in their care. Referrals were varied in nature often relating to the more severe and enduring difficulties associated with depression, anxiety, suicidal intention, interpersonal problems and personality disorders.

In this placement I was encouraged to use psychodynamic theories to conceptualise my clients’ presenting issues. I had weekly individual and group supervision in which I presented verbatim extracts from client sessions for exploration and review. These sessions provided a rich and often intense learning environment in which I felt both supported and challenged, both in terms of my therapeutic reasoning and my self-insight.

In addition to this there were weekly team meetings where the therapists would gather to read and critique a psychodynamic paper or present a client to the rest of the group. This too was a very full experience where ideas were constantly being exchanged and explored.

I thoroughly enjoyed my time at this placement and felt grateful that I was given the opportunity to partake in a range of activities. My individual and group supervision sessions were fantastic where I was encouraged to focus on theories, or aspects of theories that resonated with me. This gave me the
confidence to increasingly attend to my intuition and to take risks and further develop my therapeutic practice in a way that felt comfortable to me.
Third year placement: NHS primary care
October 2008 - July 2009

This placement was in an NHS primary care psychological therapies service. The service provided primary care in general practice surgeries in south London and the team comprised counselling and clinical psychologists. The service routinely offered computerised cognitive behavioural therapy (CBT) and short-term therapy to individuals lasting between 6-12 weeks. Group CBT was also offered consisting of 8-10 once-weekly sessions. The service was available to patients registered with G.P. surgeries within the primary care trust. Clients were usually referred to the service by their G.P., but other mental health care teams involved in their care could also refer them.

The service offered predominantly CBT to clients therefore my work was within a cognitive-behavioural focus. This model also informed my supervision and I learnt a great deal about how to conceptualise clients’ presenting concerns from a cognitive perspective. I learnt about how various tools and strategies could assist my work with clients, and I was also introduced to a broad range of psychometric tests during this placement. Effective communication within the team was essential during this placement as there were often multiple health care professionals working with a client at any one time, and the teams were located in different offices.

The organisation served a large and diverse population from a mix of social, economic and ethnic backgrounds. This population also consisted of a number of asylum seekers and during my time at the placement I conducted an assessment with an asylum seeker who required the presence of an interpreter. This was a very interesting experience for me conducting therapy with a third person.
Client's presenting issues were varied in nature. I worked with clients who presented with obsessive-compulsive disorder, health-related anxiety, depression, psychosis and panic disorder, as well as other difficulties.

I also co-facilitated a CBT group with a clinical psychologist. The group was primarily a psycho-educational forum for depressed clients. Our role as therapists was to equip the members with various cognitive behavioural skills to help them to manage better. The emphasis was on developing a 'tool kit' of manageable skills that individuals could integrate into their daily lives. The group was not an experiential group and the structure was such that each session was specific and focussed on a particular area each week. The group ran for 8 sessions and each session lasted for 2 hours.

I enjoyed both the level of support and independence that I was given at this placement. My supervision was focused but flexible and provided a perfect springboard for me to move from being a trainee towards becoming a counselling psychologist.
On finding a new identity

The past three years of training to become a counselling psychologist have been unlike anything I have experienced before. It has been at times exciting, infuriating and giddy, and as the course nears an end I am taking a while to pause and reflect on the whole experience. I see this paper as an opportunity for me to take stock and remember some of the highlights that have helped me to develop as a counselling psychologist. I will reflect upon the various aspects of my experience in training as a therapist, a supervisee, a client and a researcher. I will do this by drawing on personal and professional experiences and by reflecting on the challenges, difficulties and successes that have played a part in influencing my development. In addition to this, I intend to look at the psychological theories and research that have guided me in my emergent identity. To begin this ambitious endeavour, let us rewind 20 years back to my childhood.

A budding attraction to counselling psychology

Discovering the relationship

It was often noisy at my home, with the television blaring, sounds of clattering and the smell of spice emerging from the kitchen, and a low bassy beat coming from my brother’s bedroom. All of this was interspersed with regular cries of ‘Mum, what time’s dinner?’ or ‘Mum, where’s my school stuff?’ At others’ houses, an equally incomprehensible calmness prevailed. Why? What made the difference between my normality and that of my friends? It was at quite a young age that I started to ponder these differences. I studied psychology at university thinking that I would come closer to answering some of my questions. However, the reality of undergraduate psychology was much more to do with rats running mazes than the intricacy of human relationships. After graduating and working for a while, I decided to move to the other side of the world to volunteer for an environmental charity in the rainforests of South
America. It was during this spell, living in the jungle with a group of strangers, completely cut-off from other people and our lives back home, that I truly experienced the value of relating. We were so isolated that our only source of support was to turn to each other, and this was something that I came to love – getting to know someone, listening to them and sharing with them.

In a similar way now, attending to the relationship in therapy has become the most rewarding aspect of being a counselling psychologist for me. Focusing on the quality of the relationship in order to deepen understanding or affect change has been both enjoyable and challenging. The emphasis on the therapeutic relationship and the importance placed upon the client’s phenomenological world is, I feel, what distinguishes counselling psychology from other disciplines and attracted me three years ago. The centrality of the therapeutic relationship has also been picked up in the literature. It has been described as one of the most overriding and influential factors in the outcome of psychotherapy (Clarkson, 2003; Gelso & Johnson 1983; Adelstein, Gelso, Haws, Horvath & Symonds, 1991). This stance is also in line with developmental theory, which highlights the relational nature of human beings from the beginning of their lives (Bowlby, 1973; Schore, 1999).

The role of research

Taking science A-levels at school and going on to a bachelors degree steeped in science meant that I started my training with positivistic leanings. Needless to say, the emphasis placed on utilising research to better understand clients’ needs attracted me to counselling psychology. The conscious use of a research element suggests a readiness to reflect on practice and continually question one’s assumptions. This questioning stance is very important to me. Meara, Schmidt, Carrington and Davis (1988) talk about the scientist-practitioner model being an integrated approach to knowledge that recognises the interdependence of research, theory and practice. I feel that one needs to use the knowledge derived from each of these three areas with the aim of tailoring
the therapy according to the client's needs. Hence, in my three years of training I have endeavoured to read, think about and to draw upon theory and research to guide my practice.

I have also found it exciting to be able to carry out my own research in the field, and I feel that this has played a vital part in my development. Since starting the course I have been introduced to a number of epistemologies. With an appreciation of new and insightful methods such as interpretative phenomenological analysis (Smith, Jarm an & Osborn, 1999; Smith & Osborn, 2003) and template analysis (King, 1998), I have started to question some of my initial assumptions about objectivity and truth. The empiricist epistemological stance with which I started the course has somewhat shifted and I have found that some of these more mechanistic views do not lend themselves very well to exploration of the therapeutic encounter.

In endorsing the scientist practitioner model, counselling psychology respects the complementary contributions of both quantitative and qualitative research (Woolfe, 1996). Given this, it was very helpful to be able to use a qualitative approach in my second year and a quantitative one in my third year as it enabled me to broaden my perspectives by considering my research interest from two very different angles. This 2-pronged approach has enriched my development as a counselling psychologist by encouraging a kind of pluralism that I feel encompasses the spirit of the profession. As it stands, my approach to research posits that there are diverse views or ways of seeing the world rather than one single approach or method of interpretation.

I have loved (and at times loathed) the research process. I have enjoyed learning about the experiences of others and I have also taken a narcissistic pleasure from exploring the perspectives of people like myself (i.e. South Asians)! Equally, there have been times when the enormity of the research task has become overwhelming and unfriendly. The fact that I chose a topic that gripped me personally has carried me through those difficult times and I can now begin to see how my research might shape my own practice. I would
be keen to work with ethnic minority groups and continue to explore how my profession might help them. My research has also taught me to reconsider traditional notions of 'help', and how those notions may not always be relevant within different cultural groups. Hence, in my practice I aim to be flexible and attentive to my client's needs, aware of the effect of factors such as their ethnicity and cultural background.

The parallel journeys

Something else that attracted me to counselling psychology was that it, as a profession, also seemed to be undertaking a journey; one whereby it was being constantly re-evaluated and reflected upon. Counselling psychology has been defined as 'not set in its ways, not totally confident in what it does and how to do it' (Bor, 2006, p. 25). This stance appeals to me. It is brave and honest, and suggests an openness that makes space for the subjectivity of the client without imposing too many rules or expectations. This kind of flexible position can also take into account social context whilst being responsive to psychological research findings, and this is important to me.

This brings me on to my own journey, which has been a very full one. There are myriad experiences that have shaped my training. My theoretical approach to clients and the way in which I conceptualise their difficulties are evolving with every new client that I encounter. More sizeable shifts have occurred during my training with each placement and supervisor I have worked with, owing to the ethos and requirements of the service as well as to my supervisors' individual approach to theory and practice and the quality of our relationship. It therefore makes sense to explore my development as a counselling psychologist, and my journey, by discussing each of those experiences chronologically.
A humanistic beginning

In my first year I worked in an occupational setting at an employee counselling service. The service offered short-term contracts to clients and the therapists at the service were mainly humanistic in their approach. The client group spanned a broad demographic and particularly notable was the fact that men were referred just as often as women, and that ethnic minority individuals were referred as much as their majority counterparts. This led to a rich experience for me working with clients from a multitude of cultural backgrounds.

This set my mind ticking with questions of sameness and difference and the impact of race in therapy. My supervisor (who was mixed-race) and I were able to have frank discussions about the impact and the subtleties of race. This helped me to distil some of my thoughts about my own race and how my clients might view it, which was a valuable process for me. I learnt that however much one tries to ignore one’s own or someone else’s race, it cannot be written out of any relationship. In contrast, if race can be talked about explicitly then it can provide the basis for a much more open and frank discussion between therapist and client.

The placement provided me with the opportunity to work with presenting difficulties such as depression, anxiety, bereavement and relationship issues. This was the first time that I would be carrying out individual face-to-face therapeutic work, and I was terrified. I can still remember my heart racing as I walked to the waiting room to greet my first ever client, and yet now, this memory brings a smile. Despite my sizeable fear, there was an equally large part of me feeling excited. Through experience I have learned to harness that ‘fear’, and when I feel that familiar flutter of anxiety, I try to note it and not judge it. As Bion puts it ‘in every consulting room there ought to be two rather frightened people’ (Bion, 1990, p. 5) and these words keep me from becoming either too complacent or trapped by fear.
Rogers’ person-centred theory and ‘core conditions’ (1951) were initially like a foreign language to me. I did not know how to use the model and it felt awkward. However, I took a leap of faith and started by listening and trying to empathise with my clients and slowly, the fog began to clear. What struck me with this theory was the high regard in which people were held and the seemingly unaltering belief that all people have the possibility to fulfil their potential. To me this was the real beauty of the model and I began to enjoy trying to work in a way where I would bracket my assumptions regarding how a person ‘should’ or ‘should not’ be. I liked Rogers’ common aim for clients and therapists, which was “to be what one truly is” (Rogers, 1961, p. 163).

I explored this aim in personal therapy, where I started seeing a humanistic therapist. This first experience in ‘the client’s chair’ was invaluable as it contributed to an experiential understanding of the therapeutic relationship and helped me appreciate both the courage and the vulnerability of clients. One of the most powerful lessons came towards the end of our work.

My therapist, with whom I had developed a strong working alliance, had sold his house where we met for therapy. We discussed the options and I decided that the journey to his new house would be too long to continue therapy, but that we would work towards an ending. We met a handful of times at his new abode and I can remember the anxiety and sadness that I felt as we approached the ending. Seeing my therapist in his new house, with boxes stacked and half-unpacked was frightening and chaotic for me. I felt insecure and had two major realisations from this experience. Firstly, I learnt the importance of providing a stable, predictable environment from which to carry out therapy, and experienced first-hand the insecurity that comes when this environment is unsettled. Secondly, I learnt about the impact that endings have on me as an individual, and that I find them very difficult. This was an essential part of my development as a counselling psychologist, as I could begin to approach my therapeutic endings with more self-insight.
Rogerian therapy appealed to me in its warmth and respect for people. These core conditions have become prominent and valuable in the way that I practice, striving to be genuine, empathic and to offer unconditional positive regard. Working from a person-centred perspective in my first year, I felt like I had been given the permission to concentrate on these core conditions and to allow sessions to unfold naturally. This granted me a precious opportunity to develop and reflect upon my way of being with clients. During this time I learned that there were certain clients that I particularly enjoyed working with, and there were others with whom I struggled. For example, in my work with Miss C, a 24-year-old British-born woman of Indian origin, I felt particularly attuned to her and the sessions seemed to flow with ease. She was a woman of a similar age to me, from a similar ethnic background, presenting with depression and panic. She had come from a restrictive Hindu family background and this was an experience with which I could identify. I would look forward to our sessions, and there was a very strong bond between us. Although the warmth and my genuine concern for Miss C were helpful, I was later able to reflect on some of the parts of therapy that were less helpful.

In focussing on the similarities between us I was making a number of assumptions about Miss C, most notably by thinking her issues were similar to ones that I had encountered. This was obstructive as it meant that I missed some of the unfurling dynamics between us. Through a process of unpacking, my supervisor helped me to realise that I had been pre-occupied with the commonalities, feeling too relaxed with Miss C. As a consequence I had become blind to the fact that we were re-enacting a familiar relational pattern from Miss C's history. This was a great learning experience for me, to begin to consider the tightrope that is walked each time one encounters a 'similar' client, and how important it is to remain open rather than closing opportunities down by making assumptions.

Another client in my first year, Mr V, presented me with an equally valuable but entirely different learning experience. Mr V was a 36-year-old English man who presented with stress. He was very angry in sessions and his anger
was regularly directed towards me. For example, he would often make sardonic comments about my student status and my competency. Needless to say, I did not look forward to our sessions together. While I sometimes found myself hoping that he would not attend, he did come to all of the sessions. Towards the end of our work I began to realise how important it was for Mr V to come and be angry, and for me to tolerate his anger, as anger had been met with rejection in all other realms of Mr V’s life. We looked at situations in which Mr V became angry and explored some of the origins of his anger and I think that this was a helpful process for him. Through seeing Mr V, I was able to get in touch with some of my angry feelings and also how I respond to anger. Personal therapy was invaluable for this, allowing me the space to look again at this challenging encounter. As a result of my work with Mr V I have learned about the importance of inviting the full array of emotions into the consultation room, however uncomfortable it may feel at times.

This experience, as well as many others during the first year, helped me to appreciate the value of ‘being with’ clients. This was furthered by the support and nurturance of my supervisor who was containing, constructive and encouraging, ever urging me to use my intuition, develop my own style of working and be myself. I feel very lucky to have had her supervision whilst taking my first steps as a counselling psychologist.

**Transitioning to psychodynamic thinking**

In my second year, my placement was at a psychotherapy clinic within the NHS. The service was psychodynamic in its approach and routinely offered one year contracts to individuals. During this year I saw clients with a range of presenting issues including long-standing depression, anxiety and I also worked with adult survivors of childhood abuse.

Learning about and playing with a new modality was invigorating. I would look forward to our psychodynamic lectures and hearing about another
strange concept or way of looking at things. Psychodynamic theories seemed very mysterious and alluring, and I was captivated. At placement there was a similar story. The setting was such that the clinic was staffed by a rainbow of therapists: Jungians, Kleinians, Freudians and Winnicottians; all analysts in training. This gave me an exceedingly full experience. In the group meetings, where we would gather to share our thoughts on a piece of reading or congregate to discuss a particular client, there was always a wealth of opinions. I soaked up everything that I could from this placement, taking enjoyment from sharing ideas with other therapists who had trained in very different settings.

Two concepts with which I engaged immediately were the dual ideas of transference and counter-transference. These notions enabled me to focus on the therapeutic process with more clarity than I had done previously and they even helped me to better understand my clients from the preceding year. One client with whom the transference became alive was Ms C.

Ms C was a 60-year-old Caucasian woman who had been depressed for the past 20 years. She described at length how her father, an army general, had been very strict while she was growing up. Similarly, her ex-husband had been controlling and critical, and now her brother was the critical one. The transference was very powerful. Ms C described how coming to see me felt like going to see the head teacher at school, and she would often apologise for becoming emotional or ‘boring’ me. In the counter-transference, I felt irritated and I could occasionally hear myself becoming instructive and controlling, just like Ms C’s father, husband and brother. My key learning from these instances was the importance of noting the transference as well as my counter-transferential urges, and not acting them out. With the help of my supervisor, I slowly improved at discerning these tidal pulls, and was able instead to talk about them. For example, in the middle stages of therapy Ms C started a session saying ‘I don’t know what to say. I’ll sound silly’ and I said ‘There is a very powerful voice telling you that you are silly and it seems to silence you.’ Ms C then said ‘Yes, it’s that person holding me back again.’ This way of
describing Ms C's super-ego became a shared narrative in therapy and offered a safe way of talking about her inner world. This seemed to be helpful for Ms C who reported feeling less depressed and more mobilised at the end of our work.

When Ms C was first referred to me I was anxious about the idea of working with her and was convinced that I would not be able to help her in any way. She was a White, 60-year-old woman – old enough to be my mother, and I was her Bangladeshi, 27-year-old therapist. I dedicated time to considering what it might mean for a woman from her generation and social position to seek help from someone much younger and from a different cultural background. Upon reflection, I could see that my apprehension was to do with the age dynamic, and more specifically, the fact that Ms C was a similar age to my mother. Coming from a Bangladeshi background, I have learnt to respect and look after people in my parents' generation. As such, there were times when I felt that I had difficulties reconciling my position as a therapist and a younger woman with Ms C. I often felt as though I was her daughter and I wanted to look after her. I used supervision as a platform to air my thoughts and feelings, and slowly I was able to regain my therapeutic stance with a clearer view. Instead of being Ms C's daughter or husband, I could be a new character in her life, one that would help her to explore things in a fresh and reparative way rather than acting out old, unhelpful patterns.

Working psychodynamically and having more time was liberating. It felt spacious and allowed me the opportunity to explore childhood experiences and to make tentative interpretations about their role in adult functioning. It felt like a new challenge whereby I was required to be increasingly vigilant, both to what was being said, and to what was not being said. It reminded me of studying Indian classical dance as a teenager, and learning to scrutinise every facial, hand and body posture as a way of conveying a story. Freud's words were at the forefront of my attention. 'No mortal can keep a secret. If the lips are silent, he chatters with his fingertips; betrayal oozes out of him at every pore' (Freud, 1909, p. 269). Although problem solving is not one of the
aims of psychodynamic psychotherapy per se, this stirred the part of me that enjoys puzzles and seeing how pieces fit together.

During the second year I decided to move house and despite my outward eagerness, I was unable to start personal therapy with someone new. Looking back, I think that I was reluctant to re-start therapy, borne from the loss of my previous therapist and a need to ‘mourn’ him. This was a shame as it meant that the work that I was so enjoying at placement was not being mirrored in my personal development. Instead, I tried to immerse myself in the personal and professional development (PPD) group at university. Having an experiential group with friends and colleagues from my cohort was strange, and it often felt uncomfortable negotiating these dual roles. Nonetheless, I was able to learn about the position that I assume within a group; one of feeling anxious and trying to appease when aggression was expressed. This awareness helped me later when negotiating the politics of working within a team at placement.

One of my favourite concepts that I gleaned from my second year was Winnicott’s notion of ‘play’ in therapy (Winnicott, 1958). I liked the metaphor of children playing and the prospect of creating something new together. Similarly, there was also a sense of playfulness in supervision. My supervisor, a Kleinian psychotherapist, encouraged me to explore my fantasies and experiment with new ways of thinking and being, and this gave me great confidence and enjoyment.

The leap to CBT

During the third year I worked in an NHS primary care psychological therapies service. The service offered predominantly cognitive behavioural therapy (CBT) and the clients were seen between six to twelve sessions. I saw clients with a range of presenting concerns and also co-facilitated an eight-week group using CBT for depression.
Moving from a psychodynamic placement to a CBT way of working was difficult for me. I felt as though everything I had learnt about the transference and the importance of unconscious communication had to be boxed up and put away and I was reticent about leaving behind these tools. With a sense of trepidation, I armed myself with the worksheets and set forth into the realms of CBT.

To begin with, I think that the model tapped into a manic part of me that felt anxious to 'do' things, and I can remember writing a lot during sessions. Upon having this realisation, I decided to put down my pen and started to re-engage with my clients. This was a vital turning point in my work. By re-focussing on the relationship, the CBT was able to flow with much greater ease. For example, with one of my clients I noticed that once I had stopped note taking and engaged in continuous eye contact with her, she was much more open to exploring her thoughts and feelings in session.

I sometimes struggled with having to set goals and measurable outcomes. This was particularly challenging when working with clients with long histories of mental health problems, as it felt reductive to pick just one of many problems to concentrate on. Some of my concerns were allayed by being transparent with my clients and explaining about the principals of CBT and the nature of 'collaborative empiricism' (Beck, 1995). I was surprised that many of my clients welcomed the idea of a structured approach to therapy that offered coping strategies, especially those who had had previous types of exploratory therapy and felt that although they had increased insight, their symptoms remained unchanged. Research has shown that although there are clients for whom the cognitive approach may not be suited, there are many, perhaps the majority, for whom it will be (Hollon, Shelton & Loosen, 1991).

During both group and individual work, I came to value the nature of behavioural activation. Having experienced first hand the benefits of being active with my dancing, I liked the idea of increasing activities and rewarding
behaviour to lift my clients' moods. I also liked the idea of becoming more connected with one's body as a way of anchoring oneself in the present moment, an idea originating from Zen Buddhism. A secondary goal of such activation is that it has been found to decrease depressive rumination by having clients focus on other activities (Beck, Rush, Shaw & Emery, 1979). Reward planning and activity scheduling became pivotal in my work.

In the third year I started personal therapy with a Jungian analyst. I took pleasure in exploring my dreams with him and using symbolism to make sense of things. I enjoyed the differences working with a new therapist in a distinct modality and it reminded me that there are many different ways in which one can be a 'good enough' therapist. However, it was difficult at times to move between being an analytic client and a CBT therapist. It sometimes felt like I was switching modalities and being unfaithful to either one in the process. I dealt with this difficulty by talking with my supervisor and my therapist, who helped me to reconcile my dual-position. Having my needs met in personal therapy felt grounding, freeing me from my own introspections in session. As a result, I felt able to listen to my clients with an attitude of 'evenly suspended attention' (Freud, 1923, p. 239).

I learnt a great deal from the therapeutic encounters I had during my third year placement. One such encounter with Mr M presented me with a particularly useful insight. Mr M was a 54-year-old Pakistani man who had moved to England in the 80s. He worked as a taxi driver and had recently been the victim of a number of racist attacks while working. He was referred to the service with post-traumatic stress-like symptoms. During the course of our work I sometimes felt like I hadn't provided enough 'therapy' for Mr M, as our sessions were taken up with the immediate practicalities of ensuring his safety. I found myself adopting more of a liaison role in communication with Mr M's managers and the police.

Upon expressing concerns about my role to my supervisor, we explored the issues around providing Mr M with practical guidance, which on balance
seemed to be the most ethical path of action. This was a valuable experience as it served to remind me that politics are always present in the consultation room, and that the social context of a client’s life cannot be ignored.

Working at this placement helped me to develop my assessment skills and increased my confidence in making the most appropriate interventions for individual clients. My supervisor for this final placement was a counselling psychologist, which was most beneficial as it allowed us to speak in a shared language. I could talk candidly about my struggles in changing modality and what it meant to be joining a profession, and similarly, she was able to share her experiences with me. She instilled in me a sense of calmness, and a belief that things would be okay in the midst of a stressful final year at university.

An emergent identity

Now that I am nearing the end of the journey, I see myself as an integrative practitioner. I predominantly use psychodynamic theory to help understand the genesis of a client’s difficulties. I feel that it is imperative to use the Rogerian core conditions (Rogers, 1951) to foster a good therapeutic alliance, and I use various cbt techniques to help clients to manage better. Winnicott’s idea of play (Winnicott, 1958) is still a key element in my work, expressing itself as a curiosity and a willingness to try things out. When appropriate, I use humour as I have found it to be a useful facilitator in therapy; laughter, according to Borge, is the closest distance between two people (Borge, 1971). There is an expanding body of evidence that suggests that the quality of the therapeutic relationship is the most important factor in predicting the effectiveness of psychotherapy (e.g. Orlinsky, Grawe & Parkes, 1994). In light of this, I try to work using immediacy and focussing on the therapeutic relationship as much as I can.

I believe that an integrative perspective can offer the client a therapy that is broadly based and flexible. Some have argued against this and proposed that
an in-depth knowledge based on one theoretical model would provide therapists with a solid sense of identity (Spurling, 2002). I agree with Clarkson (2003) that no theory can claim to have all the answers about human existence and that a more holistic representation can only be reached by using different theories in a complementary manner. By developing useful skills from a wide repertoire of therapeutic frameworks, I hope to address each client's problem and work with each individual client more effectively. I see my development as progressive, and with time, personal experience and more training, I look forward to my approach maturing further.

Nearing the end of the course is both frightening and thrilling. I am excited to be entering the 'real world', but leaving the safety of university will be difficult. I anticipate that the skills that I have acquired over the past three years will equip me for the challenges that lie ahead, and I look forward to the future journeys and encounters that I will come across as a counselling psychologist.
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RESEARCH DOSSIER

Introduction to the research dossier

This dossier contains a literature review, one qualitative piece of research and one quantitative piece of research. The literature review offers a critical examination of the current theories pertaining to acculturation and the extent to which they provide suggestions to help those dealing with acculturative stress. The second paper is a qualitative piece of research that employed template analysis to explore therapists’ perceptions of ethnic minority clients. Finally the third paper is an empirical study investigating the likelihood of South Asian people to use various forms of support.

As highlighted in the statement of anonymity, all potential identifying information relating to research participants has been changed or omitted in order to protect confidentiality.
How can counselling psychologists better equip themselves to help those clients for whom acculturative stress is a predominant issue?

Abstract

This article explores the existing literature on acculturation and acculturative stress with the aim of helping counselling psychologists in their work with ethnic minority clients struggling with such issues. The two predominant models of acculturation are discussed and critiqued and existing studies are presented. The literature suggests that biculturalism is the most psychologically adaptive approach. However, neither of the two predominant models offers direct suggestions with regards to reducing acculturative stress. Tajfel and Turner (1986) propose a number of strategies for the individual who identifies with a low-status group. This paper proposes that the psychologist can utilise these strategies to better inform their practice and to meet their clients' needs.
Coping with cultural diversity is one of the major challenges facing individuals who seek counselling as well as those who provide those services (Coleman, 1995). The size of the ethnic minority population in the UK was 4.6 million in 2001 or 7.9% of the total population of the United Kingdom. Indians were the largest minority group (1.8%), followed by Pakistanis (1.3%), those of mixed ethnic backgrounds, Black Caribbeans, Black Africans and Bangladeshis (0.5%) (National Statistics, 2003). The remaining ethnic minority groups each accounted for less than 0.5% but together accounted for 1.4% of the UK population. In Great Britain, the ethnic minority population grew by 53% between 1991 and 2001, from 3.0 million in 1991. With a growing proportion of minority group members in the UK, explorations into methods of acculturation and ethnic identity formulation have become more prominent and necessary.

This literature review will address the question: how can counselling psychologists better equip themselves to help those clients for whom acculturative stress is a predominant issue? The literature on acculturation and acculturative stress is extensive. There is a vast array of material on stress and coping mechanisms (e.g. Lazarus & Folkman, 1984). However, given the sheer mass of information in this field and the word limit here, this review will restrict itself to exploring acculturative stress through the lens of the major theoretical standpoints on acculturation, with a view to finding solutions from within these models. The review will begin by looking at the concepts of acculturation and acculturative stress. It will explore the nature of acculturative stress and look into when it may occur. The paper will go on to explore the dominant model of acculturation proposed by John Berry and his colleagues (1989) and an alternative theory suggested by LaFromboise, Coleman and Gerton (1993). Through engagement with the literature, it will propose that LaFromboise et al.'s model offers a more realistic account of acculturation. However, neither theory proposes actual concepts or tools which might aid the individual who is experiencing acculturative stress. The review will then turn towards Social Identity Theory (Tajfel & Turner, 1986) which offers some theoretical guidance for the individual who identifies with a
low-status group and is therefore experiencing acculturative stress. The article will conclude with recommendations for counselling psychologists to help clients who are experiencing acculturative stress, and ideas for future research in this area.

**Acculturation**

In the classical definition of acculturation, the concept refers to “those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural pattern of either or both groups” (Redfield, Linton & Herskovits, 1936, p. 149). This definition encompasses the bi-directional nature of acculturation, in that changes can occur within both groups. Hence, acculturation is placed firmly in the realms of intergroup relations.

However, more recently, acculturation has been defined within a more individualised framework: “the extent to which individuals have maintained their culture of origin or adapted to the larger society” (Phinney, 1996, p. 921). Graves (1967) coined the term ‘psychological acculturation’ to refer to the changes that an individual experiences as a result of being in contact with other cultures, and as a result of participating in the process of acculturation that his or her ethnic group is undergoing. John Berry's definition (1980) encompasses both ideas, stating that acculturation refers to changes that groups and individuals undergo when they come into contact with another culture.

However, it is important to note the distinction between group-level acculturation and psychological acculturation. In terms of the group-level phenomena, acculturation can refer to a variety of changes such as economic, social, cultural and political transformations (Redfield et al., 1936). By contrast, at an individual level, acculturation can entail changes in behaviour, attitude and identity. Another reason for distinguishing between the two levels
is that not all acculturating individuals participate in the collective changes that are under way in their group in the same way, or to the same extent. Therefore, to understand the relationship between culture contact and psychological outcomes for individuals it will be necessary to look at changes at the population level and participation in these changes by individuals, and then relate both of these measures to the psychological consequences for the individual.

**Acculturative stress**

These changes can be minor or substantial, and range from being easily accomplished through to being a source of major cultural disruption for the individual. In addition to individual variance, acculturation may be more stressful for some ethnic groups compared to others (Berry & Kim, 1988), and it has been hypothesized that the greater the difference between the natal and the new culture (e.g. in language or religion), the higher the level of stress (Thomas, 1995). This concept has been termed cultural distance. When the cultural distance is great, behavioural changes pose a greater challenge since the amount of change required (of both groups, but more for the minority group) is greater (Padilla, 1980).

The concept of acculturative stress has been proposed to deal with the varied problematic aspects of acculturation (Berry, 1970). It is a response by people to life events that are rooted in intercultural contact. Frequently, these reactions might include heightened levels of depression (linked to cultural loss) and of anxiety (linked to how one should live in the new society). This notion is popularly known as 'culture shock' (Oberg, 1960), but acculturative stress is preferred for the following reasons.

Firstly, the term 'shock' implies that only difficulties will result from culture contact. However, the term 'stress' bases itself in the study of how people deal with negative experiences (stressors) by engaging in various coping strategies,
leading eventually to some form of adaptation (Lazarus & Folkman, 1984). Within this framework, people are seen as potentially able to deal effectively with stressors in their lives and to achieve a variety of outcomes ranging from very positive through to very negative. A second reason to favour the notion of 'acculturative stress' is that the source of the stress lies in the interaction between cultures (hence acculturative), rather than in one culture or the other.

Therefore, many people cope with acculturation and living with two or more cultures very well. For them, the process of adaptation may be fluid and they may find it advantageous; for example, acculturation may provide opportunities and enlightening experiences. However, for others acculturation may be a much more challenging and sometimes detrimental experience.

Some studies have found acculturative stress to be a strong predictor of psychiatric disorder in adolescents. A great deal of research has linked this phenomenon to suicide (Hoberman & Garfinkel, 1988), suicidal ideation (Hovey & King, 1996), conduct disorder (Apter, Bleich, Plutchik, Mendelsohn & Tyano, 1988), post-traumatic stress disorder (Bagheri, 1992) and anger and aggression (Myers et al., 1991). Aronowitz (1984) noted that among adult immigrants, early classic studies following the stress tradition reported strong associations between immigrant status and psychological disorders. However, more rigorous analysis has cast doubt on this association as several factors have been shown to moderate the relationship (Berry, 1997).

Acculturative stress has also been frequently linked with various social and psychological problems in children and adolescents including family conflict and disruption, identity confusion, psychosomatic complaints and antisocial behaviours (Nguyne, 1996). Liu (1995) found that a lack of interest in school, difficulty in concentrating, low academic functioning, truancy, school dropout, juvenile delinquency and youth gang activity were prevalent in communities with large Southeast Asian-American populations. Aronowitz (1984) noted that immigrant children under the age of fifteen manifested behavioural
problems, and in adolescents, problems of identity associated with symptoms of depression and anxiety were more common.

Other work has looked at the impact of acculturation on Native Americans. A 1990 report to the Senate Select Committee stated that Native Americans, particularly adolescents, have more serious mental health problems than are reported for all race populations in the United States (USA Office of Technology Assessment [OTA], 1990). The report lists problems such as developmental disabilities, depression, suicide, anxiety, alcohol and substance abuse, self-esteem and alienation, running away and dropping out of school as high priority areas. It has also been noted that Native American adolescents may be extremely susceptible to high stress levels engendered by the developmental task of identity establishment, in that they may feel “particularly caught between two cultures” (USA OTA, 1990, p. 1).

Differences in style and rate of acculturation between parents and their children have been identified as sources of conflict in immigrant families. Smart and Smart (1995) found that adolescent children of Hispanic immigrants acculturated more rapidly than older family members and that the intergenerational acculturation difference became the focus of conflicts that caused maladjustment in both parents and children. In families with the widest acculturation gaps, the highly acculturated youngsters tended to exhibit more antisocial behaviour and drug use than their less acculturated peers. By contrast, their mothers who acculturated at the slowest rate, tended to experience difficulty with child rearing, report serious parent-child conflicts, manifest neurotic syndromes, and abuse prescription drugs such as tranquillisers and sedatives.

the process of acculturation and change is stressful and disruptive and therefore a possible cause of developmental deviations and psychopathology.

In attempts to alleviate the sense of hopelessness and loss of identity engendered by acculturative stress, alcohol has become a primary and destructive coping mechanism for Native American people (Yates, 1987). Native Americans have higher rates of alcohol consumption than any other ethnic group in the United States (Weisner, Weibel-Orlando & Long, 1984).

**Berry's model of acculturation** (Berry, Kim, Power, Young & Bujaki, 1989)

Two distinct models have guided thinking about acculturation. One emphasises a linear bipolar model of acculturation, and the other proposes a two-dimensional model (Berry, 1997). In the linear model, ethnic identity is conceptualized along a continuum from strong ethnic ties at one extreme to strong mainstream ties at the other (Andujo, 1988). This approach implies that a strengthening of one requires a weakening of the other; that is, "increments of involvement in the....host society necessarily entail corresponding decrements of disengagement from the immigrant's traditional culture" (Rogler, Cortes & Malgady, 1991, p. 587).

A variation on this theme is represented bi-dimensionally whereby both the relationship with the traditional or ethnic culture and the relationship with the new or dominant culture are considered, and these two relationships may be independent. According to this view, minority group members can maintain involvement with their culture of origin and develop competence in a second culture (i.e. the mainstream culture), and a strong ethnic identity does not necessarily imply a weak relationship with the dominant culture, or vice versa.

This theory suggests that there are not only the two acculturative extremes of assimilation or pluralism, but four possible ways of dealing with ethnic group membership in a diverse society and the model was espoused by Berry et al. in
1989. This is currently the dominant model in the field of acculturation research.

Berry (1997) suggests the following two questions as a means of identifying strategies used by immigrants in dealing with acculturation:

1. Is it considered to be of value to maintain one’s cultural heritage?
2. Is it considered to be of value to have contact with and participate in the larger society?

Berry proposes that four acculturative strategies can be derived from answering “yes” or “no” to these questions. Individuals who see themselves as belonging exclusively to the majority group and not to the ethnic minority group have ‘assimilated’. Those who see themselves as belonging exclusively to the ethnic minority group and not to the majority group have adopted the ‘separation strategy’. Those who identify with both the ethnic minority and the majority group have assumed the ‘integrative strategy’. Finally, those who identify with neither group are ‘marginalised’ (Berry et al., 1989).

Berry’s original model failed to offer any explanation for the adoption of the four strategies. Some reflection of the societal aspects (e.g. differential size, power, rights and resources) involved in cultural relations would have been relevant as these factors have an important bearing on how individuals engage and consequently identify themselves. However, these factors are incorporated by Berry in his more recent formulations (e.g. Berry, 1997). In this revision, Berry looks at the orientations of the society of settlement and its members towards pluralism, and towards individual groups. Some societies take steps to support cultural diversity as a shared communal resource. This cultural pluralism promotes a positive multicultural ideology that corresponds to the integration strategy (Berry & Kalin, 1995). Other societies seek to reduce diversity through programs and policies of assimilation, while others attempt to marginalise diverse populations. Murphy (1965) argued that societies supportive of cultural pluralism are more likely to provide a positive
settlement environment for two reasons: firstly, they are less likely to enforce cultural change (i.e. assimilation) or exclusion (i.e. separation) on immigrants; and secondly, they are more likely to provide social support both from the institutions of wider society (for example, multicultural curricula in schools, culturally sensitive healthcare etc.) and from the evolving communities that make up plural societies. Therefore, in terms of minimising acculturative stress, the policies of larger society have a sizeable role.

Research assessing the acculturation strategies of various immigrant groups in North America has demonstrated that the integrative strategy (i.e. becoming bicultural) is the most psychologically adaptive pattern (Berry et al., 1989). The work of Berry and his colleagues showed that bicultural individuals experienced less acculturative stress and anxiety and manifested fewer psychological problems than those who were marginalized, separated or assimilated. This finding was replicated in the International Comparative Study of Ethnocultural Youth (ICSEY) (Berry, Phinney, Sam & Vedder, 2006). They found that the most strongly endorsed acculturation attitude among immigrant adolescents was integration, accounting for about one third of the individuals in their study. One quarter or fewer adolescents in the study showed any other single profile. They also found that those who had adopted the integrated stance had the highest scores for psychological and sociological adaptation, and those who had adopted the diffuse stance had the worst scores for adaptation.

Martinez (1987) looked at the effects of acculturation and racial identity on the self-esteem and psychological well-being of Puerto Rican college students living on the mainland. He found that bicultural involvement was the best predictor of esteem and well-being.

Smokowski and Bacallao (2007) looked at Latino adolescents living in North Carolina and found that perceived discrimination and parent-adolescent conflict were significant predictors of adolescent internalising problems and low-self esteem. They also found that biculturalism and familism were cultural
assets associated with fewer internalising problems and higher self-esteem. Torres and Rollock (2007) looked at acculturation and depression in Hispanic adults. Their results indicated that high acculturation and high intercultural competence were associated with fewer symptoms of depression. This pattern of biculturalism being the most adaptive strategy is so widely found in the literature (see review by Berry, 1997), that it has been proposed that it can plausibly form a basis for policy development supporting bicultural identities and multicultural institutions in plural societies (Berry, 2000).

Some research has found that parents’ level of acculturation has effects on family functioning and adolescent adjustment. For example, investigators have shown that adolescents whose immigrant parents did not adapt to the host culture (i.e. they preferred separation) had more psychological problems than did those adolescents whose parents were integrated or assimilated (Koplow & Messinger, 1990).

In terms of the assimilative strategy, Kerchoff and McCormick (1955) found that the greatest incidence of low self-esteem and negative emotional states among Ojibwa Indians occurred in those who were most inclined to identify with the majority group, but encountered a relatively impermeable barrier to assimilation with that group. Chance (1965) found that subjects who had relatively little contact with Western society but still strongly identified with that society, displayed more symptoms of personality maladjustment.

Fordham (1988) found that academically successful African-American students felt that they had to reject the values of the African-American community to succeed in school, that is, they felt they had to assimilate. Consequently, the students in her study were found to have substantial conflict in their social and academic roles. Those who chose to become “race-less” suffered more personal confusion and stress than those who maintained their African-American identity. By contrast, those who did not become race-less did not meet the standards imposed by the majority group. Therefore, social success in the African-American community was found to be associated
with academic failure, subsequently followed by economic failure. Therefore, the main bulk of research points towards the integrative strategy (i.e. biculturalism) being the most psychologically adaptive for the acculturating individual (Berry, 1997), and therefore the strategy least likely to produce acculturative stress.

Berry’s model of acculturation is fairly robust as it considers both the relationship with the ethnic culture and the relationship with the dominant culture and expresses that these two relationships may be independent. It asserts that strong ethnic identity does not necessarily imply a weak relationship with the dominant culture, and the findings seem to confirm that this is not an exclusive relationship.

This model offers a sound basis for exploration of the acculturation orientations. However, it has some drawbacks. Berry et al.’s use of fixed cultural categories and dichotomies is unhelpful and restrictive. The model assumes that cultures are independent and stable; however, it could be argued that they are ever evolving. This kind of essentialist approach to culture is picked up by Baumann (1996) who talks about the fact that individuals practice a number of different cultures at the same time. Baumann uses the example of ethnic, religious, regional and social class-related cultures and states that in today’s world different cultural cleavages do not run parallel to each other. Rather, they cut across one another to form an ever-changing pattern of ‘cross cultural cleavages’ (Baumann, 1996, p. 84). According to Baumann, cultures do not have a fixed geographical location and some recognition of the fluidity and changing nature of cultures would have been welcome in Berry et al.’s model.

In Berry’s use of the two questions (see page 10) to map out an individual’s acculturation strategy, he is making a conceptual leap. The first question pertains to what the individual does, and the second question pertains to who the individual has contact with. These are two entirely separate constructs. They may empirically correlate (for example, see Berry, 1997), but logically
they are different. In addition to this, there is also a third strand relating to identity. Hutnik (1986) collected data from Asian adolescents living in Birmingham and found evidence for the four strategies of self-categorisation (proposed by Berry et al. in 1989). However, the expected one-to-one relationship between strategies of self-categorisation and styles of cultural adaptation was not obtained. For example, her findings showed that it was possible for someone to think of themselves as Indian only and not British, but to be British in their food preferences, film choices, and dating patterns etc. Or vice versa, it was plausible for someone to think of themselves as British only and not Indian but to prefer an Indian style of life. Therefore, Hutnik's findings highlighted the disjunction between self-categorisation and cultural adaptation.

Preferences for different acculturation strategies have been measured using Likert-type scales in a number of studies, covering both participation and cultural maintenance items in various areas of life, for example, political participation, language use, religious practices, media usage, preferences in daily practices (e.g. dress, food etc.) and social relations (marriage partner, work, leisure time activities etc.) (Berry, Trimble & Olmedo, 1986). It has sometimes been difficult to distinguish between contact and participation measures on the one hand, and identity measures on the other; therefore this may have confounded some of the findings.

In the International Comparative Study of Ethnocultural Youth (Berry et al., 2006) the researchers found evidence that there were four acculturative strategies in operation. However, the reliability for the acculturation scales in the questionnaire relating to integration, separation and marginalisation were all below 0.6, which implies that there was considerable 'noise' in the measurement. This casts doubt over Berry and his colleagues' main claims.

The ICSEY data also claimed that integration was the most adaptive strategy and separation, the least adaptive (Berry et al., 2006). However, some researchers have indicated that integration is maladaptive, for example, that it
is "existentially inauthentic" (Rudmin, 2003, p. 18). Nash and Shaw (1963) argued that bicultural individuals have broad social competencies, but at the cost of inauthenticity and insecure self-identity. Glaser (1958, p. 34) argued that the bicultural person is marginalised and "may have guilt feelings and fears of discovery as a result of duplicity and inconsistency in identifying himself to others." Bochner (1982) suggested that biculturalism at an individual level could result in groups becoming split if the salient norms of the two cultures were incompatible. For example, in the case of religion; the dominant religions of Western society (i.e. Christianity, Islam and Judaism) are all mutually exclusive, and often hostile and therefore, incapable of bicultural integration.

Rogler et al. (1991) carried out a meta-analysis of thirty studies into the mental health and acculturation of Hispanics, and their findings were inconsistent. Twelve studies supported a positive relationship between acculturation and mental health, thirteen supported a negative relationship, three suggested a curvilinear relationship, and two produced both positive and negative effects.

With regards to separation, there is a temptation for psychologists to pathologise this strategy and to see it as somehow dysfunctional, and this may well be true. However, there has been very little empirical evidence to support this hypothesis. Instead, it might be that this category of people shuns the use of social identity components to define and describe themselves. Indeed, the marginal category may represent a kind of transcendence of self-limiting definitions or a greater identification with a more cosmopolitan or even global identity (Hutnik & Barrett, 2003).

Berry's work highlights the importance of a pluralistic society for the adaptation of individuals. However, even where cultural pluralism is promoted there are well-known variations in the relative acceptance of specific ethnic groups (Berry & Kalin, 1995), for example in the case of British Muslims. These groups who are less well accepted and are sometimes the objects of negative attitudes experience hostility, rejection and discrimination,
one factor that is predictive of poor long-term adaptation (Liebkind & Jasinskaja-Lahti, 2000).

Berry’s account offers little on the role of pre-existing attitudes in people. Attitudes, motives, values and abilities are all highly variable psychological characteristics of individuals and they are important factors that will impact on the individual’s acculturative strategy. Therefore, if the individual’s attitudes change, it is probable that their acculturative strategy could change and Berry’s model does not account for this. Over time, the minority group undergoes transformations and develops features that are not identical to those in the original group at the time of first contact. This would imply some form of parallel phenomena whereby individuals undergo psychological changes (as a result of influences from both their own changing group and from the dominant group) and with continuing contact, further psychological changes will take place.

Berry’s model seems to focus excessively on minority groups. This is most perplexing given definitions of acculturation, such as that of Redfield et al. (1936) that declare acculturation to be a two-way process of cultural change. Some reference to the mutual influence of cultures would have been welcomed, as majority members also acculturate in situations of intercultural contact. For example, in the UK the impact of Indian immigrants is such that their influence can be seen in everything from the generation of new styles of music to additions to the English dictionary (e.g. “chuddies”, meaning underpants). Alexander Chamberlain, the early acculturation theorist, argued that acculturative influences of the minority group on the dominant society should be acknowledged and documented both for the esteem of the minority and for the enlightenment of the majority (Rudmin, 1999).

Berry’s model seems to presume that the individual employs one acculturative strategy; however, it would seem that this is highly dependent on the context. For example, an individual at school where the dominant language is spoken
may well identify themselves differently to when they find themselves at home where another language is used.

The model does not allow for the possibility that a person is indifferent to one or both cultures. Also, there is no scope in the model for individuals who reject part of their cultural heritage, for example, sexism and also, reject part of the host society's values, for example, materialism, and are creative in evolving a new set of norms and values to suit their unique predicament (Ghuman, 2003). The rejection of two cultures may also imply preference for some other unspecified cultural option. This is highlighted by the following marginalisation items about USA-Turkish acculturation: “I prefer beliefs other than Islam or Christianity” and “Cuisine is better elsewhere than Turkey or the USA” (Rudmin & Ahmadzadeh, 2001, p.45).

Finally, Berry et al.'s model assumes that there are only two cultures in play. In an ethnically hyper-diverse city like London, this simply is not the case. Hundreds of different ethnocultural groups now live in close proximity to one another and therefore it is paramount in any model to consider the impact of multiple cultural groups living, evolving and acculturating together.

An alternative approach to acculturation (LaFromboise et al., 1993)

LaFromboise et al. (1993) proposed an interesting model, which, in their view, explains better the behaviour of individuals living in two or more cultural traditions. They suggest that there are more than four categories for the management of acculturation. LaFromboise and her colleagues found six ways that have been used to describe the process of second culture acquisition. These six descriptions represent different conceptualisations of what happens when individuals come into contact with people from a different culture. They argue that in addition to assimilation, separation and acculturation, there are strategies of fusion, integration and alternation, which are context dependent. In this model, acculturation is placed on a linear continuum with assimilation
at one pole, acculturation at some unspecified midway point and separation at
the other pole. This differs from Berry's (1970) use of the term 'acculturation'.
LaFromboise and her colleagues pointed out that the term 'acculturation' has
been used to describe both a particular strategy for coping with second culture
contact and the process for coping with second culture contact. Therefore, they
proposed that the phrase 'second culture acquisition' was used to describe the
process for coping, and that the term 'acculturation' was reserved for a way to
explain the process.

Three of the descriptions – assimilation, acculturation and separation – reflect
a traditional assumption (Stonequist, 1935) that the process of second culture
acquisition is essentially linear, that is, individuals either let go of their culture
of origin and join the second culture, or they remove themselves from contact
with the second culture. Therefore, according to this theory assimilation and
acculturation are very similar; a person who assimilates or acculturates is one
who attempts to join the dominant culture. However, the two models are
differentiated by the fact that the assimilation approach emphasises that
individuals, their children, or their cultural group will eventually become full
members of the dominant group's culture and lose identification with their
culture of origin. By contrast, the acculturation model implies that while the
individual will become a competent member of the dominant culture, they will
always be identified with their culture of origin. A person who separates is one
who withdraws from groups of people who are not members of his or her
culture of origin. The other three descriptions of second culture acquisition –
alternation, integration and fusion – represent a different conceptualisation of
the process. Each conceptualisation includes orthogonal dimensions
(LaFromboise et al., 1993) that represent a distinct behavioural pattern
operating independently of the other behavioural patterns. According to these
three models, it is possible to maintain contact with one's culture of origin and
become competent in a second culture.

The alternation conceptualisation (Ogbu & Matute-Bianchi, 1986) suggests
that it is possible to alternate between two cultures in the same way that
someone alternates between two languages in different contexts. The integration conceptualisation (Berry et al., 1989) assumes that it is possible to have individuals from different cultures coexist without compromising their cultural identities. The fusion conceptualisation (LaFromboise et al., 1993) assumes that individuals from different cultures who are in consistent contact with each other will eventually fuse to create a new culture that subsumes individuals' cultures of origin.

Coleman (1995) took this theory a stage further and argued that it is equally important to examine the contexts in which people employ various strategies to achieve specific goals, as it is to look at the kinds of strategies used. He hypothesised that the context in which the individual is operating and the aims the individual wants to achieve in that context will influence their choice of strategy. This model implies that individuals manage their behaviour in cross-cultural situations and foster what Ford (1992) called 'behavioural episode schemata'. This basically means that the individual will determine their goals in a given situation, and will employ a particular behavioural strategy they believe will help them to achieve these goals. Therefore, the strategy used will be influenced by the goals, the context in which the behaviour will be displayed, and the skills the individual possesses to use a particular strategy. He proposed that the strategy a person uses to cope with cultural difference will affect their performance in a particular context and therefore affect how they feel about themselves. Coleman (1995) also argued that the strategies may be organised sequentially rather than in a linear or orthogonal manner. Therefore he disputed the claim that the strategies are mutually exclusive. His results supported these hypotheses and he found that an individual may be able to use all the strategies at different times. Primarily, he found that the strategy an individual used was dependent on the context in which it was used. For example, an adolescent might use the assimilative strategy in the classroom, whereas they might use an integrative strategy in a social setting.
Similarly, Arends-Toth and van de Vijver (2003) argued that migrants often find themselves between two demanding groups; their own group and the majority group. These groups are not always compatible and to satisfy them both can be challenging. Therefore the researchers proposed the notion of domain-specific acculturative strategies. They found that Turkish-Dutch migrants preferred to integrate in public domains, and to separate in private domains of life (Arends-Toth & van de Vijver, 2003). This finding ties in with LaFromboise et al.'s (1993) work and the idea of alternating strategies.

Sodowsky and Carey (1988) looked at first generation Indians in America and they found that although the group as a whole reported a high level of proficiency in reading and speaking English, they preferred thinking in an Indian language (for example, Hindi or Urdu etc.). Many preferred Indian dress and food at home, but American dress and food outside of the home, and this finding also reinforces LaFromboise's idea of alternating.

Polgar (1960) studied the behaviour of three gangs of Mesquakie Native American boys in Iowa as they interacted with their own community and the surrounding Anglo-American community. Bilingual by age 7, the boys had alternative modes of expression available to them, dependent on the situation they were in. One of the gangs profiled in the study adapted to Anglo-American norms when they were in town, whereas they adapted to the roles expected of them by the traditional, political and religious leaders of the community when they were amongst the Mesquakie community, alternating their acculturation strategy dependent on context.

Gibson (1988) found that Sikhs in Sacramento, US were using the integration strategy in the economic domain and the separation strategy in the cultural and social domains. Similarly, Sapru (1999) who looked at Indian professionals in Geneva, Switzerland, found that at work they were fully integrated, whereas in the social and cultural life they were separate. This study also seems to exemplify the nature of switching acculturation strategies dependent on context, as proposed by LaFromboise et al. (1993).
In the International Comparative Study of Ethnocultural Youth the adolescents studied exhibited integration, assimilation and separation profiles; however, another group showed a diffuse profile (Berry et al., 2006). These adolescents endorsed three different acculturative attitudes simultaneously - assimilation, marginalisation and separation - and it could be argued that they were adapting their approach on the basis of the context in which they were functioning at the time, in accordance with the model proposed by LaFromboise et al. (1993).

Kazaleh (1986) studied the biculturalism and adjustment of Ramallah-American adolescents, and found that although identity conflict was present, many of the adolescents had adopted a variety of mechanisms for dealing with the dissonance, and they had become adept at alternating between the different cultures with minimal anxiety, which ties in with LaFromboise et al.'s (1993) idea of alternating.

Ramirez (1984) also alluded to the use of different coping, communication, human relational and problem-solving styles depending on the demands of the social context. Rashid (1984) looked at this type of biculturalism in African Americans and defined it as the ability to retain a sense of self and African ethnic identity whilst functioning within America's core institutions.

The notion of context-dependent behaviour can be related to code-switching theory found in the research on bilingualism. This approach implies that a person who can alternate their behaviour appropriate to the targeted culture will be less anxious than a person who is acculturating or assimilating (Saville-Troike, 1981). Furthermore, some researchers have hypothesised that individuals who are able to effectively alternate their use of culturally appropriate behaviour will have a better mental health status and exhibit higher cognitive functioning than people who are acculturated or assimilated (e.g. Rashid, 1984; Rogler et al., 1991).
With regards to the fusion model, Gleason (1979) argued that cultural pluralism will inevitably produce this kind of blending of cultures that share a common political unit. However, the psychological impact of this model is unclear because there are relatively few examples of such a new culture. That said, in the UK there are some very clear cases of fusion appearing, for example, in the music industry where Indian Bhangra and American rap and hip hop styles have melded to produce a hybrid of Indian rap.

Therefore, according to the literature, it would appear that the context in which an individual operates is hugely important in terms of which acculturative strategy they adopt. Given this, it would seem that the model put forward by LaFromboise et al. (1993) offers a more fine-grained, realistic account of what happens. The literature in this area seems to point toward the bicultural strategies as the more psychologically adaptive. However, ethnic minority and immigrant groups are not necessarily free to choose how to acculturate (Berry, 1974) as their experience depends largely on the conditions and hegemonic structures of larger society. The national society may impose certain restrictions, consciously or unconsciously, that constrain the choices an immigrant can make. In addition to this, it has been hypothesised that situational factors such as job circumstances are more important in acculturation processes than are internal attributes such as attitudes or personality and therefore choice (Seelye & Brewer, 1970).

There is now a sizeable literature on working with clients from ethnic minority groups. Researchers have mapped out cross-cultural counselling inventories (e.g. LaFromboise, Coleman and Hernandez, 1991) that outline the specific characteristics of a culturally skilled counsellor. Sue (2006) looked at a conceptual framework including the general areas of cultural awareness, cultural knowledge and cultural skills possessed by the therapist. While these competencies are important and necessary, they are relatively therapist-centred and do not offer any specific guidance for the ethnic minority client who may be struggling. Similarly, the two models of acculturation presented
thus far fail to offer suggestions for the individual dealing with acculturative stress.

Ford (1992) hypothesised that the individual determines their goals in a given situation and employs behavioural strategies to help them achieve these goals. He proposed that the strategy a person uses to cope with cultural difference will affect their performance in a particular context and therefore affect how they feel about themselves. Given this, a counselling psychologist could work with a client who is experiencing acculturative stress and look at the strategies that they are employing in different situations. Through a process of engagement and exploration, the client and therapist could begin to ascertain which strategies were the most stressful and which were the least stressful in different contexts. For example, a psychologist could be working with a client who had recently immigrated and was struggling to establish themselves in their new home. In this instance, it might be useful for the psychologist to explore the acculturation strategies their client currently used in different situations (e.g. at work, at home, and in social settings). From here they could make some steps towards understanding which strategies were most effective for the client in each area of their life. If the client took these insights and applied them, it might enable them to operate with more ease, hence reducing their acculturative stress.

However, given that the client might not always be able to change their strategies due to the hegemonic structures outlined earlier, and given that neither Berry's nor LaFromboise's theories present practical solutions to reduce acculturative stress, the psychologist would have to look further afield in order to help their client. With this in mind, Social Identity Theory (Tajfel & Turner, 1986) may offer some tangible suggestions.
Social Identity Theory and acculturative stress (Tajfel & Turner, 1986)

According to Social Identity Theory, ethnic identity is the ethnic component of social identity, as defined by Tajfel (1981): “that part of an individual’s self-concept which derives from his knowledge of his membership of a social group (or groups) together with the value and emotional significance attached to that membership” (p.255). Lewin (1948) asserted that individuals need a firm sense of group identification in order to maintain a sense of well-being, and according to this theory, simply being a member of a group provides individuals with a sense of belonging, which contributes to a positive self-concept. More recent developments in Social Identity Theory have led to Self-categorisation Theory (McGarty, 1999), which places the emphasis on categorisation processes and their importance in self-conception.

According to Tajfel (1978) ethnic minority groups present a special case of group identity and therefore self-concept. If the majority group views minority group characteristics adversely, then this may lead to the minority group developing a negative social identity. Tajfel (1978) distinguished between numerical and psychological minorities and defined the latter as a group that feels bound together by common traits that are held in low regard (Verkuyten, 2000). Therefore, this definition makes it possible to see, for example, the Black South Africans as a minority, and it strengthens the connection between the concept of minority and psychological states of uncertainty (Liebkind, 1992). Tajfel (1978) focused on the status and power differential between the majority and the minority group. He looked at the possible threat to social identity and the psychological consequences of being a member of the minority. Hogg, Abrams and Patel (1987) found that identifying with a low-status group may result in low self-regard.

Tajfel and Turner (1986) maintained that members of low-status groups may seek to improve their status a number of ways. This paper proposes that ethnic minority individuals who are affected by acculturative stress could adopt Tajfel and Turner’s approaches.
Individuals may seek to leave their group by “passing” as members of the dominant group, but this may have negative psychological repercussions (Tajfel, 1978). There are many examples of members of “inferior” groups distancing themselves physically or psychologically from their group (Brown, 2001). In this strategy known as ‘individual mobility’ the low status of one’s group is not changed. Instead, the individual dissociates from the lower-status group; therefore, this is a personal not a group solution. However, this strategy is not always possible, especially if the group boundaries are relatively fixed and impermeable (for example, if someone is visibly differentiated from one group then it may prove very difficult for them to join it).

Another solution might be for group members to seek positive distinctiveness and to develop a sense of pride in their own group (Cross, 1978). This strategy is known as ‘social creativity’ and it is a group rather than an individualistic phenomenon. This shares similarities with Breakwell’s (1986) strategies for coping with a threatened identity. Breakwell looks at language and posits that since individuals are motivated to feel good about their identities, the negative evaluation of one’s language, which can be associated with one’s identity, may create psychologically threatening situations. Breakwell (1986) notes that individuals might seek to deprecate the importance of aspects that pose a threat to the positive evaluation of one’s identity. There are various methods of exercising this kind of social creativity:

1. The group could reinterpret the characteristics deemed as “inferior” so that they no longer appear subordinate (Bourhis, Giles & Tajfel, 1973). The classic example is “Black is beautiful”. The dimension of skin colour, previously deemed negative was re-defined in the Black consciousness movement of the 1960s and is now perceived positively (Tajfel & Turner, 1986). In fact, this was so successful that Black artists in the music industry are now more marketable than ever, for example, Beyonce and 50 Cent. Verkuyten (2000) found that positive in-group evaluation, ethnic group awareness, and identification among ethnic group members are often the
reactions or responses to status differences, negative stereotyping, discrimination and racism.

2. People could compare the in-group to the out-group on some new dimension, that is, they could choose a characteristic on which the in-group comes out positively thereby creating in-group favouritism. For example, instead of comparing Black people to White on the basis of levels of employment or academic achievement, they could be compared in terms of athleticism, and sporting prowess. However, it is important to note that Black people are still relatively absent from politically powerful arenas. Given this disparity, an emphasis on excellence in sport can be problematic as it is reminiscent of the old fascination with the physicality of the ‘negro’ during the enslavement of Black people across America and Europe. Such constructions of Black people could serve to maintain old prejudices and could therefore be very damaging.

3. The out-group with which the in-group is compared could be changed; in particular, the high-status out-group could be avoided as a frame of reference. Tajfel and Turner (1986) hypothesized that where comparisons are not made with the high-status out-group, perceived inferiority is decreased and self-esteem should recover. For example, it was found that self-esteem was higher in blacks who made self-comparisons with other blacks rather than whites (Rosenberg & Simmons, 1972).

Finally, Tajfel and Turner (1986) proposed the principle of ‘social competition’. In this strategy group members may seek positive distinctiveness through direct competition with the out-group. Minority group members could improve their status by agitating for social and economic change and confront the dominant groups’ superiority (Brown, 2001). However, this may generate conflict and antagonism between dominant and subordinate groups as it focuses on the distribution of scarce resources (Tajfel & Turner, 1986). Alternatively, those in the low-status groups might seek to improve their reputation through self-promotion and re-education. For
example, there have been major drives in the last few decades to improve race-relations and increase representation of ethnic minority groups via community-led events, through teaching in schools and through the monitoring of equal opportunities in the workplace.

Thus, Social Identity Theory has some applicability for those who identify with a low-status group and are experiencing acculturative stress. The strategies for the re-conceptualisation of low-status groups provide specific guidance and practical tools for the individual to explore and consider. Therefore it is very relevant for a counselling psychologist to be accustomed with this theory and well versed on these strategies, i.e. individual mobility, social creativity and social competition to better help their clients.

To take a hypothetical example: a psychologist could be presented with a male client who was born in England to Black African parents. This individual might be experiencing difficulties in negotiating his identity as a Black, African, British man, and he may well be finding it difficult to create a coherent sense of self. He could be encountering racism, exclusion, stereotyping, or any number of things that might be causing him to experience acculturative stress. The principles from Social Identity Theory might help a client in this situation to alleviate some of his stress.

It might be difficult for the client to use individual mobility to "pass" (Tajfel & Turner, 1986) as a member of the dominant group, because his skin colour would differentiate him. However, given that it has been suggested that this strategy can have negative psychological consequences for the individual (Tajfel, 1978), it might not be an appropriate solution.

The client could be feeling marginalised due to racism. In this situation the psychologist might be able to support the client in using social creativity to help him develop pride in his ethnic group. Therefore, in session the therapist and client might explore ways in which 'negative' characteristics could be re-evaluated in a more positive light. If the client were able to develop pride in his
ethnic group, it might enable him integrate his ‘Blackness’ into his identity and this could provide him with a reinforced sense of confidence.

Alternatively, the psychologist might help the client to pursue social competition as a way of reducing the stress of acculturation. The therapist and client might inquire into possible ways in which the client could improve the reputation of his group, or indeed challenge the superiority of the dominant group. This could be a very potent therapeutic tool, helping to empower the client and helping him to re-assert his sense of worth.

These ideas are extrapolations from the theory and there is currently no empirical evidence to suggest that they would be effective in real-life settings. Therefore, further research is required in order to explore the utility of these strategies specifically in relation to the alleviation of acculturative stress. It might be valuable to examine the effects of each strategy on the acculturating individual to see which was the most successful and psychologically adaptive in each domain of their life. These findings could be used to help inform and develop therapeutic practice, and they could be integrated into the training of practitioners and trainees.

**Conclusion**

Every generation inherits a unique set of challenges. Today, the profession of counselling psychology faces a major challenge regarding how it will respond to the cultural, racial, and ethnic diversification of our contemporary society. This diversification is forging a new socio-political reality in which counselling psychologists will be called upon to work with very different types of client populations. These clients will present mental health professionals with unique developmental perspectives and personal concerns that are different from those presented by the individuals that most practitioners have typically been accustomed to serving in the past. Acculturative stress is likely to feature prominently. There is now a wealth of literature on the impact of acculturative
stress on the mental health of ethnic minorities, and counselling psychologists have a major role to play in terms of helping these client groups make a successful transition into the new culture.

This literature review has attempted to explore acculturative stress via the major models in acculturation. Berry et al.'s model (1989) provides a solid base from which to explore the process of acculturation but it misses some of the detail that the model by LaFromboise et al. (1993) picks up. These models suggest that biculturalism is the most psychologically adaptive approach. However, neither of these theories offer direct suggestions to reduce acculturative stress. Tajfel and Turner (1986) proposed a number of strategies for the individual who identifies with a low-status group. This article proposes that the psychologist can use these strategies to better inform their practice and to meet their clients' needs.
References


Appendices
Appendix 1:

Search results
Results of your search: acculturative stress.mp. [mp=title, abstract, full text, caption text]

<table>
<thead>
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<th>Viewing 1-10 of 191 Results</th>
<th>Your Recent Searches [+]</th>
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</table>

### 1. Liu, Freda F. 1,3; Goto, Sharon G. 2

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### 2. Lee, Richard M. 1,4; Noh, Chi-Young 2; Yoo, Hyung Chol 1; Doh, Hyun-Sim

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### 3. Torres, Lucas 1,2; Rollock, David

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### 4. Koinis-Mitchell, Daphne PhD 1; McQuaid, Elizabeth L. PhD 1; Selfer, Ronald PhD 1; Kopel, Sheryl J. MSc 1; Esteban, Cynthia MSN, MPH 1; Canino, Gloria PhD 2; Garcia-Coll, Cynthia PhD 1; Klein, Robert MD 1; Fritz, Gregory K. MD 1

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### 5. Spence, Richard; Wallisch, Lynn; Smith, Shanna

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1. Avis, Nancy E. PhD 1; Colvin, Alicia MPH 2 Disentangling cultural issues in quality of life data. Menopause. Publish Ahead of Print, POST ACCEPTANCE, 26 February 2007

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2. Habel, Laurel A. PhD 1; Capra, Angela M. MÁ 1; Oestreicher, Nina PhD 1; Greendale, Gail A. MD 2; Cauley, Jane A. PhD 3; Bromberger, Joyce PhD 3; Crandall, Carolyn J. MD 2; Gold, Ellen B. PhD 4; Modugno, Francesmary PhD 3; Salane, Martine PhD 5; Quesenberry, Charles PhD 1; Sternfeld, Barbara PhD 1 Mammographic density in a multiethnic cohort. Menopause. Publish Ahead of Print, POST ACCEPTANCE, 23 March 2007

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Appendix 2:

Notes regarding submission of articles to the Journal of Analyses of Social Issues and Public Policy
Content areas include, but are not limited to:

- Poverty and inequality
- Education
- Health
- the Environment
- Media influences on social issues
- Peace and conflict resolution
- Intergroup prejudice
- Increasing social awareness and activism

**Article Format:**

Papers should not be more than 40 ms pages including references. They must be submitted electronically either by themselves or as an attachment using Ascii, Rich Text, or Word Perfect format. Authors must contact the editor before sending an attachment and indicate the title of the attachment that will be sent. Submissions are free and every effort will be made to keep reviewing time at a minimum. In addition to their scholarly merit, manuscripts will be evaluated for their ability to communicate clearly their ideas to policy makers and the
general public as well as fellow social scientists.

Manuscripts will be sent electronically for review to nationally and internationally recognized scholars with expertise in the area. Their reviews will also be sent to authors electronically. Articles will be published in a timely manner as soon as they are accepted. At that time, the author will be requested to send a disk with the accepted manuscript in either WORD or WordPerfect so that articles can be converted to a PDF file. All peer-reviewed articles will also appear in a print edition of ASAP at the end of each calendar year.

Manuscripts should be in the style of the American Psychological Association.

Authors may send brief (no more than two pages) preliminary proposals to the editor of ASAP. Proposals should be sent to: Geoff Maruyama at geoff@umn.edu.

The ASAP book review section includes reviews of recently published books and other media which are likely to be of interest to SPSSI members and the broader community of behavioral and social scientists concerned with policy issues. Reviews include thematic essays, typically incorporating discussion of several books, as well as reviews of single volumes. Publishers should submit copies of books for review consideration to

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Kevin Lanning
ASAP Book Review Editor
Honors College of Florida Atl Univ
5353 Parkside Drive
Jupiter, FL 33458.

Readers are invited to submit brief comments on reviews; these should be sent via email to lanning@fau.edu. Though all reviews are written by invitation, readers interested in reviewing books on particular topics are encouraged to contact the book review editor, preferably via email, at the address given above.

Guidelines for Book Reviews

Reviews should include a description of the goals of the work(s) under review and an assessment of the adequacy with which those goals have been met. The intended audience and, if different, the appropriate audience should be noted. The review should pay particular attention to the relevance of the work(s) to the SPSSI membership.

Reviewers are encouraged to be frank, recognizing limitations as well as strengths of the works under review. Reviews should stand on their own as informative essays, should avoid technical jargon and acronyms, and should be intelligible and coherent to the broad base of psychologists, social scientists, and policy makers that make up ASAP’s intended readership. Finally, reviews should be timely.

The typical review of a single work (book, monograph, etc.) will be between 400 and 1,000 words. Thematic reviews of multiple works may be substantially longer.

Reviews should be preceded by the appropriate bibliographic information, i.e., author(s), title, publisher, year, ISBN and retail price. Following the review, authors should include a self-description, typically no more than 30 words in length. Authors must also include an email address to be published with the review.
Description of Point/Counterpoint

Point/Counterpoint is devoted to discussion and critical commentary about issues and articles published by ASAP and other SPSS! publications such as the *Journal of Social Issues*. Our goal is to take advantage of the interactive capacity of electronic publishing to engage authors and readers. Although Point/Counterpoint commentaries may include personal opinions, authors are expected to support their position with reference to social science theory and empirical research. Commentaries will be reviewed for scholarly content and importance, not for their support or refutation of particular social viewpoints. The published remarks do not necessarily represent the views of either ASAP or SPSS! as a whole.

Guidelines for Point/Counterpoint Submissions

State the target articles' argument as you understand it. Use tact to formulate a reply so that it does not cast a negative light on the competency of the author(s) of the target article. Avoid ad hominem attacks and emotional language. Offer constructive criticism that advances the debate, by for example, showing how the argument in the target article fairs in the context of new insights. Aim to amend, elaborate, clarify and expand the discussion raised by the target article. Deal with the issues in a general way that informs and educates the reader and focus on implications for a whole field rather than on small issues that matter to only a few specialists in a narrow area. Be brief - a reply should be less than half the length of the target article.

Appendix 3:

*Personal reflections*
Personal reflections

My interest in matters of race, ethnicity and acculturation stems from a number of factors, which are invariably interlinked. From a personal perspective, I am a British-born female of Asian origin. Both of my parents are Bangladeshi and they moved to London in the 1960s. Their experiences during this period, being some of the first Bangladeshis to settle in the UK, made me aware from an early age of the differences between people within society. I will never forget the story of my mother, a rarity in 1970s London, being a female Bangladeshi teacher in a predominantly White secondary school in Tower Hamlets. She came home from school one day upset, having had a board brush thrown at her head by one of her students who had called her a “paki”. One of the reasons this story stood out for me is because it was such a shock at the time, and I can remember my disbelief and sheer bewilderment as to why this had happened. Experiences like this have brought into my awareness some of the racism and inequality that are still present in our society today. Through my own musings, I have gone on to speculate about how things might have been for my parents moving to England and their acculturation processes, as well as my own process negotiating my identity as a young Bangladeshi woman living in London.

Another strand of my curiosity in this field comes from my interest in politics. I used to work for Oona King, one time M.P. for Bethnal Green and Bow constituency. This area of London comprises a large Bangladeshi population and my conversations with the constituents, Bangladeshi and Caucasian alike, gave me a fascinating insight into the interface between these cultures and how these relations affect the community.

My final interest in this area is fuelled by a professional wish to help those groups of people who are hard to reach. The profession of counselling psychology is one that espouses inclusion and I am keen to explore how its breadth can be widened to serve those who are currently outside of its reach.
Given these overlapping strands, I enthusiastically started to search for literature in the area of acculturation and acculturative stress. The first model I came across was Berry's perspective on acculturation (Berry et al., 1989). Upon initial acquaintance with this model I was thoroughly impressed and convinced that it offered a robust explanation of the process at stake. However, the more I read and the more time I spent reflecting on the literature, the more I became aware of the complexities involved. This pattern was a recurrent one for me, slowly becoming more familiar with the literature and finding more factors and twists and turns as I went along.

I sometimes engaged in this process with great interest, pondering on the findings from different studies and wondering how they related to me and my process of acculturation. I reflected on my childhood and the choices my parents had made in my upbringing, for example, they encouraged me to pursue both Ballet and Classical Indian dance, and to speak both English and Bengali. This was enlightening and enabled me to place this information into some kind of meaningful framework. However, other times I found the entire process overwhelming. I would sometimes find myself utterly confused by the contradictory findings or the sheer mass of literature in the field. These times were incredibly frustrating for me. I dealt with the frustration by sharing my thoughts with my supervisor. It was a relief to be able to vent my aggravation in an environment where I would not be judged for doing so. Also, it was often the case that these conversations with my supervisor would prove the most fruitful in terms of challenging pre-existing ways of thinking and exploring new avenues.

Given the relevance of this area of research to me and my background, it is difficult to assess whether I have presented the literature fairly, although my personal motivation has always been to find some kind of 'solution' with regards to helping those experiencing acculturative stress. I still feel motivated to help ethnic minority individuals with acculturative stress as well as other difficulties they may be facing.
Through immersing myself in this subject, I have reflected on some of the difficulties my parents and their peers must have faced during their move to this country. This has driven me throughout the process of writing the review, and I feel committed to furthering this exploration.
A qualitative exploration of therapists' perceptions of ethnic minority clients

Abstract

This paper examines the way in which a sample of therapists working in Britain conceptualise ethnic minority clients. Nine respondents were interviewed using a semi-structured schedule in order to explore their views on four hypothetical ethnic minority clients. Each of the clients embodied a different acculturation strategy and participants were asked to comment on their perceptions of the issues facing the clients. The results suggest that therapists use a dichotomous mapping of cultural issues versus universal issues in order to structure their thinking around ethnic minority clients. It is argued that the fourfold model of acculturation, which is the currently dominant model of acculturation within social psychology, fails to provide a helpful framework for representing how therapists deal with these issues in practice. Implications for therapeutic practice and training are discussed.

Short title: Therapists' views on ethnic minority clients

Key words: ethnic minority, ethnic identity, therapist views, acculturation, acculturative stress, difference
In Great Britain, the size of the ethnic minority population has grown by 53% in ten years, between 1991 and 2001 (National Statistics, 2003). Forecasts based on the current population growth rate figures put the non-White ethnic minority population in 2011 at between 6 and 7 million people, representing 11–12% of the projected population of Great Britain (National Statistics, 2003). With a growing proportion of minority group members in the UK, exploration into acculturation and ethnic identity formulation have become more prominent and necessary.

Studies have shown that stress resulting from acculturation may involve lowered mental health status (e.g. depression, increased anxiety, apathy), feelings of alienation and marginality and identity confusion (e.g. Berry, 1990). Many studies have looked at the way that ethnic minority individuals position themselves in relationship to the larger society in which they live (e.g. Berry, Phinney, Sam & Vedder, 2006). Much of this research has focused on the fourfold model of acculturation as proposed by Berry and his colleagues (Berry, Kim, Power, Young & Bujaki, 1989).

This model suggests that ethnic minority individuals are faced with two principal questions: to what extent do they wish to retain the values, practices and beliefs of their own minority ethnic culture and to what extent do they wish to have contact with people who belong to the majority national culture? It is proposed that the way an individual responds to these two questions yields a fourfold classification of acculturation attitudes: integration (where the individual wishes to maintain aspects of the ethnic culture but also to have contact with the national culture), separation (where the individual values the ethnic culture and wishes to avoid contact with the national culture), assimilation (where the individual does not wish to maintain the ethnic culture and instead only wishes to have involvement with the national culture) and marginalisation (where the individual has little interest in either the minority culture or contact with the national culture) (Berry et al., 1989). Berry et al. (2006) further argue that cultural identities are conceptually distinct from acculturation attitudes. Much of the
existing research conducted within this paradigm suggests that integration attitudes are often associated with the most positive levels of psychological and sociocultural adaptation (for detailed reviews of this extensive literature, see Berry et al. 2006 and Liebkind, 2001).

Berry's model of acculturation is fairly robust as it considers both the relationship with the dominant culture and the relationship with the ethnic culture and holds that these two relationships may be independent. The model offers a sound basis for exploration of the acculturation orientations. However, it has certain limitations.

Firstly, Berry et al.'s use of fixed cultural categories and dichotomies is restrictive and unhelpful. The model assumes that cultures are independent and stable. However, it could be argued that they are ever-evolving.

Secondly, it has been found that minority individuals can adopt different acculturation attitudes to different life domains. For example, there is a fundamental distinction between private (i.e., within the home) and public (i.e., outside the home) domains. Attitudes often vary between these two domains with, for example, a separatist approach being preferred within private domains (e.g., in child-rearing and religious matters) but an integrative approach being preferred in public domains (e.g., in the contexts of employment and extra-familial friendships) (Arends-Toth & Van de Vijver, 2003; Ghuman, 2003). These findings are supported by ethnographic and discursive studies (e.g., Alexander, 1996; Baumann, 1996; Tate, 2005) which have revealed that minority individuals commonly express fluid, multifaceted and context-dependent patterns of attitudes and identifications (rather than stable invariant patterns), constantly repositioning themselves in relationship to their own and other cultures according to the particular context and their own needs.
Thirdly, the fourfold model fails to distinguish between different forms of biculturalism such as integration (where both cultures are simultaneously affirmed and maintained), alternation (where the two cultures are alternated according to context) and fusion (where the two cultures are blended to form a novel hybrid culture) (LaFromboise, Coleman & Gerton, 1993; Rudmin, 2003). In the International Comparative Study of Ethnocultural Youth, the adolescents studied exhibited integration, assimilation and separation profiles; however, another group showed a diffuse profile (Berry et al., 2006). These adolescents endorsed three different acculturative attitudes – assimilation, marginalisation and separation - and it could be argued that they were changing their behaviour on the basis of the context in which they were functioning at the time, in accordance with the model proposed by LaFromboise et al. (1993).

Finally, Berry et al.’s model assumes that there are only two cultures in play. In a city such as London, this simply is not the case. Hundreds of diverse ethnic groups now live in close proximity to one another and therefore it is paramount in any model to consider the impact of multiple cultural groups living, evolving and acculturating together. Therefore, it is arguable that the fourfold model imposes a rigid conceptual framework onto minority individuals, which does not provide a good description of the actual attitudes, identifications and positionings of these individuals themselves.

Research and clinical literature on the delivery of mental health services to ethnic minority populations has been consistent in drawing attention to inadequacies in the provision of services (Sue & Zane, 1987). Researchers have highlighted the negative impacts of racism on ethnic minority clients and the importance of acknowledging it in the therapeutic work (Clark, Anderson, Clark & Williams, 1999). However, Kareem (1992) asserts that White therapists will find it easy to dismiss racism as it has not happened to them and it is beyond their internal and external experience. Bhugra and Bhui (1998) describe that this kind of insensitive therapeutic encounter may be experienced by the client as a repetition of racial
oppression and its accompanying power dynamics. Therefore, the under­
acknowledgment of racism in therapy could potentially exacerbate problems for
ethnic minority clients.

In a bid to improve services, there have been various studies looking at cultural
competency in the delivery of mental health services (e.g. Sue, 2006). Sue looked
at a conceptual framework including the general areas of cultural awareness,
cultural knowledge and cultural skills possessed by the therapist. However, he
found that one of the greatest problems facing the cultural competency
movement was to progress from a philosophical definition to a practice-oriented
one.

By interviewing a sample of therapists working in Britain, this paper seeks to
move to a more practice-oriented position. It aims to explore how therapists
conceptualise ethnic minority clients and implicitly seeks to unpack their thinking
surrounding the four acculturation attitudes (outlined by Berry et al., 1989). By
structuring the interview around Berry's fourfold model, this research will look at
the extent to which therapists use the existing frameworks to make sense of these
clients or whether they use something else altogether.

Method

Design

A qualitative approach was chosen to gain access to a fine-grained account of the
participant's current conceptualisations. By using interviews, it was hoped to
allow the participant to tell their own story in a meaningful way. However, the
fact that the interview and vignettes were designed around Berry's fourfold model
moves the study away from a purely phenomenological stance to a position of
critical realism.
Participants

This study had a sample of nine therapists (five female, four male), three of whom were from Black and minority ethnic groups. Inclusion criteria were that participants were aged between 20 and 60 years as it was felt that this would provide a good breadth of scope across ages. They were qualified therapists who had been practising for at least two years to ensure that they had a good base of experience from which to draw upon during the interview (see Appendix H). Participants were recruited by emailing an information sheet (see Appendix E) to therapists listed in the British Association for Counselling and Psychotherapy directory. Positive respondents were then contacted and interviews were arranged to be conducted at a venue of each participant’s choosing. Upon meeting the potential participant, the information sheet was recapped and any queries were dealt with. No mention was made of Berry’s acculturation styles so as not to cue the participant to respond in a particular way.

Interviews

The semi-structured interview schedule (see Appendix C) was developed from Chakraborty’s (2007) literature review and the questions revolved around 4 hypothetical clients outlined in 4 vignettes.

A vignette is a short description of a situation or person in a specified context and can thus be used to manipulate contextual variables experimentally. Finch (1987) described the value of vignettes in allowing the researcher to gather normative data with regards to beliefs and moral issues by eliciting context-related responses to hypothetical situations. He argued that owing to the hypothetical nature of vignettes, the participant may feel less threatened answering questions pertaining to their own experiences and beliefs, which is particularly helpful when
researching a sensitive topic like ethnicity. Indeed vignettes have been used successfully in other studies where ethnicity has been the variable being manipulated (Lewis, Croft-Jeffreys & David, 1990). Following Lewis et al.'s (1990) methodology, the amount of information included in the vignette was deliberately restricted in order to encourage participants to draw on their pre-existing perceptions.

The vignettes used in this study were based around Berry's fourfold model of acculturation (Berry et al., 1989). Each of the four hypothetical clients comes from a South Asian background and they are all either first or second generation immigrants living in Britain. They each embody one of the four acculturation strategies and the styles are conveyed via reference to some of the acculturation behaviours laid out in the ICSEY (Berry et al., 2006), for example, ethnic language proficiency, ethnic peer contacts and national peer contacts.

In brief, 'Anwar' is a depressed, 28 year old, Pakistani, Muslim man. He had an arranged marriage and feels unable to talk to his wife. He is an only child and had a good relationship with his parents and he feels some pressure to succeed.

'Jake' is a depressed, 20 year old, Indian student. He had a restricted childhood and since he left home to go to university, he has had no contact with his parents. He describes his friends as his 'real family' and goes out with them clubbing and to the pub.

'Meera' is a depressed, 43 year old, Indian woman. She recently split up from her English husband, and now lives alone with their two children. She depicts a happy childhood with 'liberal' parents.

'Monica' is a 39 year old, Bangladeshi woman who suffers from panic attacks. Her parents are both dead and she has isolated herself from her sisters. She grew up in Norfolk and was bullied at school. She had one serious relationship, which
ended twelve years ago, and although she is isolated from her family, she has made friends through joining green groups.

Once crafted, the vignettes and the interview schedule were piloted on a key informant, who was an educational professional living and working in Tower Hamlets. Tower Hamlets is an area of London that is densely populated by South Asian immigrants. Therefore the key informant, with years of experience teaching and working with these groups was expertly placed to comment. With his suggestions and feedback, final adjustments were made.

The interview process involved looking at each vignette and answering questions pertaining to each one in turn until all four vignettes had been seen. Questions were asked which explored the participant’s sense of the issues affecting each hypothetical client and whether they deemed the client’s issues inherently different from those a White British person might face. Once all vignettes had been discussed, the participants answered another set of questions comparing the clients with one another. These questions set out to investigate which of the clients they deemed to have the greatest potential for healthy well-being and which they deemed to have the least, and why.

Each interview lasted between 1 hour and 1 hour and 45 minutes, and they were digitally recorded and transcribed orthographically. It was decided that longer pauses would be expressed in the transcription of the interviews in accordance with previous interview data analysed using Template Analysis (see King, 1998). Pseudonyms were attached to each interview transcript (see Appendix I). Ethical approval was granted by the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey (see Appendix D).
Analytic strategy

The interview transcripts were analysed using Template Analysis as developed by King (1998). Template analysis was considered an appropriate method of analysis as it allowed the researcher to assume the epistemological position of critical realism (Bhaskar, 1989). Unlike other qualitative methods (such as interpretative phenomenological analysis and grounded theory), it allowed the researcher to make active and explicit use of existing research and theory in analysing data from an early stage. However, these materials were tested against the data and, in light of this, were retained, revised or rejected. Given that influential theory and much previous research had been conducted that was relevant to the topic, it made sense to choose a method of analysis that would allow these materials to be used in a critical way without overwhelming the data.

The methodology involved the construction of a coding template that comprised codes that represented themes identified in the data through careful reading and rereading of the text. Codes were organized hierarchically so that the highest codes represented broad themes in the data, with lower levels indexing more narrowly focused themes within these themes. It is important to note that codes were specified not only for themes found in most or all transcripts but also for those that were salient in only a small minority of transcripts. The list of codes was modified through successive readings of the texts until the researcher decided that she had achieved as full a description of the data as was feasible without reaching the state at which description was so finely detailed that any attempt to draw together an interpretation became impossible.

With regards to evaluating the research, Elliott, Fischer and Rennie's (1999) six qualitative research guidelines were referred to throughout the research process to ensure its robustness. Elliott et al. (1999) emphasised the value of transparency regarding the researcher's own theoretical orientations and personal
anticipations about the research question. Despite efforts to be self-aware and vigilant, inevitably analysis will draw to some extent on the researcher's own views and interpretative framework (see Appendix A).

In this paper, interpretations are supported by extracts from the raw data with the aim of allowing readers themselves to assess the persuasiveness of the analysis. In these quotations ellipsis points (...) indicate where words or a passage have been omitted from the original quotations.

**Analysis**

Three loosely-defined top level themes emerged from the data: cultural issues, universal issues and therapy. The relative complexity and variety of responses meant that these themes could be broken down into three levels of coding with various sub-themes (see table 1).
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<td>- Problems of belonging</td>
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<td>- Feeling disconnected</td>
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<td>- Racism</td>
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<td>ethnic minority individuals</td>
<td>- Rejection of ethnic culture</td>
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<td>- The importance of questioning your culture</td>
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<td>- Pretending to be English</td>
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<td>- Fear of losing ethnic identity</td>
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<td>- Fear of becoming too westernised</td>
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<td>- All experience the same phenomena irrespective of culture</td>
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<td></td>
<td>- All individuals contending with difficulties</td>
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<td>- Teenage Rebellion</td>
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<td>- Having children</td>
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<td>- Restrictive parenting</td>
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<td>Client self-questioning</td>
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<td>THERAPY</td>
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| Difference between therapist and client | - Attempting to ignore race  
- Working beyond the difference  
- Similar experiences |
| Therapist awareness of culture | - Holding an awareness  
- Bringing culture into the consultation room  
- Over-simplifying the issues |
| Westernised slant to therapy | - White middle-classed profession |
| Working alliance between therapist and client | - Trust  
- Assumptions  
- Betrayal to talk to a therapist |
| Language in therapy | - Other peoples' definitions  
- Expressing discomfort outside of your language  
- Use of language |
| Training therapists | - Studying culture on training courses |

With regards to cultural issues, 2nd level themes included the problems that come with being different from the majority group, and how conflicts can emerge when people are attempting to live within different cultures. Another theme at this level looked at discrimination towards ethnic minority groups and how this can impact on the functioning of the individual. In another 2nd level theme, participants homed in on certain acculturation behaviours that were being adopted by the clients and there was a real diversity of opinion regarding these approaches. There was a 2nd level theme regarding expectation within certain ethnic groups and how it might cause the individual to feel overly pressurised. Also, when some respondents were talking about the clients, they made certain attributions based on the client’s race or ethnicity, therefore a 2nd level theme was constructed to account for these processes.
With regards to universal issues, 2nd level themes related to the commonalities across human experience. There were themes at this level concerning the clients’ emotions and histories, focusing on relational elements and levels of support. One theme at this level focussed on the losses experienced by the clients, whereas another concentrated on the intricacies of their upbringing. Importance was given to the client’s life stage and another 2nd level theme was devoted to the client’s current situation and how that might be perpetuating their difficulties. Some participants felt that it was important to acknowledge the existential questions that had arisen for the clients, and this comprised the final 2nd level theme in this cluster.

With regards to issues around therapy, one of the 2nd level themes concerned the similarities and differences between therapist and client and how they might impact on the quality of the therapy. Another sub-theme stressed the importance of being alert and aware of cultural issues when working with ethnic minority clients. There was some mention of the traditionally Westernised slant of modern-day therapy and how this fits with different cultural groups. There was a 2nd level theme regarding the nature of the working alliance and the various processes that occur during therapy. These respondents felt that it would be necessary to pay close attention to the processes in order to best help the client. Some participants raised the issue of language and its complexities. They proposed that language could conceivably act as a barrier for the ethnic minority client who is seeking help. The final sub-theme was to do with the value of training therapists to work with different cultural groups.

Owing to space limitations and as this report is particularly interested in the way therapists think about their ethnic minority clients, this article will be mainly focussing on the theme of cultural issues. It will touch upon the theme of universal issues, as this is also relevant. However, given the abundance of literature on the effects of issues such as affect, support, loss, childhood
development and life stage on the psychological functioning of individuals, these 2nd level themes will not be expanded. The final top-level theme of therapy has also received a lot of attention in academic circles, for example, Abreu, Chung and Atkinson (2000) looked at multicultural training courses for therapists, and Flaskerud (1991) has explored differences between therapist and client, therefore this theme will not be elaborated upon.

Cultural issues

This top level theme was present in all of the interviews in various guises. Participants talked about the impact of cultural matters on the lives of the ethnic minority clients and this idea seemed to be counter-balanced by the proposal that universal issues were of greater importance.

Being different from the majority

The participants frequently brought in this 2nd level theme. They talked about the potential difficulties that could arise for the clients as a result of them being different from the majority group. Here, John invokes race and the concept of Whiteness:

"There is certainly a normative value with being White and other. White is the standard. It is a White world. It's a White country. There is a normality with being White and everybody else is kind of tinged or coloured. So there is that which will create a difference, historically, empire, contemporary, how the other is viewed in society today. So there is an inherent power-structure imbalance embedded in that phenomenon to start off with."

John is emphasising the idea of Whiteness as racially normative, therefore any other race is socially evaluated as a departure from that and he is drawing
attention to the imbalance in power and privilege associated with that position. John brings in race and places it within a wider system of meaning. His references to history and empire highlight the hegemonic structures that encircle the concept of race and allude to its social construction. Also, perhaps John is drawing from his own first-hand experience of being a Black Afro-Caribbean man living in Britain and experiencing White as ‘the norm’.

Other participants talked about the changing ethnic landscape in the UK and how this affects people’s attitudes.

“How they talk about Polish people coming into the country now, it used to be that Afro-Caribbeans weren’t acceptable but now they’re taken for granted; they’ve been here so long. And then Asian people came in, and then that’s alright but with the added ‘as long as they’re not Muslims’ because of Islam and terrorism and stuff.” (Jane)

Here, Jane is describing the shift in immigration patterns in the UK. She is inferring that the longer the ethnic group has been settled in the UK, the more the majority will accept them. She then brings in the added dimension of religion, in particular Islam, implying that it is not okay to be a Muslim in the UK because of the negative connotations surrounding the terrorist attacks in the West and Islamophobia. In Jane’s commentary, there is a sense that there will always be ill-feeling directed towards immigrant populations, but that the target will change as the immigrant group establishes themselves in the UK.

Participants also talked about the differences between living in a multicultural society and living in a society with only a handful of different cultures.

“But you’ve got people from Bangladesh plonked in Norfolk, which isn’t known for being multiracial and even if it is pleasant it’s still patronising ‘we’re letting you into our community’ (...) Also coming from Bangladesh
Here, Jane is talking about Monica's family and her upbringing. She states that they were 'plonked' in Norfolk, as though they were placed without due care and attention in an area lacking in racial diversity. She explains that there may have been an in-group mentality within the Norfolk community, which could have led to some superior or belittling attitudes towards Monica's family. Jane goes on to talk about the difference between emigrating from Bangladesh now, compared to emigrating four decades ago. Perhaps she is referring to the significant growth in the UK Bangladeshi population since 1991 (National Statistics, 2003) and how this increased figure may have affected the dynamics for future émigrés.

**Conflicting cultures for the ethnic minority individual**

This 2nd level theme was prominent in the interviews and participants approached it from different angles.

"...growing up within two different cultures and perhaps them not merging very well (...) perhaps he's feeling he may have to choose between the two, if they're in conflict with his lifestyle (...) he may be feeling torn in every direction and so his depression is sort of like you don't know which way to move." (Fern)

Fern is talking about Anwar and the fact that he is a Pakistani man who grew up in England. She speculates that there may have been some dissonance for Anwar between Pakistani and British culture and that this discord may have led to him feeling divided. Fern's use of words like 'torn' and 'conflict' imply the level of pain that living in this situation may cause and she goes on to say that Anwar's depression may have been triggered by this struggle. This kind of discourse is very similar to Park's concept of 'the marginal man' (1928). Park introduced this concept to describe the experiences of mixed-race individuals. He described the
predicament of those ‘predestined to live in two cultures and two worlds’, and stated that the marginal man was ‘condemned by fate to live in two antagonistic cultures’ (Park, 1928, p. 881). This approach seems to pathologise the ethnic minority person and their acculturation style.

Some participants talked about the difficulties of belonging. Here, Ling draws from her experience of ethnic minority clients who feel more affiliated with their parents’ birthplace than their own.

“'And some clients even say that when they retire, they will return to their homelands - where their parents came from, which is not the place where they were born and brought up. This is quite surprising for me, in a way, because you can see how much that they feel like they don't belong here and how different they feel in the country in which they were born and brought up.”

Ling is somewhat taken aback by the strong feelings of those clients who feel like they don’t belong in the country in which they were born. She states that some clients wish to migrate to their parents’ homelands and that this is an indication of the extent of their unease in their birthplace. Perhaps Ling’s level of surprise can be related to her own feelings of where she would like to live as she nears retirement age, given her ethnicity. Although Ling is a Chinese woman, perhaps she has committed herself to her new home in the UK, therefore the idea of returning to live in China could be discordant with her own feelings.

Other participants focussed on a sense of disconnection that an ethnic minority individual may feel from their roots.

“'She has no connection to that and it's completely removed from anything that her family would have experienced (...) They are the first generation who are out of context and that what they are doing is new.
They are doing stuff that no one else in their family has done before. That's got to give rise to a whole range of difficulties.” (Lee)

Here, Lee is talking about Monica and the fact that she is a Bangladeshi woman who was raised in Norfolk. Lee emphasises the degree of difference between Monica’s experiences and those of anyone else before her. He highlights that Monica, and others like her are the first to be forging something new in a novel environment. Perhaps the difficulties that Lee is describing stem from the fact that no one would be able to help or advise Monica because no one had been in her position before.

In contrast to the discourse surrounding the difficulties of living in two cultures, some participants explored the potential positive impacts for ethnic minorities:

“It makes people stronger and adds to it in all the positive sides of it as well.” (Linda)

Perhaps Linda is speaking from a personal perspective here with regards to her own experience of being mixed-race. Perhaps she has experienced the ‘positive sides’ and feels ‘stronger’ as a result of her mixedness. This idea that living within two cultures can be enriching is supported in the literature, for example, Berry et al. (2006) refer to the ‘immigrant paradox’ whereby they found that children with immigrant backgrounds exhibited better health and did as well or better than their non-immigrant peers with respect to academic achievement and psychological well-being. Berry and his colleagues believed this finding to be counterintuitive. However, certain participants in the current study might disagree.

**Discrimination towards ethnic minorities**

Most participants made some reference to elements of this 2nd level theme. Some spoke about the effects of racism.
"...dealing with racism where like even the low level prejudice which isn't always very obvious but it's still very powerful, affecting people's self esteem, causing people to doubt themselves, causing people to doubt their own worthiness, you know, finding you don't get first place in queues, or just subtle things are just as powerful as the kind of overt, nasty racism that people experience like violence or verbal abuse." (Brian)

Here, Brian states that racism, whether overt or covert can have wide-ranging negative effects. Perhaps he is speaking from personal experience as a White Irish man in Britain having fallen victim to 'low level prejudice'. Brian points out that the faintest communication of racism can be just as potent and damaging for an individual's sense of worth as the most visible form. Research also points to this conclusion indicating that all magnitudes of racist discrimination, prejudice and hostility are stress stimuli experienced by ethnic minorities, which lead to low self-esteem, depression and anxiety (Clark, Anderson, Clark & Williams, 1999).

Participants also talked about internalised racism in the clients.

"When you're victimised, you might think I'm a bad person, there's something wrong with me and then you look at what's wrong with me. It could be that I've got ginger hair or that I'm fat or that I've got brown skin. Now I've got proof that it's because I've got brown skin because all the other kids told me so it kind of starts from there. So she might have a lot of internalised self-hatred where racism is the cause of it." (Jane)

Jane is talking about Monica's background and the fact that she was bullied as a child. Jane states that being victimised because of your race can be so influential that the victim internalises the negative self-image. As a consequence, the victim may feel that there is something faulty or wrong with them, and perhaps Jane is suggesting that this could cause them to act in a way that might put them in
jeopardy. Clark and Clark (1947) found that Black children suffered from identity confusion and low self-esteem because they internalised white people’s negative views of their race.

“It also gets me thinking about him being a devout Muslim, how he looks, his attire, does he have a beard? (...) issues that he needs to contend with on a day-to-day basis, may impact on him feeling low, and the inability to really express why he is feeling low may come from what’s happening in society at large vis-à-vis Muslim men (...) latterly everything has changed, he stands out all of a sudden, he’s a potential threat, he is a potential suicide bomber, he is a terrorist, and so those issues might be a real cause of difficulty. ” (John)

John is talking about Anwar and his faith, and he is referring to the shift in attitudes since the 9/11 bombings. John is suggesting that Muslim men are now viewed as threatening and that such prejudice can have a pervasive and damaging effect on an individual’s well-being and self esteem. Williams and Berry (1991) also imply that personal experiences of discrimination may be among the most important acculturation experiences for the psychological well-being of immigrants.

**Acculturation stances of ethnic minority individuals**

This 2nd level theme was referred to many times by the participants. Various different aspects and approaches were discussed and evaluated.

Some participants talked about the importance of embracing both cultures and integrating.

“...securely hold on to their own values and pass those on in a healthy way, while allowing their offspring to integrate into the country they’re
living in and embrace some of the values that are inevitably around them, living in a different culture." (Brian)

Here, Brian is describing being a parent from an ethnic minority group and the process of encouraging your offspring to adopt the values of both the ethnic and the mainstream culture. Although Brian does not explicitly render his judgement on this kind of integration, his use of words like 'securely', 'healthy' and 'embrace' imply that he deems this approach to be favourable. This kind of discourse is echoed in the literature (e.g. Berry, 1990) where researchers state that the immigrant living in a new cultural context requires the ability to deal with the culture of both the society of origin and the society of settlement, and that in these circumstances the integration strategy is the most adaptive.

Some participants homed in on the assimilation strategy.

"People sometimes feel alienated by their own difference instead of celebrating it, they attempt to tone it down or blend in." (Richard)

Richard is outlining the potential for people from ethnic minorities to feel estranged and isolated as a result of being different from the majority and as a consequence, they may attempt to conceal their difference (i.e. their ethnicity). This position implies a degree of denial and shame in the individual, as the phrase 'tone it down' is commonly used when referring to an embarrassing, undesirable characteristic.

"Cutting off from your background is almost like chopping off part of yourself, and I think that would be really, really painful for him, internally on a psychological level." (Ling)

Ling is talking about Jake rejecting his ethnic culture. She is inferring that your ethnic culture is as much a part of you as a limb from your body. The implication
being, that it would be as detrimental to reject your ethnic culture as it would be to chop off a limb. Perhaps this also reveals something about Ling's feelings towards her ethnicity. Maybe it would be inconceivable for her to separate from her Chinese background.

At the other end of the spectrum, some participants talked about the value of questioning your ethnic culture.

"There's a real sense of having to question cultural values and norms and to be able to do it in a way which gives you responsibility for it (...) M. Scott Peck's 'The Different Drum', he talks about anything that is built; an organisation, a structure, a culture, anything. In order for something to be strong, it has to be questioned to the point where it is almost rejected, and the point at which you decide not to reject it, you then take it on, on your terms. And it is because you have made that choice to accept it, that's where the value is, as opposed to having been made to do it." (Lee)

Lee is alluding to the need to critically interrogate what might otherwise be taken for granted. By doing that, if the questioner decides that the construct is worth holding on to, then it is accepted on their terms. Lee seems to be saying that it is only when a construct has been taken apart in this critical manner that it carries any worth.

"At the end of the day, however much he pretends to be English, he will have had influences from his childhood and he isn't English." (Fern)

Fern is describing Jake's predicament, cutting off from his family and associating with his university friends. It could be that Fern is saying that for Jake to adopt English customs would be a pretence, rather than any real expression of his identity. Therefore, it would be impossible for him to reject his ethnic culture in favour of the majority culture (i.e. assimilate).
Some participants referred to the separation approach:

"...parents were still in the traditional state that they had left 20 years before. They hadn't moved on (...) and sometimes they become overly strict because they're frightened of losing their identity." (Richard)

Richard is describing a phenomenon where ethnic minority immigrants hold on to the dated values and customs of the country they left, and they vehemently pass them on to their children. The speaker describes this as an act of fear and perhaps he is saying that the parents’ concern is that unless the ethnic culture is instilled cogently in the children, their identity will become subsumed by the majority culture. Fern elaborates this point:

"It sounds like they were very fearful of him being infected by British/English culture."

She is talking about Jake and the possibility that his parents feared him becoming too westernised. Fern’s use of the word ‘infected’ highlights the negative viewpoint that immigrant parents can have towards the majority culture. It could be interpreted that they may deem this culture disgusting or noxious, or feel that it may silently contaminate their children, like an infection.

However, Brian brings in a more positive perspective on separating.

"...wear their cultural origin with vengeance and pride"

Interestingly, he alludes to wearing one’s cultural origin with ‘vengeance’. This implies that one’s culture is under threat of attack, and perhaps Brian feels that this is the case for certain ethnic minority groups in the UK, and perhaps even his own Irish ethnic group.
Processes adopted by participants when thinking about ethnic minority

This 2nd level theme arose in the interviews, as participants seemed to be employing various processes when they were thinking about people from ethnic minorities.

“They talk about being the only Bengali girls in quite a smart White school and it was kind of alright but they were very keenly aware that they didn't belong.” (Jane)

Jane switches from referring to ethnicity to referring to race, as though ‘race’ has some kind of meaning. It could be argued that ‘racial meanings’ are neither naturally arising nor static but are socially constructed and dynamic social processes. People are therefore ‘racialised’, rather than having a biological ‘race’ (Tizard & Phoenix, 2002).

“Most White lads, they couldn't give a monkeys really (...) Somebody could get arrested and end up doing 18 months inside and in Anwar's situation, that would be the source of the most colossal shame, whereas in this culture no one would really care” (Lee)

Lee is comparing Anwar’s outlook to that of ‘most White lads’. Lee attributes the experiential differences to race, and this invokes the kind of essentialism that has been criticised in feminist and social science literature because it treats people as though they possess characteristics which are unchanging and which, for example, unite them with those within their ‘race’ and differentiate them from those outside their ‘race’ (Brah, 1996).
Universal Issues

The top level theme of universal issues was prominent throughout the interviews. Participants both raised topics explicitly and implicitly referring to the universality of human experience. Some felt that universal experiences were more significant, while others felt that cultural factors were key.

Universality of human experience

This 2nd level theme arose when participants focussed on the commonalities across people.

"...the difference is there and work with the difference and it's really important and it's enriching, but there are human themes that we all share, and that's where you make sense. " (Jane)

Jane is talking about when the therapist and client are from different ethnic groups. She is suggesting that although it's important not to ignore the difference, we all share universal traits and therapy is realised through focusing on those. This kind of discourse is present in the literature on cross-cultural counselling where researchers maintain that by attending to the humanness and with respect for differences between individuals, therapists should be able to overcome cultural differences (Vontress, 1988).

"They have issues that they're contending, that they are coming to terms with and navigating their way through, holding down jobs, some of them are married, have children, have siblings, journeying from one country to another. I could be talking about a White group when I said that, or I could be talking about a Black group or an orange group. " (John)
John is talking about the ethnic minority clients from this study. He feels that 'journeying from one country to another' is just one of a number of issues facing the clients, and he goes on to infer that the issues are not attributable to their race. One possible interpretation of John’s point could be that a therapeutic approach that focussed overly on race and difference would be missing the point.

“
My way of working is that first of all people share fundamental universal issues but those can be and are influenced by obviously their ethnicity, their religion, their experience of living in this country, whether they were born here or whether they've come.” (Suzy)

Here, Suzy refers directly to her mode of practice. She explains that she concentrates on the shared elemental issues that people face but goes on to say that these issues are influenced by a multitude of factors, and perhaps she is highlighting the need to be attentive to both the commonalities and the nuances.

Discussion

The present study aimed to explore how therapists think about their ethnic minority clients. This kind of qualitative exploration does not seek, in the way a quantitative study would, to claim generalisability. However, it does aspire to shed some light onto the current frameworks that the participants used in their thinking and to move toward a better understanding of this area.

Despite the diversity in the participants' approaches, there were some key concepts that seemed to characterise their thinking. The top-level theme of 'cultural issues' was present in all of the interviews. Participants made reference to hegemonic structures within society, which could affect the acculturation of ethnic minority clients. Bhatia advocates such a dialogical approach to acculturation: 'A dialogical approach, especially with regard to acculturation of
There was some allusion to in/out-group mentality around the migration of ethnic minorities to the UK and the impact of such thinking. Dijker, Koomen, Van Den Heuvel and Frijda (1996) looked at the nature of out-groups and they found that authoritarians would be inclined to project their negative emotions on to out-groups that would function as 'scapegoats'. It was hypothesised that this could have far-reaching negative effects on the psychological well-being of those defined as members of out-groups.

In the current study there were many examples of participants referring to 'culture clash' and the negative implications of living in two cultures. This seems to run contrary to the most recent research on young people (e.g. Berry et al., 2006), which suggests that children with immigrant backgrounds exhibit better psychological health than their non-immigrant peers. Perhaps this divergence can be explained by looking at the mean age of the participants in this study (43 years) and the recent shift in migration patterns into the UK. For example, in the past when there were fewer South Asian immigrants, perhaps the discourse around cultural conflict may have been more salient, whereas now, since the influx of South Asians into the UK, this difficulty may have (to some degree) dissipated. Therefore, perhaps the age and social context of the participants will have shaped their perceptions.

Some participants talked about ethnic minority clients feeling compelled to 'tone down' their ethnic attributes and assimilate. Fordham (1988) found that academically successful African-American students felt that they had to reject the values of the African-American community to succeed in school, i.e. they felt they had to assimilate. Other participants talked about the negative effects of assimilating. This is supported in the literature; for example, Tajfel (1978)
suggested that attempting to 'pass' as a member of the dominant group could have negative psychological consequences for the individual.

Participants talked about the negative impact of racism on the ethnic minority client and the importance of acknowledging it. However, Kareem (1992) asserts that White therapists will find it easy to dismiss racism as it has not happened to them and it is beyond their internal and external experience. Bhugra and Bhui (1998) describe that this kind of insensitive therapeutic encounter may be experienced by the client as a repetition of racial oppression and its accompanying power issues. Therefore, it would appear that racism and the acknowledgment of racism is a very important issue for the ethnic minority client.

Participants also made regular reference to the top-level theme of 'universal issues'. A consistent finding was that participants seemed to question whether cultural issues or universal issues would predominate for the ethnic minority client. There was a sequence of discourse alluding to the idea that universal human traits should be prioritised and should constitute the focus of therapy with the ethnic minority client. However, Sue (2006) warns that there is a concern that therapists frequently make assumptions, or apply concepts that are developed in their own culture to clients from different cultures and that this can cause difficulties. Therefore if the client and therapist are from different ethnic backgrounds, this could potentially become problematic.

In the current study, the participants picked up three out of four of Berry’s acculturation strategies. No one participant seemed to be using the three strategies; rather they were used in a distributed manner across all the respondents. The three acculturation strategies used by the participants were integration, assimilation and separation. There was no reference to the marginalisation strategy. Given the absence of one of the strategies, perhaps it could be seen that this is not a helpful framework for representing how therapists deal with these issues in practice. This adds to the weight of empirical evidence
against Berry's model of acculturation (for a detailed critique see Chakraborty, 2007). This finding would tie in with ethnographic and discursive studies (e.g., Baumann, 1996; Tate, 2005), which have revealed that minority individuals commonly express multifaceted, fluid and context-dependent patterns of attitudes and identifications (rather than stable invariant patterns). These individuals are constantly repositioning themselves in relationship to their own and other cultures according to the particular context and their own discursive needs. Perhaps a more useful mapping to describe how therapists conceptualise their ethnic minority clients would be using cultural versus universal issues, as is suggested by the current findings.

It is important to note that there are a few limitations to this study that require careful consideration. Studies such as this always tend to disproportionately attract the participation of enthusiasts, and this must be borne in mind in interpreting the findings. One of the interview questions queried whether the problems facing the ethnic minority client were inherently different to those a White British person might face. By raising the issue of race, the interviewer was inviting a racialised discourse that may have affected the direction of the discussion. Participants were asked to consider whether there might have been an order effect depending on the order in which they had seen the vignettes. Although most participants felt that this wouldn't have affected their responses, one participant felt that as the interview had unfurled, they had structured their thinking in such a way that by the time they had seen the final vignette, their answers had evolved as a result of the process. Participants were also asked to consider whether their answers were affected by the fact that the interviewer was from an ethnic minority background. Similarly, most participants stated that they had attempted to answer the questions honestly and that the ethnicity of the interviewer had not affected them. However, one of the participants felt that the ethnicity of both the interviewer and interviewee would inevitably impact on the responses.
With regard to practice and training implications, the research and clinical literature on the delivery of mental health services to ethnic minority populations has been quite consistent in drawing attention to inadequacies in the provision of services (Sue & Zane, 1987). Although efforts have been made to rectify these shortcomings, there has been little exploration into therapists’ current approaches to working with ethnic minority clients. This study aimed to take the first steps towards a better understanding. If the present findings are in any way reflective of the experiences of therapists generally (and this question requires further empirical investigation through complementary studies), it seems sensible to question the use of the fourfold model of acculturation as a lens through which therapists ‘see’ their ethnic minority clients. In contrast, it would appear that therapists use a mapping of cultural issues such as difference, discrimination, cultural conflict etc. versus universal human issues like loss, support and developmental background. If therapists currently structure their thinking as such, it might be helpful to explore how ethnic minority clients understand their own difficulties. Future research could ask ethnic minority clients about their own understanding of their difficulties and whether a mapping of cultural versus universal issues would ‘fit’ for them. Illumination of this alternative framework could help policy makers and those involved in the training of therapists to better identify the strengths and weaknesses of current practice. This will mean that recommendations for future practice can be more targeted and specific.

With a growing proportion of minority group members in the UK, this kind of exploration is becoming increasingly urgent. The present study merely represents an initial exploration into how therapists formulate their ethnic minority clients’ issues. Further research needs to test this out more directly and systematically, and perhaps to include some input from the client group to explore their perceptions of therapy.
References


Appendices
Appendix A:

Personal reflections
**Personal reflections**

This project has been a huge learning experience for me - one that has enhanced my thinking and challenged it at the same time. My interest in acculturation and ethnic minority groups stems from a personal level. I am a British-born Bangladeshi woman whose parents moved to London in the 60s. Following conversations with them and on my journey into adulthood, I have begun to question the nature of my own identity and what it means to be a second generation immigrant growing up and living in the UK.

My introduction to the field of acculturation was broadly characterised by Berry's fourfold model. His theory has led the field of acculturation for twenty years, and when I first came across it, I was quite impressed. It seemed to offer a sound explanation of the processes involved. However, upon reading more and having the time to ponder and reflect upon my own systems, it became clear that this account did not offer a full picture. I felt that a more fine-grained, context-dependent narrative would be necessary to explain this complex process. This seemed to be confirmed by the literature in the area which I acquainted myself with in the first year. Therefore, when it came to undertaking this current piece of research I was most curious about the direction it would take.

I had a hunch that participants wouldn't necessarily engage with the model in their thinking, but my training as a counselling psychologist enabled me to be aware of these feelings so that I could remain relatively open during the interview process. In addition to this, I had to make a conscious effort during the analysis of the data to be aware of my own interpretative framework and any inclination I might have had to report my version of things. This was very difficult as the nature of this kind of qualitative work requires the researcher to imbue themselves in the data and the analytic process. However, in stating my position
and attempting to reflect upon it, my aim was to make this piece of work as transparent as possible.

In compiling the vignettes I was prompted to reflect upon the characters I have met over the years that have adopted different attitudes towards acculturation. It was my aim to produce real flesh and blood depictions of individuals who were facing difficulties. During the interviews a few of the participants even remarked upon how real some of the hypothetical clients seemed, or how they were reminded of their friends or of previous clients. This was interesting for two reasons. Firstly, I was pleased that the participants were sufficiently engaged with the clients as it led to some very thoughtful discussion. Secondly, it enabled the participants to access a deeper level of feeling and intuition as they were drawing from their own personal experiences.

I found the interview process enlightening. This was the first set of interviews I have ever conducted so I set about the task with some trepidation. My instinct as a trainee therapist was to broaden out and expand on the responses of the participants to understand and further clarify. However, I needed to stick to the content of the participants’ responses, so as not to lead them in any way. As the interview process unfurled, I felt freer to expand on themes that seemed interesting but not to such a great extent that the focus and purpose of the interview was lost. This flexibility added to the richness of the data and to my experience as the interviewer. Overall, I found the process of meeting therapists and hearing their perspectives thoroughly enjoyable and informative.

My introduction to template analysis was characterised by enthusiasm and increasing engagement with the process. The analysis allowed for the concept of multiple meanings and gave space for the complexity and variety of responses. This was complicated as it meant that the process of making decisions about specific meanings entailed returning to the data via the template, a process that was entirely new to me. Despite this, I can genuinely state that I had an
increasing enthusiasm as the research progressed and even that I had fun, some of the time!
Appendix B:

Vignettes
**Anwar**

Anwar is a 28 year old I.T. specialist who describes feeling very low about himself. He reports being increasingly withdrawn in social situations and explained that he is fearful of becoming depressed.

Anwar had an arranged marriage 2 years ago but feels unable to talk to his wife about his problems as he feels he will be “burdening her”.

Anwar’s parents are Pakistani and although he was born and brought up in England, his heritage is very important to him and he speaks Urdu fluently. He is a devout Muslim. However, even his faith has been flagging recently. Anwar is an only child and reports having a very close relationship with his mother and father. He states that his family values are paramount but, as the only son, feels some pressure to succeed and do well in the eyes of his family.

He describes a happy childhood and, as an adult, Anwar takes an active role in his community. He feels bewildered by his recent problems.

**Monica**

Monica is a 39 year old British-born, Bangladeshi woman who has recently started having panic attacks. She describes her anxiety levels increasing when she is in large groups and as a consequence, finds it very difficult to spend any prolonged time in a group. This has impinged on Monica’s personal life, having had just one serious relationship twelve years ago.

Monica’s father died when she was 4 years old and her mother died last year. Monica is the eldest of 3 daughters and reports that she was never particularly
close with her mother and can 'barely remember' her father. She feels that her sisters were favoured and that she was deemed the rebel of the family, unwilling to conform.

Monica has isolated herself from her family ties and feels closer to her environmentalist friends whom she has met through membership of various Green groups. However, given her recent panic attacks, she is finding it increasingly difficult to socialise with them.

She grew up in rural Norfolk and was bullied at school for being one of the few Asian children in the area. She describes being lonely much of the time, preferring to isolate herself rather than mix.

**Meera**

Meera is a 43 year old accountant presenting with depression. She reports having very low self-esteem and describes feeling fine one moment and spiralling downwards the next.

Meera was born in India and moved to London with her parents when she was 8 months old. She has a younger brother with whom she is close and describes her parents as 'liberal'. She depicts her childhood as fairly happy and describes how her parents allowed her to have a similar level of freedom as her English school friends, but also encouraged her to speak Hindi at home and with her brother.

The depression was triggered by the recent breakdown of her marriage when her husband, who is English, decided to move back to Cumbria where he was from originally. Meera and their 2 children now live alone in north London and although she has many friends, both English and Indian, she reports feeling 'confused' and 'isolated'.

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Jaykumar (preferred name - Jake)

Jake is a 20 year old student who is depressed. He feels stressed much of the time and he has recently developed a stomach ulcer.

Jake’s parents are from Gujarat and he has had no contact with them since he left home to go to university. He portrays his friends as his ‘real family’ and describes being happiest during nights out with them clubbing and going to the pub.

Jake felt dejected through much of his childhood. He describes feeling restricted by his parents and he states that he ‘couldn’t wait to leave home’. Jake describes being locked in his bedroom for hours at a time by his parents as punishment for what he deemed as ‘trivial’. Jake has spoken of one incident when he asked his parents if he could learn karate at school and he was locked in his bedroom for 2 days.
Appendix C:

Interview schedule
Interview schedule for each vignette

- Would you like to work with (insert name)?
- What do you think are the issues at stake for (insert name)?
- What do you think are the root-causes of (insert name)'s issues?
- What do you think will be the most salient issue for (insert name)?
- Do you feel that the problems facing (insert name) are inherently different from those a White British person might face in Britain?
- Have you ever worked with someone like (insert name)?
- If yes, what was it like?

Questions once all vignettes have been seen & discussed

- As ethnic minority individuals living in Britain, which of the 4 people do you feel has adopted an approach with the greatest potential for healthy well-being and why?
- Which of the 4 has adopted the (2nd/3rd/least) healthy approach and why?
- Have any of the people adopted a maladaptive approach and if so, why?
- Do you think your answers would have been different if you'd have seen the vignettes in a different order and if so, why?
- What do you think has been the purpose of this interview?
- As your interviewer, I am from an ethnic minority group. Do you think that your responses would have been different had I been White British and if so, why?
- Those are all the questions I wanted to ask. Is there anything else you would like to add?
Appendix D:

Letter of approval from the

University of Surrey Ethics Committee
28th March 2008

Dear Anita

Reference: 212- PSY- 08
Title of Project: A qualitative exploration of therapists' perceptions of ethnic minority clients

Thank you for your resubmission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Mark Cropley
Appendix E:

Participant information sheet
Dear [Name of manager of service/therapist],

I am a second year trainee on the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. As part of my doctoral studies I am conducting a research project exploring how therapists perceive ethnic minority clients, supervised by Professor Martyn Barrett and Dr Adrian Coyle in the Department of Psychology.

This research seeks to explore how therapists think about their ethnic minority clients. I hope that it will shed some light on current practices and ways of thinking with a view to enabling counselling psychologists and therapists to work more effectively with this client group.

I am seeking therapists, aged between 20 and 60 years who are qualified and have been practising for at least 2 years. The therapists must conduct at least part of their therapeutic work outside of an NHS setting. Those who volunteer will be interviewed and the interviews will be conducted at a venue of their choice and will last roughly 1 hour. Each interview will be heard and transcribed only by myself. Tapes will be destroyed immediately after transcription. Professor Barrett, Dr Coyle and I will be the only people who have access to the information. In order to illustrate common experiences in this research, I may use
extracts from individual interviews. However, to protect the participant's confidentiality, they will be allocated a pseudonym and no information will be included in the extracts that could readily identify them. This means that information such as names of people and places will also be changed. The consent form that will bear the participant’s name will be stored securely, separately from the data. Transcripts will be stored for 5 years from the date of any publication based upon them, after which they will be destroyed.

If you chose to participate, you would be free to withdraw from the study at any time without having to justify your reasons for doing so. Consequently, any material collected in relation to you would be removed from the study.

The research report will be submitted to the University of Surrey as my second year research report. A copy of the report will be available on request. The project has been approved by the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.

If you have any questions regarding any aspects of this study, please do not hesitate to contact Professor Barrett or myself at the above university address or alternatively by emailing me at ac00012@surrey.ac.uk.

I look forward to hearing from you.

Yours sincerely

Anita Chakraborty
Trainee Counselling Psychologist
Appendix F:

Participant consent form
Consent form

I the undersigned voluntarily agree to take part in the study on ‘Therapists’ perceptions of ethnic minority clients’.

I have read and understood the information sheet provided. I have been given a full explanation by the investigator of the nature, purpose, location and likely duration of the study and what I will be expected to do. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

I understand that all documentation held on a volunteer is in the strictest confidence and complies with the Data Protection Act (1998). I understand that extracts from my interview might be used as examples within the analysis but that no information will be included that could readily identify me.

I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions.
Name of volunteer .................................................................
(BLOCK CAPITALS)

Signed .................................................................

Date .................................................................
Appendix G:

Background information sheet
Background information

Thank you for participating in this research study. Before we go on to the interview, it would be helpful if I could have some basic information about you (such as you age, gender and ethnicity). The information that you give will not be used to identify you and pseudonyms will be used throughout.

If you feel comfortable doing so, please fill in this brief questionnaire.

Gender ............................................................

Age ............................................................................

Ethnicity ...............................................................
Appendix H:

Participant details
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<td>Linda</td>
<td>Female</td>
<td>46</td>
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Appendix I:

Interview transcript
Interview transcript

Participant 1 (Jane)

A: Okay. So you've just looked at the vignette on Anwar. What do you think are the issues at stake for Anwar?

J: He is presenting with depression, (pause) being confused about that and he saying that he has various values and supports which are important to him, but he doesn't feel very connected to any of that at the moment so he's torn, isolated.

A: He's feeling torn?

J: Kind of, or isolated in how he's feeling in that the things that he normally turns to in other circumstances aren't available to him. He feels he can't turn to his wife, but maybe his wife was never a support to him, that would have to be explored. And he's making assumptions about his parents because he says that he is close to them but the depression seems to be isolating him from talking to them about it. He feels that they've got expectations of him, but obviously it's his own expectations of himself as well. And it doesn't sound like his faith is particularly holding him together at the moment either.

A: Okay thank you. What you think of the root causes of Anwar's issues?

J: I could hazard guesses and that would direct me into exploring further. For instance, saying that he's not so attached to his faith (pause), also I have to be careful because I haven't got strong spiritual beliefs, and it's not about having a belief about Islam, but if somebody says "I believe in something, but I don't believe in it now" it is about exploring what that's about. It might be that his
relationships aren't all that great. His marriage is quite new but I'd be exploring, not necessarily as a priority, but what his hopes and expectations of marriage were. It might be really important to him that he can't talk to his wife. But I have no idea, I can't make assumptions. He's quite a young man. There might be things going on for him at work, perhaps areas where he feels driven or that he needs to achieve. It's not clear from the scenario, I would need to know more.

A: Okay. So it would be good to have some more information, but there are certain issues around his relationships with perhaps his religion, his wife?

J: Yes. I don't know if you want me to answer this now but have I felt that sometimes raising the issue of working trans-culturally is really important, and it struck me that there is information that he might not feel he could trust me with. Not assuming (pause), because I'm a woman and I'm White, and all those things, but to give him an opportunity and say "how does it feel talking to me?" because sometimes people say "great! You're so different. It's easier for me to say it out loud". All new clients bring a resistance but he might be putting up a front, like any client, whether we are the same or different (pause), they've just got to check me out.

A: So there might be some issues around trust?

J: Yes. And he'll be bringing lots of assumptions and thinking that I'm making assumptions. And I will be making assumptions I guess, but he won't know what assumptions I'm making. He'll assume what my assumptions are (pause), given the media and the fact that he is a Muslim from Pakistan, he might assume that I have extreme views about Islam and Muslims. So I think it will be important to acknowledge the difference between us and create some kind of alliance. The way that I work, my clients need to be able to show me who they are so I can understand them and so I can help them. So the information given is
quite superficial in a way. “I am a man. I am Muslim.” It’s the beginning, not the end of it.

A: Thank you. Given your first impressions, what you think will be the most salient issue for Anwar?

J: I think it’s his depression and the sense of isolation. We can explore and understand and I can help him fill in more details that make him unique because not all Pakistani men are the same and I think he needs to be seen and to be valued. There’s a sense of drive and achievement and I’m getting the sense that he thinks he ought to achieve but he’s not quite there. And I suppose I could make assumptions about him working in I.T. Certain types of guys go for that kind of work so maybe he is.....I’ve got to check out what kind of support he has there and where the ambition and the race to achieve is. And it's quite isolating doing I.T.

A: So perhaps there are some issues around his work and his sense of achievement.

J: Yes. And also has anything happened? Because that is the immediate past history and presenting problem. Why now? Apart from his recent marriage, but I don’t know.

A: Okay. So there are still questions?

J: Yes.

A: Okay, thank you. Do you feel that the problems facing Anwar are inherently different from those a White British person might face in Britain?
J: Not inherently. I think they've got different details, but it just seems quite familiar for men and women. Not inherently different, but they're not the same because there might be issues about identity and stuff. Everybody's got their sense of being different and not belonging. So, if he's got that, is he pinning that on his race? Or did he come from another country and when he went to school, was he the only Pakistani boy in the school? Stuff like that and how important it is to him because some people say it doesn't matter, and I wouldn't like to put that on him if that's not how he feels. So that might be a difference. But you kind of see with everybody when they're growing up, identity issues.

A: Okay so possibly exploring issues around identity and whether that links in with his race.

J: Yes, but he's got to define it, not me. I think that when I meet anybody, it's important to deal with what they present really and the rest is important detail, fleshing out the picture. But it's for them to show me, rather than for me to decide that's what it is.

A: So it's for them to come and bring what they are bringing?

J: Yes otherwise I'll be talking to someone that is different, someone that I've met before, and that's not right.

A: So it's important to not make any assumptions about the client?

J: Yes. And there's another difference between Anwar and me and that's the generation gap, so that would also create different transferences and projections so I'd have to work with those as well.

A: Okay. Have you ever worked with someone like Anwar and if so, what was it like?
J: Yes. I've worked with a lot, and at the beginning, I don't know about them, but I would be very aware of the difference. And with the years of experience, you realise that the difference is there and work with the difference and it's really important and it's enriching, but there are human themes that we all share, and that's where you make sense. The issues seemed to be about trust and connecting, and understanding the assumptions they were putting on me because I was different. I have worked quite a lot with young Asian men. Recently I've worked with older men, and mainly Sikhs, and that's been qualitatively different, because of how they behave with women I think. They're terribly, terribly polite, and older people, and manners and stuff so that's different. And younger Asian men vary a lot depending on where they grew up and their life experience is part of it as well. It's not just racial identity.

A: There might be some cultural differences?

J: Yes definitely, but there is also generational cultural differences. That's what I'm trying to say.

A: So it's not merely a cultural thing. Age comes into it as well?

J: I think so, (pause) as well as issues around manhood, and male identity and sexuality and things like that and how that's expressed, or not to expressed.

A: Okay. You've just looked at Meera's story. What do you think are the issues at stake for Meera?

J: She may have been depressed before but I think that the depression is exacerbated by a sense of loss from the breakdown of her relationship, and trying to establish herself as a single parent with a foot in two cultures - one foot in each
culture. So again, it's isolation, because maybe her depression is getting in the way, but where is she getting her support from?

A: **A foot in two cultures? Could you say some more about that?**

J: Well this comes from my experience of people I actually know. I think that when you feel vulnerable, in a sense you regress and you go back to what you learnt as a child and where you felt safe, so getting away from the cultural thing at the moment, emotionally, people want to feel held and safe. In a way it's like going back to your mum and dad. So, you can be Indian, but you've had a liberal upbringing, you went to English schools but you can get confused trying to fit in and belong. Some of the times you're Indian, some of the times people can say "it doesn't matter that you're Indian", like an honorary White person if you know what I mean. Living in two cultures and then marrying outside your original culture, and your children are from two cultures and probably for most people they wouldn't have ever thought it would be an issue, but when your life is fragmenting, you want to go back to a safe place. And perhaps Meera's not quite sure, emotionally, where her safe place is, even if your mother and father are there and they're supporting you. And a lot of people I know, the midlife, when they're miserable they think "maybe I should have done what my parents said and lived the life that they told me I should have lead when I was younger, and then I wouldn't be being punished in this way".

A: **So possibly some regrets?**

J: Yes, a kind of regret. Because people make life choices when they're younger and then they review them and think "maybe that was a mistake". And yet Meera could have quite an enriched life because she's still got her friends and her culture both to help her get her resources back together again. It just sounds as if she's in a fragmented place at the moment and doesn't know where she is (pause), so again, questioning identity.
A: identity

J: Yes, because most of the time it's fine, but sometimes you end up questioning yourself – "have I done the right thing?" not that one's right or one's wrong, but I guess it's confusion and that's the way that confusion is expressed (pause), but it might actually be just confusion about the loss, separation and abandonment.

A: I was wondering if you could say some more about the enrichment in Meera's life.

J: It's not necessarily different from one culture to another, but we look at our lives and we want things and need things and we meet those needs in different ways. Had all the stuff that Meera was looking for been Indian, she wouldn't have looked outside. Having said that, she grew up and went to school in England and how do you survive in school by going "I'm just Indian" - you can't, so you have those identity and integration issues as a child, because children just want to fit in wherever they are. So there's extra things in her life. And I'm just thinking about the children- they had English grandparents and Indian grandparents. So that might be potentially enriching, although she might not see it that way. She might have horrible in-laws (laughs). Also she's here and how do you survive here and not in India or wherever in the face of difference? And where she lives in the country, there is political and social battering about difference and she might find that harder to deal with when she's on her own.

A: Okay thank you. What you think are the root causes of Meera's issues?

J: I don't know, I'd be exploring. They might be rooted in her childhood. Anybody who says they've got liberal parents might not have enough boundaries,
and she might actually not know who she is. And to fit in, she might do the right thing to please them, and the right thing to please everyone else and she might have been doing that with her husband and that might be at the root of why the relationship failed. I'm not saying it's all her fault, but if she doesn't know who she is and what she wants and what she needs, it's not a very good basis and she probably picked a husband who didn't know who she was and didn't know how to meet her needs as well. So probably stuff like that. And I'll be looking at her attachment issues and how she's dealing with things because it's not very clear how she's dealing with the breakdown of the relationship. It might be organic. She is in her 40s - she might have moods and things. There's lots and lots of things to explore with her really.

A: Okay. Out of those issues, which you have touched upon, which do you think would be the most salient issue for Meera?

J: I would start with where she is now, so I guess issues around the relationship breakdown (pause), of being on her own and rebuilding her life. So it would be treating the depression, basically but she's got to live day-to-day so they kind of go hand-in-hand. If you can support her to be a bit more resourceful, it's like empowering her to get some control in her life. It might be supporting her motivation because if she is so depressed and things start falling apart and get worse, it might be helping her access more practical stuff and getting her to reframe how she sees her support. She might not be using her family in the way that they can give her support. So potentially there's lots in there.

A: Okay. Do you feel that the problems facing Meera are inherently different from those a White British person might face in Britain?

J: Not all of them. I think Meera's got additional things. Just in my experience, I think that people from both sides underestimate how difficult it is belonging to two cultures. And because quite often they feel that they don't
belong, but they're seen to belong to one, which they do, but what about the other side of them? And I think that for people who I've worked with and people I know who are the children of mixed families, some of the time they're fine with it and other times it's very, very difficult, when they're confronted by it. And they've found it hard to talk to their non-White parent about it and their White parent is slightly different, but the non-White parent doesn't really understand, because they know who they are. They have their cultural identity. So I don't know if it's inherent, but I think it's an extra and very important difference.

A: So that extra dimension might be to do with belonging?

J: Yes and its identity again, a very important aspect of belonging which I think can be skated over sometimes. I know I've done it. Its years and years of people telling me what it's like, why I'm saying this, but it's developed my understanding of how profound it can be. And it's deeper than the colour of your skin. It is at the heart of who you are. So it's really important stuff. But whether, in terms of working with Meera, that that would be where you go because it's quite deep and she might not want to go there. But it's being prepared to do it and enabling it to be touched on.

A: Okay thank you. Have you ever worked with someone like Meera and if so, what was it like?

J: Yes I have. There are two women I'm thinking of. I think building the therapeutic alliance worked because we were women of a similar age and how they checked me out in terms of building the trust was that they felt that I understood enough of it being a woman and being a mother. They needed help and they were reaching out anyway, so when we established the trust, we could touch on the identity stuff a bit, but neither of them wanted to go that far.
A: So you've just read about Jake. What do you think are the issues at stake for him?

J: Well he's presenting with depression. I'd say there's developmental trauma - childhood abuse basically and my concern for him is his isolation and he's probably got poor attachments and very poor boundaries. So he's probably heading for a mess, probably. It's interesting at 20 he's come forward. He's probably quite disturbed and distressed, but he might not be presenting quite like that.

A: Okay. What you think of the root causes of Jake's issues?

J: The way he was treated as a child, because irrespective of culture, if a child is basically neglected and treated cruelly, it's going to disturb how they see themselves in whatever world they grow up in and it's indicative in the fact that he is running very fast in the opposite direction from where he comes from. So he may have a lot of identity issues where he is rejecting his culture, in some senses. He's probably angry, and that's maybe to do with his age as well but he might also go over the top, over embracing being a young Asian man and doing all the more extreme things that angry young men do. And he's vulnerable to a powerful male role model because he needs a father and that may take him down the wrong road and exploit his vulnerability. So I'd actually be very concerned about Jake and I would be wondering how I could help him because it's not necessarily appropriate for me to rescue him from all that. Transferentially, he might be putting too much on me to be the good mother he never had. So how would you work with someone who was so needy, but doesn't know that they're needy? This would be true if he were a young White man as well. Having cut off from his parents, he is wide open to choose many paths, but he is more likely to choose a destructive path because he's broken free of the room they locked him in when he was little. But they won't have taught him what to do when he is free because they restricted him so much.
That's the sense of it, but obviously all that needs checking out. I can't assume how bad it was. It's quite dramatic locking children in rooms.

A: You were talking about Jake running fast in the opposite direction from where he came from. Can you say some more about that?

J: Well that's the image that I got, actually. He's been locked up. He's been restricted. He's had strict rules. One thing I thought when I read it was who is paying for him to be at university? So maybe he's still kind of connected to the family so in a way, he is running wild, but supported by them. And he's drinking, which is what young people do, but I think he's really open to getting in with what you call a 'bad crowd' or bad influences. It would be attaching to a different kind of parental role model (pause), not saying that he'd get into gang culture, but that kind of thing - a powerful person that will carry on abusing his trust, making him do things he doesn't want to do. And that can happen on all sorts of levels. Culturally, he is Gujarati and presumably, culturally, parents are supposed to tell you what to do, but this is quite extreme so he's running away from the extremity of it. Therefore if he rushes off to university and he's got lots of white friends and they are accepting of him. That enhances his rejection of where he comes from. It doesn't mean that later on in life he won't do what Meera did and want to go back to it because actually it is a safety (pause), the familiarity of it.

A: Yes. Like he is rejecting it at the moment?

J: Yes. But I can also imagine there will be a challenge when he finds he has to stand shoulder to shoulder, possibly with other Asian men but not necessarily from his culture. Then he might actually take up with friends who are from the subcontinent, kind of thing, but different religions, say (pause), well maybe he was told as a child "you're not supposed to play with boys from that one", maybe it's kind of a rebellion. I can't say that that's what will happen, there are lots of
possibilities there. I just think he's really vulnerable, now drinking and rejecting his parents.

A: Thank you. What do you think will be the most salient issue for Jake?

J: Well he is presented with depression and I suspect he'd present as quite angry, you'd feel it in the room. And then there's how he's acting out his anger. I do think there is possibly risky behaviour. I suspect he might project on to me something that I'm not in terms of looking after him. And actually, he's a young adult, but he is an adult, so how do you have a more adult-to-adult interaction rather than a parent-to-child interaction?

A: Thank you. Do you feel that the problems facing Jake are inherently different from those a White British person might face in Britain?

J: I suppose I have a problem with the word 'inherently'. In some ways it would be similar, but I think that the race issue makes it different. You're cut off from being acceptable, and making friends. You cut yourself off because making assumptions, and the predominant culture also isolates people. Racism is there and also racial assumptions are there, which can be a disadvantage because nobody understands because they're making assumptions about you.

A: You talked about racism.

J: Well I suppose I relate that term to more to proactive cruelty, but I think we do more harm to each other by making assumptions that we think are benign. I suppose when I say racism, I think of something more active but it's still there.

A: So may be you're talking about a more subtle version of racism?
J: Yes, making assumptions based on race, and there's a lot of denial about doing that because you just think "oh you're nice. You're just like me. You speak like me, so we're similar". And in terms of working therapeutically, it just brings a whole load of assumptions. And you and I are talking quite comfortably now, but we're both possibly hiding things. And working cross culturally I know that some people are a lot more private about lots of things because it's normal. A White therapist comes in and goes "oh we are building therapeutic alliance. It will be an equal two-way street" and it isn't. You can build up trust and have a really good working alliance, but there has to be an exchange in valuing that person's meaning, which you have to do if you are the same race, but the meaning is different.

A: That's interesting.

J: Well you could say "I go home at night to my parents and we cook the tea and watch Coronation Street" and I could say "yeah I know what it's like", but I don't know what it's like. We're all doing different things. There's a different hierarchy in the family and politeness and all sorts of things.

A: Cultural differences?

J: Absolutely.

A: Thank you. Have you ever worked with someone like Jake?

J: Not as a therapist, in another role.

A: What was it like?
J: At first it was okay because he was polite, you know, and it was like a niceness and he wanted support and advice and things. I knew him for quite a long time and with familiarity other emotions that came out, not quite as extreme as Jake - he wasn't quite so vulnerable. Kind of really enjoying being a student, but it's more like, his relationship with his parents wasn't shattered. So he was like pretending, in a way (pause), so living this life, so the duality of it. And some of the time he was enjoying it, but actually it was a struggle. Anybody at that age (pause), you're finding out who are as a young man in the world so again you come back to identity and masculinity.

A: You used the word 'pretending'. Can you explain what you mean?

J: I think it happens across the races and it's the people pleasing type because "I don't know who I am, so if I'm this sort of a person then I'll impress or they'll accepted me". And he was like showing off - "look at all the gadgets I've got. I can do this and I know a man who can do that" in a way that is quite alienating for English people because we're not supposed to show off. It's changed now with business culture, but when I was growing up you weren't supposed to show off. It was this kind of false modesty. So it's quite alarming when somebody comes leaping in saying "I'm great! Look at this" especially when there's no substance behind it. But it was saying "look at me and like me. Can I come and play with you". And also, what I haven't covered it is internalised racism. Where people of other races think they have to be in this particular way to be acceptable to English people. And that's more apparent when working with younger people, perhaps because older people have a stronger sense of their identity that they're not going to compromise on. Jake, for example might be looking to see how other people respond to him. He might be a bit changeable, trying things on for size that work and don't work and then getting confused.

A: Almost like experimenting?
J: Yes, and experimenting with friendships as well and it's quite painful when you know that you're not being true to yourself and perhaps every so often something will push your button and you'll think "I don't like myself when I do that". And the drinking will be exacerbating his depression too.

A: So, you've just seen the vignette on Monica. What do you think are the issues at stake for Monica?

J: Well she wants help with her panic attacks. And I guess you'd be working to help give her something practical to manage those, but I'm really concerned about what the underlying cause is, because it's an anxiety response to something quite difficult and you might find in the exploration that the panic attacks are new. She might have had a different response in the past to the same issue. She is getting older, and she is single, and she is bereaved. Because it's been a long time since her mum died and you don't know how she is navigating her bereavement process, so it might have something to do with that. And possibly there's cultural stuff (pause) because it implies that she is not married, so that's going against the grain for her culture, which might not have mattered, but when you're getting older and your hormones are telling you that it's a last ditch for babies, that can trigger off all sorts of responses. I would need for her to tell me that. So as with any client it's like why now? And has anything happened? When did the panic attacks start? And I'm just guessing, but she might be quite well defended against going into the deeper stuff that is causing the panic attacks. I'd be exploring what support she has, because it's interesting that she isolated herself. So, are there problems with her getting the support from her sisters or a couple of friends in her green group? Underneath that, always being a bit of a rebel, well she's been an outsider since she went to school. To begin with, she was victimised, so as a victim, she is an angry little person so she started fighting back. She joined a kind of fringe group that doesn't belong. Green groups didn't used to be very acceptable here either, and the membership challenge and campaign, and some of
them would be angry so Monica would be finding an outlet for that. I'm not saying that she doesn't believe in green issues but becoming a rebel is her solution to becoming victimised. And depression and anger go hand-in-hand and sadly, she is an angry person and panic attacks can come from frustration of expressing your feelings. And she does feel a bit bruised and battered by her life and not very resourceful. But having said that, she has lived that long living a complete counter-to-her-culture kind of a life, so I guess any time you've lost something, some of the issues about the loss of her relationship 12 years ago will come to the surface (pause). So there might be issues around that and also loneliness. But it would be very easy to make huge assumptions about her being from Bangladesh. And again it depends on her background in Bangladesh. My question is why were her family in Norfolk? It is very different being brought up in Tower Hamlets compared to Norfolk. If you're the daughter of a factory worker or the daughter of a doctor, it's a very different upbringing. Also coming from Bangladesh 39 years ago is very different from coming from Bangladesh now. And it's also interesting that she's obviously grown up in a very female world, with her mother and her sisters (pause), so girls and absent fathers, that's an issue.

A: You've already touched upon this, but what do you think are the root causes of Monica's issues?

J: Emotional abandonment in childhood. What happened in their family when the father died? And being bullied at school. Being bullied really has a huge impact on how you view yourself and how you survive in the world, and whether she got support or whether she had to go in by herself. Because it is not dealt with adequately now, but all those years ago it wasn't recognized, and you had to, sort of, find a way to survive it. I think she had quite a difficult childhood and whether or not she had a good relationship with her mother. When your mother dies, that brings up lots of stuff. So I should imagine her mother's death had a big impact and I wouldn't be surprised if we ended up working on bereavement issues as much as on how to manage panic attacks.
A: Thank you. What do you think will be the most salient issue for Monica?

J: Helping her manage the panic attacks but looking at where she is in her life now, so her isolation and loss issues and where does she go from here? How can she get her life back on track? Knowing about her past will give you an idea of where her resources are, and what she can use that will work for her as well to get her life back on an even keel.

A: Okay. Do you feel that the problems facing Monica are inherently different from those a White British person might face in Britain?

J: Yes and no. With Monica, her options, because of where she grew up and her culture were probably very salient, and how is she going to deal with that? And again, she will have quite powerful internalised racism. And to build her self-esteem and her self-worth and her self-motivation might be quite hard. And it might be harder to do because she's probably got quite a good way of pleasing White people.

A: Could he say some more about the internalised racism?

J: If you are small and bad things happen to you, your frame of reference is quite limited, so how you make sense of it when you're victimised (pause), you might think “I'm a bad person, there's something wrong with me” and then you look at what's wrong with me. “It could be that I've got ginger hair or that I'm fat or that I've got brown skin. Now I've got proof that it's because I've got brown skin because of all the other kids said to me” so it kind of starts from there. So she might have a lot of internalised self-hatred, where racism is the cause of it. And I should imagine it's hard to deal with that little because your parents can't help
you with it because, for whatever reason, good or bad, they’re in Norfolk and they want you to get on with it.

A: **So it feels quite isolating.**

J: I should think so. And I think all of them would have elements of that and they've picked on different solutions to deal with it. Perhaps they've got slightly stronger foundations, but Monica's a little girl in a family where her daddy died when she was quite young, so the family is not on an even keel, irrespective of race. But you've got people from Bangladesh plonked in Norfolk, which isn't known for being multiracial and even if it is pleasant it's still patronising "we're letting you into our community" [*patronising tone*] and then she's bullied at school very small, so she hasn't got very good foundations to cope with things in later life.

A: **Okay, thank you. Have you ever worked with someone like Monica?**

J: This is where I start to get confused. I know somebody very much like Monica, or kind of an amalgam. The people I know are a woman, her sister and her friend, and they talk about being the only Bengali girls in quite a smart White school and it was kind of alright but they were very keenly aware that they didn't belong. They weren't bullied and they had quite a lot of resources. They were older and they'd gone to school in Libya before coming to England, and they were quite privileged as well. They didn't have all the outside community attacking them all the time so they had quite good foundations before they got to England but they said that that was difficult. Then you kind of get accepted, people get used to you and make friends with you, and you start achieving at school and it starts making sense and it's okay. But they are also the children of doctors, and doctors were well thought of, so they have status within the community, but they were also aware of racism in their lives.
A: So racism came into it?

J: Yes. How they talk about it, they were aware of it but they don't feel damaged by it, but it's there. So they're not angry in a way that they challenged it, but it they'd let you know about it if you asked, which is important, to say it's not all hearts and flowers. None of them has become English to suit English people if you know what I mean.

A: Could you say some more about that?

J: Well, a different example of someone I know who is Asian from East African origin and he was sent to public school in England to do his A-levels 25 years ago, and he speaks very Oxbridge, and stuff, and he was always saying that it's easier for people who are black or brown-skinned to get a job if they sound English and non-threatening. So what happened to him to know that or to believe that? And to say it doesn't matter about all your qualifications and that stuff. So everybody is having those experiences all the time, when you least expect it and you internalise all that, and you feel like I am being penalised on the grounds of something I can't change, and don't want to change and why should I change? See, you could have a nice life, be accepted and everybody loves you at school, but do they? So it's always around.

A: You talked about needing to conform.

J: And I guess they're kind of decisions that we all have to make, in a sense, because we all want to fit, and where do we belong? And it's being strong enough with your individuality and your ego strength. This is who I am and what I believe in, and that's okay. And you don't have to make everyone like you, and you don't have to compromise on everything. You can find a way of coming together and not threatening, and it being okay. But a lot of people get messages in childhood,
so they become apologies for being who they are. And you can see why, because I think politically, and socially, there is a huge battering going on. For example, how they talk about Polish people coming into the country now, it used to be that Afro-Caribbeans weren't acceptable but now they're taken for granted; they've been here so long. And then Asian people came in, and then that's alright but with the added “as long as they're not Muslims” because of Islam and terrorism and stuff. There is always some socio-political anti thing that all White people can latch on to, and people from other cultures as well. A friend of mine is Indian and her dad was saying things about immigration, and he was an immigrant, and he was saying “there's too many people now, stop”. And you can understand that because we are all threatened by the stranger, and looking after our own. So I think it's a hugely complex area, hugely, hugely complex.

A: Yes, it sounds like there are many layers.

J: And generational, where you were born, what your parents made of it, the displacement stuff if you came from another country.

A: So, issues around moving?

J: Moving, separation anxiety and culture shock, things like that. So, in some of the scenarios the generational stuff will be.... say somebody came from Uganda, so the parents are displaced (pause), lost status and wealth and they come here in and they're doing their best for their family, they're adjusting and then they have children born here, and the children will be learning more about England quicker than their parents will, so who helps who? I think it's fascinating. People are really strong and the way they re-establish and get through these things, but then some people fall through the cracks.

A: Thank you. I just have some final questions now we've looked at all the vignettes. As ethnic minority individuals living in Britain,
which of the four people do you feel has adopted an approach with the greatest potential for healthy well-being and why?

J: There is stuff going on for Anwar that was difficult, but it didn't sound like his world was falling apart and he'd made a life for himself. So, I wouldn't like to say for any of them to be honest, but possibly Anwar. Monica might be okay. She's carved a life out and even though she's got panic attacks, it might be around losing her mother, so if she can get back on an even keel. But then Meera, with the children, she's got something she has to get into gear for and has to look after them, so they might be her saving grace. I'm most concerned about Jake because of his developmental stuff really, because that seemed much more harmful. The others, even though Monica was bullied, she might have had a good enough childhood. They've survived this long, they've got some resources, so I'd be looking at that. You will never get me to make a decision really, but of the four scenarios, I think Jake is much more concerning.

A: Do you think that Jake has adopted a maladaptive approach as an ethnic minority individual living in Britain?

J: Possibly, and also Meera, up to a point. Monica sounds like she's just being Bangladeshi in Norfolk, in a sense, and that's probably okay for her. And Anwar as well really - it sounds like he's got a modern life, it sounds kind of okay-ish. So, those two probably. It's difficult to say with Jake because it is not so clear, but there is the possibility of it, so I would be checking out.

A: You also talked about Meera.

J: Well, I'm interested in mixed-race relationships and why they happen, or even people from similar ethnicities but different countries marrying because you've both got internalised cultures the other one doesn't know about. But you think you know what it's like being English because you live here, and I don't
mean an angry way, but actually, you don’t. Like I might think I know a lot about what it's like being you, but I don't. So it's interesting about why people get together because it's about relating to the other and the otherness of it. What's the attraction? And all those sorts of things, because if you relate to somebody that is the same, then there is an element of comfort and you don't have to explain. And if you're relating to the other, then you're hidden and you don't have to explain, in a sense.

A: So you're thinking about why Meera's chosen a partner from another ethnicity and what that means?

J: Well I kind of think, is it going towards the opposite of what you know because what you know, you don't like? I'm just thinking about friends and people who I've worked with, Asian women who say “I can't be bothered with Asian men”, and “what you expect from Indian men?” and all that stuff. And I can't say that, I have absolutely no idea, so they're putting stereotypes in. And I've got one Asian friend who really finds White, blonde-haired, public school Englishmen very attractive because she's projecting something on to them. Whereas I'm saying that they are all twits, which is another stereotype. [amusing tone] I'm just giving you silly examples, but that kind of thing. The Other is such a mystery, so they become really attractive, so probably there is something in Meera, but you can't say that without exploring it more because it's how she sees herself, and how she is operating, how successful it all is, where she lives in Britain, all sorts of things really.

A: So it is quite complicated.

J: Yes. And with Jake, he's probably likely to be maladaptive because he is rejecting everything that he knows. I suspect he'd be quite angry and tell his therapist exactly why he wants nothing to do with his parents, and not wanting to be like them. It's quite common that we don't want to be like our parents anyway,
but you've got a healthier kind of relationship with your parents. There is a
natural being adolescent and rejecting all the rules and regulations, but Jake's
gone beyond that because he's had too many rules and regulations and cruelty.

A: Okay.

J: I think White therapists are quite happy if the client says “race isn't an
issue and I have no problem working with you” and they go “yeah okay, phew”
and actually it doesn't go away.

A: The therapist heaves a sigh of relief?

J: Kind of, yeah.

A: Thank you. Do you think your answers would have been
different if you'd have seen the vignettes in a different order and if so,
why?

J: I think if I'd have seen them altogether, not that they're all the same, but
the generalised stuff about maladaptive approaches might have been different.
But at the time, apart from the fact that they are all Asian and depressed, they are
different. I wasn't seeing them as similar. With the two women I can see things in
common. I was actually seeing them as Monica is like Meera, because they've got
a shared experience with their gender and their culture. The guys, who knows?
Maybe Anwar's more repressed than Jake. But who knows? I don't know about
doing them in a different order but probably is the answer, isn't it really.

A: Okay. Why do you think your answers would be different having
seen them in a different order?
J: I if I'm looking at one person and I'm discussing them, I learn something about what I'm saying and my reactions, so I've been informed by that bit of information, therefore I'm more informed about the next person. So that's how they could have been different. And doing more and more of them, like internalised racism popped into my head, but that's true of all of them.

A: Thank you. What do you think has been the purpose of this interview?

J: When you asked me to do this, I thought it was a good thing because you find out things and you would be feeding into the body of knowledge about what actually happens between therapists and their culturally different clients and hopefully find out that the experience is different from the assumption. From my experience, therapists like to say “I'm not racist” and lots of therapists actually have quite limited experience of working with people from other cultures and some of think “Oh it's fine. I've read a book on the trans-cultural issues” when actually it's more complex than that. All I can say, from my experience and my work background, is that it's been challenging for me and I've enjoyed it and I've learnt a lot and I'm aware of the mistakes that I have made and assumptions that I have made and I'm not perfect, but it just reinforces the thing in training that every client is unique, but it's really important not to minimise how painful it is being different and not to make a fuss about that either but not to dismiss it. I think that being displaced or growing up obviously different adds to the whole difficulty. It makes people stronger and adds to it in all the positive sides of it as well, but it's an area of vulnerability I suppose. I guess I'm interested in identity and who am I? Where do I fit in the world? And we all have that. That is inherent in all of us. So I just thought you wanted to get a better perspective on what really happens and whether therapists in general need to add other things to their knowledge.
A: Okay thank you. As your interviewer, I am from an ethnic minority group. Do you think that your responses would have been different had I been White British and if so, why?

J: I'd say I hope not and I've tried to be honest in terms of my experience, and I've responded personally rather than theoretically. So I hope not. But there must be a difference because we are different. Because I know you, well I've met you before, I haven't felt defensive about what I've said but I could see that if I'd have seen you cold, I might feel more defensive and try to be more polite, and not hurt your feelings, and use the right words and stuff like that will stop (pause) and I can't say I deliberately tried not to do that, I just tried to answer your questions to help you but that might be because in my life, I'm not saying all my friends are Black, but I've come across lots of people from different cultures for a long, long time. Whereas, if I worked in Norfolk, in the country, it might be very different. And living in London now, my experience is much broader.

A: Okay thank you. Those all questions I wanted to ask. Is there anything else you would like to add?

J: No I don't think so. I just think it's a hugely interesting area and it's not black and white either with issues around class, and with my Punjabi friends sometimes issues around the partition come up. It's an enormous area and I think it's really fascinating how psychology shows you how similar we are in our basic needs.
Appendix J:

Notes regarding submission of articles to the Journal of Community & Applied Social Psychology
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
How do acculturation strategies and acculturative stress predict the likelihood of a person from a South Asian group to use psychological services?

Abstract

This paper examines the way in which acculturation and acculturative stress are related to the likelihood to seek different sources of psychological support in South Asians. One hundred and seventy one participants completed a questionnaire comprising scales to measure acculturation, acculturative stress and likely source of support. The results suggested that South Asian people were most likely to speak to a family member, then a non-ethnic group member, and they were least likely to speak to an ethnic group member. In addition to this, it was found that those with a high ethnic identification were more likely to seek help within their family and those with a high religious identification were more likely to seek help from an ethnic group member. This indicates that South Asian people may have different views and needs with regards to seeking help and that their needs may be unmet within the current system or better met elsewhere. Implications for therapeutic practice and training are discussed.
Introduction

A growing diversity of ethnic and cultural groups now live in Western societies. In the UK, the ethnic minority population increased by over 50% between 1991 and 2001, and forecasts predict that numbers will continue to rise (National Statistics, 2003). With a growing population of ethnic minorities in the UK, research into acculturation and acculturative stress has become more pressing.

One of the most cited theories on acculturation comes from Berry and his colleagues who proposed a four-fold model of classification (Berry, Kim, Power, Young & Bujaki, 1989). In brief, this model puts forward four acculturation strategies: integration (where the individual maintains aspects of the ethnic culture but also has contact with the national culture), separation (where the individual values the ethnic culture and avoids contact with the national culture), assimilation (where the individual does not maintain the ethnic culture and instead only has involvement with the national culture) and marginalisation (where the individual has little interest in either the minority culture or the national culture). More recent theories have suggested that individuals may alternate between different acculturation strategies dependent upon context, thereby implying that the process is more fluid and less fixed (LaFromboise, Coleman & Gerton, 1993; Coleman, 1995).

The vast majority of research into acculturation has found the integrative strategy to be the most psychologically adaptive (for a more detailed review see Chakraborty, 2007). For example, Berry found that those who had adopted the integrative stance experienced less anxiety and acculturative stress than those who had assumed the marginalised, assimilated or separated stances (Berry, 1997).
Acculturative stress has been found to be a strong predictor of psychiatric disorder in immigrants. Research has linked this phenomenon to suicide (Hoberman & Garfinkel, 1988), suicidal ideation (Hovey & King, 1996), post-traumatic stress disorder (Bagheri, 1992), conduct disorder (Apter, Bleich, Plutchik, Mendelsohn & Tyano, 1988) and anger and aggression (Myers et al., 1991). Yates (1987) found that Native American people commonly used alcohol as a coping mechanism to alleviate the sense of hopelessness and loss engendered by acculturative stress. Acculturative stress has also been frequently linked with various social and psychological problems including family conflict, identity confusion, antisocial behaviours and psychosomatic complaints (Nguyne, 1996).

Given the detrimental effects of acculturative stress on mental health, one might expect the proportion of ethnic minority individuals seeking help to be higher in mental health care settings. This is not the case. Conversely, ethnic minority populations have been found to be underrepresented in such settings (Snowden & Cheung, 1990; Sue, Fujino, Hu, Takeuchi & Zane, 1991; Wells, Hough, Golding, Burnam & Kano, 1987).

Epidemiological studies have shown that low socioeconomic status (SES) and ethnic minority individuals perceive more instrumental barriers to using mental health services, such as lack of time and transportation, than high SES and ethnic majority individuals (Takeuchi, Leaf & Kuo, 1988). While research has shown that removing economic barriers improves service use in ethnic minorities (Norquist & Wells, 1991), some differences persist even when access is similar across ethnic groups (Padgett, Patrick, Burns & Schlesinger, 1994). Therefore, it would appear that there are other barriers that prevent ethnic minority individuals from using mental health services.

Research has suggested that cultural and attitudinal factors play a key role in the lower use of services by Black and Hispanic people (Bestman, 1981; Rogler, Malgady & Rodriguez, 1989). Padgett and her colleagues proposed that cultural
factors could take various forms, from reluctance to use a health service dominated by English-speaking White people, to a preference for religious leaders more attuned to the culture of the individual (Padgett et al., 1994).

While there have been many studies looking at ethnic variations in mental health service use, there has been little exploration into the possible explanations for and relationships between service use, acculturation style and level of acculturative stress of the ethnic minority individual. The current study seeks to redress this balance.

Given the fact that South Asian groups now constitute the largest ethnic minority group in Great Britain (National Statistics, 2003), the current study asked South Asian individuals about:

1. Their level of ethnic, religious and national identification, thereby obtaining an indicator of their acculturation style;
2. Their life satisfaction, self-esteem, perceived stress and perceived discrimination, thereby gaining an indicator of their level of acculturative stress;
3. The likelihood of them using a mental health service or alternative source of support (e.g. friend or religious leader etc.)

In a review of studies looking at ethnic variations in UK mental health service use, Bhui and his colleagues (2003) highlighted certain methodological considerations and limitations. They stated that it would be difficult to make generalisable claims about the ethnic groups involved in the studies as they often comprised different ethnic subgroups. For example, South Asians were frequently referred to as a single ethnic group, despite within-group differences in place of birth or country of origin within the Indian subcontinent (Bhui et al., 2003). They also suggested that ‘future research should address potential explanatory factors’ (p. 114), with greater attention paid to place of birth and religion amongst other things.
Additionally, it was stated that ‘cultural identity could also refine the interpretation of data beyond assigning all differences to ethnic origin’ (Bhui et al., 2003, p.114).

The current study attempts to address these concerns by asking participants explicitly about their ethnicity, ethnic identification, religion, whether they were born in the UK as well as other possible explanatory factors that might contribute towards their likelihood to use services and other sources of support.

*Who to talk to?*

Research has suggested that ethnic minority individuals tend to rely on the family for help with difficulties rather than use mental health services (Robbins & Greenley, 1983). A viewpoint has been identified within certain ethnic minority groups whereby the family is felt to share responsibility for an individual’s problems (Sabogal, Marin, Otero-Sabogal, Marin & Perez-Stable, 1987), therefore the individual might feel more inclined to talk to their family if they needed support. Other researchers have also found that within particular ethnic groups, it is felt that mental illness is best treated within the family (Edgerton & Karno, 1971). Therefore, it was hypothesised that South Asians would be most likely to talk to a family member if they needed support.

There has been some evidence to suggest that psychiatric disorders may have a greater stigma attached to them in ethnic minority populations. Silva de Crane and Spielberger (1981) found that in a student sample, compared to White students, the Black and Hispanic students held more negative views of mental illness, for example, that mentally ill individuals should be isolated from others and were morally inferior. There has also been some evidence to suggest that stigma and family shame may be particularly important within British South Asian cultures (Jacob, Bhugra Lloyd & Mann, 1998). This may be crucial when
considering attitudes towards mental health problems and help-seeking within this group. Therefore, a second hypothesis was that the likelihood of a South Asian person seeking help from a medical professional would be lower.

It was also hypothesised that those with a high level of religious identification would be more likely to speak to a religious or community leader for support. This may be because they feel better understood or have their needs more appropriately met by such individuals.

Acculturative stress

Research has highlighted the negative and far-reaching effects of racist discrimination, prejudice and hostility, which can lead to low self-esteem, depression and anxiety when experienced by ethnic minorities (Clark, Anderson, Clark & Williams, 1999). Williams and Berry (1991) also imply that personal experiences of discrimination may be among the most important acculturation experiences for the psychological well-being of ethnic minorities. Liebkind and Jasinskaja-Lahti (2000) found that discrimination was related to poor long-term adaptation in ethnic minority groups. Smokowski and Bacallao (2007) looked at Latino adolescents living in Carolina and found that perceived discrimination was a significant predictor of internalising problems and low-self esteem. Therefore, in this study it was predicted that high levels of perceived discrimination and stress, as well as low levels of self-esteem and life satisfaction would be correlated, and these factors were taken as indicators of acculturative stress.

In summary, this study sought to investigate whether the acculturation style and level of acculturative stress can predict the likelihood of a person from a South Asian group to seek help from various sources. It was hypothesised that South Asians would be most likely to talk to a family member if they needed support.
It was also hypothesised that South Asian individuals would be less likely to talk to a medical professional, and that those with a higher level of religious identification would be more likely to talk to a religious leader if they needed support. Finally, it was predicted that high levels of perceived discrimination and stress would be correlated with low levels of self-esteem and life satisfaction.

Method

Participants

The participants were South Asian adults aged between 18-75 years. The study had a total sample size of 171 participants, 79 of whom were male (46.2%), and 92 of whom were female (53.8%). Of the total number of participants, 56 were born in the UK (32.9%) and 114 (67.1%) were not. Four of the participants were 3rd generation immigrants, with the remaining 167 either 1st or 2nd generation immigrants. The ethnicity of the participants is presented in Table 1.

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<th>Ethnicity</th>
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<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladeshi</td>
<td>66</td>
<td>38.6</td>
</tr>
<tr>
<td>Indian</td>
<td>48</td>
<td>28.1</td>
</tr>
<tr>
<td>Pakistani</td>
<td>20</td>
<td>11.7</td>
</tr>
<tr>
<td>Sri Lankan</td>
<td>18</td>
<td>10.5</td>
</tr>
<tr>
<td>African-Asian</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>Asian Other</td>
<td>5</td>
<td>2.9</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>7.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>171</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

For the purposes of the study the participants were divided into 3 age groups: group 1 included those aged between 18-29 years (N=63, 37.3%, 21 males, 42
females), group 2 included those aged between 30-49 years (N=59, 34.9%, 33 males, 26 females), and group 3 included those aged between 50-75 years (N=47, 27.8%, 24 males, 23 females).

Measures

A 64-item questionnaire was used and designed specifically for this study (see Appendix C). The questionnaire was sub-divided into 8 sections (A-H). The first part of Section A included demographic questions (e.g. age, gender, ethnicity etc.). The second part of Section A included the Strength of Identification Scale (SoIS) (Barrett, 2007), which was used to assess the individual’s level of ethnic identification. This included 4 items on a 7-point Likert scale ranging from 1 (high identification) to 7 (low identification).

Section B included questions about the participant’s religion and level of religious identification. Firstly, the participant was asked if they were religious and if so, which religion they subscribed to. Then the SoIS (Barrett, 2007) was used to assess the individual’s level of religious identification.

Section C included questions about the participant’s level of British identification. Firstly, the participant was asked if they were British, then the SoIS (Barrett, 2007) was used to assess the individual’s level of British identification.

Section D comprised the Perceived Discrimination Scale (Cassidy, O’Connor, Howe, & Warden, 2005), a standardised scale that attempts to assess an individual’s perceptions of how frequently they feel discriminated against because of their ethnic or religious background. A 7 point Likert scale was used to assess frequency ranging from 1 (never) to 7 (very often).
Section E comprised the Rosenberg Self-Esteem Scale (Rosenberg, 1989), a standardised scale that assesses an individual's level of self esteem. The participant was presented with ten statements pertaining to self-esteem and was asked to respond to each statement with their level of agreement from 1 (strongly agree) to 4 (strongly disagree).

Section F comprised the Satisfaction with Life Scale (Diener, Emmons, Larsen, & Griffin, 1985) a standardised scale that attempts to assess an individual's level of life satisfaction. The participant was presented with five statements pertaining to life satisfaction and was asked to respond to each statement with their level of agreement from 1 (strongly disagree) to 7 (strongly agree).

Section G comprised the Perceived Stress Scale (Cohen, Kamarck, Mermelstein, 1983), a standardised scale that attempts to assess the degree to which situations in an individual's life are appraised as stressful. For example, one of the questions was based around the frequency an individual felt they were coping effectively. A 5 point Likert scale was used to assess frequency ranging from 1 (never) to 5 (very often).

Section H comprised questions designed specifically for this study to assess an individual's likelihood to use various forms of social support if they were overwhelmed with stress. The participant was presented with eight statements pertaining to who they would talk to if they needed support. The participant was then asked to respond to each statement with their level of agreement from 1 (strongly disagree) to 7 (strongly agree).

Once the questionnaire was constructed, it was given, along with the information sheet, to eight, randomly recruited South Asian participants for feedback on its ease of completion, the clarity of the items and the time taken to complete it which potential participants were informed of on the information sheet (see Appendix B).
The questionnaire was followed with a debriefing sheet (see Appendix D), which outlined the purpose of the study, what would happen to the completed questionnaires and who to contact should they feel unsettled by the study.

Procedure

The participants were recruited via a number of means. Some were recruited at university by approaching South Asian individuals. Others were recruited through attendance at community gatherings. The vast bulk, however, were recruited through snowballing techniques whereby one participant would distribute a further ten or more questionnaires amongst friends, colleagues and peers. The participants were asked to read the questions and to answer as honestly as possible. The completed questionnaires were then returned to the researcher by post or by proxy. Completion and return of the questionnaires was taken as indicating participant consent, as explained in the information sheet.

Ethical considerations

Ethical approval was granted by the Faculty of Arts and Human Sciences Ethics Committee at the University of Surrey (see Appendix E). The identities of the institution, supervisor and researcher were explicitly stated on the information sheet and contact information was provided clearly. Participants were invited to contact the researcher or supervisor should they have any questions regarding the research or require further information. Participants were informed that there was no obligation to complete the questionnaire and should they decide not to complete it, they would not have to justify their reasons. They were also informed that they could withdraw from the study at any time. Participants were not asked to provide any identifying information, thus ensuring the data set remained
anonymous. Given that the research was not of an overtly sensitive nature, it was not expected that participants would be upset by the questions. However, on the debriefing sheet, participants were assured that should they feel unsettled by the questionnaire, they could contact the researcher who would help them in finding further support.

**Power calculations**

Tabachnick and Fidell (2007) recommend using $N = 50 + 8M$ participants for multiple regression (where $N =$ size of the sample, $M =$ number of predictor variables). The current study used 7 predictor variables, which means that a minimum sample size should be 106, which was surpassed ($N = 171$).

**Results**

**Recoding and data preparation**

Some of the items had been devised with a score of 1 corresponding to the positive end of the scale i.e. 'very important' or 'strongly agree', and a high number corresponding to the negative end of the scale. These items were therefore reverse coded so that a high number would represent a positive response and a 1 would represent a negative one.

All of the scale items were initially subject to exploratory factor analyses (principal components method of extraction, oblimin rotation) with the aim to discover the main constructs within the questionnaire and to identify whether and how items related to each other. These factors then underwent reliability tests to test their internal reliability.
Factor analysis on items 7, 8, 9, and 10, which looked at ethnic identification, uncovered one component accounting for 53.89% of the variance. The eigen value was 2.16. The reliability test revealed a Cronbach’s Alpha of 0.69, a sufficient degree of internal reliability. Therefore, an ethnic identity variable was derived as the mean of the responses on these items.

Factor analysis on items 13, 14, 15, and 16, which looked at religious identification, uncovered one component accounting for 62.74% of the variance. The eigen value was 2.51. The reliability test revealed a Cronbach’s Alpha of 0.78, a good degree of internal reliability. Therefore, a religious identity variable was derived as the mean of the responses on these items.

Factor analysis on items 18, 19, 20, and 21, which looked at national identification, uncovered one component accounting for 62.56% of the variance. The eigen value was 2.50. The reliability test revealed a Cronbach’s Alpha of 0.79, a good degree of internal reliability. Therefore, a British identity variable was derived as the mean of the responses on these items.

Factor analysis on items 22, 23, 24, 25, 26, and 27, which looked at perceived discrimination, uncovered one component accounting for 59.56% of the variance. The eigen value was 3.57. The reliability test revealed a Cronbach’s Alpha of 0.86, an excellent degree of internal reliability. Therefore, a perceived discrimination variable was derived as the mean of the responses on these items.

Factor analysis on items 28, 29, 30, 31, 32, 33, 34, 35, 36, and 37, which looked at self-esteem, uncovered two components which accounted for 42.17% and 13.36% of the variance respectively. The eigen values were 4.22 and 1.34. However, these two factors were not readily interpretable and a reliability test on all items together revealed a Cronbach’s Alpha of 0.84, an excellent degree of internal reliability. Therefore, it was decided that a single self-esteem variable could be derived as the mean of the responses on these items.
Factor analysis on items 38, 39, 40, 41, and 42, which looked at life satisfaction, uncovered one component accounting for 59.90% of the variance. The eigen value was 3.00. The reliability test revealed a Cronbach’s Alpha of 0.82, an excellent degree of internal reliability. Therefore, a life satisfaction variable was derived as the mean of the responses on these items.

Factor analysis on items 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, and 56 which looked at stress, uncovered three components which accounted for 35.92%, 16.08% and 8.28% of the variance respectively. The eigen values were 5.03, 2.51 and 1.16. However, these three factors were not readily interpretable and a reliability test on all items together revealed a Cronbach’s Alpha of 0.84, an excellent degree of internal reliability. Therefore, it was decided that a single stress variable could be derived as the mean of the responses on these items.

Factor analysis on items 57, 58, 59, 60, 61, 62, 63, and 64 which looked at who the individual would talk to, uncovered three components. These three factors were interpretable as: talk to a non-ethnic group person (questions 57, 58, 59 and 62) talk to a family member (questions 60 and 61) and talk to an ethnic group member (questions 63 and 64) which accounted for 34.01%, 16.43% and 13.62% of the variance respectively. The eigen values were 2.72, 1.32 and 1.09 respectively. A reliability test on the factor relating to talking to a non-ethnic group member revealed a Cronbach’s Alpha of 0.64, a sufficient degree of internal reliability. Therefore, a variable, ‘talking to a non-ethnic group member’ was derived as the mean of the responses on items 57, 58, 59, and 62. A correlation analysis revealed that the two items relating to talking to a family member (i.e. items 60 and 61) were significantly correlated (r = 0.55, p < .001). Therefore, a variable, ‘talking to a family member’ was derived as the mean of the responses on the items pertaining to it. A correlation analysis revealed that the two items relating to talking to an ethnic group member (i.e. items 63 and 64) were significantly correlated (r = 0.49, p < .001). Therefore, a variable, ‘talking to an
ethnic group member was derived as the mean of the responses on the items pertaining to it.

 Ethnic, religious and British identification

A 3 (age group) x 2 (gender) x 3 (identification) mixed design ANOVA was carried out with independent groups on the first and second factors and repeated measures on the third factor. This revealed a highly significant main effect of identification, $F(2, 246) = 44.49, p < .0001$. Post hoc Tukey HSD tests revealed that religious identification ($M_R = 6.32, SD = 0.97$) was significantly higher than ethnic identification ($M_E = 6.01, SD = 1.02$), and that was significantly higher than British identification ($M_B = 5.16, SD = 1.26$). There were no other significant main effects or interactions.

 Perceived discrimination

A 3 (age group) x 2 (gender) between groups ANOVA with Tukey HSD post hoc tests showed a significant main effect of gender, $F(1, 162) = 6.22$, and a significant main effect of age group, $F(2, 162) = 3.95$ on perceived discrimination. There was no significant interaction between age group and gender. Perceived discrimination was significantly higher with men ($M_M = 3.46, SD = 1.22$) than with women ($M_W = 2.88, SD = 1.28$). The mean score for perceived discrimination was 2.77 for age group 1 (SD = 1.20), 3.28 for age group 2 (SD = 1.31), and 3.50 for age group 3 (SD = 1.25). The post hoc tests revealed that perceived discrimination was significantly higher in age group 3 than age group 1, with age group 2 not being significantly different from either of the other two scores.
Self-esteem

A 3 (age group) x 2 (gender) between groups ANOVA showed no significant effects on self-esteem. The overall mean score for self-esteem was 3.23 (SD = 0.50).

Life satisfaction

A 3 (age group) x 2 (gender) between groups ANOVA showed no significant effects on life satisfaction. The overall mean score for life satisfaction was 4.85 (SD = 1.21).

Stress

A 3 (age group) x 2 (gender) between groups ANOVA showed no significant effects on stress. The overall mean score for stress was 2.79 (SD = 0.55).

Talk to an ethnic group, non-ethnic group or family member

A 3 (age group) x 2 (gender) x 3 (who the individual would talk to) mixed design ANOVA was carried out with independent groups on the first and second factors and repeated measures on the third factor.

The analysis revealed a highly significant main effect of who the individual would talk to, F (2, 328) = 98.11 p < .0001. Post hoc paired t-tests revealed that the likelihood to talk to a family member (M_f = 4.92, SD = 1.53) was significantly higher than the likelihood to talk to a non-ethnic group member (M_N = 3.83, SD = 1.24), and that was significantly higher than the likelihood to talk to an ethnic group member (M_E = 3.04, SD = 1.55). There were no other significant effects.
**Born in the UK**

An independent samples t-test was carried out to see if there were any differences in the dependent variables when the participant was born in the UK and when they were born elsewhere. The analyses revealed a significant effect of birth place on perceived discrimination ($t = 2.70$, $df = 166$, $p < .01$). If participants were not born in the UK, the level of perceived discrimination ($M_N = 3.34$, $SD = 1.27$) was significantly higher than if they were born in the UK ($M_U = 2.78$, $SD = 1.25$).

The analyses also revealed a significant effect of birth place on ethnic identification ($t = 3.28$, $df = 166$, $p < .001$). If participants were not born in the UK, the level of ethnic identification ($M_N = 6.19$, $SD = 0.98$) was significantly higher than if they were born in the UK ($M_U = 5.67$, $SD = 1.00$).

Finally, the analyses revealed a significant effect of birth place on whether the participant would talk to a non-ethnic group member ($t = 2.64$, $df = 168$, $p < .01$). If they were not born in the UK, the likelihood to talk to a non-ethnic group member ($M_N = 4.01$, $SD = 1.25$) was significantly higher than if they were born in the UK ($M_U = 3.48$, $SD = 1.16$). There were no other significant effects of place of birth.

**Ethnicity**

A one-way ANOVA showed a significant main effect of ethnicity (Bangladeshi vs. Indian vs. Pakistani vs. Sri Lankan)$^2$ on: ethnic identification, $F(3, 146) = 3.59$, religious identification, $F(3, 143) = 6.57$, $p < .0001$, British identification, $F(3, 121) = 4.23$, $p < .01$, stress, $F(3, 151) = 3.89$, $p < .01$, likelihood to talk to a non-

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$^2$ The other ethnicities were omitted due to low frequencies.
ethnic group member, $F(3, 151) = 7.39$ $p < .0001$, and likelihood to talk to an ethnic group member, $F(3, 151) = 3.74$. Means and standard deviations are shown in Table 2.
Table 2: Means and standard deviations for ethnic groups

<table>
<thead>
<tr>
<th>Dependent variable</th>
<th>Ethnicity</th>
<th>N</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic identification</td>
<td>Bangladeshi</td>
<td>64</td>
<td>5.90</td>
<td>0.99</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>48</td>
<td>6.21</td>
<td>0.95</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>20</td>
<td>5.50</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>18</td>
<td>6.35</td>
<td>0.85</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>150</td>
<td>6.00</td>
<td>0.99</td>
</tr>
<tr>
<td>Religious identification</td>
<td>Bangladeshi</td>
<td>61</td>
<td>6.49</td>
<td>0.84</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>46</td>
<td>5.96</td>
<td>1.05</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>19</td>
<td>6.89</td>
<td>0.35</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>18</td>
<td>6.51</td>
<td>0.64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>144</td>
<td>6.38</td>
<td>0.90</td>
</tr>
<tr>
<td>British identification</td>
<td>Bangladeshi</td>
<td>56</td>
<td>5.46</td>
<td>1.16</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>38</td>
<td>4.66</td>
<td>1.10</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>20</td>
<td>5.06</td>
<td>1.19</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>8</td>
<td>4.47</td>
<td>1.62</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>122</td>
<td>5.08</td>
<td>1.22</td>
</tr>
<tr>
<td>Stress</td>
<td>Bangladeshi</td>
<td>66</td>
<td>2.60</td>
<td>0.47</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>48</td>
<td>2.94</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>20</td>
<td>2.80</td>
<td>0.59</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>18</td>
<td>2.78</td>
<td>0.52</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>152</td>
<td>2.76</td>
<td>0.55</td>
</tr>
<tr>
<td>Talk to a non-ethnic group member</td>
<td>Bangladeshi</td>
<td>66</td>
<td>4.35</td>
<td>1.12</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>48</td>
<td>3.40</td>
<td>1.15</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>20</td>
<td>3.60</td>
<td>1.09</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>18</td>
<td>4.14</td>
<td>1.11</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>152</td>
<td>3.93</td>
<td>1.20</td>
</tr>
<tr>
<td>Talk to an ethnic group member</td>
<td>Bangladeshi</td>
<td>66</td>
<td>3.40</td>
<td>1.57</td>
</tr>
<tr>
<td></td>
<td>Indian</td>
<td>48</td>
<td>2.46</td>
<td>1.55</td>
</tr>
<tr>
<td></td>
<td>Pakistani</td>
<td>20</td>
<td>3.23</td>
<td>1.61</td>
</tr>
<tr>
<td></td>
<td>Sri Lankan</td>
<td>18</td>
<td>3.28</td>
<td>1.25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>152</td>
<td>3.07</td>
<td>1.58</td>
</tr>
</tbody>
</table>
Student-Newman-Keuls (SNK) post hoc tests revealed the following significant
differences. The Pakistani participants' scores for ethnic identification were
significantly lower than the Indian and the Sri Lankan participants' scores. For
religious identification, the Indian scores were significantly lower than the
Bangladeshi, Sri Lankan and Pakistani scores. For the likelihood to talk to a non-
ethnic group member, the Indian scores were significantly lower than the Sri
Lankan scores, which were significantly lower than the Bangladeshi scores. There
were no other significant differences.

For British identification, stress and the likelihood to talk to an ethnic group
member, SNK post hoc tests failed to locate the differences. Therefore, by default,
the difference must lie between the lowest and the highest means for each factor
(see Table 2). Hence, for British identification, the Bangladeshi mean was highest
and the Sri Lankan mean was lowest. For stress, the Indian mean was highest and
the Bangladeshi mean was lowest, and for the likelihood to talk to an ethnic group
member, the Sri Lankan mean was highest and the Indian mean was lowest.

Relationships between the variables

The relationships between all the variables were explored using partial
correlations, controlling for age. The correlation coefficients and the significance
of the correlations are presented in Table 3.
Table 3: Correlation coefficients for all variables, controlling for age

<table>
<thead>
<tr>
<th></th>
<th>Ethnic Identification</th>
<th>Religious Identification</th>
<th>British Identification</th>
<th>Perceived Discrimination</th>
<th>Self-esteem</th>
<th>Life Satisfaction</th>
<th>Stress</th>
<th>Talk to a non-ethnic group member</th>
<th>Talk to a family member</th>
<th>Talk to an ethnic group member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Identification</td>
<td>-</td>
<td>.24**</td>
<td>.29***</td>
<td>-09</td>
<td>.31***</td>
<td>.22*</td>
<td>-.02</td>
<td>.06</td>
<td>.38***</td>
<td>.06</td>
</tr>
<tr>
<td>Religious Identification</td>
<td>-</td>
<td>.19*</td>
<td>.05</td>
<td>.10</td>
<td>.09</td>
<td>-.16</td>
<td>-.03</td>
<td>.09</td>
<td>.30**</td>
<td></td>
</tr>
<tr>
<td>British Identification</td>
<td>-</td>
<td>-.10</td>
<td>.16</td>
<td>.06</td>
<td>-.03</td>
<td>.07</td>
<td>.15</td>
<td>.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived Discrimination</td>
<td>-</td>
<td>-.23**</td>
<td>-.21*</td>
<td>.28*</td>
<td>.25**</td>
<td>.00</td>
<td>.19*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem</td>
<td>-</td>
<td>.45***</td>
<td>-.38***</td>
<td>-.04</td>
<td>.23**</td>
<td>-.12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>-</td>
<td>-.45***</td>
<td>-.05</td>
<td>.14</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>-</td>
<td>-.07</td>
<td>-.01</td>
<td>.02</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to a non-ethnic group member</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talk to a family member</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td>.19*</td>
<td></td>
<td></td>
<td></td>
<td>.33***</td>
<td></td>
</tr>
<tr>
<td>Talk to an ethnic group member</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.26**</td>
<td></td>
</tr>
</tbody>
</table>

Note: * = significant at the .05 level, ** = significant at the .01 level, *** = significant at the .001 level
Multiple regression

Multiple regression analyses were carried out to see if there were any effects of the predictor variables (ethnic identification, religious identification, British identification, perceived discrimination, self-esteem, life satisfaction and stress) on the three outcome variables (talk to a non-ethnic group member, talk to a family member and talk to an ethnic group member).

For the likelihood to talk to a non-ethnic group member the regression model was significant ($R^2 = 0.14$, $F(7, 127) = 2.71$, $p < .05$). Perceived discrimination was found to be a significant predictor as was stress (see Table 4).

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Identification</td>
<td>.145</td>
<td>.119</td>
<td>.117</td>
</tr>
<tr>
<td>Religious Identification</td>
<td>-.146</td>
<td>.116</td>
<td>-.111</td>
</tr>
<tr>
<td>British Identification</td>
<td>.100</td>
<td>.090</td>
<td>.100</td>
</tr>
<tr>
<td>Perceived Discrimination</td>
<td>.291</td>
<td>.081</td>
<td>.316***</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>-.166</td>
<td>.292</td>
<td>-.058</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>-.093</td>
<td>.113</td>
<td>-.084</td>
</tr>
<tr>
<td>Stress</td>
<td>-.563</td>
<td>.247</td>
<td>-.230*</td>
</tr>
</tbody>
</table>

Note: * = significant at the .05 level, ** = significant at the .01 level, *** = significant at the .001 level

For the likelihood to talk to a family member the regression model was significant ($R^2 = 0.19$, $F(7, 127) = 3.92$, $p < .001$). Ethnic identification was found to be a highly significant predictor (see Table 5).
Table 5: Multiple regression for the likelihood to talk to a family member

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>(\beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Identification</td>
<td>.526</td>
<td>.141</td>
<td>.348***</td>
</tr>
<tr>
<td>Religious Identification</td>
<td>-.060</td>
<td>.138</td>
<td>-.037</td>
</tr>
<tr>
<td>British Identification</td>
<td>.060</td>
<td>.107</td>
<td>.050</td>
</tr>
<tr>
<td>Perceived Discrimination</td>
<td>.091</td>
<td>.097</td>
<td>.081</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>.451</td>
<td>.347</td>
<td>.129</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>.059</td>
<td>.134</td>
<td>.044</td>
</tr>
<tr>
<td>Stress</td>
<td>.084</td>
<td>.293</td>
<td>.028</td>
</tr>
</tbody>
</table>

Note: * = significant at the .05 level, ** = significant at the .01 level, *** = significant at the .001 level

For the likelihood to talk to an ethnic group member the regression model was

significant (\(R^2 = 0.14\), \(F(7, 127) = 2.77\), \(p < .05\)), and religious identification was found to be a significant predictor (see Table 6).

Table 6: Multiple regression for the likelihood to talk to an ethnic group member

<table>
<thead>
<tr>
<th></th>
<th>B</th>
<th>Std. Error</th>
<th>(\beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Identification</td>
<td>.070</td>
<td>.147</td>
<td>.046</td>
</tr>
<tr>
<td>Religious Identification</td>
<td>.459</td>
<td>.144</td>
<td>.283**</td>
</tr>
<tr>
<td>British Identification</td>
<td>.048</td>
<td>.111</td>
<td>.039</td>
</tr>
<tr>
<td>Perceived Discrimination</td>
<td>.199</td>
<td>.101</td>
<td>.174</td>
</tr>
<tr>
<td>Self Esteem</td>
<td>-.508</td>
<td>.361</td>
<td>-.144</td>
</tr>
<tr>
<td>Life Satisfaction</td>
<td>.034</td>
<td>.139</td>
<td>.025</td>
</tr>
<tr>
<td>Stress</td>
<td>-.095</td>
<td>.305</td>
<td>-.031</td>
</tr>
</tbody>
</table>

Note: * = significant at the .05 level, ** = significant at the .01 level, *** = significant at the .001 level
Discussion

The present study aimed to explore the relationships between acculturation, acculturative stress and the likelihood to use various sources of support in South Asian people.

Who to talk to?

Overall it appeared that South Asians would be most likely to talk to family members, then non-ethnic group members and they would be least likely to talk to ethnic group members. This is in accordance with the first hypothesis. This may be partly explained by a stance within some ethnic minority groups whereby the family is felt to share responsibility for an individual’s problems (Sabogal, Marin, Otero-Sabogal, Marin & Perez-Stable, 1987), or that mental illness is best treated within the family (Edgerton & Kamo, 1971). This could tie in with the finding that those with a higher level of ethnic identification were more likely to talk to a family member. Those with a stronger sense of ethnic identity may be more likely to align themselves with the above-mentioned views and as a result, may be more likely to talk to a family member if they needed support.

The second hypothesis posited that South Asians would be less likely to talk to a medical professional. This hypothesis was partially supported. On the whole, South Asians were less likely to talk to a medical professional than a family member. However, it was found that those not born in the UK would be more likely to talk to a non-ethnic group member. Perhaps this could be put down to a post-colonial sense of trust in medical professionals that some first generation immigrants have. The view of such professionals is that they are somewhat deified as those who can ‘cure all’.

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From another perspective, those that were born in the UK were less likely to talk to a non-ethnic group member. This may be as a result of the stigma or shame relating to mental illness felt by some ethnic minority groups (Silva de Crane & Spielberger, 1981). In Silva de Crane and Spielberger's study (1981) they used a young sample of college students and they found that the views of the ethnic minority students towards mental illness were more negative than their majority counterparts'. Therefore, the finding in the current study may be more indicative of the shame felt by younger ethnic minority individuals, as reflected in Silva de Crane and Spielberger's study.

In accordance with the third hypothesis, those who had a high level of religious identification were found to be more likely to talk to a member of their ethnic group. This is not particularly surprising as someone with stronger religious connections may well feel more comfortable talking to a religious leader than someone with no religious affiliations whatsoever.

It was found that those with high levels of perceived discrimination would be more likely to talk to a non-ethnic group member. Research has shown that ethnic minority individuals who experience high levels of discrimination may either identify with their own ethnic group or try to associate with the majority group (Barrett, Eade, Cinnirella & Garbin, 2006). Contrastingly, the current study found that perceived discrimination impacted on the practice of the individual (i.e. whether they would speak to a non-ethnic group member) rather than on their identity.

The results showed that those with a high level of stress would be less likely to talk to a non-ethnic group member. Research has shown that high levels of stress can be associated with a sense of hopelessness (Abramson, Metalsky & Alloy, 1989). It is possible that those who were stressed felt more hopeless and less motivated to seek help from a non-ethnic group member, perhaps in the belief that doing so would not help.
In addition to this, it was found that those who would talk to a member of any one category (ethnic, non-ethnic and family) would be more likely to talk to a member of the other categories, hence, someone willing to talk to one group would be more likely to talk in general. This finding makes sense, as it seems plausible that someone who saw the value in communicating their difficulties would be prepared to do so in a number of different settings.

**Acculturative stress**

It was found that perceived discrimination and stress were correlated. Levels of perceived discrimination and stress were both negatively correlated with self-esteem and life satisfaction, as predicted in the hypothesis. Therefore, in this study, high levels of perceived discrimination and stress, as well as low levels of self-esteem and life satisfaction, were taken as an indicator of acculturative stress.

The results revealed that men experienced a greater degree of perceived discrimination than women. This could be because South Asian men enter into more life contexts where there is the possibility of experiencing discrimination (e.g. in the work place). The discrimination may come in the form of being less well accepted, being the object of negative attitudes, or experiencing hostility or rejection. In its myriad different forms, discrimination is a factor that is predictive of poor long-term adaptation (Liebkind & Jasinskaja-Lahti, 2000).

**Identity**

In the sample it appeared that religious identity was stronger than ethnic identity, which was in turn stronger than British identity. This would suggest that South Asians have a higher level of religious identification than ethnic or national
identification. However, in the questionnaire, if a participant stated that they did not have a religion they were instructed not to answer any further questions on religious identification. Consequently there was a much smaller sample of those who deemed themselves 'religious' and this may have skewed the results in favour of a religious bias.

Additionally, it was found that those who had a high level of identification on one of the scales (e.g. ethnic identification) tended to have a high level of identification on the other two (that is, religious and British, and vice versa). In acculturation terms, this would imply that these participants had assumed the integrative strategy, or to use LaFromboise's terminology, perhaps they were 'alternating' (LaFromboise, Coleman & Gerton, 1993). Another possibility is that this finding could reflect a measurement issue. Perhaps participants were using the Strength of Identification Scales differentially, but they may have been giving the same meaning to the different scales.

The findings also showed that a high level of ethnic identification was related to high levels of self-esteem and life satisfaction. This would imply that separation and integration are the most adaptive strategies for South Asian immigrants. This is partially reinforced by previous literature, which has found integration to be the most adaptive strategy (e.g. Berry, Phinney, Sam & Vedder, 2006).

**Birthplace**

The results revealed that those not born in the UK, i.e. the first generation immigrants and the non-British nationals, had higher levels of ethnic identification, higher levels of perceived discrimination and they would be more likely to talk to a non-ethnic group member if they needed support. Perhaps unsurprisingly, the levels of ethnic identification of this group were higher as a result of their early experiences being associated with their country of origin.
Also, assuming that their first language was that of their country of origin, this may have had a sizeable impact on how they identified themselves in adulthood.

Many of the first generation of South Asian immigrants came to the UK in the 60s and 70s when there were still relatively few non-White people living in the UK. As a result of this, as well as the political climate at the time (e.g. Powell, 1969), there was a greater degree of racism in society at large. This may go some way to explaining the higher degree of perceived discrimination amongst those who were not born in the UK, which is backed up by the higher levels of perceived discrimination in those in age group 3 (i.e. those aged 50-75 years).

*Ethnic group differences*

There were some curious ethnic group differences. Indians and Sri Lankans were found to have stronger ethnic identification than Pakistanis. This could be explained by considering the fact that in Pakistan the dominant religion is Islam, which in its ethos stresses the importance of an Islamic ‘brotherhood’ uniting Muslims around the world. Therefore perhaps Pakistani people, as a result of their religion would prioritise their Muslim identity over their ethnic identity. However, given that the majority of the Bangladeshi population is also Muslim, one might expect Bangladeshis to have a lower level of ethnic identification, but this was not the case in the current study.

With regards to religious identification, Bangladeshis, Sri Lankans and Pakistanis had a higher religious identification that Indians. This could be because India is a plural country where many religions co-exist, therefore there might be less emphasis placed upon religion in India. However, in Bangladesh, Sri Lanka and Pakistan, there are only one or two main religions in each country, therefore it might be more prominent in the way people from these countries identify themselves.
Bangladeshis were more likely to talk to a non-ethnic group member than Sri Lankans, who were more likely than Indians. It is possible that Indian people, who were historically the first from the Indian sub-continent to migrate to the UK depend more on other sources for support than the relatively newer Sri Lankan and Bangladeshi migrants, who may feel more inclined to talk to medical professionals or friends for support.

In practice, much of the Sri Lankan data was collected face-to-face and it was noted by the investigator that the majority of Sri Lankan participants were Tamil. Bangladeshis were found to have a stronger sense of British identification than Sri Lankans. This could be as a result of the recent warring in Sri Lanka where British Tamils have sought the support of the British government to help put a stop to the violence. The British government have not intervened and this has caused a degree of ill-feeling amongst British Tamils. Therefore, they may feel less inclined to identify themselves as British than their Bangladeshi counterparts.

Indians were more stressed than their Bangladeshi counterparts. This increased level of stress might be as a result of a degree of pressure to succeed and status anxiety that is stereotypically common amongst Indians in the UK.

Sri Lankans were more likely to talk to an ethnic group member than Indians. Sri Lankans are a numerically smaller group than Indians in the UK (National Statistics, 2003). Being a member of a numerical minority can lead to an increase in in-group cohesion, which might explain why Sri Lankans would be more likely to speak to member of their own ethnic group. Whereas Indians, who are a larger group, might be more integrated into British society and less focussed on their in-group, therefore less inclined to speak to a member of their own ethnic group.
Limitations and further research

There were various limitations of the study. The use of single item measures (i.e. the items inquiring about the likelihood to talk to different people) is problematic in that these measures are more prone to random error, and they are unable to fully explore the complex factors that influence attitudes. It is also worth noting that although the sample varied with regard to age, gender and ethnicity etc., it is possible that some of the findings are due to other confounding variables that have not been measured. In addition to this, it cannot be inferred from the findings that participants would act on the views expressed by their responses, i.e. participants were asked who they would talk to as a hypothetical question. Therefore, the findings can only give an indication of their preferences. Future research should explore the relationships between acculturation and acculturative stress in those who have opted to seek help within a medical setting or elsewhere.

Implications for practice

This study highlights the fact that South Asian people would rather seek help from a family member than a professional. This has far-reaching implications, as the help that they would get from an un-trained person might not be the most appropriate for their concerns. This could leave a lasting impact on the individual and have future repercussions on their mental health. Therefore, it is vital to have further follow-up studies investigating the role of psychology outreach teams as well as better education for psychologists to improve access to ethnic minority individuals.

Research has shown that ethnic minority individuals are more likely to seek help within the mental health service system when ethnic-specific agencies are used as opposed to when mainstream providers are involved (Akutsu, Snowden & Organista, 1996). Therefore, perhaps mental health services should be tailored to
meet the distinctive needs of the ethnic minority groups in different community settings. Locally based services may be able to reduce health care inequalities by being directly in touch with service users. This may include increased collaboration with community or religious organisations to provide information about services.

In addition to this it might be helpful to have a greater accommodation of religious and cultural values in providing mental health treatment to ethnic minority individuals. Counselling psychologists will require an increased sensitivity to cultural and spiritual matters to ensure engagement with their ethnic minority clients. Sue (1977) talked about the need for therapists working with ethnic minority clients to be 'sensitive to each client's cultural milieu' (p. 622). Researchers have developed cross-cultural counselling competencies (e.g. Sue et al., 1982) and psychologists as well as training bodies will have to integrate such competencies into their work to avoid the alienation of ethnic minority clients. More active monitoring and a review of current services would be beneficial in order to gain a better understanding of current practice. In order to minimise ethnic disparities in service use and access, appropriate care pathways must be encouraged.
References


Appendices
Appendix A:

Personal reflections
Personal reflections

I had very distinct expectations about carrying out a quantitative study this year having undertaken a qualitative piece last year. During last year's research I felt emotionally involved throughout the process, drawing up vignettes and carrying out interviews, and this year I thought that I would be much more detached. I was wrong.

Compiling the questionnaire encouraged me to consider my future participants and wonder about how the questions might come across to them. I thought about my mother and father (both first-generation Bangladeshi migrants) and how they might respond to the questions. This immediately drew me in to their content, and I felt quite propelled to construct both a 'good', scientific questionnaire, and one that would capture the participants and represent them fairly. This felt quite pressurised for me. The support of my supervisor was invaluable. With his encouragement and containment, I felt able to proceed with the task at hand without becoming overwhelmed.

Once the questionnaire was constructed, I began to plan my mode of distribution. I found myself in contact with old family friends and peers of my mother and father who had also come to England in the 60s. This was a fascinating process, meeting with them and gaining a snapshot into their lives. I also arranged meetings with groups, for example the university Sikh Society. This too was interesting as I became aware for the first time of groups that existed for people like me. On the whole, people were enthusiastic about the project and in a short space of time my questionnaires were being distributed amongst friends of friends, work colleagues and neighbours. It was brilliant. It was as though the project was organic and had developed a life of its own and I was so pleased that people were responsive and willing to help.
I found the process of going through the returned questionnaires quite touching at times. The participants’ age and ethnicity, the ways in which they had marked their responses, their handwriting styles and the coloured ink in which they wrote all contributed to my fantasies about them. I imagined what they might look like and what they were like. Some of the responses were particularly moving, for example, the questions on perceived discrimination. Some participants had stated that they often felt excluded and bullied as a result of their ethnic or religious background. This was sad to hear. It brought back memories for me of being excluded as a school girl and I felt shocked and angry that this could still be happening now, to adults, some twenty years later.

I felt frustrated that I couldn’t ask participants why they had responded in the way that they had, and it seemed like some participants had also felt frustrated at times. Some had annotated their questionnaires with feedback, as well as a more textured response than my tick boxes were allowing them. For example, when asked about their level of religious pride, one participant had marked that they were very proud of their religion and had written underneath ‘I am not an extremist’. This captivated me. I wondered about whether the participant had felt judged by the question and how easily questions can assume a certain tone.

When asked how important their ethnicity was, another participant had written ‘Depends on the issue, e.g. food – yes, very important! Otherwise, not really.’ This set my mind racing with theoretical questions about identification and context, but it also brought my attention to one of the main difficulties with questionnaires. In a questionnaire study, participants are often forced to reduce a complex thought into a one-word, tick-box answer. This can become overly simplistic and it appeared to me that some of my participants had felt boxed in. This was exasperating and I sometimes felt unsatisfied with the process of gaining a tantalising window into someone’s life without the opportunity of filling in the blanks. On the other hand, I was able to access 171 participants and I felt very grateful for each questionnaire returned to me.
Overall, the process was an enjoyable one although it was at times frustrating. I learnt that quantitative research needn't be the dispassionate, sterile venture that I imagined it would be.
Appendix B:

Information sheet
Dear participant,

I am a final year trainee on the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. As part of my doctoral studies I am conducting a research project exploring how South Asian people view themselves, supervised by Professor Martyn Barrett in the Department of Psychology.

I need your help to do this – please fill in the enclosed questionnaire. The aim of this questionnaire is to find out how you think and feel about various things. This means it is your own ideas and thoughts that count. There are no right or wrong answers, so please just be honest and open when answering all of the questions. If you do not know the answer to a particular question, please don’t worry about it. Just write on the questionnaire that you do not know the answer to that question, and move on to the next question. And if you do not want to answer any of the questions, please just leave it blank. Please note that there is no obligation to
complete the questionnaire and should you decide not to complete it, you will not have to justify your reasons.

If you have any queries about this research project, you can contact me by email, Anita Chakraborty (ac00012@surrey.ac.uk) or my supervisor, Professor Martyn Barrett (m.barrett@surrey.ac.uk).

Any information that you give will be kept in strict confidence. The results will be analysed and written up in such a way that no one who has completed the questionnaire will be identifiable. The questionnaire should take about 10-15 minutes to complete.
Appendix C:

Questionnaire
Section A

[1] What is your age? □

[2] What is your gender? □


[5] Was your father born in the UK? (y/n) □

[6] How would you describe yourself in terms of your ethnicity? Please mark just one of the following boxes, and write in any further details as necessary:

Bangladeshi................................................................. □
Indian........................................................................... □
Pakistani......................................................................... □
Sri Lankan........................................................................ □
African-Asian................................................................. □
Asian Other..................................................................... □
Mixed White and Bangladeshi................................. □
Mixed White and Indian............................................... □
Mixed White and Pakistani........................................... □
Other............................................................................. □

Thinking about your ethnicity as you have shown this above, please mark only one box below the number which shows best how you feel about your ethnicity:

[7] How proud are you of being [your ethnicity]?

Very proud  □  2  3  4  5  6  7

Quite proud □

Not at all proud  □

[8] How important is it to you that you are [your ethnicity]?

Very important □  2  3  4  5  6  7

Neither important nor unimportant □

Not at all important □
[9] How do you feel about being [your ethnicity]?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

[10] How would you feel if someone said something bad about people who are [your ethnicity]?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
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</thead>
<tbody>
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<td>□</td>
</tr>
</tbody>
</table>

Section B

[11] Do you have a religion?

Yes □  No □

If your answer is No, please go to section C (page 3).
If your answer is Yes, please answer the following questions.

[12] How would you describe yourself in terms of your religion? Please mark just one of the following boxes, and write in any further details as necessary:

- Hindu............ □
- Sikh............. □
- Muslim.......... □
- Buddhist........ □
- Christian....... □
- Other............. □  Please specify:  

Thinking about your religion as you have shown this above, please mark a box below the number which shows best how you feel about your religion:

[13] How proud are you of being [your religion]?

<table>
<thead>
<tr>
<th>Very proud</th>
<th>Quite proud</th>
<th>Not at all proud</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

264
[14] How important is it to you that you are [your religion]?

<table>
<thead>
<tr>
<th>Very important</th>
<th>Neither important nor unimportant</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
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</tr>
</tbody>
</table>

[15] How do you feel about being [your religion]?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[16] How would you feel if someone said something bad about people who are [your religion]?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>4</td>
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<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Section C

[17] Are you British?

Yes □ No □

If your answer is No, please go to section D (page 4). If your answer is Yes, please answer the following questions.

[18] How proud are you of being British?

<table>
<thead>
<tr>
<th>Very proud</th>
<th>Quite proud</th>
<th>Not at all proud</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[19] How important is it to you that you are British?

<table>
<thead>
<tr>
<th>Very important</th>
<th>Neither important nor unimportant</th>
<th>Not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[20] How do you feel about being British?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>6</td>
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<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
[21] How would you feel if someone said *something bad* about British people?

<table>
<thead>
<tr>
<th>Very happy</th>
<th>Neither happy nor sad</th>
<th>Very sad</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4</td>
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<td>6</td>
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<td>7</td>
<td></td>
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</tbody>
</table>

**Section D**

Please answer the following questions by marking one box below the appropriate number to show your response.

[22] How often are you ignored or excluded because of your ethnic or religious background?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[23] How often are you bullied or made fun of because of your ethnic or religious background?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>4</td>
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<td>6</td>
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<tr>
<td>7</td>
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</tbody>
</table>

[24] How often do you feel that other people do *not* see you as British?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Very often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>4</td>
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<td>6</td>
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<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[25] How often do you *not* feel accepted by British people?

<table>
<thead>
<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Very often</th>
</tr>
</thead>
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[26] How often are you called names and teased when you are at work/university because of your ethnic or religious background?

<table>
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<tr>
<th>Never</th>
<th>Sometimes</th>
<th>Very often</th>
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[27] How often are you called names and teased when you are outside work/university because of your ethnic or religious background?

<table>
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<tr>
<th>Never</th>
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Section E

Below are ten statements with which you may either agree or disagree. Using the scheme below, indicate your level of agreement or disagreement with each statement by marking a box below the appropriate answer. Please be open and honest in your responding.

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<tr>
<td>Strongly agree</td>
<td>Agree</td>
<td>Disagree</td>
<td>Strongly disagree</td>
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[28] On the whole, I am satisfied with myself

[29] At times I think I am no good at all

[30] I feel that I have a number of good qualities

[31] I am able to do things as well as most other people

[32] I feel I do not have much to be proud of

[33] I certainly feel useless at times

[34] I feel that I’m a person of worth, at least on an equal plane with others

[35] I wish I could have more respect for myself

[36] All in all, I am inclined to feel that I am a failure

[37] I take a positive attitude toward myself

Section F

Below are five statements with which you may either agree or disagree. Indicate your level of agreement or disagreement with each statement by marking one box below the appropriate answer. Please be open and honest in your responding.

[38] In most ways my life is close to my ideal


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<tr>
<td>The conditions of my life are excellent</td>
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<tr>
<td>I am satisfied with my life</td>
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<tr>
<td>So far I have got the important things I want in life</td>
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<td>If I could live my life over, I would change almost nothing</td>
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Section G

Please answer the following questions by marking one box below the appropriate answer to show your response. Please be open and honest in your responding.

[43] In the last month, how often have you been upset because of something that happened unexpectedly?

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[44] In the last month, how often have you felt that you were unable to control the important things in your life?

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[45] In the last month, how often have you felt nervous and stressed?

[46] In the last month, how often have you dealt with irritating life hassles?

[47] In the last month, how often have you felt that you were effectively coping with important changes that were occurring in your life?

[48] In the last month, how often have you felt confident about your ability to handle your personal problems?

[49] In the last month, how often have you felt that things were going your way?

[50] In the last month, how often have you found that you could not cope with all the things you had to do?

[51] In the last month, how often have you been able to control irritations in your life?

[52] In the last month, how often have you felt that you were on top of things?
[53] In the last month, how often have you been angered because of things that happened that were outside of your control?


[54] In the last month, how often have you found yourself thinking about things that you have to accomplish?


[55] In the last month, how often have you been able to control the way you spend your time?


[56] In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?


Section H

Below are eight statements with which you may either agree or disagree. Indicate your level of agreement or disagreement with each statement by marking one box below the appropriate answer. Please be open and honest in your responding.

[57] If I were feeling overwhelmed with stress, I would talk to my G.P


[58] If I were feeling overwhelmed with stress, I would talk to a counsellor

[59] If I were feeling overwhelmed with stress, I would talk to someone at work

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[60] If I were feeling overwhelmed with stress, I would talk a family elder

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[61] If I were feeling overwhelmed with stress, I would talk another member of my family (other than a family elder)

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[62] If I were feeling overwhelmed with stress, I would talk to a friend

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[63] If I were feeling overwhelmed with stress, I would talk to a community elder

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[64] If I were feeling overwhelmed with stress, I would talk to a religious leader

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Appendix D:

Debriefing sheet
Dear participant,

Thank you for taking the time to complete this questionnaire.

In this study, we are interested to see if people who have a strong religious, ethnic or national identity will be more likely to seek help from a religious leader, community elder or medical professional. There were also some questions about life satisfaction, self esteem and stress. These were included to see if there is a link between these factors and likelihood to use various sources of support.

Your responses will now be analysed and the results will be written up in such a way that no one who has completed the questionnaire will be identifiable.

If you have any queries about this research project, you can contact me by email, Anita Chakraborty (ac00012@surrey.ac.uk) or my supervisor, Professor Martyn Barrett (m.barrett@surrey.ac.uk).
If you feel at all unsettled by completing this questionnaire, please speak to me and I will help to put you in touch with the relevant support.
Appendix E:

Letter of approval from the

University of Surrey Ethics Committee
Anita Chakraborty
Psychotherapeutic and Counselling Trainee
Department of Psychology
University of Surrey

27th January 2009

Dear Anita

Reference: 280-PSY-08 RS
Title of Project: Do acculturation and/or acculturative stress predict the likelihood of a person of South Asian origin to use psychological services?

Thank you for your submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

Dr Adrian Coyle
Appendix F:

Notes regarding submission of articles to the

British Journal of Social Psychology
MATERIAL REDACTED AT REQUEST OF UNIVERSITY