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A Qualitative Study Exploring Psychologists' Experiences of Establishing Cross-Cultural Therapeutic Alliances

By

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Submitted in partial fulfillment for the requirements for the degree of Master of Social Science in Clinical Psychology in the School of Applied Human Sciences, College of Humanities, University of KwaZulu-Natal.

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2019

DECLARATION

I, **Lauren Barker**, hereby declare that the following study entitled: "*A qualitative study exploring psychologists' experiences of establishing cross-cultural therapeutic alliances*" is my original work except where otherwise stated. I affirm that this dissertation has not been submitted previously for any qualification at any another university. All work of others has been referenced and acknowledged accordingly.

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Signed:  **Date:** **9 July 2019**

ACKNOWLEDGEMENTS

Throughout this study, I have received tremendous support and assistance. Firstly, I would like to acknowledge my research supervisor, Mr. Sachet Valjee, for his invaluable expertise, without his guidance this study would not have been possible.

I'd also like to acknowledge all of the psychologists who provided me with such rich experiences, and for putting aside some of their precious time to participate in this study.

Finally, I would like to thank my mother, Joanne Barker, for her unconditional support throughout my entire academic journey. Thank you for your wise words and unquestionable devotion to being an excellent mother.

ABSTRACT

The therapeutic alliance has been found to be an important component for the successful outcome of psychotherapy. Much research has been dedicated to uncovering the attributes and techniques that aid in the establishment of meaningful therapeutic alliances. However, there is a lack of qualitative research focused on the influence of cross-cultural dynamics on the establishment of therapeutic alliances. Thus, this study aims to explore psychologists' experiences of establishing cross-cultural therapeutic alliances in South Africa and to uncover the attributes and techniques that influence cross-cultural alliances through the use of an explorative, cross-sectional design. In this study, eight clinical/counselling psychologists were purposively selected via an online registry of practicing psychologists in the Durban area of Kwa-Zulu Natal. The participants were interviewed about their experiences of establishing cross-cultural therapeutic alliances through the use of open-ended, semi-structured interviews. The data was interpreted and analyzed thematically with Bordin's (1979) Working Alliance Model as a theoretical framework in mind. The results of this study highlight that there are some limitations to this model, with cultural sensitivity not being acknowledged as an important component of the working alliance. The psychologists' experiences of culturally different client-therapist pairings illustrate how cross-cultural dynamics (i.e., race, gender, language, age, beliefs about mental health, and worldviews) complicate the process of forming meaningful therapeutic alliances in intercultural therapeutic dyads. Cultural knowledge, interpersonal sensitivity, structural flexibility, and conscious awareness of personal/cultural biases were found to be essential when working cross-culturally. Based on these findings, this study suggests that cross-cultural experiences meaningfully influence the establishment of a therapeutic alliance in the South African context and psychologists practicing cross-culturally should continue to reflect on how the complex dynamics of culture infiltrate their therapeutic relationships.

KEY WORDS: *therapeutic alliance, culture, cross-cultural, psychologist, South Africa*

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CHAPTER ONE

INTRODUCTION

The main goal of psychotherapy is to assist clients to change or reduce the problem or distress that brought them to therapy (Koç & Kafa, 2019). Studies in the existing literature indicated that there is much research dedicated to uncovering the factors that facilitate this therapeutic change. A large majority of these studies paid particular attention to the role of the positive client-therapist bond and how this is considered a necessary component of effective psychological treatment (Castonguay, Constantino & Holtforth, 2006).

This meaningful bond, commonly referred to as a 'therapeutic alliance', may be established by enhancing specific personal attributes and utilizing certain therapeutic techniques in order to facilitate a shift in relation to the client's psychological wellbeing (Wampold, 2011). There are various authors who provide therapeutic models that attempt to guide the establishment of a meaningful therapeutic alliance (e.g., Ackerman & Hilsenroth, 2003; Bordin, 1979). However, such guidelines may not adequately accommodate or account for the difficulties or complex dynamics that may be encountered in cross-cultural therapeutic settings. Despite the recent emphasis on multicultural awareness and competency in psychotherapy, there is a lack of research regarding the impact of cross-cultural dynamics on the establishment of the therapeutic relationship, as well a lack of literature that demonstrates how human beings are understood differently in relation to their cultural affiliation in the context of therapeutic alliances in South Africa.

One's cultural context informs one's ability to build trust, establish alliances, communicate effectively and manage the issues related to disclosure (Macewan, 2008). The concept of 'culture' emphasizes intrinsic and extrinsic value and belief differences among individuals and between groups; these cultural dynamics infiltrate the therapeutic environment and may predispose the therapist and client to potential misunderstandings or misinterpretations which could hinder the establishment of a positive, trusting, and meaningful therapeutic relationship (Macewan, 2008). Although there is much research dedicated to the importance of the therapeutic alliance in cross-cultural therapy (e.g., Spangenberg, 2003; Castonguay et al., 2006; Comas-Diaz, 2016), there is a lack of qualitative attention paid to psychologists' experiences of establishing cross-cultural therapeutic alliances in the South African context. Essentially, therapists may be required to approach the 'relational' aspect of therapy from a different angle if they are to construct a meaningful, workable therapeutic alliance with their client within an intercultural dyad. Mainstream

psychotherapy typically upholds a mono-cultural bias that is rarely addressed explicitly and challenging to manage during the establishment of a therapeutic alliance (Comas-Diaz, 2016). This reaffirms the significance of paying careful consideration to the cultural-relational aspects of human life when attempting to establish cross-cultural therapeutic alliances (Vasquez, 2007; Comas-Diaz, 2016).

It is important, then, to explore the experiences had by psychologists of working with cross-cultural clients and to uncover the challenges and relational dynamics that emerge during the process of establishing therapeutic alliances. Expectantly, the results of this study hope to provide useful information to current and future therapists practicing in a multicultural setting, such as South Africa, as well as provide a critical understanding of the experiences that psychologists encounter when working cross-culturally and the techniques or attributes that may hinder or facilitate the cross-cultural alliance. Moreover, it is expected that this study will provide greater awareness about the potential challenges that emerge during therapists' efforts to establish meaningful cross-cultural therapeutic alliances, particularly for those individuals working in culturally-diverse settings.

1.1. Research Aims and Objectives

Study Aims:

- To explore psychologists' experiences of establishing cross-cultural therapeutic alliances.

Study Objectives:

- To determine psychologists' perceptions of the factors that facilitate the establishment of cross-cultural therapeutic alliances.
- To determine psychologists' perceptions of the factors that hinder the establishment of cross-cultural therapeutic alliances.

Study Protocol:

- Data will be collected in the form of semi-structured interviews which will explore psychologists' experiences of establishing cross-cultural therapeutic alliances.
- Structured questions will be used to uncover psychologists' perceptions of the factors that facilitate cross-cultural therapeutic alliances.

- Structured questions will be used to uncover psychologists' perceptions of the factors that hinder cross-cultural therapeutic alliances.

1.2. Research Questions

The following questions are considered in relation to this study:

- What are psychologists' experiences of establishing cross-cultural therapeutic alliances?
- What are psychologists' perceptions of the factors that facilitate cross-cultural therapeutic alliances?
- What are psychologists' perceptions of the factors that hinder cross-cultural therapeutic alliances?

1.3. What to Expect

The need for qualitative research about the cross-cultural therapeutic alliance has been described in this initial chapter. Also, the research aims, objectives, and questions have been put forth to organize the reader's thinking and to clarify what this study hopes to achieve. The subsequent chapters and sub-sections in this study will provide: a thorough review of the relevant literature on the therapeutic alliance and cross-cultural dynamics; a detailed description of the methodology, including the study design, participant description, sampling procedure, selection criteria, data collection procedure, interpretation and analysis, and efforts to ensure trustworthy and ethical research; a clear description of the results of the study, consisting of the emergent themes and sub-themes supported by verbatim quotations; a critical discussion of the findings against the existing literature; and a conclusion that sums up the study and links the findings with the original research aim. Included in the conclusion are the limitations to this study and recommendations for future research and practice.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

The following chapter aims to provide a review of the literature that is relevant to this study. In South Africa, a country characterized by diversity and individual differences, the process of establishing meaningful working alliances between cross-cultural client-therapist pairings may prove challenging for the therapeutic process.

This chapter will provide a review of the significant, existing literature on the role of the therapeutic alliance and cross-cultural dynamics in therapy by offering a review of the following: a conceptual understanding of the therapeutic alliance; the origins and importance of the therapeutic alliance; the relationship between a meaningful alliance and positive therapeutic outcome; existing models of the therapeutic alliance; influential attributes and techniques; cultural dynamics in relation to the South African context; cross-cultural therapeutic alliances; cross-cultural difficulties within the alliance; the role of culture in establishing therapeutic boundaries; the influence of culture on the experience of transference and countertransference; and the role of discrepant cultural explanations of mental illness.

2.2. Conceptualizing the Therapeutic Alliance

The therapeutic relationship has been a key component of both the theory and practice of psychotherapy since its emergence in the late 1870s (Asbrand, 2012). Various diverse conceptualizations of psychotherapy exist in the literature. However, the American Psychiatric Association (2006) provided a relevant, useful conceptual definition:

> *"Psychotherapy is a change process designed to provide symptom relief, personality change, and prevention of future symptomatic episodes and to increase the quality of life, including the promotion of adaptive functioning in work and relationships, the ability to make healthy and satisfying life choices, and other goals arrived at in the collaboration between client/patient and psychotherapist"* (p. 271).

This definition emphasized the importance of the collaboration between the client and the psychologist in achieving therapeutic goals. Frank and Frank (1991) provided a more relationship-focused conceptualization of psychotherapy which demonstrates the importance of a meaningful, well-established therapeutic alliance:

> *". . . A planned, emotionally charged confiding interaction between a trained, socially sanctioned healer and a sufferer"* (p. 24).

Their conceptualization of the alliance focused on the emotional, supportive nature of the relationship between a client and a psychologist, with the psychologist harboring a set of skills and attributes that benefit a suffering individual. Pritz (2002) attempted to provide a cross-sectional definition of the developing field of psychotherapy:

> *"Psychotherapy is the systematic application of defined methods in the treatment of psychic suffering and psychosomatic complaints as well as life crises of various origins. The basis for treatment is the relationship of the psychotherapist to the patient, or in a non-clinical setting to the client. The target group for psychotherapy includes people with emotional problems but also people who would like to extend their possibilities for social and 'inward' actions. Psychotherapy is thus also in many cases preventative"* (p. 13).

In order to consolidate the varying conceptualizations of psychotherapy, Wampold (2001) identified four common, defining components of psychotherapy present across most definitions, namely: (1) psychotherapy is primarily an interpersonal treatment modality as it relies on the establishment of a relationship between two separate individuals; (2) psychotherapy involves a therapist and a client – one individual with expertise and one individual with a presenting problem that requires assistance; (3) psychotherapy is remedial as it attempts to 'remedy' or help the client work through their presenting problem; and (4) psychotherapy may be individualized to the specific needs of the client (Wampold, 2011).

However, across most definitions, one of the most important aspects of psychotherapy is its interpersonal and dynamic nature that is represented by the therapeutic relationship (Wampold, 2001). As the typical goal of psychotherapy is to assist clients to work through their problems in life, it is essential that therapists understand the various dynamic factors in therapy that facilitate or hinder this process (Macewan, 2008). Research by Ackerman and Hilsenroth (2003) illustrated how the characteristics and actions of the therapist were essential to consider during the establishment of a positive, meaningful therapeutic alliance with the client. Hence, such factors are invaluable when assisting the client work through their presenting problems or psychological distress. Upon review, there is a wealth of literature exposing the factors that facilitate this therapeutic change with particular attention paid to the role of the therapist and the positive client-therapist bond (Castonguay, Constantino & Holtforth 2006). Before reviewing the literature on the role of the therapeutic alliance, one should consider the origins of the therapeutic alliance and the perspectives of

various therapeutic orientations in relation to the role and perceived importance of the alliance for successful psychotherapy outcomes.

2.3. Origins of the Therapeutic Alliance

The therapeutic alliance may be described simply as a client-therapist bond that develops in a therapeutic space and dictates how a therapist and client connect, behave, and engage with each other (Harley Therapy, 2016). Depending on one's theoretical orientation, one's view of the therapeutic alliance may differ from another. In the context of South Africa, the dominant frameworks in psychology and psychotherapy curricula in undergraduate and post-graduate studies are deeply rooted within Western thinking (Baloyi, 2008). In South African universities, the training, philosophy and cultural background have entrenched and maintained theories and treatment methods originating from Western epistemologies (Baloyi, 2008). The typical theories and treatment methods emphasized in psychological training are psychoanalytic/psychodynamic therapies, cognitive therapy, behavioural therapy, and humanistic approaches to therapy; these specific therapy schools are common in psychology training globally (American Psychological Association, 2018). Thus, one should consider these typically-utilized frameworks' value of the therapeutic alliance and how it is understood from the various theoretical positions. Three typically-utilized frameworks' perspectives of the therapeutic relationship will be discussed below, namely: psychoanalytic theory, humanistic theory, and cognitive-behavioural theory.

2.3.1. Psychoanalytic perspective

Interest in the interpersonal aspects of the client-therapist relationship dates back over 100 years and has its roots within early psychoanalytic theory, specifically within Sigmund Freud's concept of 'transference' (Macewan, 2008; Freud, 1913). The main assumption of 'transference' involves the unconscious projection of positive and/or negative attitudes and emotions from the client onto the therapist who replaces the clients' parental figures (Ardito & Rabellino, 2011). Initially, the concept of transference was regarded as a negative factor in the therapeutic setting. However, Freud shifted his initial negative perspective of transference whereby later he considered the possible benefits of an attachment that develops between the therapist and the client (Ardito & Rabellino, 2011). Since Freud introduced the interpersonal dynamics between the therapist and the client, numerous other psychotherapists have contributed to the existing knowledge of the client-therapist relationship (Macewan, 2008). Psychoanalyst, Elizabeth

Zetzel (1956), first coined the term 'therapeutic alliance' and she considered it to be the relationship between a psychologist and the healthy part of a client/patient's ego. Zetzel (1956) emphasized that a sound therapeutic alliance is imperative for effective psychoanalysis and that interpreting transference is only useful once a meaningful therapeutic alliance has been established. Similarly, Ralph Greenson (1965) emphasized the importance of the therapeutic alliance and considered it to be a reality-based collaboration between a therapist and a client. Greenson (1965) proposed that a positive, meaningful therapeutic alliance that encourages active collaboration between a client and a therapist is a necessary component for the client's overall improvement in therapy.

2.3.2. Humanistic perspective

From a humanistic perspective, Carl Rogers (1959) considered the therapeutic alliance to be comprised of three curative elements: empathy, congruence, and unconditional positive regard. Here, it is the therapist's relationship behaviours and personal attributes that are central to facilitate the establishment of a meaningful therapeutic alliance and, ultimately, therapeutic change (Booth, Thompson & Campbell, 2009). To conceptualize this further, an article by Feurtes, Brady-Amoon, Thind and Chang (2015) explained that the alliance includes a positive perception of the each other which allows for greater genuineness and the utilization of emotional displacements in a warm, therapeutic manner. Their understanding of the therapeutic alliance borrowed from Gelso's (2013) conceptualization of the therapeutic alliance; this will be discussed in a subsequent subsection (Feurtes et al., 2015).

2.3.3. Cognitive-behavioural perspective

Sander and Wills (1999) asserted that the role of the therapeutic alliance in Cognitive-Behavioural Therapy (CBT) was not as appreciated as in other theoretical perspectives and was viewed as a 'container' for the use of specific, evidence-based techniques. According to these authors, many psychologists who gravitate towards the CBT perspective pay less attention to the therapeutic alliance which may hinder the overall therapeutic progress (Sander & Wills, 1999). Previously, as mentioned by Giovazolias (2004), the therapeutic relationship was not viewed as necessary to instill change as greater value was placed on restricting automatic thoughts and irrational beliefs. Although recognition was given to the psychologist's characteristics of genuineness, empathy, and warmth, they were not seen as sufficient to create positive change in the client (Beck, Rush, Shaw & Emery, 1979 as cited in Easterbrook & Meehan, 2017). More recently, the therapeutic alliance has been offered

greater recognition in the CBT field as researchers have found that the use of both techniques and interpersonal dynamics typically result in positive therapeutic outcomes for clients (e.g., Giovazolias, 2004). In a study by Whisman (1993) which reviewed research on the therapeutic alliance as an agent of change in CBT, it was found that the therapeutic alliance is a partially-significant factor to create change when used in addition to specific techniques. Beck (2011), as one of the pioneers of CBT, emphasized the need for a warm, supportive therapeutic alliance against the perception of CBT psychologists being emotionless and rigid.

As shown, the majority of psychotherapy schools recognize and appreciate the client-therapist relationship as a core factor in psychological treatment and as a robust predictor of positive therapeutic change (Comas-Diaz, 2016; Vasquez, 2007; Lambert, 2013). According to Norcross (2002, p. 5), "both clinical experience and research findings underscore that the therapy relationship accounts for as much of the outcome variance as specific treatment".

2.4. Therapeutic Alliance and Outcome

There has been a great deal of research conducted on the relationship between the therapeutic alliance and the outcome of therapy (e.g., Ardito & Rabellino, 2011; Booth et al., 2009; Arnow et al., 2013; Horvath & Symonds, 1991; Safran & Muran, 2000). Various studies have shown that the therapeutic alliance is a strong predictor of treatment outcome whereby the stronger the alliance, the more successful the therapeutic outcome (e.g., Martin, Garske & Davis., 2000; Booth et al., 2009). Martin and colleagues (2000) conducted a meta-analysis in order to uncover the relationship between the therapeutic alliance and the outcome of therapy. They emphasized that if a meaningful alliance is established between the client and the therapist, then the client will experience the relationship as therapeutic regardless of the theoretical orientation of the therapist and the treatment interventions used. Hence, they perceived the strength of the alliance as predictive of the therapeutic outcome (Martin et al., 2000; Macewan, 2008). Furthermore, research by Arnow and colleagues (2013) showed that the quality of the therapeutic alliance not only predicts positive change in depressive and anxiety symptoms, but also for medical-physical symptoms. This finding is evident throughout various clinical populations and theoretical orientations whereby the therapeutic alliance was related strongly to positive outcomes. Due to the alliance being an important element for therapeutic change, various authors have developed models that serve as guidelines to

assist therapists with establishing good, strong alliances with their clients – such as Edward Bordin (1979) and Charles Gelso (2013).

2.5. Theoretical Frameworks

2.5.1. Bordin's (1979) Working Alliance Model

Despite widespread acknowledgement of the benefits of a therapeutic alliance, it was Edward Bordin who first proposed a working model of the alliance which emphasizes the collaborative relationship between the therapist and the client in their attempts to overcome the client/patient's distress (Ardito & Rabellino, 2011). Bordin (1979) proposed that the therapeutic alliance is an essential component to therapy and an important agent of change. He emphasized that a focus on the alliance is applicable to different types of therapeutic orientations, and that utilizing his guidelines will ensure a positive alliance. Bordin's Working Alliance Model (WAM) consists of three major elements that he believed to be both necessary and sufficient to the establishment of a meaningful therapeutic alliance, namely: addressing the *goals* of therapy; the *tasks* of therapy; and the *bond* between the therapist and the client (Macewan, 2008).

Firstly, according to Bordin (1979), agreeing on the *goals* of the therapy is an essential component of the therapeutic alliance as the goals constitute the client's stressors, frustrations, and dissatisfactions. Thus, when both the client and the therapist share similar beliefs regarding the goals of treatment and both view the causes of illness and potential treatment methods as relevant and useful, then there is a stronger likelihood of developing a meaningful, agreeable therapeutic alliance (Ardito & Rabellino, 2011).

Secondly, the *tasks* of therapy are the mutually-agreed-upon ways in which the client and therapist will approach psychological treatment (Bordin, 1979). The tasks of therapy also include the concrete components of therapy, such as establishing a contract with the client, negotiating fees, and educating the client (Macewan, 2008). The effectiveness of these tasks will depend on the therapist's ability to connect the tasks with the client's difficulties and the client's ability to understand, accept, and follow through with these tasks (Macewan, 2008; Ardito & Rabellino, 2011). However, the 'goals' and 'tasks' components of therapy may only develop fully once there is an established personal relationship or 'bond' between the therapist and client whereby the client feels comfortable and confident in the therapist's ability to help him/her (Ardito & Rabellino, 2011).

Therefore, Bordin's third component of the WAM is the *bond* between the therapist and the client; this bond should represent a strong, positive connection between both parties characterized by high levels of trust, reliability, and confidence (Bordin, 1979). The *goal* component of the therapeutic alliance relies on the mutual agreement about what constitutes the client's stressors, frustrations, and dissatisfactions. These are essentially the clients' 'problems' and are, in part, a function of their way of thinking, feeling, and acting-out behaviour (Macewan, 2008). Thus, as Bordin claimed, the therapeutic alliance facilitates therapeutic change by driving the treatment interventions (Booth et al., 2009).

Bordin (1979) noted that if the working alliance is not sufficiently developed, then further therapeutic work becomes clouded by the tensions within the alliance – the bond, goals, or tasks (Tsang & Bogo, 1997). Therefore, the assumption is that a therapist who satisfies all three components of Bordin's (1979) Working Alliance Model will set a strong foundation to develop a meaningful therapeutic alliance with the client. However, as according to Ardito & Rabellino (2011), a therapist needs to facilitate some sort of positive 'bond' between himself and the client. In order to do so, the therapist may need to possess certain personal attributes and utilize specific techniques (Ackerman & Hilsenroth, 2001). Another model that focuses on the alliance, the Tripartite Model (i.e., Gelso, 2013) also recognized and elaborated on Bordin's (1979) concept of the working alliance.

2.5.2. Gelso's Tripartite Model

Charles Gelso (2013) has been involved in the recent development of a conceptual model of the therapeutic alliance that he claimed has applicability to all psychotherapy frameworks and is considered a guideline to measure the strength of a therapeutic alliance, namely the *Tripartite Model of the Therapeutic Alliance.* Gelso's motivation for developing this model stemmed from the need for the therapeutic alliance to be differentiated from typical psychotherapy techniques and pre-ascribed roles as 'patient' and 'therapist' (Gelso, 2013). His Tripartite Model hypothesizes that all therapeutic alliances, regardless of the psychologist's theoretical orientation, is made up of three interrelated elements, namely: (1) a real relationship; (2) a working alliance; and (3) a transference and countertransference pattern (Gelso, 2013). Gelso (2013) asserted that during psychotherapy, each element is present and, at some times, one may be more prominent than the others.

(a) The real relationship

Gelso (2013, p. 119) defined the real relationship as, "the personal relationship between the therapist and patient marked by the extent to which each is genuine with the other and perceives or experiences the other in ways that befit the other". Thus, according to the aforementioned definition, two components are necessary for a real relationship, namely: genuineness and realistic perceptions of each other (Gelso, 2013). Gelso (2013) and his colleagues further refined the 'real relationship' concept to account for the extent of the genuineness and realistic perceptions; they termed it 'magnitude'. Furthermore, they also refined the extent to which the genuineness and perceptions are positive or negative; they termed this 'valence'. Gelso (2013) illustrated this construct by stating that one may be genuine but still perceive the other negatively. Thus, the magnitude and the valence of the relationship will indicate the strength of the therapeutic alliance, or 'real relationship' (Gelso, 2013).

(b) The working alliance

Gelso (2013) then asserted that if the 'real relationship' is the foundation for the overall therapeutic alliance, then the working alliance is what allows for the core work of psychotherapy. According to Greenson (1967), experiencing 'real relationships' is part of typical human existence but a working alliance is an object of psychotherapy and the only purpose for its existence is to allow for therapeutic work. Essentially, the working alliance emerges from the 'real relationship'. Gelso (2013) recognized Bordin's (1979) conditions for an effective alliance: (1) that the therapist and the client should experience a working bond; (2) they should agree on the goals of therapy and both should perceive these goals to be attainable; and (3) they should agree on the tasks necessary to achieve those goals. In Gelso's (2013) work, he cited Horvath and colleagues (2011) who concluded that the development of a strong, 'good enough' therapeutic alliance early in the therapy is imperative for successful therapeutic outcomes.

(c) The transference-countertransference configuration

Gelso's Tripartite Model views transference as a universal phenomenon that occurs within all therapies and relationships. Gelso (2013) concluded that transference has effects on both session and treatment outcomes. Gelso and Bhatia (2012) defined transference as:

> *"The patient's experience and perceptions of the therapist that are shaped by the patient's own psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to and in earlier significant relationships"* (p. 385).

In one of his studies, Gelso and Hayes (1998), found that the effect of transference and countertransference can either facilitate or hinder the therapeutic alliance depending on the therapist's perception of the client's level of insight and ability to process such emotional transactions. Both Bordin (1979) and Gelso (2013) acknowledged the importance of a 'bond' or 'real relationship' in establishing a good working alliance. The bond or 'real relationship' may be influenced by cultural factors, specifically cultural differences between the psychologist and the client. Thus, extra consideration may need to be paid to one's perceptions of the client and the manner in which one attempts to establish the therapeutic bond. Although Gelso's Tripartite Model is discussed in this sub-section, it is illustrated only as an addition to the original work put forth by Bordin (1979). Studies that focused on Gelso's model typically involved measuring the strength of therapeutic alliances and its relation to therapeutic outcomes in quantifiable terms (e.g., Gelso, Kivlighan & Markin, 2018). However, Bordin's (1979) Working Alliance Model provides therapists with guidelines as to how they *should* go about establishing a meaningful working alliance (i.e., if his guidelines are followed, the alliance will be successful). As the aim of this study is to explore how psychologists experience the establishment of cross-cultural therapeutic alliances, Bordin's (1979) model appears to be more suitable to utilize as the core theoretical framework.

2.6. The Role of Culture

Psychology, as a discipline and profession, has remained dominated by Western ideas and principles of mental health (Awaad & Riecherter, 2016). A psychology based on such Western principles predisposes therapists to developing a perspective of their client that is incongruent to their cultural context. The Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) are both prepared by the American Psychological Association (APA) and are regarded as the dominant psychological/psychiatric classification systems in the world (Kriegler & Bester, 2013). This preferred use of the DSM and ICD, as well as a reliance on Western-oriented theories of mental illness in South Africa, risks ignoring alternative explanatory models of mental illness that provide a more balanced view of the complex and dynamic relationship between biological and socio-cultural forces in the manifestation of one's mental disorder or psychopathology – this will be discussed further in a later sub-section section (Kriegler & Bester, 2013). Over the past 20 years, much literature has emerged

surrounding the need to adjust psychology training and practice to be more culturally relevant (e.g., Rock & Hamber, 1994) in order to assist therapists to develop contextually-appropriate, holistic understandings of communities, individual cultural identities and diverse understandings of mental health and healing.

2.6.1. Culture in South Africa

As South Africa is known for its diversity and multiculturalism, it is expected that a therapist in this context is highly likely to treat a client who belongs to a culture greatly different to their own. Culture is one aspect of diversity that places emphasis on the differences between individuals and members of groups belonging to various ethnicities and races, as well as those differences between religions, genders and ages (Mayer & Viviers, 2013). However, clients' cultural dynamics are unlikely to be 'left at the door' of the therapy room (Mayer & Viviers, 2013). These factors infiltrate the discipline and practice of psychology and are viewed as part of the therapeutic process, rather than separate from it. Culture should form an important component of therapeutic interventions as it shapes individuals' perceptions and interpretations; this further influences or determines an individual's goals, expectations, relating styles, and understanding of mental illness and healing (Mayer & Vivers, 2013). One's cultural affiliation or cultural identity may further inform one's value system, social and moral reasoning, and sense of judgment (Mayer & Viviers, 2013). A psychologist who is not attuned to these aspects of their client's cultural context may incorrectly assume their client's understanding of their problem and the source of their distress, contravene their personal beliefs, or disrespect their community, family, or cultural norms, such as: asking the client to reveal intimate personal information about themselves or family members; or, by forcing the expression of emotion and affect; and requesting that their clients divulge interpersonal familial disputes prior to establishing credibility and earning their trust (Comas-Diaz, 2016). In such instances, one may assume that cultural dynamics not only feature within the theoretical aspects of psychology but also the relational aspects of therapy, such as within the formation and maintenance of a meaningful client-therapist relationship.

Following this, one may assume that a therapist who is working with a cross-cultural client may have more experiences tainted by obstacles and initial anxieties during the development stage of their therapeutic relationship. A study by Cartwright and Gardener (2016) investigated trainee psychologists' difficulties with engaging their clients in the therapeutic process. The study drew its sample from both Clinical and Counselling

Psychology students in their first year of training at the University of KwaZulu-Natal, South Africa. The sample consisted of 14 female trainee psychologists and 4 male trainee psychologists. The ethnicity of the participants varied as 9 were Black African, 3 were Indian, and 6 were white. Additionally, the ages of the participants ranged between 22 and 42 years of age. Thus, data collected from the study was varied in terms of the participants' cultural background. The study found numerous challenges, such as: difficulties with 'personal material'; difficulties with certainty, control, and idealized intentions; frustrations with the client's presentation; difficulty in becoming the focus of attention; reactions triggered by perceived exclusion; interpersonal strategies to manage intense emotions; and, importantly, *anxieties about differences* – that is, culture, race, religion and age. Therapists' anxiety about differences induced feelings of inadequacy as they felt less able to connect to their client (Cartwright & Gardener, 2016). This was due to the uncertainty about whether certain issues were 'appropriate' to discuss within therapy, or whether certain techniques may affect the therapy negatively, such as a fear of addressing certain issues (e.g., client's defense mechanisms or a client not listening) creating tension (Cartwright & Gardener, 2016). Hence, there appears to be a degree of hesitancy when working with cross-cultural clients based on the therapists' concerns with inherent differences, such as religion, age, and race.

Although the Working Alliance Model provides a basic foundation for the therapist and the client to develop a positive therapeutic alliance, Comas-Diaz (2016) explained that mainstream psychotherapy has a mono-cultural bias that is seldom addressed and difficult to manage in the development of a therapeutic alliance. As the origins of therapeutic models were driven by individualism, attention to the therapeutic alliance with clients from collectivist cultures or different ethnic backgrounds may require special consideration (Vasquez, 2007). Due to therapeutic goals and expectations being determined by an individual's beliefs and values, establishing a meaningful therapeutic alliance with the client requires the therapist to examine and reflect on their own worldviews, beliefs, values, and prejudices in order to be truly empathic and facilitate a genuine helping relationship with the client (Cravener, 1992). Thus, therapists need to recognize that all individuals, including themselves, are influenced by their contexts, including: historical, biological, and sociopolitical factors (Comas-Diaz, 2016). There is a vast amount of literature that acknowledges the profound effect of culture on clinical practice. This may be emphasized by the well-visited issues of utilizing mainstream, individualistic psychological principles and ideas in a non-Western collectivist society (Comas-Diaz, 2016).

2.6.2. Cross-cultural therapeutic relationships

When working cross-culturally, one should consider the socio-cultural dynamics that are inherent in the therapeutic alliance, including the dynamics of race, language, gender, age, and religion (Vasquez, 2007). According to Social Identity Theory, an individual's sense of self is derived from the groups to which that individual belongs. When that individual perceives himself as a member of a group, he identifies with that 'in group'; other individuals who do not suit the criteria for that in-group form the 'out-group'. Thus, this establishes an 'us' versus 'them' mentality characterized by intergroup comparisons and magnified differences between the in- and out-group (Tajfel & Turner, 1986). In the context of a cross-cultural psychotherapy dyad, each party may identify each other as a member of an out-group; consequently, maximizing the differences between each other. This point may be further emphasized by visiting Wood and Petriglieri's (2005) writings on the psychology of polarization and binary thinking, as will be discussed subsequently.

2.6.3. Binary thinking

Reducing multifaceted and complex cultural phenomena into simpler binary sets of choices is reported to be a natural occurrence in human existence and is passed down through generations (Wood & Petrilgieri, 2005). Wood and Petriglieri (2005, p. 31) asserted that "it [binary thinking] can continue to exert an archaic hold on us beyond its usefulness if it prevents us from looking beyond the polarity of opposites". In their writings, Wood and Petriglieri (2005) discussed how human beings develop a habit of thinking and perceiving the world in binary categories, that is two mutually-exclusive groups. Additionally, human beings tend to consider individual differences not as normal variations but as complete opposites. Wood and Petriglieri (2005) cited Melanie Klein's (1985) work on how people 'split' the world into good-and-bad and like-and-do not like positions. In support of Klein's (1985) concept of splitting, Simmel (1950), noted that splitting can occur in larger social groupings which aids in the creation of a polarization of society with the one side as positive (i.e., our side) and the other side as negative (i.e., their side). Again, this re-emphasizes Tajfel and Turner's (1986) concept of in-groups and out-groups. This effect may be illustrated with the well-known Apartheid segregation laws in South Africa. The division of racial categories as white and non-white has trickled down the generations and possibly infiltrates the establishment of the therapeutic alliance (Ruane, 2010). This brings into question the role of ethnic similarity in therapy and its potential beneficence for the client.

2.6.4. Ethnic similarity

Ethnic-matching, or racial similarity, has been described as part of culturally responsive care, an element to reduce mental health problems, and a factor aiding in the establishment of a good working alliance (Meyer & Zane, 2013). A North American study by Rude, Erdur, Baron, Draper and Shankar (2000) focused on the working alliance and treatment outcome among ethnically similar and dissimilar client-therapist pairings. While the study found that cross-cultural pairings did not directly determine the nature of the working alliance, it did find that most clients preferred to enter therapy with therapists who were perceived as ethnically similar. Ethnicity in South Africa is well researched and it is widely acknowledged that the South African society is categorized according to demographic divisions, such as: race, language, socio-economic status, and religion (Lever, 1983). According to Lever (1983), the most prominent social factor that divided the nation is the social construction of racial categories and its permeation into daily life. In relation to ethnicity, Nwoye (2010) discussed the profession of psychology in Africa and how it is a complex field in terms of its targets of intervention and its inherent Western underpinnings. Attending to the needs of the non-white South African population requires a therapist to be aware of their client's history of institutionalized oppression, dehumanization, racial discrimination and prejudice, ethnic conflicts, poverty, and exploitation, among other social injustices (Nwoye, 2010). A psychologist who has not personally lived through social injustices may find challenges in forming a meaningful therapeutic bond with their client based on implicit understanding.

This emphasizes Comas-Diaz's (2016) aforementioned point that emphasized that mono-cultural pairings may lead to fewer therapeutic barriers and interpersonal challenges. Conversely, Rude and colleagues (2000) highlighted that client-therapist similarities have little-to-no effect on the therapeutic alliance; rather, it is the congruence of their attitudes, values, and personality that would most likely influence the establishment of the alliance. However, one's attitudes and values form part of the self, which according to Tafjel and Turner (1986) is constructed around one's similarities and differences within one's community and often guided by one's cultural context. Thus, the similarities and differences between the therapist and client possibly inform each party's attitudes, values, and beliefs about mental health and illness. Hence, one might assume that ethnic-matching within therapy, or mono-cultural pairings, would be predisposed to experience less incongruence in terms of each other's attitudes, values, and worldviews (Comas-Diaz, 2015).

Chao, Steffen and Heiby (2012) conducted a study which investigated the effects of ethnic-matching on the therapeutic alliance and found that: (1) ethnic matching emphasized a higher degree of agreement and collaboration about treatment goals and tasks between therapists and clients; (2) ethnic matching constituted a stronger interpersonal context for therapeutic engagement; (3) there was a significant, direct relationship between ethnic-matching and therapeutic alliance; and (4) an ethnic match extended the client's adherence to the therapeutic process.

Thus, cross-cultural pairings may require greater effort from the therapist to facilitate the establishment of a meaningful therapeutic alliance as early cross-cultural therapeutic interactions may be characterized by poorer collaboration, disagreements surrounding the tasks and goals of therapy, histories of oppression and discrimination, racial-bound difficulties, and missed empathic opportunities (Comas-Diaz, 2016). Missed empathetic opportunities are "moments when a clients report emotional issues and the therapist changes the topic without addressing the client's feelings" (Suchman, Markakis, Beckman, & Frankel, 1997, as cited in Comas-Diaz, 2016, p. 84). These missed empathic moments may go unnoticed in cross-cultural therapy interactions as therapists may not recognize certain culture-bound cues and meanings, whereas signs and symbols may be more easily recognized and understood within mono-cultural therapeutic interactions.

2.6.5. Cross-cultural difficulties

The research on cross-cultural factors has focused mainly on the effects of race or ethnicity on the therapeutic alliance and multiple studies acknowledge that there is an influence of 'racial difference' within therapy settings (Comas-Diaz, 2016; Hickman & Christie, 1989). Culture encompasses multiple aspects of differences and similarities found across and within communities and societies. However, cultures are often differentiated visibly by means of racial category; that is, Black, White, Indian, Coloured, Asian, and Other. Although not generalizable to all, one's racial group is often accompanied by racial commonalities, such as language, religion, socioeconomic status, education, degree of discrimination, and history of oppression (Comas-Diaz, 2016).

Although the concept of 'race' is ultimately socially-constructed, this study will refer to racial categories concretely in order to contain the commonalities experienced within each racial category. Nonetheless, the study will continue to acknowledge the complexity of culture and the existence of subcultures within wider cultures and how not each individual within a given racial category is a 'puppet' to the dominant cultural context. As racial

differences are known to influence the therapeutic process, therapists are challenged with the overwhelming reality of overcoming cross-cultural hurdles in order to establish an essential element to therapeutic success – the therapeutic bond.

Aside from the well documented 'racial' factor, Vontress (1969) conducted a study that focused on other cultural barriers often present in the cross-cultural counselling relationship. The results noted six main cross-cultural barriers to effective therapy. These included: (1) *the racial attitudes of each party*. A therapeutic alliance is an interpersonal relationship that demands the establishment of rapport prior to applying therapeutic interventions. Although the therapist may consciously dedicate himself to Carl Rogers' (1959) ingredients of empathy, unconditional positive regard and congruence, this may not be enough to shift the fact that he is 'white' and his client is 'black', or vice versa. Due to the legacy of Apartheid in South Africa, many racial misconceptions and discriminations became insidious and were passed down through generations and are maintained through current system/structural and attitudinal factors; (2) *ignorance of the client's background*. The therapist may have assimilated the values and perspectives of a Western, middle-class environment and deprived himself of understanding other worldviews; (3) *the inescapable language barriers*. Therapy is based mainly on communicating via verbal interaction. Not only is this an issue for those therapists who are not fluent in the client's mother-tongue, but also for those clients who have poor verbal fluency overall. This may be particularly trying for both therapists and clients when attempting to convey certain understandings, emotions, and experiences. Since much of the psychological literature is termed in the English language, certain areas of the therapeutic process may not be understood by a client who does not identify with Western terminology or metaphors; (4) *the clients may be unfamiliar with the objectives of therapy*, especially when the client identifies the therapist's role as an expert or 'assister'; (5) *the cultural beliefs surrounding self-disclosure*. On the one hand, some clients may be reluctant to share their experiences with others as it may be divulging information about their community or intimate parts of themselves, especially with a therapist who may be perceived as judgmental. On the other hand, a therapist may feel uncomfortable about addressing certain sensitive areas due to their own culturally-derived values and norms; here, the therapist's own cultural standards may not be congruent with the client's; (6) *the taboo surrounding race issues*. As previously discussed, racial differences may represent an automatic obstacle between cultures (Vontress, 1969).

To support the abovementioned findings, a study by Padilla, Ruiz and Alvarez (1975) found that there are three major factors that influence the development of a therapeutic

alliance: (1) *language barriers* decrease client-therapist ability to communicate; (2) *class-bound values* may dissuade the client from continuing therapy if the therapist conducts therapy in accordance with the value system of the middle-class. This raises the issue of intersectionality – whereby social categories (e.g., race, class and gender) are interconnected and create interdependent systems of discrimination or power (Crenshaw, 1989; Rodriguez, Holvino, Fletcher & Nkomo, 2016). Thus, therapists may encounter cross-cultural challenges that are layered with class-related barriers; particularly, within public health hospitals as the majority of mental health patients belong to a lower socio-economic status; and (3) *culture-bound values* may influence the therapist to diagnose and prescribe treatment for the client based on their own personal understanding of the distress without acknowledging how the client may experience this distress. According to Kleinman's (1978) Explanatory Model of Illness, clinicians should try to understand the patient's beliefs about the illness or distress, the personal and social meaning they attach to the illness or distress, and their expectations about what will happen during treatment, as well as their own therapeutic goals. Here, the therapist may develop a more holistic view of the cross-cultured patient and his beliefs before reverting to their understanding of clinical models; the impact of Western and non-Western explanations of psychological problems on alliance ruptures will be discussed in a later subsection.

2.6.6. Culture and boundaries

Boundaries in therapy refer to the rules that govern the therapeutic relationship and aid in differentiating it from a business or social relationship (Drum & Littleton, 2014). Boundaries include various structural elements, such as time, place of therapy, payment, and so forth. Such structural elements of therapy may be addressed within the Working Alliance Model's '*task*' component (Bordin, 1979). Other boundary issues include the receiving of gifts or bartering, self-disclosure, physical proximity, nonsexual touch and clothing (Drum & Littleton, 2014). Setting boundaries promotes the establishment of a trusting therapeutic alliance, however these boundaries may be difficult to operationalize in cross-cultural contexts as they are dependent upon numerous factors, such as: the client's diagnosis; the context; and *cultural differences* (Drum & Littleton, 2014). Thus, there is the potential for boundary issues to arise during the establishment of a cross-cultural therapeutic alliance which may require careful consideration when dealing with such. Gutheil and Gabbard (1993) found that the most common boundary issues to arise in traditional therapeutic settings included those related to place and space, time, money, the role of the therapist,

exchanging of gifts, physical touch, language, clothing, and self-disclosure. As Drum and Littleton (2014) emphasized, it is imperative that therapists acknowledge and deeply understand the cultural context of their client and themselves when setting boundaries in order to maintain an ethical, beneficial therapeutic alliance. Without establishing culturally-appropriate therapeutic 'rules', either party stands the risk of crossing or violating boundaries due to different cultural expectations, customs and values about boundaries. Failure to establish appropriate, compatible boundaries may lead to the delay or demise of a positive therapeutic alliance – ultimately derailing the therapeutic process and outcome (Drum & Littleton, 2014).

Various authors (e.g., Aviera, 2002; Sue & Sue, 2002) emphasized the need to abandon the Western role of the psychotherapist when working with diverse populations. For example, the use of barter may be used as a sign of 'thanks' in collectivist cultures – which are inherent in South Africa. Certain cultural traditions should be acknowledged, respected, and managed, such as receiving a gift or exchanging a hug, so as to enhance the therapeutic relationship; however, one should act to preserve ethical-correctness (Aviera, 2002). Depending on a therapist's theoretical orientation, a therapist may adhere to the traditions of the client, such as receiving a 'thank-you' gift, so long as the therapist acknowledges this gesture as a cultural tradition, rather than a symbol of deeper psychological issues (Nathan, 1994, as cited in Barnett & Bivings, 2003). Perhaps, such attention to each party's differences may encourage an acceptable crossing of boundaries in order to avoid damage to the therapeutic alliance (Barnett & Bivings, 2003). Adhering to Western ideals of boundaries and what constitutes a boundary crossing may be misinterpreted by the client as cold or distant. It is therefore necessary for therapists to possess some degree of cultural judgment and understanding when forming therapeutic boundaries so that one may secure a positive *bond* (Bordin, 1979).

2.6.7. Cross-cultural transference and countertransference

The concepts of transference and countertransference can be utilized in cross-cultural contexts as they serve to frame strong and irrational reactions by both the client and the therapist in terms of cultural conflict and cultural identity (Freud, 1913; Sciarra, 1999). According to Sciarra (1999), clients are involved in two main transference stages: firstly, the *conformity stage* whereby the client may conform to the therapist's dominant culture in an attempt to see themselves in relation to that dominant culture; secondly, the *resistance stage* may involve the transfer of anger and depreciation onto the therapist as they may then be

viewed as an instrument of oppression. Thus, cross-cultural transference may have less to do with client's primary caretakers, but rather their cultural identity.

Similarly, the therapist's countertransference may be related to their own cultural identity (Sciarra, 1999). As therapists are not immune to stereotypes, they should be cautious when working with cross-cultured clients who may conform to cultural norms that inform the way in which they dress, behave, speak, and understand. Sciarra (1999) suggests that therapists should analyze their countertransference honestly in order to detect whether their negative reactions to their clients are the result of cultural imperialism. Thus, in order for a therapist to be open to- and enriched by diverse clients, a therapist needs to develop his/her own cultural identity. The assumption here is that a therapist with a cultural identity similar to his/her client's cultural identity will experience fewer negative countertransference reactions to the client. The back and forth of cultural transference and countertransference may hinder the establishment of a meaningful therapeutic alliance and disrupt the therapeutic process (Sciarra, 1999).

To expand, a study by Abernethy and Lancia (1998) investigated religious transference and countertransference reactions in therapy. They found the following factors to be critical to enhance therapists' skills when working with religious clients, the therapist should ensure: (1) to monitor their own attitude toward the religious content, as Macewan (2008) noted, for therapists to be cognizant of their own attitudes and beliefs; (2) to attend to the religious content as these themes are typically overlooked in therapy due to the therapists' lack of knowledge about religion, their own strong religious beliefs, or due to the stigma placed upon talking about religion as per the ideas of Freud; (3) to seek consultation from other professionals who may be more experienced in a certain religious culture; and (4) to use religious content within interpretations as it may serve as an important pathway to the client's wishes, fears, and conflicts. However, this should be handled with openness, sensitivity, and care as an essential element of the therapeutic alliance is respect for the client and non-judgment.

> *"God's appearance in treatment also has meaning for therapists"* – Abernethy & Lancia (1998, p. 287).

The abovementioned statement by Abernethy and Lancia (1998) refers to the religious transference and countertransference experienced in therapy. According to Comas-Diaz and Jacobsen (1991), there are major therapeutic responses that may arise for therapists and clients in cross-cultural therapeutic relationships, also referred to as ethno-cultural

transference and countertransference. This refers to how the client's cultural background influences their response to the therapist and how the therapist's cultural background influences their response to the client (Abernethy & Lancia, 1998). According to Comas-Diaz and Jacobsen (1991), ethno-cultural differences may hinder the development of positive rapport. However, they may also act as catalysts for tackling the client's deeper psychological issues, such as mistrust, anger, acknowledgment of uncertainty and ambivalence, and fostering an acceptance of incongruent parts of the self (Comas-Diaz & Jacobsen, 1991).

Literature by Spero (1985) focused on psychotherapy with religious clients, and he emphasized the importance of distinguishing the clients' normal needs from their neurotic needs for religious belief and practice, as well as the importance of recognizing how religious similarities and differences influence the therapist's response. Clients' perceptions of therapists' religious association and the clients' fantasies regarding assumed similarities and differences may form a foundation that depicts the strength and quality of the future alliance, as well as provide rich transference/counter-transference experiences (Spero, 1985; Abernethy & Lancia, 1998). A therapist's increased sensitivity to the overt and covert religious transferences in their clients' communications will therefore form a vital part for securing a meaningful therapeutic alliance. Thus, the religious differences and similarities between therapists and their clients form potential challenges in their therapeutic work and perceived strength of the alliance. However, there appear to be many other cultural issues that may evoke transferential and countertransferential reactions, and subsequent challenges, that include race, gender, ethnicity, and class. An increased sensitivity, on behalf of the therapist, to these cultural dimensions can enhance the therapeutic alliance greatly and deepen the therapists' understanding of themselves and the clients (Abernethy & Lancia, 1998).

2.7. Cross-Cultural Explanations of Mental Illness

Agbayani-Siewert, Tackeuchi and Pangan (1999) argued that individuals' understanding of mental illness cannot be separated from their social and cultural contexts. They asserted that culture plays a large role in individuals' perceptions and explanations of mental illness and consequently influence their attitudes about mental health and responses to treatment (Agbayani-Siewert et al., 1999).

2.7.1. Western perspectives

The Western, or American-European, understanding of mental illness is primarily focused on the individual with particular attention paid to individual thoughts, feelings, and

the role of physiological occurrences as emphasized in the Medical Model which values biological or psychological causes of mental illness, such as neurotransmitter imbalances or traumatic upbringings (Vukic, Gregory, Martin-Misener & Etowa, 2011). Although the Western models of treatment and assessment assume cultural universality, the transferability and relevance of such Western diagnostic systems (i.e., the DSM-V) and treatment modalities is questionable in non-Western populations. This is due to the majority of the informing research being conducted on smaller white, middle-class, Euro-American populations (Vukic et al., 2011). Thus, mental health service providers (e.g., psychologists, social workers, counselors, and psychiatrists) may struggle to conduct accurate clinical assessments with culturally diverse clients when utilizing the available standardized tests that do not account for cultural variation and multicultural conceptualizations of mental illness (Vukic et al., 2011). Vukic and colleagues (2011) discussed the challenge for therapists and other healthcare providers to provide useful client/patient assessments and treatments without having familiarity with the cultural norms of emotional expression, mannerisms, and cultural explanations of illness.

2.7.2. Non-Western perspectives

It is important, then, to consider non-Western models for explaining mental illness, psychological problems or symptoms, and how a lack of understanding of- or no freedom to discuss such explanations may result in potential alliance ruptures. According to Awaad and Reicheter (2016), Western psychology's tendency to assume its applicability to all contexts has led to less attention paid to non-Western cultural considerations. Although the DSM-V has included cultural considerations as part of good clinical judgment, there is not much guidance in terms of diagnosis for specific cultural groupings. Consequently, psychological research has been geared toward developing assessment methods and treatment modalities aimed at treating middle-class, Euro-American research populations (Awaad & Reicherter, 2016). According to Awaad and Reicherter (2016), each cultural group has its own set of 'disorders' or maladaptive behavioural patterns that may be explained in Western terms as 'culture-bound syndromes'. Culture-bound syndromes are typically described as 'folk' illnesses but, more accurately, are understood as local ways of explaining mental illness or personal distress (Awaad & Reicherter, 2016). Again, Kleinman's (1978) Explanatory Model of Illness emphasizes that attempting to understand the client's explanation of their distress may facilitate a more meaningful therapeutic alliance and reduces the possibility of alliance

ruptures due to the client's perception of the therapist as forceful, misunderstanding, or culturally disrespectful.

2.7.3. Indigenous perspectives

Literature by Tsang and Bogo (1997) attempted to integrate the concept of the 'working alliance' with cross-cultural psychotherapy in South Africa. According to their research, mental health issues are explained and described differently depending on the client's cultural background, as per Kleinman's (1978) assertion that different cultures have their own casual explanations about what is happening to them. According to Tsang and Bogo's (1997) work which focused on engaging with cross-cultural clients, cross-cultural therapeutic dyads seek a form of compatibility rather than Bordin's (1979) 'agreement with tasks and goals', which emphasized and acknowledged the cultural variation in the relationship (Tsang & Bogo, 1997). They also found a need for therapists to facilitate the development of trust in the context of a legacy of racial distrust, which is the legacy of South Africa's Apartheid, thus highlighting a degree of openness to the client (Tsang & Bogo, 1997).

Tsang and Bogo (1997, p. 82) provided their understanding of 'therapeutic trust' as "the client's expectations of the therapist's intention and ability to help the client, plus evidence of the therapist's acceptance of- and respect for the client". Therefore, it is imperative for therapists working cross-culturally to achieve some level of compatibility of tasks and goals with the client, as well as instill a degree of trust in the alliance – or bond (Bordin, 1979; Tsang & Bogo, 1997). Disagreement on the cause of a client's mental state may lead to alliance ruptures, particularly in the South African context where there are multiple interrelated cultural groupings each with their own explanation of their distress or illness. In many Black South African cultures, there is a belief that ill-health has material, supernatural and pre-natural origins and that in order to 'heal' such illness one must address the issues via those channels (Ezeabasili, 1977). A study by Sigida (2016) that focused on conceptualizing mental illness from an indigenous South African perspective found that some traditional African cultures locate the cause of their mental illness or psychological distress in witchcraft, spirit-possession (i.e., *amafufunyana*), spiritual emergences or ancestral callings (i.e., *ukuthwasa*), and poisoning. In response to such explanations, such cultural groupings were found to find more value in traditional forms of healing, such as steaming, enemas, and traditional herbal medicines (i.e., *muthi*); such difference in cultural explanation of mental illness may impinge the establishment of a meaningful therapeutic alliance if the therapist

does not acknowledge or understand such explanations (Sigida, 2016). Alliance ruptures due to cultural differences may not always be explicit and may emerge in more subtle forms.

2.8. Alliance Ruptures

At times, during psychotherapy, the therapeutic alliance is confronted with potential and actual ruptures in the working relationship. Safran and Muran (1996) defined an alliance rupture as:

> *"…deteriorations in the relationship between therapist and patient. They are patient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration"* (p. 447).

Ruptures may emerge when therapists unintentionally partake in maladaptive interpersonal cycles that resemble the way in which the client interacts with others on the outside; thus, perpetuating such maladaptive cycles may confirm the clients' dysfunctional interpersonal schemas or generalized representations of their self-other interactions (Safran & Muran, 1996). Or, ruptures may involve empathic failures, resistance, or transference-counter-transference issues (Safran, 1993). According to Safran (1993), ruptures in the therapeutic alliance vary in intensity, duration, and frequency depending on the specific therapist-patient dyad. In terms of a cross-cultural dyad, many alliance ruptures occur in the beginning phase of psychotherapy (Keenan, Tsang, Bogo & George, 2005). According to Keenan and colleagues (2005), the sources of ruptures in cross-cultural alliances include client maladaptive patterns, therapist empathic misunderstandings, cross-cultural misunderstandings due to cultural variations, and asymmetrical power relations involving the impact of prior experiences or current therapy practices.

At times, alliance ruptures may go undetected by the therapist or remain out of conscious awareness for the client and may not drastically obstruct the therapeutic progress (Safran, 1993). However, in extreme instances, alliance ruptures can lead to therapy dropout or treatment failure (Safran, 1993). Although ruptures impede the establishment of a meaningful alliance, if they are managed promptly and effectively, they hold the potential to provide an important opportunity for therapeutic change (Safran, 1993). Safran and Muran (1996, p. 447) stated, "by systematically exploring, understanding, and resolving alliance ruptures, the therapist can provide [clients] with a new constructive interpersonal experience that will modify their maladaptive interpersonal schemas". However, Keenan and colleagues (2005) emphasized the need for a theoretical model for therapists to comprehend misunderstandings and discord that occurs early on in the therapeutic alliance in order to

offer direction to repair such ruptures in the first few sessions of therapy – they found this is particularly important due to the shorter therapy-life associated with cross-cultural relationships and poorer outcomes compared to ethnically-matched therapeutic alliances (Keenan et al., 2005). To revert back to Bordin's (1979) Working Alliance Model, a strong working alliance is theoretically comprised of some form of interpersonal connection, care, and understanding together with a level of agreement or compatibility with the goals and tasks (Keenan et al., 2005). A therapeutic rupture may be considered to be a result of a disagreement between the therapist and client in terms of treatment goals, a lack of collaboration on therapeutic tasks, or difficulties in their emotional bond (Eubanks, Muran & Safran, 2018).

2.8.1. Micro-ruptures

As discussed, the therapeutic alliance develops over time alongside the different stages of therapy. Therefore, an alliance rupture will have varying significance depending on the phase in which the rupture occurs (Safran, 1993). According to Tsang and Bogo (1997), therapists who experience ruptures in the early phase of the relationship may have very little resources from the relational connection upon which to draw, whereas ruptures that occur in the middle phase of therapy may have a more meaningful and well-developed therapeutic alliance acting as a 'buffer'. Cross-cultural alliances are likely to suffer some form of micro-ruptures, which are 'subtle shifts' that occur in the relationship (Keenan et al., 2005).

There are various sources of micro-ruptures in cross-cultural relationships. As psychotherapy involves a bidirectional, mutually-influencing process between a client and a therapist, one can assume that each individual is comprised of personal qualities and prior interactional experiences in specific contexts (Keenan et al., 2005). These qualities and experiences may be understood as 'real' aspects of the therapeutic relationship; that is, the way in which cultural groups enact beliefs and interact within and between groups (Keenan et al., 2005). There is a challenge, however, in differentiating whether ruptures in the alliance are due to the client's maladaptive patterns, misunderstandings by the therapist, or to difficulties with the 'real' aspects of the therapeutic alliance (Keenan et al., 2005). According to research by Keenan and colleagues (2005) and Sue and Sue (1990), micro-ruptures in the early stages of cross-cultural dyads may occur because of cross-cultural misunderstandings regarding role expectations, problem explanation, negotiation of goals, or the meaning of verbal and non-verbal communications. Issues in the 'bond' may arise when therapists make incorrect inferences about a client's response; for instance, a therapist interpreted the client's

response as confrontational whilst the client experienced his response as disclosing. Here, the difference in understanding may have been due to discrepant communication styles (Keenan et al., 2005). Micro-ruptures may also be influenced by power dynamics in cross-cultural therapeutic relationships based on race, language, age, and gender (Keenan et al., 2005). According to Leary (1995), observable cultural differences – such as one's race, socioeconomic status, age, gender, and ability – may trigger reactions by either the therapist or the client which stem from previous experiences with others that are associated with those differences. Whether such attacks on the alliance are conscious or unconscious, it is vital that therapists employ some form of repair on the alliance in order to reestablish a positive therapeutic alliance or to continue yielding positive change in the client (Leary, 1995).

Keenan and colleagues (2005) put forth various repair techniques for micro-ruptures in cross-cultural therapy settings. They explained that when a therapist becomes aware of a micro-rupture in the relationship, one should identify the dimension of the relationship impacted by the rupture (i.e., the tasks, bonds, or goals) and search for the source of the rupture which will assist the therapist to select the appropriate repair technique (Keenan et al., 2005). Due to the early stages of the alliance focusing on the tasks and goals of therapy and the embryonic development of a bond, direct processing or meta-communication (i.e., providing verbal feedback that targets the thematic relationship issues) does not prove effective due to the instability of the bond between the therapist and client (Keenan et al., 2005). According to Keenan and colleagues (2005, p. 280), "there are multiple techniques that target the bond, tasks or goal dimensions that can be used instead of meta-communication". *Table 1* provides a description of direct and indirect responses to ruptures that may be applied to various forms of therapy; such responses are divided according to the dimensions of Bordin's (1979) working alliance.

Table 1

Therapist Rupture Repair Interventions

Direct Interventions	
Task & Goal	*Bond*
a. Providing rationale or micro-processing tasks that provide experiences of internal process associated with therapeutic change	a. Clarifying misunderstandings
b. Exploring core interpersonal themes that affect client ability to work on tasks/goals	b. Exploring core interpersonal themes (e.g., transference interpretation)

Indirect Interventions

Task & Goal	*Bond*
a. Changing task or goal	a. Empathic characterization (e.g., reframing client's actions or style in an empathic manner)
b. Reframing the meaning of task or goal	b. Corrective emotional experience (e.g., therapist acts in a way that provides a new interpersonal experience for the client).

Note. Table [Adapted] from "Resolving therapeutic alliance ruptures: Diversity and integration," by J. D. Safran and J. C. Muran. (2000). *Psychotherapy in Practice,* 56(2), 233–243.

According to the information provided in *Table 1*, Keenan and colleagues (2005) suggested that the therapist should decide whether to address the rupture directly or indirectly based upon the perceived development of the therapeutic alliance; as well as the client's psychological capacities, the type of therapy being offered, the cultural norms of both the therapist and client, and the impact of power relations within the relationship. Attention to these 'subtle shifts' in the cross-cultural relationship may assist the therapist to facilitate the establishment of a strong, positive, working therapeutic alliance (Keenan et al., 2005).

However, alliance ruptures may also be due to differences in client-therapist explanations of mental illness or psychological distress. Differences in opinion with regard to the cause of the client's presenting problem and the best method to address it may lead to ruptured therapeutic alliances. When the client-therapist dyad is intercultural, cultural explanations of mental illness may more likely differ.

2.9. Therapist Attributes and Techniques

The professional role of the therapist is that of a facilitator in creating client awareness, emotional growth and psychological development in order to reduce client distress, anger, frustration, and sadness (Fischer, 2013). To facilitate this role, the therapist needs to create a comfortable, safe and non-judgmental therapeutic environment for the client (Fischer, 2013). Developing this 'safe' therapeutic environment is subject to the influence of the therapist's own personal characteristics and their utilized techniques and interventions. Although there has been much research conducted surrounding the importance of the therapeutic alliance, there has been little research focused on the role of the therapist in the development of a strong, positive therapeutic alliance (Constantino, Castonguay & Schut, 2002; Macewan, 2008). Ackerman and Hilsenroth (2001) conducted

a study that investigated therapists' personal characteristics and techniques that may positively or negatively impact the establishment and maintenance of a therapeutic alliance. The findings suggested that both the therapist's personal characteristics and the therapeutic techniques utilized have the ability to positively or negatively influence the development of a strong therapeutic alliance.

The *personal characteristics* that were found to contribute positively to the development of the therapeutic alliance include one's ability to be honest, respectful, flexible, trustworthy, confident, comforting, interested, and open (Ackerman & Hilsenroth, 2003). Carl Rogers (1959), a founding father of the humanistic approach to psychology, believed that constructive change in the client during psychotherapy is dependent upon three essential attitudes in the therapist, as discussed in a previous subsection. These essential attitudes are held to be more important than the therapist's professional qualifications, their therapeutic orientation, or their interview techniques (Rogers, 1965). These attitudes are considered to be the active components in the therapeutic alliance: congruence or genuineness in the relationship; acceptance or prizing of the client; and an accurate empathic understanding of the client's world (Rogers, 1965). The personal attributes of therapists that were found to have a *negative* influence on alliance development included therapist rigidity, uncertainty, exploitation, criticism, distance, aloofness, and distractibility (Ackerman & Hilsenroth, 2001; Macewan, 2008).

The *therapeutic techniques* that were found to positively influence the therapeutic alliance included exploration, reflection, noting past therapy success, accurate interpretation, facilitating the expression of affect, and attending to the client's experience (Ackerman & Hilsenroth, 2003). The findings also suggested that the therapists' characteristics that negatively influenced the development of the therapeutic alliance include being rigid, uncertain, critical, distant, tense, and distracted (Ackerman & Hilsenroth, 2001). The techniques that were found to *negatively* influence the establishment of the therapeutic alliance included over-structuring the therapy, inappropriate self-disclosure, inappropriate use of transference interpretation, and the improper use of silence (Ackerman & Hilsenroth, 2001).

These findings echo Strupp's (2001) finding that the outcome of therapy is influenced by the *non-specific factors* of therapy, specifically: the personal characteristics of the therapist and the positive feelings that arise as a result of those characteristics. The non-specific factors of therapy refer to the dimensions of therapy that are shared across therapeutic orientations. This includes the therapeutic alliance, the therapist's

competence, and the therapist's adherence to treatment protocols. These factors differ significantly from the *specific factors* of therapy which refer to the techniques and interventions used by therapists that characterize certain therapeutic orientations (Chatoor & Krupnick, 2001). Thus, the personal attributes of therapists were found to influence, both positively and negatively, the development of a therapeutic alliance.

In order to establish an all-inclusive guideline for developing a strong, meaningful therapeutic alliance, Wampold (2011) conducted a meta-analysis of studies focusing on the qualities and actions of effective therapists and his findings provided a comprehensive list of personal characteristics and therapeutic actions that facilitate the development of a positive therapeutic alliance. The qualities and actions included: (1) a sophisticated set of interpersonal skills, including verbal fluency, appropriate affective expression, warmth and acceptance, a focus on the other, and empathy; (2) creating an environment characterized by trust and understanding; (3) coming to an agreement about the tasks and goals of therapy through an interactive, collaborative approach; (4) offering an acceptable explanation for the client's distress; (5) an awareness of the context of the client, including issues of culture, socioeconomic status, race, and ethnicity; (6) providing hope to the client; (7) being authentic and showing a genuine interest or concern when investigating the client's problems; (8) openness to flexibility and adjustment to therapeutic treatment if the client is showing discomfort or dissatisfaction with therapy; (9) being aware of the verbal and nonverbal cues that indicate resistance to the diagnosis, explanation, treatment, or therapeutic approach; and (10) being aware of his or her own psychological processes, biases, and blind spots (Wampold, 2011).

Previously, researchers and therapists understood the use of techniques and the therapeutic alliance as separate concepts (Macewan, 2008). However, more recently, researchers (e.g., Goldfried & Davila, 2005) are considering the alliance and techniques as tantamount, mutual, on-going processes that work collaboratively in order to achieve the therapeutic outcome (Macewan, 2008). Although a therapist may possess the necessary attributes and utilize the suggested techniques, they may stumble across unavoidable challenges when forming a meaningful therapeutic alliance, specifically with cross-cultural clients.

2.10. Conclusion

The therapeutic alliance is considered to be an important element for successful therapeutic outcome across a wide range of theoretical orientations. Various authors suggested ways in which therapists may facilitate this alliance via utilizing therapeutic techniques, enhancing personal attributes, and following alliance guidelines. However, is the employment of certain models, such as Bordin's (1979) Working Alliance Model and techniques of effective counselling, sufficient for the development of a meaningful, well-established cross-cultural therapeutic alliance? According to the relevant literature, there are various cultural dynamics that a therapist may experience within the cross-cultural alliance, including: therapist anxiety and hesitancy; setting acceptable boundaries; managing cultural-relational issues; overcoming intercultural incongruence; and the struggle of employing suitable models of diagnosis and treatment.

Since cross-cultural dynamics have the potential to influence client-therapist interpersonal cooperation and successful therapeutic process, it is also hypothesized that cross-cultural pairings may experience the establishment of the therapeutic alliance as more challenging than mono-cultural alliances. The questions, then, are: how have psychologists experienced this process of establishing cross-cultural alliances? What difficulties have they encountered when dealing with cultural differences or similarities? And in which ways do they perceive their personal attributes and therapeutic techniques to have influenced their cross-cultural therapeutic alliances?

CHAPTER THREE

METHODOLOGY

3.1. Introduction

The following chapter aims to provide a detailed description of this study's methodology. The methodology describes the research aims, study design, study sample, the actions that were taken to explore the research questions, and the rationale for the application of specific procedures used to collect, process, and analyze information (Kallet, 2004). This study utilized a qualitative, methodological approach and data was collected using open-ended, semi-structured interviews. Interviews were conducted with eight (N=8) clinical/counselling psychologists in order to explore psychologists' experiences with establishing cross-cultural therapeutic alliances. The participants were asked to discuss their experiences and perceptions of cross-cultural therapeutic alliances, as well as their thoughts surrounding the therapist attributes and techniques that facilitate or hinder meaningful cross-cultural therapeutic alliance development. Again, the objectives of this study were to explore the experiences encountered by psychologists when trying to establish cross-cultural therapeutic alliances in South Africa, and to uncover psychologists' perceptions of the factors (attributes and techniques) responsible for facilitating or hindering the establishment of cross-cultural therapeutic alliances.

This chapter begins by providing a description of the aims of the study, study design, core conceptual framework, research participants, data collection method, data analysis, followed by various ethical considerations and the validity and reliability of the study.

3.2. Aim of Study

This study aims to explore psychologists' experiences of establishing cross-cultural therapeutic alliances. Also, this study aims to uncover the factors that psychologists perceive to facilitate or hinder the establishment of cross-cultural therapeutic alliances.

3.3. Study Design

This study is qualitative in nature. According to Astalin (2013, p. 118), "qualitative research is a systematic scientific inquiry which seeks to build a holistic, largely narrative, description to inform the researcher's understanding of a social or cultural phenomenon". McMillan and Schumacher (1993, p. 479) defined qualitative research as "primarily an

inductive process of organizing data into categories and identifying patterns among categories". The qualitative nature of this study permitted the use and analysis of subjective experiences and participant perceptions, along with the opportunity to explore their experiences of establishing cross-cultural therapeutic alliances and their perception(s) of the factors that are facilitative or hindering to the establishment of such alliances. Thus, this research attempted to explore, in detail, the unique experiences of each participant. A qualitative design was most appropriate for this study due to the lack of qualitative research concerning psychologists' experiences of establishing cross-cultural therapeutic alliances in South Africa. Additionally, a qualitative design allowed the researcher to explore certain phenomena in-depth, utilize subjective information, examine/probe complex topics in order to reveal more valuable data, and explore new areas of research. Hence, this 'bottom-up' approach allowed for the yield of richer, greatly detailed data. More specifically, this study adopted an exploratory, cross-sectional design in order to explore, develop and refine ideas after the data collection process and to bridge these ideas using the data in an ongoing, interactive process; this means that the data collected from the study's target sample was analyzed at one specific point in time (Neuman, 2011). The results from a cross-sectional research design are derived from a specific population and can be used to describe the prevalence of specific experiences within that population (Neuman, 2011).

In an attempt to arrive at an understanding of how the participants experienced the establishment of cross-cultural therapeutic alliances, this study utilized an interpretive framework, informed more specifically by the interpretive paradigm (Neuman, 2011). An interpretive paradigm is a form of qualitative research where researchers must attempt to gain access to participants' thoughts, experiences and perceptions by listening to and observing them (Bryman, 2001). An interpretive paradigm allowed the researcher to understand the subjective experiences from the perspective of the participants, leading to an in-depth understanding of their experiences and rich data.

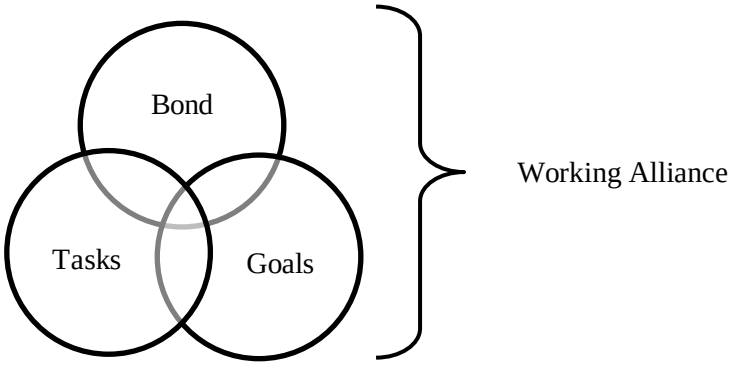
3.4. Theoretical Framework

This study utilized Bordin's (1979) Working Alliance Model as a theoretical framework against which the participants' experiences were understood. Bordin (1979) presented three elements which he believed to be both necessary and sufficient for the establishment of a meaningful therapeutic alliance, that is: (1) an agreement on the *goals* of the therapy; (2) an agreement on the *tasks* of the therapy; and (3) a positive *bond* between the

psychologist and the client. The absence of achieving any of these three elements might indicate a negative or fragile therapeutic alliance (Bordin, 1979). Utilizing this model allowed the participants' experiences to be framed against a guideline typically utilized during the establishment of therapeutic alliances.

Figure 1

Working Alliance Model



Note. Adapted from "The Generalizability of the Psychoanalytic Concepts of the Working Alliance" (p. 253) by E.S. Bordin, 1979, *Psychotherapy: Theory, Research and Practice,* 16 (1).

3.5. Participants

This study's sample comprised of eight (N=8) clinical/counselling psychologists, four (N=4) males and four (N=4) females, who were identified as working within private practice and registered with the Health Professions Council of South Africa (HPCSA) under 'Independent Practice'; and who have baseline experience working with cross-cultural clients. Baseline experience may be considered a minimum of one (1) year experience of work within an accredited South African internship training facility (i.e., government hospitals or tertiary education institutions). South African government facilities are utilized by a wide variety of individuals from varying cultural backgrounds; experience within these institutions (i.e., internship, community service, or permanent posts) offers psychologists or psychologists-in-training adequate exposure to multicultural clients/patients. Of the eight participants, the majority (N=6) were white, one (N=1) was Black African, and one (N=1) belonged to the 'other' ethnic group.

3.5.1. Participant selection

This study utilized a non-probability sampling technique; specifically, purposive sampling. This sampling technique allowed the researcher to select participants from the

sample population who were appropriate for the study and who satisfied the sample description, as well as the (a) inclusion criteria and (b) exclusion criteria.

a) Inclusion criteria

- The participant must be registered with the HPCSA as a Psychologist in 'Independent Practice'.
- The participant must have baseline experience working with cross-cultural clients.

b) Exclusion criteria

- Participants with unresolved or ongoing legal cases.
- Participants not currently registered with the HPCSA as a Psychologist in 'Independent Practice'.
- Participants who do not have baseline experience working with cross-cultural clients.

3.5.2. Recruitment procedure

The participants were recruited via an online registry of practicing psychologists in the Durban area of Kwa-Zulu Natal via the Durban Practicing Psychologists Group (DPPG). Permission was requested in order to utilize the DPPG online registry of practicing psychologists as this ensured the legitimacy of the sample *(see Appendix A for Gatekeeper Permission Request Letter)*. Once permission to utilize the online database was granted by the DPPG Chair *(see Appendix B for Gatekeeper Permission Letter)*, the eligible psychologists were invited via a group email to consider participating in this study *(see Appendix C for Invitation to Participate in Study)*. If the prospective participant showed an interest in participating in the study, they replied back (via e-mail or telephonically) to the researcher and consented to participate in the study *(see Appendix D for Informed Consent Letter)*. An interview date and time was then scheduled and the participants were interviewed at their place of professional practice or via an online video-chat service (i.e., Skype) depending on the suitability and convenience for the participant. Six (N=6) participants were interviewed at their private practice offices and two participants (N=2) were interviewed via Skype for their convenience. Participants were not excluded based on their gender, age, race, or ethnicity. The participants did not receive any compensation for their participation in the study; however, refreshments were made available and a small token of appreciation was sent to the two participants who were interviewed via Skype. All of the study's interviews were conducted by the principle researcher, a post-graduate student who conducted the present study for her Master of Social Science (Clinical Psychology) dissertation.

3.6. Data Collection

In order to gather an in-depth, qualitative understanding of the participants' experiences of establishing cross-cultural therapeutic alliances, the data was collected using open-ended, semi-structured interviews *(see Appendix G for the interview schedule)* as this tool provided the interview with added structure, but also offered the researcher enough flexibility to probe certain areas for greater clarification, further exploration, and to refocus the interview. The probes and follow-up questions allowed the researcher to gain a deeper understanding of the responses given. The interview instrument was produced with core themes mind which were developed on the basis of a review of relevant empirical literature (see for e.g., Bordin, 1979; MacEwan, 2008; Gelso, 2013) and consultation with identified professionals in the field. The interviews were approximately 45-minutes each in order to yield sufficient qualitative data. Two (N=2) of the interviews were 30-minutes in duration due to the participants' time constraints; however, this did not hinder the sufficiency of the data. With permission from each participant, interviews were audio-recorded in order to be transcribed *verbatim (see Appendix E for Permission to Audio Record)*.

3.7. Procedures

Prior to the commencement of this study, a comprehensive research proposal was submitted to the research supervisor in order to refine the topic and discuss the study idea. Thereafter, the study proposal was submitted to the HSSREC Humanities for ethical approval *(see Appendix F for Ethical Approval Letter)*.

In September 2017, during the preparation of the study, two pilot interviews were conducted with experienced psychologists, a retired psychologist at her place of residence in Hillcrest, Kwa-Zulu Natal and a registered psychologist currently working in academia at the University of KwaZulu-Natal (Howard College). The purpose of the pilot interviews was to gather information aimed at refining the initial interview questions, obtain feedback about the structure and content of the interview schedule, the interview process, and the viability of the study. After completing the interviews with the pilot participants, their feedback suggested the rearrangement of the questions in order to improve the interview flow and clarity; as well to combine two questions which may have reduced the time-efficiency of the interview due to redundancy. The data obtained in the pilot interviews was not included or analyzed in the

study. The pilot interviewees served mainly as an aid in the development and refinement of the interview schedule.

During the interviews, eight (N=8) clinical/counselling psychologists were questioned about their experiences of establishing cross-cultural therapeutic alliances. The participants were asked to discuss: their overall experiences of the establishment of cross-cultural therapeutic alliances; their perspectives of the therapist attributes and techniques that impede or facilitate the development of a positive cross-cultural therapeutic alliance; and the techniques or methods that they utilized in order to repair alliance ruptures in the process of establishing cross-cultural alliances. The semi-structured interview *(see Appendix G for the Interview Schedule)* was a revised version of the interviews used during the pilot interview, and was conducted as in-person interviews or via Skype interviews; the interviews lasted approximately 30-45 minutes. All interviews were audio-recorded and transcribed *verbatim* by the researcher; no third party was utilized for the transcription of the data. Prior to each interview, the participants were required to complete a participant characteristic sheet *(see Appendix H for Participant Demographic Form)* which requested their gender, race, age, years of clinical/counselling experience, the setting of their practice, highest level of qualification, and their professional interests; this allowed for their demographic information to be recorded accurately.

3.8. Data Analysis

The audio recordings from the semi-structured interviews were transcribed *verbatim* in the English language using Microsoft Office Word (*see Appendix J for a Transcription Example*). After the raw data was transcribed *verbatim*, a thematic analysis was conducted in order to identify, analyze, and report patterns or themes within the data set.

In terms of this study, the data was organized according to Braun and Clarke's (2006) six-phase guide to conducting a thematic analysis, that is: (1) *familiarizing oneself with the data set* – this was done through the process of transcribing, reading, and re-reading the data which allowed for the identification of initial themes in the data set; (2) *generating initial codes or themes* – this was done by grouping different aspects of the data into codes so that they related to one another by sifting through the data systematically. The data was coded using Miles and Huberman's (1994) method of coding, that is: data reduction, data display, and conclusion drawing. An additional coding technique, '*in vivo* coding', was used whereby the researcher assigned words and phrases to the data set in order to form categories and

reduce unnecessary data (Strauss & Corbin, 1990); (3) *searching for themes* – this was done by sorting the different codes into potential themes and collating all of the relevant coded data extracts within identified themes; (4) *reviewing these themes* – this was done by combining and documenting related patterns into subthemes and searching for coherent themes and data that needed to be discarded or revised; (5) *defining and naming themes* – this was done by building a valid argument for choosing such themes through defining what each theme meant and identifying what was interesting about each theme; and (6) *writing up the research report* – this involved the final analysis of the results and making an argument in relation to the research question and informing theory.

The audio recordings and transcriptions of the interviews were saved electronically onto a password-protected folder on a USB flash drive that remains locked away and accessible only by the researcher herself and the research supervisor. Additionally, the emergent themes were entered into a table on Microsoft Office Excel to create a clear summary of the data. After the research project is complete, all of the information gathered from the interviews shall be deleted permanently from the flash drive after a period of five years.

3.9. Ethical Considerations

3.9.1. Informed consent

When conducting the formal study, each participant was required to complete and sign a participant consent form prior to participating in the interview. The consent form educated participants about the purpose of and nature of the research *(see Appendix D for Informed Consent Form).* Each participant was informed of the requirement to audio-record the interview for transcription purposes. They were then asked to sign a consent form granting the researcher permission to audio-record the interview *(see Appendix E for Audio-Recording Consent Form).*

3.9.2. Anonymity

The informed consent form informed the participants that the study was strictly anonymous and that all participant information would remain strictly confidential at all times. The participants were required to enter their full name and sign the consent forms but at no time will their information be published. The interviews did not require the participants' name, but rather a study number was assigned to them whereby no correlations may be found between the identity of the participant and this number. All information that may have been

associated with the participants (e.g., names of practice areas, institutions, colleagues, etc) was removed.

3.9.3. Data security

All relevant data (i.e., audio recordings, transcribed data, and coded data) from each interview was saved onto a USB flash drive and password-protected which is available to the researcher and researcher's supervisor only. All of the information gathered from the interviews and transcriptions will remain existent on the USB flash drive and stored in a safe space for a period of five years, after which all data will be destroyed.

3.9.4. Feedback

The research participants had the option to receive a final electronic copy of the research dissertation. Within the Interview Consent Form *(see Appendix D)*, the participant was provided with the option to receive a final electronic copy of the study. If the participant wished to receive a copy of the study, that participant will receive an electronic PDF-version of the study only. If the participant does not wish to receive a copy of the study, an electronic copy of the final research study will be kept in the event that the participant changes their mind.

3.9.5. Inquiries

In the event of participants requiring further information, feedback, or to make queries, they were provided with the contact details of the research supervisor and the telephone number of the University of KwaZulu-Natal's Centre for Applied Psychology (Howard College).

3.10. Potential Research Bias

Due to the nature of individual cultural identities, it was important for the researcher to be aware of any potential biases or self-held beliefs that may infringe an objective view of each participant's experience. Unfortunately, due to the sampling technique being purposive, selection bias was introduced into the study. By using a sample of convenience rather than a random selection, selection bias will occur as not all clients will be eligible to participate; however, the chosen selection technique was the most appropriate for this particular study.

3.11. Researcher as Instrument

The level of researcher involvement in qualitative research has been widely acknowledged (Pezalla, Pettigrew & Miller-Day, 2012). Because the researcher is the research instrument in semi-structured or unstructured qualitative interviews, unique researcher attributes have the potential to influence the collection of empirical data (Pezalla, Pettigrew & Miller-Day, 2012). Thus, it was important to practice researcher reflexivity and acknowledge the researcher as the primary instrument in this study (Pezalla, Pettigrew & Miller-Day, 2012). Such reflexivity included acknowledging the interview as an exchange between two parties, and reflecting on the ways in which the researcher may have affected the organization of these interactions (Pezalla, Pettigrew & Miller-Day, 2012).

As a white, English-speaking, female, I am aware that the data was collected and interpreted against my pre-existing cultural lens and analyzed with the possibility of bias. As I was raised in a culture afforded with privilege and informed by individualistic, Western ideals of health and mental-health treatment, I understood more clearly those participants with whom I shared similar backgrounds and characteristics. I also acknowledged how my cultural position, as both a white-female and the research interviewer, may have affected the participants' responses. Also, I acknowledged how my cultural identity may have impacted the interview procedure with those participants from different cultural backgrounds, such as extra effort on my part to be 'culturally sensitive' with those participants who were not white, and to probe more gender-related areas with male participants. However, great effort was made to be self-reflective and consistent guidance was provided by my research supervisor. It was through the understanding and appreciation of the inter-relationship of personal and methodological concerns that I became aware of my contribution to the construction of meanings and of lived experiences throughout the research process (Palaganas, Sanchez, Molintas & Caricativo, 2017).

3.12. Research Trustworthiness

Research 'trustworthiness' refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Pilot & Beck, 2014). In order to ensure research trustworthiness, this study utilized Schou and colleagues' (2011) guidelines to assess the trustworthiness of qualitative research. The following aspects will be covered: credibility, transferability, dependability, and confirmability.

***Credibility*.** The confidence in the 'truth' of the study's findings is important when establishing research credibility, analogous with internal validity (Connelly, 2016). To ensure this study's credibility, the purpose and the method of the study were clearly described, arguments for the choice of the method were provided, the method provided is suitable to the study's aims, there was a description of how data were registered, and the research process has been described (Schou et al., 2011). Additionally, this study was conducted using standard procedures used typically in the qualitative approach; this included prolonged engagement with participants, persistent observation if the questions asked were appropriate to the study, and continuous self-reflection (Connelly, 2016).

Transferability. The nature of 'transferability', or the extent to which the findings of this study are useful to persons in other settings, is determined by the readers themselves about how applicable the findings are to their situation (Polit & Beck, 2014). In order to support transferability and trustworthiness, this study provides a detailed description of the context within which the research was conducted (including the study's location, participant demographics, and practice setting), the reasons why such participants were selected, and the assumptions that were central to this study. The results of this study may not be transferable or generalizable to other populations or contexts due to the context within which South African psychologists practice and the area-specific cultures with whom they work. Thus, those who wish to transfer the results of this study to a different context will assume responsibility for making the judgment regarding the sensibility or suitability of the transfer (Schou et al., 2011; Amankwaa, 2016).

Dependability. Research dependability refers to the stability of the data over time and over the conditions of the study (Polit & Beck, 2014). This concept of trustworthiness is likened to 'reliability' in quantitative research, but with the understanding that the stability of conditions depends on the nature of the study (Connelly, 2016). To ensure dependability, a logical connection between data and themes is described, the process of data analysis is described, there is a clear description of the findings, all quotations provided are reasonable and supportive of the interpretations, and there is agreement between the findings of the study and the conclusions (Schou et al., 2011).

Confirmability. Research confirmability is considered the 'neutrality' or the degree to which the findings are consistent and could be repeated (Connelly, 2016). This is equivalent to objectivity in quantitative research (Polit & Beck, 2014). This study attempted to capture

the very best information with the least bias as possible. In order to ensure confirmability, a description of the researcher's background and perceptions is provided, other theorists and their perceptions are referenced, a clear description of who conducted the study is provided, and a reflection on how the researcher's position may have influenced the findings is provided (Schou et al., 2011).

3.13. Conclusion

This chapter provided a detailed overview of the methods used in the execution of the study. This included a description of the research design, participants and sampling techniques, the interview procedure, and the data collection and data analysis process. Additionally, both the ethical considerations and the reliability and validity of this study were discussed.

CHAPTER FOUR

RESULTS

4.1. Introduction

The development of a therapeutic alliance has been well recognized as a necessary component across all psychotherapeutic modalities (Asbrand, 2012). Establishing alliances, according to Bordin (1979), requires a focus on three key factors: the tasks, the goals, and the bond of therapy. The South African context has historically and currently evidenced intrinsic value and belief differences among individuals from different cultural backgrounds. There is a paucity of qualitative research that explores psychologists' personal experiences with establishing cross-cultural therapeutic alliances in South Africa. Encountering cross-cultural therapeutic dyads within the domain of psychological practice can be considered a certainty, both from a training perspective (i.e., a component of professional training and development requires working with clients in the public health sector and institutions of higher learning) and from an accessibility perspective (i.e., the ratio of psychologists to the general population is 0.069 to 10,000) (Flanagan, 2014). Thus, this research aimed to explore cross-cultural dynamics and how they were experienced in the formation of therapeutic alliances. This was achieved through an exploration of psychologists' personal experiences of working cross-culturally, as well as the qualities and techniques perceived to be necessary for facilitating therapeutic alliances.

The following chapter is organized into eight sections. The first section contextualizes the data obtained in the study by providing demographic descriptions of the study participants; this will allow the emergent themes to be understood within a particular context and it will enable the reader to interpret the material from the cultural context of the participant. The subsequent sections will focus on organized themes and relevant sub-themes which were obtained from the interpretation and analysis of the transcribed material as explicated in Chapter Three (i.e., the Methodology). Each theme will include supporting *verbatim* text segments taken directly from the interview transcriptions (*see Appendix I for a Summary of Themes*).

4.2. The Study Participants

There were eight (N=8) clinical/counselling psychologists who were interviewed for this study. All eight psychologists are currently working in private practice in KwaZulu-Natal

and are registered with the Health Professions Council of South Africa (HPCSA) as 'Independent Practice'. All eight participants have had exposure to the public domain either through their mandatory internship year and community service year or by engaging in community-based projects; thus, they all have baseline exposure to working in highly diverse settings. The eight participants are registered in categories of either Counselling or Clinical Psychology. Any other relevant descriptions of the participants such as race, gender, religion and type of practice area are highlighted in *Table 2* below.

Table 2:

Participant Demographic Descriptors

Participant	Race	Gender	Age	Religion	Home language	Domain
P1	Other	Female	25 – 30	Hindu	English	Counselling
P2	White	Female	30 – 40	Christian	Afrikaans	Counselling
P3	White	Female	30 – 40	Agnostic	English	Clinical
P4	White	Female	30 – 40	Christian	English	Counselling
P5	White	Male	50 – 60	Christian	English	Counselling
P6	White	Male	50 – 60	Atheist	English	Clinical
P7	White	Male	40 – 50	Christian	Afrikaans; English	Counselling
P8	Black	Male	25 – 30	Christian	isiZulu; English	Clinical

As observed, the majority (N=6) of the participants are white and the primary language of communication was English (N=6). The transcription codes that were implemented in terms of the material text are: *LB* which represents the researcher and *P1, P2, P3, P4, P5, P6, P7,* and *P8* which represent each participant respectfully. In addition, to clarify the demographic information of each participant, combinations of demographic descriptor codes will be included in the verbatim quotes as shown in *Table 3* below:

Table 3:

Demographic descriptors

Race/Ethnic Group		Gender	
B	Black African	**M**	Male
W	White	**F**	Female
I	Indian (Asian)	**O**	Other
C	Coloured (mixed race)		
O	Other (e.g., Latina)		

For example, participant one will have the code: P1 (OF) [other; female]; and participant two will have the code: P2 (WF) [white; female]. To expand on the verbatim quotes, the punctuation used within the transcribed text material is, to some extent, the researcher's interpretation of what was said during the interviews. The use of punctuation marks, such as commas, full-stops, ellipses, and quotation marks were used to separate sentences and to clarify meaning. The subsequent sections will illustrate the themes that emerged in the interview data (*Table 4* below provides a tabulated summary of the main themes and subthemes).

Table 4:

Summary of themes and subthemes

MAIN THEME	ORGANIZING THEME	SUB-THEME
1. Conceptualizing the Therapeutic Alliance	1.1. Forming a connections 1.2. Establishing the structure	
	1.3. Agreeing on acceptable boundaries →	a. Maintaining the client-therapist relationship b. Expected self-disclosure c. Perceptions of physical contact d. Perceptions of cultural forms of appreciation
	1.4. Expectations of mutual agreement →	a. Understanding the scope of practice b. Role confusion
2. Differences in Practice Setting	2.1. Private sector 2.2. Public domain	
3. Perception of Cultural Congruence	3.1. Initial Anxieties 3.2. Experiences of racial similarity 3.3. Assumed cultural uniqueness 3.4. Perceived cultural incompatibility	
4. Influence of Observable Cultural Differences	4.1. Racial dynamics 4.2. Age differences 4.3. Gender dynamics 4.4. Religious affiliations	
5. Challenges to the Alliance	5.1. Different communication style 5.2. Language barriers 5.3. Respecting cultural explanations of illness 5.4. Stereotyping the client 5.5. Managing power dynamics	
6. The Role of Attributes and Techniques	6.1. Therapist attributes →	a. Facilitating attributes b. Hindering attributes
	6.2. Therapist techniques →	a. The role of theoretical perspectives b. Facilitating techniques c. Hindering techniques

4.3. Theme 1: Conceptualizing the Therapeutic Alliance

All of the participants were asked to describe, in their own words, their understanding of a therapeutic alliance. Due to the nature of this study, this served as a starting point for further questioning and to gather an understanding of how they conceptualized the alliance. All of the participants (N=8) described the therapeutic alliance in similar terms pertaining to it being a collaborative, working agreement to assist the client in achieving a goal or working through a problem.

> **P2 (WF):** *The first thing that comes to mind is a working agreement where both of you have the same goals … as an alliance with a therapist and a client who both aim for the same end result.*
>
> **P3 (WF):** *I guess it's a professional relationship between a client and a therapist. Hmm, both working together to achieve certain goals.*
>
> **P5 (WM):** *I see it as the, um, the foundation of therapy. I consider it to be that healing bond between myself and my client.*
>
> **P6 (WM):** *It is the grounding and … the base for all other therapy work. It's the collaboration, um the working together, between me and my patient where we both set certain goals.*

Some of the participants (N=3) highlighted their experience with establishing therapeutic alliances and how the quality of the alliance was further influenced by the person's mental state at the time of consultation. Thus, participants engaged in two processes in their attempts to establish the therapeutic alliance. The first included determining the client's mental state at the time of consultation; the second involved being mindful of cultural differences between self and client. The purpose of which was for the therapist to initially differentiate cultural factors from potential psychopathology interceding the establishment of a therapeutic alliance. Quotes from participants 1, 6, and 8 illustrate this point below:

> **P8 (BM):** *I think the therapeutic alliance is formed quite easily with some patients and it's quite challenging with others … I think it just depends on the presentation and the person's personality of course.*
>
> **P1 (OF):** *Um, I would say more than the culture, it is just what the client is presenting with … there was one client who said she wants to see a Black therapist but there was so much more in that. Um, a little bit borderline.*
>
> **P6 (WM):** *Generally, we are on the same page. Sometimes pathology comes into play, um, like with the patient's level of insight and understanding of psychology.*

After the participants reflected their view of the therapeutic alliance, the topic of culture and cross-cultural interactions was introduced. The participants were informed that culture can include an array of individual and group differences, such as race, age, gender, religion, socio-economic status, sexual orientation, and political standpoint, etc. The participants were then asked to discuss what they have experienced as important for establishing meaningful cross-cultural therapeutic alliances. The participants varied on what they felt to be the most important or most beneficial for establishing meaningful cross-cultural therapeutic alliances. The participants' responses were separated into three major factors for establishing an alliance, namely: (1) forming a good connection; (2) setting the structure of the therapy; and (3) being in accordance with each other.

4.3.1. Sub-theme: Forming a connection

All of the participants (N=8) felt that forming a good connection with their clients was one of the most important aspects of establishing meaningful cross-cultural therapeutic alliances. The participants' perceptions about how to form good connections with their cross-cultural clients included: the psychologist creating a safe, containing space; being genuine and showing a willing effort to understand their individual differences; and showing unconditional positive regard.

> **P5 (WM):** *We have to work together to build this relationship, building up trust, and respect, and comfort with each other. Hmm, it's not always easy but it's key.*
>
> **P2 (WF):** *It's a genuine effort to understand an individual. Not pretending to know where they are coming from but to really understand. Hmm, to really um understand the context of something, to ask questions, to show an interest.*
>
> **P1 (OF):** *Provide a space for the client to reflect on whatever is going on with them. Umm, I also think just the space itself, so like the welcoming, holding containing space is very important for them.*
>
> **P7 (WM):** *Maybe in all therapeutic alliances the relationship connection is really important … to make a strong relationship between you two based on, um, trust, non-judgment, fairness, uh and equality.*

Two of the participants (N=2) indicated the importance of finding a connection with a client, but how there are challenges therein if there is personal dislike or a sense of irritation with the client, and vice versa. Thus, they described how one's perceived likeability of the other may lead to difficulties with forming a therapeutic connection.

> **P3 (WF):** *For me it's being on the same page together … But also (pause), also liking the person? Ha-ha (laughing), I'm not sure if you're getting me? If your client likes*

you, and vice versa, it's easier to connect with, with- them, um, and work with that person.

P2 (WF): *I think every therapist will say 'there are some people we can't work with'.*

From the data obtained, it appeared that the participants had their own perceptions of what works best for them when attempting to form a therapeutic connection. However, all of them (N=8) felt that their connectedness with the client was imperative to establish before any other therapeutic work could commence. As Participant 7 illustrated, establishing a connection with someone from a different cultural background, with different beliefs, values, and attitudes may require exaggerating the typical manner in which one attempts to form a connection.

P7 (WM): *With culturally different clients I think we have to enhance those qualities [positivity, trust, non-judgment] even more.*

4.3.2. Sub-theme: Establishing the structure

Four of the participants (N=4) felt that the therapeutic alliance requires an active structuring of therapy to ensure that the relationship remains professional and that boundaries remain intact. This process was described to be somewhat emotionless and tedious. Setting up the structure of the therapy included sorting out payment information, medical aid details, time of sessions, number of sessions, and the process of cancelling therapy sessions. Three of the participants (N=3) who described the importance of the structure of the therapy in therapeutic alliances were white males; this was reflected by their value of mainstream theory and business organization.

P5 (WM): *Uh, also the setting up of the relationship might seem a bit cold. Um, like, setting the price or cost of the sessions and sorting out medical aid details … It's quite robotic in the beginning ha-ha (laughing), although I do try and be warm about it.*

P6 (WM): *The therapy relationship is not like typical relationships so there is a structure that needs to be put in place, like … the times and cancellation of sessions. I find it … makes it easier for me to work with clients who stick to that structure.*

P7 (WM): *Like, uh, you have to talk about things like payments. You got to talk about things like the length of sessions, also number of sessions. What happens if you come late to sessions? If you push those boundaries at the beginning and allow things to slack then … the relationship will no longer be therapeutic.*

In relation to clients belonging to non-Western cultures, two participants (N=2) highlighted that due to some clients' limited exposure to the discipline of psychology, the

initial consultation involved adding psychoeducation into the structure of therapy and an explanation of the expected roles of- and between the client and therapist. Thus, the psychoeducation of non-Western clients was experienced as beneficial to the therapeutic alliance.

> **P1 (OF):** *Explaining to your client that this is what therapy is, this is my role, this is your role, um, and this is how we are going to work through that.*

4.3.3. Sub-theme: Agreeing on acceptable boundaries

Some of the participants (N=4) felt that establishing and managing boundaries, both personal and professional, is an important aspect of structuring the therapeutic alliance, particularly with clients who may not be familiar with psychotherapy and the role of therapeutic boundaries. The issue of managing boundaries and boundary violations emerged throughout the interview data across all participants.

> **P1 (OF):** *In South Africa we have so many different cultures and you kind of need to learn how to manage them and deal with different people so maybe an email at 10 o'clock at night is not the most appropriate thing.*

All of the participants (N=8) discussed managing boundaries as part of establishing the structure of the therapeutic alliance. Although psychology in South Africa has attempted to shy away from the more orthodox, Western practices, some of the participants perceived psychology as a foreign concept with their collectivist clients and the concept of receiving structured, boundary-laden treatment from an unknown individual was described as 'unnatural' for some of their clients. Hence, the participants experienced boundary pushes from clients who perceived the therapeutic alliance as unnatural and too one-directional (i.e., the therapist not discussing their own problems). The following cross-cultural boundary issues were experienced as the most prominent which required quick and/or ongoing management: (a) maintaining a professional relationship; (b) self-disclosure; (c) physical touch; and (d) gift-giving.

(a) Maintaining the therapist-client relationship

Three of the participants (N=5) described difficulties with maintaining the professional therapist-client relationship with non-Western clients as the notion behind healing typically revolved around the community and helping each other. Non-Western, collectivist clients were also perceived to not understand fully the importance of the structure

of the relationship as they were described to see less importance in the structure of the therapy and more importance in the social aspects of it.

> **P1 (OF):** *I struggle a lot with boundaries (sigh), because therapy is not a concept that exists in many cultures outside I would say 'white' culture (laughing). So the idea of healing through talking is more, in African cultures, is more about a community, it's very narrative, and very like 'we all help each other'. So then you come to therapy, and there is this divide … so, setting boundaries is so difficult because at some point they feel like, 'oh, but I'm talking to you, I'm your family now, I'm your community, I'm your friend' and it's hard to make that divide.*

> **P2 (WF):** *a person from a more laid-back cultural background comes late or doesn't cancel appointments; so, there is an element to ascribe the way people manage or handle the structure of therapy*

> **P3 (WF):** *Like, ha-ha, the alliance is already set and now it's like I must do the client a personal favor. Sometimes offense has been taken and that's had to be managed.*

(b) Expected self-disclosure

The issue of self-disclosure was experienced by all participants (N=8) as something that occurred in all therapeutic relationships regardless of the client's cultural background. However, four of the participants (N=4) described challenges in managing self-disclosure with clients from collectivist cultures as they experienced their expectations of automatic self-disclosure as a challenge to the typical helping relationship as they were trained to be objective, neutral, and non-disclosing . This concept of self-disclosure is linked with the challenge of maintaining that therapist-client relationship as one that is 'professional', rather than one that is 'social'. Again, the concept of 'not knowing' the person to whom one is speaking was perceived to create blocks in the connection between the client and the psychologist. These participants(N=4) felt that their flexibility in self-disclosure, as well as their explanation about why one should not self-disclose, assists in managing potential barriers to forming a good therapeutic connection.

> **P1 (OF):** *I think they expect me to disclose … they don't understand the boundaries and that they not supposed to be speaking about my personal life. So, it does affect it [the therapeutic alliance] in a way, but, again rupture-and-repair so it's like such a great moment for learning in that space.*

> **P2 (WF):** *I will disclose it [personal information] unless I feel my answer will clash with what they're saying and hinder their view of me then I will give a neutral response to not distract them from the therapy but ya, if it's just part of the session then I disclose and move on.*

> **P3 (WF):** *We have to bend those rules [about non-disclosure] because we want the client to trust us. I understand the concept of talking to a stranger about your deep secrets is not a well known phenomenon in African cultures.*
>
> **P7 (WM):** *It may just bring them a little bit of peace knowing the person that they're talking to.*

(c) Perceptions of physical contact

The perception and management of physical contact in therapy was discussed by six of the participants (N=6) as necessary to ensuring appropriate professional boundaries with cross-cultural clients. The Western concept of 'no-touch' in therapy was described as unnatural for some clients, particularly those from collectivist backgrounds. Greeting styles, as well as means of comforting those who are suffering, included elements of physical touch such as hugging, kissing, and hand-holding. The perception of boundary crossings was addressed by the participants and five (N=5) of the participants acknowledged the need to be flexible in terms of physical touch to ensure that the psychologist respects culturally-acceptable manners of greeting or containing. These participants experienced flexibility as beneficial to the establishment of a meaningful therapeutic alliance, as long as one continues to reflect on one's ethical code of practice. Also, to be cognizant of boundary pushes and potential transference/countertransference by using one's clinical judgment.

> **P3 (WF):** *Is this a PD [personality disorder] or some form of boundary push? But it's not, you know? It's just the way they want to greet and the way they were brought up to greet.*
>
> **P5 (WM):** *Some of my clients expect a hug hello and I think it's more culturally acceptable in certain race groups.*
>
> **P7 (WM):** *I don't psychoanalyze them greeting me in their own way. If we psychoanalyze everything, we will start to lose touch of their cultural ways of doing things.*
>
> **P8 (BM):** *In terms of hugs, children will hug especially in the last session … I just hug back because we're all human after all.*

(d) Perception of cultural forms of appreciation

Four of the participants (N=4) described their experiences with managing the exchange of gifts or forms of 'thanks' with cross-cultural clients. The exchanging of gifts was described to be typically harmless and, in some cases, culturally acceptable as a manner of offering thanks. Some of the participants mentioned initial discomfort with the gift as they

are aware of their ethical code, as well as Western understandings of gift-giving and boundary crossing in therapy. However, introducing culturally flexible thinking regarding the exchange of gifts was experienced to be beneficial to the therapeutic alliance as it showed an appreciation of their thanks and portrayed respect.

> **P5 (WM):** *I have had people bring me gifts … um, I equate it to cultural and, um, gender norms, like um with women offering food … But they tend to explain the reason for the gift and I thank them kindly.*
>
> **P8 (BM):** *Especially with the gifts some people give, it depends on the gift that they're giving you. If it's something that they've made and put effort into then they might see it as disrespectful and might impact the therapeutic relationship negatively.*

4.3.4. Sub-theme: Expectations of mutual agreement

Four of the participants (N=4) emphasized the importance of the psychologist and client being in agreement with each other in order to have a harmonious therapeutic alliance. The participants described an expectation that both themselves and their client need to be in constant agreement, and thus any discrepancy was perceived to hinder the alliance. There was an expectation that it is necessary for them to agree on the goals of therapy and the process that will take them there, the psychologist's limits, and the expected role of each other.

> **P2 (WF):** *A working agreement where both of you have the same goals. Hmm yes, as an alliance with a therapist and a client who both aim for the same end result.*
>
> **P5 (WM):** *I'd also say agreeing with each other. Um, not so much in a way that is colluding but in a way that's, uh, harmonious? I don't know if that's the right word (laughing) … Having the same set of ideas and wishes for the end result.*

(a) Understanding the scope of practice

Some of these participants (N=3) explained how being in agreement with the cross-cultural client is occasionally a difficult endeavor and may require compromise from both parties to ensure that the psychologist and the client agree on achievable, ethically-appropriate goals; as well as to come to a general understanding of the abilities and limits of the psychologist and what the psychologist is able to do for the client within their scope of practice.

> **P3 (WF):** *It becomes challenging when you're* both *in conflict with the goals or the direction of the treatment you know? I guess the understanding of what I was capable of doing was not understood well. So, I guess this lead to difficulty in coming to realistic goals, like I can't persuade your husband to come back to you or read his mind if he's cheating. Whereas in white clients, I think there was more of an*

understanding of what psychologists do … I guess it made it easier to set more realistic goals?

P5 (WM): *Sometimes our expectations and goals of therapy needed to be compromised.*

(b) Role confusion

Some of the participants discussed how part of their experience of establishing a meaningful therapeutic alliance was delineating the roles of each party clearly. As illustrated by Participant 2's example, the client's parents' expectations of her role was as an ally to them rather than a psychologist to the child; this reflected a lack of agreement in roles and goals of treatment. This discrepancy compromised the therapeutic alliance and treatment.

P2 (WF): *When the dad [Black African] found out he [his son] smoked marijuana, then he said he will catch him. They took him out of therapy when they found out my goals were not in line with what they wanted, because depression doesn't exist for them. It was a nightmare. They were very upset with the goals not being in line. I don't have a magic wand that would stop him smoking weed. Is it culture related? Well the man came back, and that's where they took him out [of therapy].*

After the participants described their conceptual understandings and experiences of the therapeutic alliance and what was most important for establishing cross-cultural therapeutic alliances, they were asked a further set of thematically-structured questions to further explore their experiences with establishing meaningful cross-cultural therapeutic alliances. The emergent themes will be discussed subsequently.

4.4. Theme 2: Differences in the Practice Setting

The participants were asked to describe their overall, initial impressions or feelings when coming into contact with a client from a different cultural background in the first telephone call or session. Their experiences varied depending on where such experience took place as they described stark differences between the private sector and the public domain.

4.4.1. Sub-theme: Private sector

In the private sector, there was a perception by some of the participants (N=3) that the clients in the private sector have already established an expectation of the psychologist via information found online, through a referral, or via their name. Some of the participants (N=3) shared the same understanding that if a client has come to their practice, that they have a basic understanding of their race, language, and gender.

P2 (WF): *Umm, I think the first thing before they can see me is that they can pick up from my name that I am Afrikaans and white so they won't be surprised when they see me.*

P5 (WM): *For him it was different a bit as he, I assume, knew that she [the participant's colleague] was a white female based on her medical page details.*

Then, the overall notion is if the client felt uncomfortable seeing a male, female, or someone of a different race group, then they would have not come to that psychologist in the first place. Thus, being aware of who the psychologist was, and vice versa, reduced initial anxieties and allowed the participants time to prepare for potential discrepancies.

4.4.2. Sub-theme: Public domain

All of the participants (N=8) have completed an internship year, and for others also a community-service year at a government hospital, depending on their category (i.e., Clinical versus Counselling). Thus, all of them have had experiences with not knowing who to expect as their clients/patients. It seems that the experiences of establishing cross-cultural alliances and the psychologist's first experience of the client are much more anxiety-provoking in the public domain than in the private sector as neither the psychologist nor the client have an expectation of the other, or even a choice as to who they see. Participant 3 explained how her experience of a same-cultured client brought relief to the client and Participant 5 described the public domain as a 'lucky packet', with neither party knowing what to expect. Participant 1 then explained her experience of a cross-cultural client who was somewhat disappointed with the psychologist that he/she was assigned.

P3 (WF): *I can say that after internship, there are very few things that surprise me anymore. More in my intern years, I guess. My experiences there were varied. Like, some clients looked relieved that I was white. More so the white clients … Some of them would even, like, tell me to my face 'oh gosh I'm relieved to see a face like yours'. Sometimes I wouldn't comment on it, I'd just let it go.*

P5 (WM): *It was hard in government … it was like a lucky packet of clients and sometimes we didn't get lucky.*

P1 (OF): *I have experiences with some clients that say, 'oh! I want to see a Black therapist', or 'I want to see a male therapist', this happened every now and again.*

By reviewing the participants' experiences in the government sector it appears that establishing cross-cultural alliances may prove more challenging when neither the client nor the therapist has an expectation of- or a choice with whom they will be working.

4.5. Theme 3: Perception of Cultural Congruence

The participants were asked a series of questions pertaining to their experiences about the degree of similarity, or their perception of congruence, between themselves and their clients. The participants reflected on their experiences with same-cultured and cross-cultured clients, as well as their perception of difference or similarity in their alliances and how such cultural dynamics influenced their ability to build meaningful relationships.

4.5.1. Sub-theme: Initial anxieties

A majority of the participants (N=6) described experiencing a degree of anxiety when discovering that their client was from a different culture to theirs. Again, in relation to the setting of one's practice, the participants who were not sure of the client they'd be seeing described heightened anxiety, an increased awareness of their differences, and potential barriers to the alliance. Even some of the participants who were aware of the cultural background of their clients (e.g., P5 and P6) described feeling anxious about their cultural differences.

> **P5 (WM):** *I kind of expected what I saw because I knew what I was getting myself into [community project]. I knew what type of patients they'd be. But I had anxieties that's for sure. I already anticipated my race, language, gender*.

> **P6 (WM):** *Yeah it felt hopeless. Like if I was a younger, Black woman I would have been able to knock it out of the park but I felt like an alien waltzing around trying to form relationships with these people*.

One of the participants (P2) highlighted how she assumed the client's comfort with her as she was comfortable. Thus, she found it important to reflect on her own initial anxieties (or lack of) as well as consider the clients' initial anxieties about cultural differences.

> **P2 (WF):** *The onus is on the therapist to be aware that the client might be uncomfortable and just to assume that because you're comfortable that … (Pause) Maybe that's something I need to start working on because I am always comfortable.*

4.5.2. Sub-theme: Experiences of racial similarity

The participants were asked about their experiences of racial-pairing or racial similarity in therapy. All participants commented on their experiences with working with racially-matched clients and there were mixed opinions on the beneficence of racial-matching in therapy. On the one hand, some of the participants (N=6) felt that there was intrinsic value

in racial-matching in therapy as it offered the client a perceived cultural comfort as well as a sense that the psychologist understood them implicitly without constant, explicit explanation.

> **P1 (OF):** *I feel that for some clients there is a level of comfort in knowing they can see someone who understands them … I wouldn't say it happens a lot but … they have said they'd prefer to see someone who kind of 'understands' what my culture is and where I come from.*

> **P2 (WF):** *It [racial matching] would definitely help because there will be some understanding … I can relate by thinking of some of the Afrikaans clients and I think 'ah, thank God you're not with another therapist' because they will not know where you're coming from. So yes, there is that 'I can forgive you because I know where you're coming from' but ya, someone else wouldn't know.*

> **P5 (WM):** *Some issues are race-bound or culture-bound and when people are feeling stuck, they, they may not have the energy to entertain someone's curiosity and would rather just have someone who knows, hey. So, ya, I think it has its place.*

> **P7 (WM):** *There's nothing better than being understood, um, and sometimes we can't ever fully understand what, like, a certain race might have been through.*

However, some of the participants felt that their experiences of racial-matching limited their personal and cultural growth; some of the participants (N=4) experienced a tendency to become culturally complacent whilst working mono-culturally, and some of the participants (N=4) found beneficence in being racially-different as it required more effort on behalf of both parties to establish a foundation and learn about each other's culture. Participant 1 reflected on her view of racial-matching as ineffective for certain issues:

> **P1 (OF):** *They [a Black African client] would rather tell me about their sexual adventures than tell an older Black person … umm so, I feel there is almost a bit of openness when you're not as similar, when you're not the same or matched to your therapist.*

Two of the participants (N=2) felt that racial-matching is not necessary in South Africa, especially within the public domain due to the limited number of psychologists and time available to facilitate those matches. Racial matching was described as an option available only in the private sector.

> **P8 (BM):** *It [racial matching] wouldn't be feasible in terms of our context and country and how people are…it can't happen that way, it's not possible in our context.*

> **P6 (WM):** *Um, well my opinion is that it's not necessary…I can understand when it comes to language barriers. But if my Black patient can speak English then I don't see the point.*

Although the majority of participants felt that racial-matching in therapy has a place in therapy, most of them have found that racial similarity or difference has not largely facilitated or hindered the establishment of a meaningful therapeutic alliance.

4.5.3. Sub-theme: Assumed cultural uniqueness

Some of the participants (N=3) described how the cultural differences between themselves and their clients lead to an automatic assumption that one would not understand the other. This perceived difference and assumed inability to understand each other was reported to create conceptions that the psychologist may not be able to appreciate the client's struggle or help them effectively. From the participants' experiences, many of them found that although they were culturally different to their client (i.e., in terms of race, gender, age, or religion), that many of the experiences that they assumed were 'culturally unique' were actually shared across many cultures (e.g., parenting styles, marital dynamics)

> **P1 (OF):** *South Africans in different cultures think they're so unique … Now, each of them think it's a unique experience through their culture and actually, like no, all of you have the same thing but it's a kind of disjointedness that, you know, 'I'm the only one who experience this'.*

> **P5 (WM):** *It's like an assumption that because I am white I won't understand. I do not know how many times my clients will say 'you know with us black people, etc…' like white people don't know what it's like.*

> **P2 (WF):** *Like sometimes a Black girl may tell me about their marriage and say 'you don't know how Black men are'; like she wants to portray her husband in a negative light and she wants to put him into a cultural context or highlight the context which is a truth for them. And then, ya, sometimes there is a need to say 'it's not just Black men, but Afrikaans men are like that too'.*

4.5.4. Sub-theme: Perceived cultural incompatibility

Five participants (N=5) discussed how they have experienced some cross-cultural clients as less compatible than same-cultured clients due to many experiences being culture-bound, as well as beliefs, attitudes, and opinions regarding mental illness, life, marriage, work, etc. being culturally dependent. There was an overall underlying assumption that the more cultural differences between them, the less compatible they were, and the harder they had to work to achieve a therapeutic connection with each other.

> **P3 (WF):** *Or, like, their experiences are just too far removed from mine. Like, we are never exactly or perfectly compatible with our clients, we are all different and unique*

… But I think our cultural background, where we have come from and the beliefs that we have been growing up around, uh, I think they sometimes just seem distant to me.

P2 (WF): *Hmm, I think every therapist will say 'there are some people we can't work with'.*

P5 (WM): *In general, the [cross-cultural] relationships have worked out but there have been times where I have thought, 'boy, this is gonna be tough'.*

4.6. Theme 4: The Influence of Observable Cultural Differences

The participants discussed culture in terms of observable/visible differences. By observable difference, it appeared to be the physical representations of one's culture, such as the colour of one's skin tone, gender or appearance of gender, degree of aging, and physical connections to one's religion, such as wearing a Christian cross. This was as opposed to unobservable cultural differences, such as sexual orientation, socioeconomic status, or political position. The participants did not describe their experiences in terms of unobservable cultural differences and focused mainly on how their overt, explicit differences influenced their perception of their clients and the establishment of cross-cultural therapeutic alliances. Each observable difference will be separated into the following sub-themes and discussed according to the relevant experiences: race; age; gender; and religion.

4.6.1. Sub-theme: Racial dynamics

One's racial category appeared to be a metanarrative among all eight (N=8) participants. When the topic of culture was introduced, the concept of race emerged as the largest, most-mentioned cross-cultural factor in the therapeutic alliance. Although all eight participants were provided with a definition of culture and the factors included in the definition of culture, they all spoke of culture generally in terms of race.

P3 (WM): *Hmm, when you say 'culturally', I automatically think of race.*

P1 (OF): *Um, we talking culture race-wise, right?*

South Africa's legacy of Apartheid was mentioned by five (N=5) of the participants who acknowledged how the history of racial segregation and institutionalized racism may have had an influence on the way in which clients perceived them. Also, how the country's history may have influenced the participants themselves in terms of how they perceived their client.

P5 (WM): *Well, ha-ha (laughing), you know the history of the country. We have to, have to, have to acknowledge it in therapy when it [race] matters.*

P3 (WF): *I'd say our country's history has groomed us to see race as separating us? Like there's an assumption that we would be different. I guess that starts the alliance on a negative thought pattern before it even begins.*

Four of the participants (N=4) described their clients' potential hesitancy in opening up with them due to South Africa's sensitivity around the issues of race and the historical perceptions of racial groups. Some of the white participants perceived their non-white clients as fearful of their potential racist attitude toward them. This, again, speaks to the residual impact of Apartheid in a supposedly free, democratic society.

P6 (WM): *I think some of these patients also have their defenses up because of media, derogatory news, um, common stereotypes [of racist white people].*

P3 (WF): *Their perception of me is also probably based on their experiences. Like, some of the older Black patients probably were hesitant to talk to me because of Apartheid. But the race issues … like, maybe a fear of my attitude towards them… it's like there was a block and a fear of letting me in or working with me.*

P5 (WM): *I think there must be some reservation about speaking about the therapist's race ... I am quite comfortable with speaking about racial things and stereotypes but it is still a highly sensitive issue in this country.*

One of the participants (N=1) spoke about his perception of his clients' attitudes toward him being a Black psychologist. He indicated that he reflected on the issue of race often during his training years and that he has grown more comfortable with the idea of white clients' negative perceptions of him. He did indicate that such perceptions may create hesitancy in the clients' trust in him, particularly with the older white or Indian clients.

P8 (BM): *With white or Indian patients, they will come with those perceptions … When I was at [Hospital X] it was a problem. Different kinds of patients there, it's just the context so you'd get it more [racism].*

Some of the participants (N=3) described how the issue of race and racism emerged in therapy and how they have struggled, at times, to manage those tensions accordingly or address those issues directly with the client. From the white participants' experiences, addressing issues of race was a challenging subject as they felt that it might hinder the progress of forming the therapeutic alliance. Participant 6 believed it to be 'ignoring the obvious'.

> **P6 (WM):** *I think white therapists are scared to discuss issues such as race ... In this country it is part of the nation and not talking about it would be like not addressing the elephant in the room.*
>
> **P2 (WF):** *Racism does emerge. But I am quickly able to pick it up and pack it away. But the challenges would be … where we might dwell upon something that is not within the therapy.*

4.6.2. Sub-theme: Age differences

Two of the participants (N=2) discussed how their age has been challenging in establishing some therapeutic alliances. Both of these participants are in the youngest age bracket out of all the participants and they explained how their age has been a major factor related to perceived mistrust, assumed inexperience, and reduced faith in their ability to help treat their clients' problems or psychopathology.

> **P8 (BM):** *Patients will come in and won't come back. They will come and speak to you for a session and you get the sense that this person won't come back. Maybe because they feel you're experienced, they didn't come back … As soon as they walk in they say 'wow you look young'. And then already now you need to prove yourself.*
>
> **P1 (OF):** *The first thing they'd say is 'she's too young', ha-ha (laughing)… I look a lot younger than I am I would say, I've been told that. So, I do often get that where I get questioned on my qualifications, what I've done.*

On the other hand, there appeared to be greater respect paid to the psychologist when the client was younger than the psychologist; this speaks to a perception that there is a positive relationship between older age and psychological experience. Additionally, one's cultural affiliation was reported to play a large role in how one perceives an older person. Participant 1, who also described her age being problematic with older clients, further explained how she is respected by clients who are younger than her.

> **P1 (OF):** *Because I am an older female there is a, kind of, weird level of respect that happens which I know is often cultural. Like, they know you're older and you're supposed to respect them. Again, I mostly see black populations so that's who I am speaking about … so yeah, you're like someone with knowledge and 'we've got to respect you' and so it's this kind of like this weird, distant situation, um, as they get older its flips to the whole 'but you won't understand'.*

The abovementioned text illustrates the role of age as a potential cultural factor and the role that it plays in facilitating or hindering the establishment of a strong cross-cultural therapeutic alliance.

4.6.3. Sub-theme: Gender dynamics

Gender was a cultural factor that was discussed in terms of male-female differences. Five participants (N=5) discussed their experiences with gender differences and its role in the formation of a meaningful cross-cultural therapeutic alliance. Two female participants (N=2) described how their feministic attitudes created tension in relationships with patriarchal male clients and how it became an issue that required reflection and management within the therapy.

> **P1 (OF):** *Look, in my personal capacity I am a feminist in that situation and I have had some clients who were very abusive toward their girlfriends.*
>
> **P2 (WF):** *For me, I have to be aware of my feministic biases…So [working with] a client from a more patriarchic background. I would approach the client in a way that shows respect…I don't know if they interpret my respect as being a humble woman, ha-ha, but I think it prevents them from seeing me as a challenge or someone trying to dominate them. So, ya um… I think it's a neutralizing factor to be humble and respectful towards my clients.*

Participant 1 also described how she has experienced differences with the way in which the different genders open themselves up to the process of therapy. She described her experiences of male clients being less open than female clients. Thus, they require more effort on behalf of the psychologist to establish a meaningful alliance.

> **P1 (OF):** *From whether it's your culture or gender or whatever, especially gender, I think males tend to not be as open in the beginning … but I find they do the most progress from what I have seen … so there is those kind of general limitations.*

4.6.4. Sub-theme: Religious affiliations

The concept of religion was reported to have been introduced into therapy by six (N=6) of the participants. Their experience of religion as a factor in the therapeutic alliance revolved around the issues related to inherent religious belief differences, encouraging the participant to convert to the client's religion, and disclosing religious beliefs. All of the aforementioned issues were experienced as challenging factors to manage while attempting to create strong, meaningful therapeutic alliances. P1, P5, and P7 reflect on these challenging factors below:

> **P1 (OF):** *I've had two interesting ones who tried to convince me to come to their church (laughing). So they were very keen to know what my religion was and, of course, I didn't tell them … it's not about me, it's about you!*

> **P4 (WF):** *I respect religion and know there's a place for it in the world … but this lady, when I referred her to the psychiatrist [for depression], she told me 'no', ha-ha. She, uh, told me that it would be better to visit the church.*

> **P7 (WM):** *I've even had clients try convince me to come to church or want to pray for me, and when I set the boundaries they get very upset … not all of them but I can count a good few.*

One of the participants (P2) described two positive experiences with religion as facilitative for the therapeutic alliance. She described how a psychologist and a client from different religious groups may result in less judgment if the issues are related directly to that client's religion. Additionally, she perceived a client's fascination with her religion as an attempt to form a connection with her.

> **P2 (WF):** *He said if he told someone from his own culture or religion that he'd be judged. So he went on about how Allah could allow this and so he had a religious crisis that didn't allow him to go to anyone in his family, not his kids or wife or anyone.* [*Different religions]

> **P2 (WF):** *I have had many Black people asking me 'are you Christian'. Maybe it's a form of conformation like 'do you know where I am coming from'.* [*Same religion]

All four of the abovementioned cultural differences (i.e., race, age, gender, and religion) were discussed throughout the participants' experiences and appeared to influence their perceived connection with the client. These observable differences were found to mediate further challenges in establishing meaningful cross-cultural connections, as will be discussed in the following sub-section.

4.7. Theme 5: Challenges to the Cross-Cultural Therapeutic Alliance

Multiple challenges to establishing meaningful therapeutic alliances with cross-cultural clients emerged in the participants' experiences. These revolved around psychologists' experiences with communication styles, language barriers, respecting cultural explanations of mental illness, stereotyping, and minimising power differences.

4.7.1. Sub-theme: Different communication styles

Two of the participants (N=2) described their experiences of working with cross-cultural clients' different styles of communication and the challenges that lay therein. Communication styles and non-verbal communication was perceived to be influenced by one's culture and how being unaware of these cultural differences in communication may have hindered the psychologist's complete understanding of the client's problem or presentation.

P1 (OF): *I struggle with white and Indian students in terms of openness. They are very, very sheltered and inward. So lots of intellectualizing their answers, lots of that kind of stuff. It's almost like I am pulling bits out of them. So in terms of that, culture plays a role.*

P2 (WF): *Eye contact is a big factor … I know certain cultures avoid it to show respect and then I have had a black male deliberately fixing eye contact, and I thought 'what does this mean?' … But we are all different so I even asked my colleague 'is this his personality style' or 'is he challenging me'.*

4.7.2. Sub-theme: Language barriers

Language differences were experienced more when working with clients from a different racial background. Some of the participants (N=5) reported difficulties with direct translation from isiZulu to English and a sense that significant meaning was lost in those translations. Thus, there was a general feeling that the client's true feelings and thoughts were not being communicated directly or were not being received accurately by the psychologist. Additionally, the psychologist's feedback, interpretations, empathy, and assessment may not have been received by the client in the manner in which it was intended; this was found to lead to misunderstandings and ruptures in the therapeutic alliance. Also, the importance of 'talk' was emphasized as language is the medium in which individuals typically express themselves. It appears that a large portion of what helped build alliances was missing when language difference was a barrier.

P1 (OF): *Of course English affects it sometimes because they want to express something that I can't really understand … But I would say that English has been a difficulty in that they can't express exactly what they're thinking and they cannot understand and I have to go over and over again until they define it.*

P2 (WF): *There was a case where a person did ask 'how good is your Zulu' and I said 'not good at all' (laughing); but … then I gave her another person's number.*

P4 (WF): *Also, I have had to do it [refer onwards] for language problems. I guess it's hard [for the client] to do talk therapy with someone who doesn't speak Zulu like them, or whatever their home language is.*

P5 (WM): *When I couldn't communicate my understanding to the client because of language barriers, I felt like I was doing the client a disservice and there wasn't a way of telling them that I do care and it made me feel bad as a novice … But all these little cultural issues disconnect the relationship I feel.*

4.7.3. Sub-theme: Respecting cultural explanations of mental illness

Two of the participants (N=2) brought up how they found it challenging to compromise their Western theoretical perspective of mental illness when the client had another cultural explanation for their presenting problem.

> **P3 (WF):** *Traditional callings, and uh, bewitchment are big barriers to treating someone psychologically and ya, we just have to respect that. I cannot force someone to attend, even if I really think they need it.*

> **P2 (WF):** *There are cases where they'd [Black African] say 'in our culture we don't believe in these psychology things'.*

Participant 2 illustrated this discrepancy with different cultural perceptions of mental illness by providing an example of her experience with managing a cross-cultural challenge regarding and how the successful management of this discrepancy may have contributed to the establishment of a meaningful therapeutic alliance.

> **P2 (WF):** *You don't have to be an expert on cultures but it's important to know a little bit. So the other example was a challenging one, and I believe if it wasn't for my [Area X] experience that I wouldn't have handled it. So I was working at [University X] for the [Y Department] and in the beginning of the year, the client [Black African female] came in for an abortion which required counselling first … Culturally, it wasn't the abortion but it was 'ukuthwasa', a calling to be a healer … So she had to go into a hut, go into the mountains and not see anyone. It was traumatizing for her. So when I saw her, I just felt like she didn't want to go through with it. She came to me because she needed concession to postpone her exams because she wasn't ready to write the exams … Whether or not I believe in it is not the point, psychologically it will hinder her if she doesn't follow what the elders what. So, I felt very comfortable writing that letter and motivating for the concession. I wrote it from a Western perspective in case someone from the Western community was reading it and didn't believe in cultural problems like hers. But yes, I fully supported that she should go for it.*

4.7.4. Sub-theme: Stereotyping the client

Categorizing, or stereotyping, cross-cultural clients was admitted by four of the participants (N=4). Much of the stereotyping was related to their clients' race and the participants found that stereotypes influenced their perception of their client; thus, introducing an assumption that the client will think, feel, and behave according to typical societal stereotypes. Stereotyping according to race further entrenched an 'us' versus 'them' manner of thinking which elucidated perceived differences between the client and the participant.

> **P2 (WF):** *We tend to stereotype its 'them not us'. So, it comes into play … I have found myself falling in the trap of stereotyping when a person from a more laid-back cultural background comes late or doesn't cancel appointment … like if someone does something that is typically Black, it will annoy me … or even Indian. But it wasn't a big hindrance. It's more a point of a back track of me being aware of my own racial stereotypes.*

> **P3 (WF):** *I could say I have had more of my Indian clients want to negotiate a cheaper price. I'm not sure if that fits into a … racial stereotype of the Indian population wanting a bargain or looking for the best prices. Like, none of my white clients have ever done that.*

> **P5 (WM):** *When he [Black African male] opened his mouth and spoke fluent English and had the most gentle manner, she [his colleague] realized how she had judged him before he'd even said anything.*

Participant 2 further explained how one's client may also stereotype the psychologist. Her client assumed that her being 'white' indicated that she would also be racist in her thinking. Stereotyping from both the client and the psychologist may negatively influence the establishment of a meaningful therapeutic alliance as the preconceptions about each other might create close-mindedness and judgment.

> **P2 (WF):** *When the Afrikaner 'boer' [farmer] banged his fists on the table and assumed I was with him [in terms of white people being explicitly racist], I was very annoyed … but if it was a social setting I would have put him in his place.*

4.7.5. Sub-theme: Managing power dynamics

Three participants (N=3) discussed experiencing strong power dynamics related to the cross-cultural therapeutic alliance. Being a psychologist in a mono-cultural dyad already assumed a power difference with the psychologist being perceived as more powerful than the client. However, when the client was from a previously disadvantaged background (e.g., Black African, Indian, or Coloured) then the power differences were illuminated. The participants acknowledged the effects of power differences and they felt that it created a divide between them and their client, thus influencing the quality of the connection in the alliance. Participant 5 (WM) illustrated his experience with losing touch with his 'humanness' and thrived on feeling a greater sense of importance. On the other hand, Participant 8 (BM) felt that he needed to prove himself to his white clients.

> **P1 (OF):** *I feel that creating the divide between 'I'm the knowledgeable one' on your life is so terrible in therapy … I'd say power, it's so huge! Like power differences between the therapist and the client, we seldom take stock of those things.*

> **P5 (WM):** *I think psychologists are put on a pedestal by many. Um, even I am guilty of this. But you lose touch of your humanness? I think, in a nutshell … psychologists working cross-culturally don't pay honor to their position of power. Even white-with-white setups, we may both be male and both be white … but I'm still in a position of power.*

> **P8 (BM):** *With white or Indian patients they will come with those perceptions … and then all ready now you need to prove yourself.*

4.8. Theme 6: The Role of Therapist Attributes and Techniques

This study further aimed to explore psychologists' perceptions on the attributes and techniques that facilitated or hindered the establishment of cross-cultural therapeutic alliances. All of the participants (N=8) were asked to discuss their perceptions of the attributes/techniques that facilitate alliance development and the attributes/techniques that they have experienced to hinder alliance development.

4.8.1. Sub-theme: Therapist attributes

All participants (N=8) discussed the personal qualities that they have experienced as most helpful when establishing therapeutic alliances with their cross-cultural clients. The participants all expressed similar facilitative and hindering attributes.

(a) Attributes that facilitate the alliance

There was a general consensus among all participants (N=8) about the qualities essential for psychologists to possess for the establishment of meaningful cross-cultural therapeutic alliances. The key attributes perceived to facilitate strong cross-cultural alliances were: openness (N=3), being an empathic person (N=6), being a good listener (N=3), genuineness (N=4), and being non-judgmental (N=3).

> **P8 (BM):** *I think you need to be a good listener and non-judgmental and more importantly being empathic. I think they can feel when you're not being authentic.*

> **P6 (WM):** *What's worked for me is being warm and reassuring. Some patients of mine have felt uncomfortable with discussing cultural issues and it takes a mindset of openness and kindness … Without that, I feel like the patient will draw shut*

Being aware of personal biases and 'blind spots' (i.e., lack of cross-cultural knowledge) was a common response among the participants as illustrated below.

P1 (OF): *Definitely honesty about your own limitations…and what you're able to do and your role … and I think what they looking for … is that we have empathy, we have the caring part of us.*

P5 (WM): *Having awareness and insight into your differences. For me, it's my privilege as a white male … so I think that once we can convey to our clients that we have insight into who we are and how we were shaped, it makes them feel more comfortable … and showing them that you have an open mind to both yourself and to them.*

(b) Attributes that hinder the alliance

All of the participants (N=8) discussed the attributes that they felt have hindered the establishment of meaningful cross-cultural therapeutic alliances. The participants felt that characteristics such as showing judgment (N=4), not being reflective of one's own personal limitations or 'blind spots' (N=3), assumed competence (N=3), and defensiveness (N=2) would hinder the formation of a therapeutic alliance with cross-cultural clients. Such views are reflected by P1, P2, P6, and P8 below.

P1 (OF): *[Psychologists] not having openness to being vulnerable in therapy … You know, just acceptance is not enough… it's about educating yourself and learning.*

P8 (BM): *Um, if you're judgmental number one. I think if you're judgmental. I mean, we all have our perceptions you know…Sometimes we may make a comment, and think, 'oh, I shouldn't have said that'. So if it comes across as being judgmental the patient may not come back.*

P2 (WF): *I think…not being aware of our own biases and being blind of how they come into play. For me, I have to be aware of my feministic biases … Putting away my biases and bracketing it out so my response isn't influenced by my beliefs.*

P6 (WM): *I think that comes with lack of personal development and not broadening your understanding of the world … We never know everything and we never will ever know everything. Once that thirst for learning dries up, we become rigid and complacent and our clients will start picking it up.*

Three of the participants (N=3) also perceived psychologists' conceitedness, arrogance, or need for affirmation to hinder therapeutic alliances. They felt that maintaining humility was of utmost importance for the alliance.

P5 (WM): *Oh, so what I mean is a lack of humility.*

P7 (WM): *And also a smugness when they get something right. Like to make an interpretation and they get it right and the client keeps affirming them as 'good'. I think psychologists like that keep getting too comfortable. So yeah, lacking modesty might create a stiff dynamic.*

P6 (WM): *I've met people … in our profession who have an attitude of 'I have got my PhD so I'm at the top and I know everything'.*

4.8.2. Sub-theme: Therapists' techniques

One of the study's aims was to uncover the techniques that psychologists have used to assist in the establishment of positive cross-cultural therapeutic alliances as well as their general experience of using a range of psychological techniques on culturally-different clients. Interestingly, when the topic of techniques emerged, the psychologists tended to discuss general theories instead and theories that they have experienced to be beneficial or hindering to the alliance.

(a) Theoretical perspectives

As mentioned, the participants included their experiences of using certain theories with particular groups of clients. Freud's Psychoanalytic Theory was experienced as least useful with non-Western clients.

P2 (WF): *Hmm…psychoanalytic perhaps … It almost feels too rigid and strict.*

P3 (WF): *Like, um, if I used psychoanalytic therapy on a client who values their community … it's so focused on the individual.*

P8 (BM): *Um, generally in the public context … I lean towards that [Cognitive Behavioural Therapy] much more than psychoanalytic … I know in the African community these things get sorted out at the community level.*

When working with traditional African or Indian cultures, some of the participants (N=2) indicated that they wanted to include a spiritual element to the therapy as a way of respecting cultural elements of the person. They experienced this as beneficial to establishing a strong cross-cultural therapeutic alliance. Others indicate the need for an approach that is more aligned with their needs and cultural background, such as using a solution-focused approach, behavioural techniques, a family-systems approach, or to adopt a transpersonal approach.

P1 (OF): *I work from a very integrated perspective and also I'm into transpersonal psychology which talks a bit more about integrating the spiritual aspect of the person into therapy.*

P8 (BM): *I personally lean towards techniques included in CBT, trauma counseling, solution-focused, supportive therapy… because if patients can only make it for two or three sessions, most of them don't come back.*

> **P3 (WF):** *Family systems therapy in a bigger, more integrated family, like the Indian families may be more suited as family is valued much more in collectivist cultures than is in mine I suppose.*

(b) Techniques to facilitate the alliance

Basic counselling techniques were perceived by some of the participants (N=5) as the most beneficial to use when trying to establish cross-cultural alliance. Included in these techniques are active listening, empathic responding, and allowing for client feedback. Additionally, the importance of using methods or techniques of finding similarities between the participant and the client was described as beneficial to bridging perceived cultural divides (e.g., P1)

> **P7 (WM):** *Across all therapies, I think the counseling skills are what is most important to making the client feel comfortable. Umm, like active listening, being empathic, and also being open to criticism for yourself … I think my clients appreciate the chance to give feedback.*

> **P4 (WF):** *Empathy is my go-to … If you don't understand, you just don't understand. We cannot pretend to understand.*

> **P1 (OF):** *I try see my connectedness to my client and I see their connectedness to me, um, and I try work somewhere in between that.*

Although being empathic was considered a necessary quality when working cross-culturally, empathy as a skill was also emphasized. It seems that being empathic and conveying empathy are two different factors. Conveying empathy was described as it were a skill/technique and as something that required practice and enforcement in intercultural therapeutic relationships. Participant 6 further emphasized the importance of the skill of flexible boundary-setting and how this contributed to the establishment of good therapeutic alliances, whether it was with same- or cross-cultural clients.

> **P6 (WM):** *If boundary-setting is a skill, and flexibility, then those too. When working with culture, we have to have good boundaries but also the ability to be flexible when needed to, um, accommodate those differences.*

(c) Techniques that hinder the alliance

All of the participants (N=8) discussed the techniques that they found to hinder the establishment of meaningful cross-cultural therapeutic alliances. From some of the participants' responses (N=4), it appears that inflexible techniques were not beneficial to the therapeutic alliance as the manner in which one conveyed meanings or confronted clients

may have needed to be adjusted based on what was culturally-acceptable. In line with this, some of the techniques experienced to be a hindrance to the alliance included: confrontation (N=2), inaccurate interpretation (N=1), non-directive interventions (N=2), and direct/blunt questioning (N=2).

> **P7 (WM):** *Interpretations can be quite tricky sometimes … It may come across as you telling them how it is but it's based on a half-truth or a half understanding which may, um, well lead to a problem in the relationship.* [*Interpretation]
>
> **P5 (WM):** *As a younger therapist, I remember confronting an older African woman about her discipline of her children … So even with the right intentions, the confrontation was taken as an attack and she didn't want to come back, although she had to because the school requested it*. [*Confrontation]
>
> **P8 (BM):** *Like, even the standard questions that we ask about if you were sexually abused or physically abused … culturally-speaking if I speak to an old Black female she just looks uncomfortable … then they'd be gone.* [*Blunt-questioning]

Participant 8 indicated that one may have to consider utilizing a different technique when interviewing certain types of clients as it may be culturally inappropriate and render unfavorable responses, inaccurate assessments of the presenting problem, client discomfort and potential alliance ruptures. Participant 5 described how his experience of confrontation was not accepted by the client and how his age may have influenced the appropriateness of such intervention. When working cross-culturally, it appears that the participants generally agree that having flexibility with the in which techniques are executed is important to ensure that the alliance is maintained as professional and therapeutic. Participant 6 further emphasized his experience with structuring the therapy too much in a way that may portray the psychologist as too rigid. As emphasized throughout the study, psychology is a Western profession and many of the ideologies and principles that underlie the practice and profession may be perceived as uncomfortable or unnatural for those individuals who do not conform to such ideology. Thus, inflexibility in one's approach was experienced as a hindrance to the alliance.

> **P6 (WM):** *Most probably this is done with good intentions but in this country, structuring the therapy too much makes certain people uncomfortable.*
>
> **P2 (WF):** *I guess anyone who is rigid in their approach will hinder it. You don't have to be totally eclectic but you must be open to adjust your style to the patient.*

4.9. Conclusion

Chapter Four aimed to report on the themes and patterns that emerged as the main findings of this research study. Firstly, this chapter conceptualized the therapeutic alliance according to the participants' perspectives of the factors that constitute a well-established, meaningful cross-cultural therapeutic alliance. The subsequent subsections expanded on the participants' experiences of establishing cross-cultural therapeutic alliances according to common themes and sub-themes, namely: the differences in setting (i.e., private versus public); initial anxieties; perception of cultural congruence; the influence of observable cultural differences (i.e., race, age, gender, and religion); the challenges to the alliance; and the therapist techniques and attributes perceived to be responsible for the facilitation or hindrance of cross-cultural therapeutic alliances. Overall, this chapter presented a description of psychologists' common experiences of forming cross-cultural therapeutic alliances and the techniques and attributes they assigned as facilitative or hindering for such alliances. An integrated discussion of these findings will be presented in the next chapter, Chapter Five.

CHAPTER FIVE

DISCUSSION

5.1. Introduction

A psychology that values Western principles of therapeutic relationships stands the risk of psychologists developing a perception of the client that is incongruent to their cultural context (Awaad & Riecherter, 2016). In South Africa, encountering cross-cultural psychotherapeutic relationships is likely in both training and practice (Flanagan, 2014). The intrinsic value- and belief differences inherent in individuals' cultural contexts are known to permeate the therapeutic relationship and affect the establishment of such (Vasquez, 2007; Idang, 2015). In this study, the main objectives of the researcher were to explore psychologists' experiences of establishing cross-cultural therapeutic alliances, as well as to explore their perceptions of the attributes or techniques responsible for the facilitation or hindrance of such alliances. In this discussion chapter, the researcher aims to offer an integration of the findings, as detailed in Chapter Four, using Bordin's (1979) Working Alliance Model as a structural framework against which to frame the participants' experiences and perceptions. Bordin's (1979) model emphasizes the collaborative relationship between the therapist and the client in their attempt to overcome the client's distress (Ardito & Rabellino, 2011). Bordin (1979) emphasized that utilizing his guidelines, as set out in the model, will ensure a meaningful therapeutic alliance. His model contains three main elements which he stated to be critical to the development of a meaningful working alliance, namely: addressing the *goals* of therapy; the *tasks* of therapy; and the emotional *bond* between the therapist and the client (Bordin, 1979).

The following chapter will include a discussion of the pertinent findings using the Working Alliance Model to critically explain and understand the participants' experiences of establishing cross-cultural therapeutic alliances. Further to this, this chapter hopes to challenge and extend the existing knowledge within the limits of critically-bound assumptions regarding the above.

5.2. Expectations of Mutual Agreement

Torrey (1986) emphasized that one of the most significant elements in establishing cross-cultural relationships is being in mutual agreement and sharing similar worldviews. The results of this study illustrate psychologists' experiences with aligning the clients' goals

with their own and how cultural dynamics tend to complicate such process. Firstly, according to Bordin (1979), the *agreement on goals* of therapy is an essential component of the therapeutic alliance as the goals represent clients' stressors, frustrations, and dissatisfactions. Thus, when both the client and psychologist share similar beliefs in terms of the goals of therapy and they both consider the treatment methods (i.e., techniques and therapy-style) as relevant and useful, then there is a stronger likelihood of developing a more meaningful therapeutic alliance (Ardito & Rabellino, 2011). Rather than discussing *goals* directly, the participants emphasized the importance of 'mutual agreeability' regarding the etiology of the client's distress, the nature and extent of the distress, the manner in which the distress is best addressed, and the role of the psychologist in achieving the desired outcomes. Their experiences highlighted that being in agreement with clients' worldviews may render more difficult when cultural difference comes into play; thus, compromising the establishment of a therapeutic alliance. Wampold's (2011) meta-analysis, which focused on the therapeutic actions responsible for facilitating the development of a strong alliance, emphasized the significance of coming to an agreement about the goals of therapy through an interactive, collaborative approach and by offering a culturally-acceptable explanation for the clients' distress. Therefore, when considering the degree of mutual agreement in therapy, one might consider clients' acceptance of psychologists' psychological diagnoses, Western explanations of the distress, and their treatment methods for addressing such distress.

5.2.1. Cultural explanations of mental illness

Psychologists practicing within the multicultural South African context require an awareness and vast knowledge of the diverse cultural explanations of mental illness. Discrepant explanations and treatment pathways between the client and psychologist regarding mental illness may compromise the establishment of a therapeutic alliance through disagreements. In line with Kleinman's (1978) Explanatory Model of Illness, psychologists should try to understand clients' core beliefs about mental illness or psychological distress, the personal and social meaning that they attach to mental illness, and their expectations about what will transpire prior to- and during the course of treatment. In this study, some of the participants discussed their challenges with compromising their Western theoretical understandings of mental illness to accommodate their clients' own explanations of mental illness. The difficulty therein lies that most psychological training is structured according to mainstream, Western theory and practice, thus lacking cross-cultural

relevance (Sue, 1981). According to Atkinson, Morten and Sue (1979), psychological theory and practice has been developed for the White middle-class person and conceptualized using Euro-Western, individualistic terms. Resultantly, psychologists practicing within this mono-cultural perspective appear to have difficulties with aligning their cultural knowledge to their clients in a workable manner. Although the relevance of psychology in South Africa has been challenged by many in the profession (e.g., Naidoo, 1996; Clay, 2017), much more development is required in terms of coming to a general agreement about what constitutes a 'relevant' psychology in South Africa (Makhubela, 2016). The results of this study suggest a need for psychologists to be more flexible in their understanding of what constitutes mental illness and psychological suffering within different cultural contexts. Doing so, psychologist s may develop a more holistic view of the client and their beliefs before reverting to their understanding of clinical models; emphasizing this at a practical level within psychological training may prepare more culturally-responsible therapists for practicing psychology in South Africa. With a focus on Bordin's (1979) Working Alliance Model, a strong working alliance is theoretically comprised of a level of agreement or compatibility with the goals of therapy (Keenan et al., 2005). Hence, differences in opinion with regard to the cause of the client's presenting problem and the best method in which to address it may lead to ruptured therapeutic alliances. From the results, when the client-therapist dyad is intercultural, explanations of mental illness seem to be more likely to differ.

5.2.2. Diverse worldviews

Different cultural contexts lead to the development of different worldviews, beliefs, assumptions, models of social conduct, and therapeutic expectations; thus, psychologists are required to assist the client from their primary cultural assumptions whilst maintaining the individuality of the client (Ibrahim, 1985). During the initial consultation, psychologists need to understand how a constellation of factors form the client's worldviews and in what ways their worldviews clash or merge with their own. According to Ibrahim and Kahn (1987), understanding both client and therapist worldviews can profoundly enhance therapy by providing information that can affect diagnosis, process, and outcome; this includes the goals in psychotherapy as one's worldview mediates the decisions and solutions that are meaningful to the individual (Ibrahim & Kahn, 1987). According to Ibrahim (1985), in psychotherapy, individuals' worldviews have been identified as critical variables that can facilitate or obstruct the therapeutic process.

5.3. Tasks of Therapy

The *tasks* of therapy are the mutually-agreed-upon ways in which the client and therapist will approach psychological treatment (Bordin, 1979). Here, the *tasks* of therapy also include the concrete components of therapy, such as establishing a contract with the client, negotiating fees, and psycho-educating the client about the process of therapy (Macewan, 2008). The results of this study suggest that the structure of therapy may also be conceptualized as the *tasks* of therapy, hence such terms were used interchangeably. The participants' experiences described a need to establish a solid therapeutic structure to ensure that the relationship remains professional and to ensure that appropriate boundaries are maintained. Establishing the structure of therapy was explained to include the negotiation of payment, exchanging medical aid details, time of sessions, number of sessions required, and the process/implications of cancelling therapy sessions. These typical structural components of therapy were experienced as 'unnatural' and 'foreign' for many non-Western cultures and managing these cultural differences in terms of structural flexibility was experienced as a challenge to the therapeutic alliance. Hence, the following factors will be discussed in terms of the participants' experiences with establishing the tasks/structure of therapy, namely: the setting of practice; perceived comfort with structure; the need for structural flexibility; and the role of psychoeducation.

5.3.1. The role of context

The tasks/structure of therapy appeared to be influenced by the context in which the therapy occurred. In the public domain, payment or medical aid details are not components of the therapy. Nonetheless, the time, dates, and length of sessions are still considered necessary tasks. In the private sector, however, the process of negotiating the tasks of therapy was experienced as clinical, 'cold', and mechanical, particularly with clients who were not accustomed to the practice of psychology. Furthermore, it is expected that psychologists working within the public domain will have more exposure to client diversity as will psychologists within private practice. In line with this, Stein and colleagues (2008) emphasized the direct relationship between one's ethnicity and socio-economic status. In South Africa, it is inherent that the white population has more socioeconomic advantage than other non-white population groups, such as Black African, Indian, and Coloured. Thus, the white population's increased ability to afford private services seems to lead to a limited cultural population within the private domain as compared to the

culturally-diverse, lower socioeconomic populations who make use of the public domain. Managing therapy tasks, then, is further influenced by the setting of practice (Slabbert, 2015).

5.3.2. Perception of structure

The results of this study alluded to the participants experiencing a sense of comfort with having a concrete therapy structure. Interestingly, the participants who believed that the structure/tasks of therapy were the most important to the cross-cultural therapeutic alliance were white males; thus, highlighting their value of Western ideals of psychotherapy. Reverting to the structural factors of therapy (i.e., time, payment, cancellation policies, etc.) may speak to one's level of discomfort or inflexibility when one is unsure of how to manage cultural issues (Sumari & Jalal, 2008). Structure in therapy, then, may be perceived to be a safety net or default procedure for managing such difficulties, such as with payment alternatives (e.g., bartering, *pro bono* requests, or personal favours), treatment method discrepancies (e.g., religious interventions, traditional healers), and managing boundary issues (e.g., physical touch). Conversely, some of the participants' experiences alluded to there being a sense of discomfort with the administrative aspects of consultations which, on the one hand, implies that the consultation process has professional rules and boundaries and involves transactions for services; and, on the other hand, negotiating a therapeutic relationship requires an implicit sense of being unstructured and value-free with the client (Thompson, Bender, Lantry & Flynn, 2007).

5.3.3. The need for structural flexibility

From the participants' experiences of establishing cross-cultural therapeutic alliances, there is an apparent need for flexibility in the tasks/structure of therapy if one wishes to foster a meaningful therapeutic alliance. The introduction of spirituality into treatment, as well as focusing on the client's specific cultural background and presenting problems, is experienced as beneficial to the alliance. As religion and spirituality form a large component of human culture that shapes people's beliefs, values, and behaviour, introducing it into therapy was experienced as beneficial to the therapeutic alliance. Earlier research by Shafranske and Malony (1990) found that some psychologists felt unprepared to address religious and spiritual concerns with their clients. The results of this study indicated that religion has become a point of discussion in many psychologists' experiences and addressing religious questions has required the use of clinical judgment about whether or not the disclosure of their religious background will facilitate or hinder the alliance. From the participants' experiences, belonging to the same religion as their client had benefited the therapeutic

alliance, whereas belonging to different religious groups contributed to a perceived rupture, with the therapist then re-negotiating their understanding of the client via more in-depth exploration and relational effort.

Additionally, various authors (e.g., Aviera, 2002; Sue & Sue, 2002) emphasized the need to abandon the Western role of the psychotherapist when working with diverse cultural backgrounds; thus, shying away from some of the more orthodox psychological practices. Most of the participants felt that traditional psychoanalysis was not a beneficial task to achieving the cross-cultural client's goals as there was a clash between the individualist and collectivist cultures; with psychoanalysis valuing the role of the individual's experiences of mental distress as opposed to the role of the non-Western conceptualization of community identity when understanding mental illness. Rather, methods of treatment should be aligned with the client's needs and cultural background, such as using a solution-focused approach (e.g., Diale, 2014), behavioural techniques (e.g., Young, 2009), or a family-systems approach (e.g., Somni, 2014) depending on what the client values and perceives as the best method of treatment. South African research by Bantjies, Kagee and Young (2016) asserted that it is necessary for psychology to make its interventions culturally-relevant and adapt its models to a variety of South African settings. Further research by Slabbert (2015) focused on the need for psychologists to pay attention to the manner in which they assess, diagnose and treat clients from differing ethno-cultural orientations. Thus, interventions based on individualistic conceptualizations of mental illness and intra-psychic conflicts may overlook the core intra-familial or intra-community conflict and render as counterproductive (Dwairy, 2015).

Lo and Fung (2003) referred to the abovementioned point by exploring how the explanatory model of the client may differ from that of the psychologist, and how a process of negotiation may be necessary to maintain therapeutic harmony. For example, some clients may prefer to focus on practical issues, such as somatic symptoms or employment issues that may appear to be too concrete for some psychologists (Lo & Fung, 2003). As found in this study, psychologists may need to respond to these issues to maintain the therapeutic alliance (Lo & Fung, 2003). Additionally, when managing the *tasks* of therapy, the participants noted the importance of being aware of individual therapy as an uncommon practice in the assessment and management of mental distress in some cultures (Carducci, 2012). Preserving the therapeutic relationship as one that is professional requires maintaining the tasks of the therapy (Bordin, 1979); however, in the context of a cross-cultural dyad, the psychologist should be aware that having structured processes (i.e., times, dates, and boundaries) may not align to the client's expectations in relation to the cross-cultural context. This may be

attributed to the lack of exposure to psychological services, clients' different perceptions/expectations regarding their role in the therapy process, and a sense of distrust between the client and the therapist which is further influenced by historical and current socio-political dynamics in South Africa.

5.3.4. Incorporating psychoeducation into the structure

Psychoeducation was a structural factor or *task* discussed by only two (N=2) of the participants. Psychoeducation typically refers to the imparting of knowledge about mental illness to a client and their family, including information about the etiology of mental illness or psychological distress, the available treatment options, and the importance of complying with psychotherapy or medication (Prost, Musisi, Okello & Hopman, 2013). Incorporating psychoeducation as an element of structuring the alliance with cross-cultural clients was experienced as beneficial to uncovering the client's expectations and their existing level of psychological understanding. Orne and Wender (1968) noted a positive relationship between the perception of psychotherapy and therapeutic outcome when clients were provided with a basic understanding of how psychotherapy works and for what to expect from the psychologist. Psychoeducation provides a rational basis for the client to engage in psychotherapy, clarifies the role of client and therapist, and identifies the oscillating feelings that typically emerge within psychotherapy, such as negative transference (Orne & Wender, 1968). Although psychoeducation has not been proven to be effective in all non-Western groupings (e.g., Yeomans, Forman, Herbert & Yuen, 2010), incorporating psychoeducation into the structure offered both the psychologist and the client an opportunity to reflect on the worldviews, health beliefs, and current standpoint of each other.

However, according to Ardito and Rabellino (2011), the *goal* and *task* components of therapy may only be developed successfully once there is an established personal relationship or 'bond' between the therapist and client. The *bond* component of the therapeutic alliance was found to be the most important factor in creating and maintaining a strong working relationship (Bordin, 1979). However, it was also the component with the most cross-cultural challenges.

5.4. The Therapeutic Bond

Bordin's (1979) third component of the Working Alliance Model is the *bond* between the psychologist and the client. Theoretically, this bond should represent a strong, positive connection between both parties and should be characterized by high

levels of trust, reliability, and confidence (Bordin, 1979). The results of this study suggest that forming a connection with the cross-cultural client is the most important factor in establishing a strong therapeutic alliance as all of the participants (N=8) believed this to be their main priority. The experience of forming a bond with cross-cultural clients was influenced by demographic differences (i.e., race, gender, age, and religion), the perceived cultural similarities and differences between the client and psychologist, as well as the psychologists' experience of attempting to connect with the client whilst using culturally-acceptable boundaries.

5.4.1. Racial-matching in therapy

Racial/ethnic-matching was described as part of culturally-responsive care, an element to reduce mental health problems, and a factor aiding in the establishment of a sound working alliance (Meyer & Zane, 2013). The participants' experiences with racial-matching were mixed. On the one hand, the majority of the participants felt that ethnic-matching in therapy is beneficial as it offers both the client and the psychologist a sense of comfort and an implicit understanding of each other's cultural backgrounds. Their perceptions of racial-matching are mirrored by Rude and Colleagues (2000) who found that most clients preferred to enter therapy with psychologists who are racially-similar due to higher levels of interpersonal comfort. Additionally, the concept of 'interpersonal similarity' or racial-matching was found to be associated with perceived therapist credibility and a reduction in stereotyping (Ames, 2004; Simons, Berkowitz, & Moyer, 1970). In South Africa, due to the significance of race and ethnicity, psychologists working cross-racially need to be aware of the client's history of institutionalized oppression, dehumanization, racial discrimination and prejudice, struggles with poverty, and exploitation, among other social injustices (Nwoye, 2010). It might be assumed, then, that a psychologist who has not lived through such experience, or been a part of that oppressed system, might not be able to understand fully the implicit cultural experiences of those who did. Thus, a psychologist who has not directly experienced such social injustices may find challenges in forming a strong, meaningful bond with their client based on understanding, trust, and mutuality (Nwoye, 2010). This is supported by Cabral & Smith (2011) who asserted that cross-cultural dyads were found to be less likely to trust one another and less likely to assume similar worldviews.

On the other hand, some of the participants did not experience racial-matching to be necessary in the facilitation of meaningful cross-cultural therapeutic bonds. From the results, it appears that some of the participants displayed sufficient comfort with ethnically dissimilar

clients, and this was due to their personal background, training, or working in diverse clinical contexts, including public health facilities and tertiary educational institutions. It was acknowledged, however, that one cannot assume that because the psychologist is comfortable, that the client would be too. This was illustrated with three examples of clients requesting a psychologist from their racial background. Research by Snowden (1999) and Sue (1977) illustrated how white clients may be implicitly mistrustful of non-white psychologists, and how non-white clients may be mistrustful of white psychologists. In South Africa, this position is not uncommon based on the historical difficulties with racial segregation and discrimination. Nevertheless, international research data indicated that the efficacy of therapy does not differ substantially when the clients are racially-matched to their psychologists (Sue, 1998).

The participants also reflected on their experience of working mono-culturally and how this experience limited them in terms of personal growth. The issue of 'assumed understanding' was also experienced in mono-cultural pairings, whereby the psychologist would assume that they understood their client based on their similar cultural backgrounds, thus preventing them from investigating further. According to Cabral and Smith (2011), this discrepancy between one's 'perceived similarity' and 'actual similarity' could weaken the therapeutic alliance. 'Perfect similarity' of client and psychologist was described by Cabral and Smith (2011) as not only unattainable but also adverse to the therapeutic alliance as cultural differences may promote greater insight and offer different perspectives.

Again, looking at this concept in terms of the setting of practice, being exposed to many diverse cultures in the public domain contributed towards increased levels of cultural sensitivity and a sense of cultural competence. Being racially different was experienced as a challenge, however this was subsequently managed whereby the client-therapist dyad negotiated cultural understandings and experiences to harness the therapeutic bond. In the public domain, the amenities for racial-matching are not available as there are a limited number of public-service psychologists. Additionally, the system for 'matching' works on a first-come-first-serve basis, whereby the client will see the psychologist who is on duty for that specific day. In private practice, it was assumed that if a client chooses to see a particular psychologist, that it is part of an informed choice that incorporates the client's knowledge about the psychologist's age, gender, and race.

5.4.2. Perceived cultural differences

The participants' perceptions of cultural differences were experienced to impact the establishment of cross-cultural therapeutic alliances. Their evaluation of the client based on numerous demographic and/or social factors lead to various assumptions about the client's culture and the discrepancies that may lie ahead. The participants described an initial sense of anxiety pertaining to the perceived cultural differences between themselves and their clients and they identified these cultural differences in terms of the following categories: *demographic* – race (i.e., skin colour), gender, religion, and age group (i.e., older generations vs. younger generations); *linguistic* – primary language of communication; and *contextual* – the client's existing knowledge of psychology as a profession. These cultural differences influenced the participants to exercise greater caution in their attempts to establish the alliance and to re-evaluate or reflect on their own perceptions of 'differences'. A study by La Roche and Maxie (2003) focused on whether or not psychologists should address these cultural differences within the initial stages of therapy. They described how cultural differences are subjective and dynamic; thus, it is the psychologist's own perception of 'difference' enforced by their own subjective meanings of what makes people 'different' and 'similar' (La Roche & Maxie, 2003). Therefore, psychologists should not assume a standard way to treat clients from a specific cultural background. Rather, they should explore the meanings that they and their clients ascribe to these cultural differences (La Roche & Maxie, 2003). Most of the participants assumed that because the client was not white, that they would require a non-Western mode to treatment. Thus, the exploration of clients' perceptions of cultural differences is important to consider prior to proceeding with therapy. Additionally, most of the participants described cultural differences as separate factors with little consideration of the intersection of these factors to create complex, interrelated cultures (Crenshaw, 1989). Psychologists should, then, be encouraged to engage in ongoing explorations of the subjective meaning of cultural differences rather than presuming that explicit, concrete, demographic differences assume inherent cultural differences between them and the client (La Roche & Maxie, 2013).

Although the participants discussed their experiences in terms of perceived differences, some of them also noted how they found many similarities in cross-cultural clients with whom they'd assumed total difference. The participants felt that some of their clients' experiences were not unique to their cultures (i.e., culture bound), such as parenting styles and masculinity among races. By either the psychologist or the client assuming inherent difference based on demographic differences (e.g., race), it negates the possibility

that either of them might straightforwardly understand their dilemma or be knowledgeable about a particular issue. Assoud (2014) asserted that directly discussing cultural differences early on in the therapeutic relationship may be vital in assisting in the development of mutual understanding, trust, and the client's perception of the psychologists' multicultural competency – all important components of establishing a therapeutic bond (Bordin, 1979).

5.4.3. Managing acceptable boundaries

The participants' experiences of managing boundaries were described to be an essential component of establishing and maintaining a cross-cultural therapeutic alliance. Boundaries in therapy refer to the rules that govern the therapeutic relationship and aid in differentiating it from a social relationship (Drum & Littleton, 2014). The major boundary issues that arose in cross-cultural dyads were expected self-disclosure, physical touch, gift-giving, and maintaining the professional vs. social relationship. Although establishing appropriate boundaries promotes a trusting therapeutic alliance, these boundaries may be difficult to operationalize in cross-cultural contexts as they are dependent upon numerous factors, such as: the client's diagnosis; the context; and cultural differences (Drum & Littleton, 2014). The participants' cross-cultural boundary difficulties mirrored Gutheil and Gabbard's (1993) finding that the most common boundary issues to arise in therapeutic settings included those related to the role of the therapist, exchanging of gifts, physical touch, clothing, and self-disclosure. As Drum and Littleton (2014) emphasized, it is vital that psychologists acknowledge and deeply understand the cultural context of their client when setting boundaries in order to maintain an ethical, beneficial therapeutic alliance. Research by Burkard, Knox, Groen, Perez, & Hess (2006) studied helping skills within cross-cultural relationships and they found that increased psychologist self-disclosure was identified as a factor to improve the therapeutic relationship with African-American clients, among other cross-cultural dyads.

Viewing boundary-setting in terms of the Western principles of psychology may not render effective in the South African client population as what may be considered as 'culturally-acceptable' in one culture may be viewed as 'culturally-inappropriate' in another. Ensuring that one is flexible enough with one's boundaries to respect the client, but also to ensure the maintenance of a professional therapeutic alliance was experienced as challenging to some of the participants. This is in line with Nathan (1994, as cited in Barnett & Bivings, 2003) who emphasized that certain cultural traditions should be acknowledged, respected and managed accordingly, such as receiving a gift or exchanging a hug, so as to enhance the

therapeutic relationship; however, one should act to preserve ethical-correctness. For instance, hugging was experienced as a common manner of greeting in non-white clients, and it was emphasized by Nathan (1994, as cited in Barnett & Bivings, 2003) that a psychologist may adhere to the traditions of the client, such as receiving a hug or a gift, so long as the psychologist acknowledges this gesture as a cultural tradition, rather than a symbol of underlying psychological issues (Barnett & Bivings, 2003). Again, such attention to each party's cultural differences may encourage an acceptable crossing of boundaries in order to avoid damage to the therapeutic alliance (Barnett & Bivings, 2003). The participants' experiences illustrated that adhering to Western ideals of boundaries may be misinterpreted by the client as 'cold', distant, or mechanical. It is therefore necessary for therapists to utilize a degree of clinical and cultural judgment when forming therapeutic boundaries so that one may secure a positive *bond* (Bordin, 1979).

5.5. Cross-Cultural Challenges to the Therapeutic Bond

Various challenges to establishing cross-cultural therapeutic alliances emerged in the participants' experiences. The main challenges associated with culture included communication barriers, racial attitudes, stigma, respecting cultural explanations of mental illness, addressing taboo issues, stereotyping, and minimizing power differences. These will be discussed subsequently.

5.5.1. Communication barriers

According to Lo and Fung (2013), effective communication forms the basis of any psychotherapeutic intervention. They put forth that therapists may need to compromise their communication style, both verbal and nonverbal, to that of their cross-cultural client because, for example, seemingly similar words may bring about different psychological associations (Lo & Fung, 2013). The participants' experiences illustrated communication difficulties, both verbal and non-verbal, within cross-racial and cross-lingual dyads. Most of their difficulties revolved around direct translation from English to isiZulu and vice versa, as well as analyzing non-verbal communication accurately.

(a) Language

Psychologists working in South Africa have a high probability of encountering clients whose primary language of communication is not English due to there being 11 official languages in the country. The English participants reflected on their experiences of semantic

meanings being lost through translation. If a psychologist is not able to speak the dominant language of their client, it may have detrimental consequences for the outcome of therapy and ultimately hinder the therapeutic alliance (Bamford, 1991). A Spanish study found that Spanish-speaking clients were more positive about their experience in therapy if their psychologists were bilingual (Padilla & Salgado de Snyder, 1988). Thus, a bilingual psychologist who is familiar with the client's home language may help the client to elucidate the various semantic meanings of words (Fung & Lo, 2013). Again, the context of practice is important when considering translation. In the private sector, there is an assumption that a client will choose to see a psychologist (preferably of the same ethnicity) if that they believe that they can communicate effectively. Psychologists who have worked within the public domain experienced translation as a challenging experience as many district, regional and central government hospitals in KwaZulu-Natal are faced with inadequate clinical resources and do not have the financial budget to employ professional translators, as implemented within the South African legal system.

Translation, anyway, has its own challenges. Larson (1984) believed that one does not merely translate language, but culture. Larson (1984, p. 431) argued that, "language is part of a culture and, therefore, translation from one language to another cannot be done adequately without a knowledge of the two cultures and well as the two language structures". Thus, the clients' cultural context and their inner most feelings and thoughts may be inaccurately communicated due to an inability of either party to speak each other's home language. Moreover, the psychologist's feedback, interpretations, conveyed empathy, and assessment may not be received by the client in the manner in which it was intended which was found to lead to misunderstandings and ruptures in the therapeutic alliance (Mount, 2007). The importance of 'talking' in psychotherapy emphasizes language compatibility as a necessary medium for effective communication between cross-cultural dyads. Most of the participants were not able to speak a second language fluently, and none of the white participants could speak a Black African language, thus the Black African client was expected to communicate using his second, third, or fourth language which was found to greatly compromise the development of an effective therapeutic alliance (van den Berg, 2016). Hence, it seems that a large factor that helps build a therapeutic alliance is missing in therapeutic relationships when language differences are a barrier.

(b) Non-verbal communication

The results of this study highlighted how non-verbal communication plays a role in understanding the client and their current mental state, feelings, and attitudes. A lack of cultural knowledge about particular non-verbal cues was experienced as detrimental to the development of a therapeutic alliance. Gamble and Gamble (2002) argued that culture plays a significant role in the use of non-verbal language as it guides individuals on how to interact according to interpersonally- and socially-acceptable manners. According to Levine and Feldman (1997), cultural acceptability of certain non-verbal communications, such as personal space, gestures, touch, facial expressions, and eye-contact may lead to misunderstandings in an intercultural therapy dyad.

The participants' experiences of communication misunderstanding seemed inevitable due to their diverse cultural orientations and experiences. De Vito (1992) put forth that one of the reasons for intercultural communication misunderstanding is when the psychologist ignores the differences in meaning; that is, a difference between the perceived meaning and the intended meaning (De Vito, 1992; Gamble & Gamble, 2002). Silungwe (2014) asserted that communication is received and perceived according to the perceptive abilities of each party in the therapeutic alliance, as well as the ways in which these abilities have been shaped by past experience, background, and cultural affiliations. Communication with cross-cultural clients may then be most effective when the psychologist is implicitly and explicitly aware of the difference in the meanings associated with certain words and non-verbal cues or gestures (Silungwe, 2014).

5.5.2. Race as a Social Construct

(a) Stereotyping

The social construct of 'race' was experienced as a factor contributing to initial anxiety and stereotyping clients. According to the social constructionist perspective of race, one's skin colour denotes separate categories that divide and classify human beings according to social processes, cultural norms, and greater political and economic domination and marginalization (Foster, 1992). Thus, race is a social construction intrinsically utilized as a form of social categorization and stratification (Foster, 1992). In the context of cross-cultural therapeutic dyads, the concept of race exerted a pervasive presence in the narratives of the participants and influenced the therapists' perceptions of the clients prior to any engagement. Gamble and Gamble (2002) acknowledged the effects of racial stereotyping as creating and perpetuating inappropriate, unsupported conclusions about other individuals; thus, leading to

failed communication and prejudgment of an individual. The cross-cultural client may feel sensitive to common stereotypes appointed to their race or gender, such as 'all whites are racist', and consequently perform opposed to that stereotype, thus reducing the genuineness of the client or psychologist. Steele (1997) termed this a *'stereotyped threat'* which occurs when an individual is asked to perform a task in which that individual is stereotyped to perform a certain way. According to Steele (1997), clients who are typically stereotyped (i.e., Black African) may be especially sensitive to the experiences of negative judgment, rejection, and critique of their non-Black psychologist without that psychologist being aware of this implicit sensitivity. Due to a history of oppressive and rejecting experiences, many non-White clients may be sensitive to their psychologists' perceptions of them and become easily shamed; this was emphasized by one of the participants who explained that she could not assume that the client was comfortable just because she was comfortable. Thus, it is imperative for psychologists who are working cross-culturally to be reflective of their perceptions of race and how they act in accordance with those perceptions (Vasquez, 2007).

Again, stereotyping of individuals based on typical, unsupported beliefs about particular groups of people tends to be most associated with racial categories in South Africa. South African individuals typically classify themselves according to defined racial groups, that is: Black African, white, Indian, or Coloured. When that individual perceives themselves as a member of a group, they identify with that 'in-group'. Other individuals who do not suit the criteria for that in-group form the 'out-group'; thus, establishing an 'us' versus 'them' mentality characterized by intergroup comparisons and maximizing differences between the two groups (Tajfel & Turner, 1986). Racial constructions, such as white and Black, may be socially created but they still hold very real consequences for the therapeutic alliance; specifically, in terms of ethnocentric stereotyping whereby the psychologist may perceive their own cultural group as superior to the client's (Öğretir & Özçelik, 2008). 'Whiteness' has been constructed as a dominant and normative space against which difference is measured. In this manner, 'whiteness' is often viewed as a standpoint from which the self and others are perceived and understood, thus influencing one's perception of the other who is not 'white' (Garner, 2006; Garner, 2007). Consequently, 'blackness' may be viewed as the antithesis to 'whiteness', for that reason it is perceived to be inferior and subordinate (Garner, 2006; Garner, 2007). Thus, such socially-influenced perceptions of race are problematic in a discipline based on social engagement, trust, and assumed neutrality and non-judgment (Cabaniss, Cherry, Douglas & Schwartz, 2016). In the context of cross-cultural therapy

dyads, the social construction of race and stereotyping may lead to binary thinking and hinder the establishment of an effective bond in the cross-cultural therapeutic alliance.

(b) Binary thinking

Perceiving the client in terms of 'Black' or 'white' creates an inflexible, reductionist style of thinking which the participants experienced as elucidating differences between them and their client. Viewing an individual as fitting into set 'categories' ignores the grey area which includes the multifaceted and complex phenomena of culture, including cultural assimilation (Lakey, 2003). Wood and Petriglieri (2005, p. 31) asserted that "it [binary thinking] can continue to exert an archaic hold on us beyond its usefulness if it prevents us from looking beyond the polarity of opposites". The participants tended to differentiate individual differences as complete opposites; for instance, male-female, black-white, and young-old. Assuming this mode of thinking polarizes the therapist-client relationship and automatically places each party in a position of thinking that emphasizes challenges and blocks to establishing a strong therapeutic alliance. Again, this illustrates how simple observable, demographic differences have effects on one's implicit attitude toward the client or the therapist; this further highlights the beneficence of racial similarity in therapy and its potential usefulness for the therapeutic alliance (Ruane, 2010).

(c) Race and the 'rainbow nation'

The concept of race and racial difference was experienced as a sensitive topic within cross-cultural dyads. This sensitivity to race points to pre- and post-democratic circumstances. The development of South African identities and relationships may be influenced by the country's racialised past and its present socio-cultural context (Puttick, 2011). Pre-1994, one's identity and social relations were influenced by the narrative of race which was eagerly promoted by the Apartheid regime (Steyn, 2001). Post-1994, the new master narrative of the 'rainbow nation' assumes the inherent acceptance of all races as one without unpacking entrenched constructions of racism (Puttick, 2011).

Within the current socio-cultural context of South Africa, where racism carries undesirable social connotations, attempting to portray oneself as 'colour blind' and racially accepting may render oneself as inauthentic in therapy as the nation still exists with societal, economic, and political differences despite the strive for it to exist as one (van Djik, 2002). The common goal for acceptance mediates the post-democratic narrative for unity and the fact that cultures still exist as separate entities (Puttick, 2011). A therapist's goal to appear culturally accepting and racially-tolerant is a way of managing one's negative beliefs about

the other through denial of such beliefs or adopting disclaimers against certain beliefs (e.g., "I'm not racist because I like working with Black clients") which intend to dispel any negative impression with their clients (van Djik, 2002). Thus, one should acknowledge the impact of pre-and-post democratic narratives on cultural identity and one's perception of race in the therapeutic relationship (Puttick, 2011).

5.5.3. Managing stigma

The issue of managing mental illness stigma was experienced as a necessary part of establishing a cross-cultural therapeutic alliance. Some of the participants believed that the clients' cultural background contributed to preconceived understandings of psychology as only treating 'mad people'. Thus, the alliance was experienced as fearful, mistrusting, and shameful. According to research by Nakash, Nagar, and Levav (2014), the client's perception of stigma was significantly and inversely related to the psychologist's Working Alliance Bond Scale. Specifically, stigma towards psychological treatment was associated with increased therapist negativity toward the quality of the therapeutic alliance (Nakash et al., 2014). The findings by Nakash and colleagues (2014) relate to the experiences of the participants as they found that stigma toward psychological care plays a role in the implicit appraisal of the quality of the therapeutic alliance by the psychologists. Thus, clients' concerns about the ethnicity of the therapist, skepticism about psychotherapy itself, and mental health stigma served as barrier to accessing care, establishing therapeutic alliances, and adhering to treatment (Nakash et al., 2014; Moritz, Schröder, Meyer & Hauschildt, 2012).

Some of the participants found use in addressing the issue of stigma directly to ensure that the client trusted them and engaged fully. As put forth by Nakash and colleagues (2014), the traditional focus of psychological interventions has been on the person's individual psychopathology. Thus, the results of this study suggest the need for therapeutic efforts to be geared toward providing relief from mental health stigma by providing an explicit discussion about stigma and allowing for client education and empowerment. Doing so may offer the psychologist a chance to explore and understand the belief system of the client and offer them the opportunity to structure the tasks and goals of therapy around such beliefs. For instance, an individual identifying with largely collectivist cultural values may perceive the need for psychotherapy as a symbol of weakness or embarrassment to one's family or community (Furukawa & Hunt, 2011). This perception should be made explicit, particularly if treatment progress or adherence is negatively affected (Furukawa & Hunt, 2011). Additionally, offering

validation and overt respect for the client's perspective on mental health treatment will further enhance clinician-patient trust and strengthen the therapeutic bond (Furukawa & Hunt, 2011; Asnaani & Hoffman, 2012).

5.5.4. The role of power

Some of the participants experienced implicit and explicit power differences in their cross-cultural therapeutic alliances. Although mono-cultural dyads already assume power differences in terms of 'the helper' and 'the helped', introducing additional cultural factors, such as race and gender, predispose the alliance to being influenced by further power dynamics (Leary, 1995). Sue and colleagues (2007) referred to power dynamics in cross-cultural interactions as 'micro-aggressions' that express attitudes of dominance, superiority, and condemnation towards those who are historically oppressed. That is, the implicit attitude that a client of colour (i.e., non-white) is less intelligent, capable, and worthy (Sue et al., 2007). The participants' experiences varied according to their race, with the white participants assuming a position of dominance as compared to the non-white participants who experienced both overt and subtle discrimination from their white clients. Some of the participants acknowledged such power differences and felt that it created a divide between them and their client, thus influencing the *bond* in the alliance. Again, the construct of race infiltrates the therapeutic alliance and creates divisions in terms of power. As argued by Fouad and Arrendondo (2007), micro-aggressions are often perpetrated by people who hold democratic beliefs but who have not become fully aware of their negative attitudes and stereotypes about other ethnicities and who remain limited in terms of the culture of clients they treat. In line with Fouad and Arrendondo's (2007) argument, most of the participants acknowledged some form of power differential in cross-cultural dyads and described its effects in terms of the *bond* of the therapeutic alliance. Resultantly, they focused on creating a corrective emotional experience in light of any ruptures in the *bond* of the alliance (Safran & Muran, 2000). Nonetheless, whether such attacks on the alliance are conscious or unconscious, it is vital that psychologists employ some form of repair on the alliance in order to reestablish a meaningful working relationship.

5.6. Relational Factors

Bordin (1979) noted that if the working alliance is not sufficiently developed, then further therapeutic work becomes clouded by the tensions within the relationship; thus, establishing a meaningful therapeutic alliance is essential to achieving successful therapeutic

outcomes (Tsang & Bogo, 1997). However, as per Ardito & Rabellino (2011) and Ackerman and Hilsenroth (2001), a psychologist needs to facilitate this alliance between himself and his client through personal attributes and specific techniques. The results of this study indicate that there are qualities of the psychologist (i.e., non-specific factors) which both facilitate and hinder a cross-cultural therapeutic alliance, as well as techniques or theories (i.e., specific factors) that facilitate and hinder the alliance.

5.6.1. Non-specific factors

The non-specific factors of therapy are described in terms of the therapists' attributes or characteristics that were found to facilitate or hinder effective, meaningful therapeutic alliances.

(a) Facilitative attributes

The participants experienced a number of attributes as facilitative: firstly, there was consensus among all of the participants who regarded *empathy* as the main therapist quality responsible for facilitating the cross-cultural therapeutic alliance. In Wampold's (2011) meta-analysis of studies focusing on the qualities of effective therapists, empathy was found to be a large facilitating factor. Quantitative research by Nienhuis and colleagues (2016) also found a significant relationship between the therapists' perceived empathy and the strength of the therapeutic alliance. Being culturally empathic is viewed as a quality or attitude that assists in bridging the cultural gap between the client and the psychologist (Dyche & Zayas, 2001). Cultural empathy, according to Dyche and Zayas (2001, p. 246), "integrates an attitude of openness with the necessary knowledge and skill to work successfully across cultures". However, it is important to consider the manner in which empathy is manifested according to cultural norms. All of the participants conceptualized empathy in terms of how they were taught, that is from the Western perspective. According to Parson (1993), empathy is expressed differently across cultures and what may be considered empathic in one culture may not be in another. According to Parson (1993) and Dyche and Zayas (2001), culturally-sensitive empathy requires psychologists to renounce their traditional psychotherapeutic stance of asking for complete openness from the client while maintaining the privilege of self-concealment. Thus, being empathic in certain contexts may require an element of self-disclosure to facilitate the *bond* between the psychologist and the client in the therapeutic alliance (Parson, 1993).

Secondly, therapist *genuineness* was experienced as beneficial to the cross-cultural alliance as it allowed the client to view the therapist as a non-threatening human being with a genuine interest in learning and a voracious curiosity (Skovholt & Jennings, 2016). According to Rogers (1965), genuineness is an essential element in the therapeutic alliance. Further quantitative research by Nienhuis and colleagues (2016) found a positive correlation between the therapists' perceived genuineness and the strength of the therapeutic alliance. Wampold (2011) found that being authentic and showing a genuine interest or concern when investigating the client's problems is beneficial to the alliance. In the South African context, ensuring that cross-cultural clients are comfortable with their psychologist is important to allow for discussions without a fear of repercussion, judgment, and worries about cultural difference.

Thirdly, *openness* was considered an essential quality. In terms of openness, the participants alluded to an open frame of mind that allowed for flexibility in terms of the *tasks* and *goals* of therapy, as well as openness to perceive the client from their cultural standpoint and not from their own standpoint. This need for openness appeared more in terms of religious/spiritual beliefs. Religious differences appear to be strongly held and sometimes lead to less flexibility/openness in therapy, especially if the topic emerges. Some of the participants actively included spirituality, whereas others packed it away; those who tried to avoid it experienced more challenges with forming the therapeutic alliance. These experiences are congruent with Shafranske and Malony's (1990) finding that mental health professionals feel unprepared to address religious and spiritual concerns with their clients. This may be due to the prominent role that religion/spirituality plays in people's lives, and a lack of understanding of- or preconceived ideas about religions – a challenge to the establishment of a meaningful therapeutic alliance. Furthermore, Abernethy and Lancia (1998) argued that psychologists frequently polarize religion as either 'important' or 'insignificant' and this way of perceiving religion has prevented them from maintaining an openness to the client's worldviews. Their experience of openness as facilitating factor is further supported by Wampold's (2011) finding that openness to flexibility and adjustment to therapeutic treatment is essential for maintaining therapeutic alliances.

Fourthly, *awareness of one's cultural blind-spots or limitations* was considered an imperative quality in the establishment of cross-cultural alliances, particularly in terms of implicit racial- or culture specific experiences in South Africa. Most of the participants reflected on their own culture and its relevance in the South African practice. Having this

awareness reduced the participants' perception of their culture as ethnocentric. According to Moncrief (2007), having an ethnocentric view of one's own culture limits one's understanding of how cultural identity is both shaped and maintained. Wehrly (1995) argued that people's assumptions and behaviours are guided by hidden cultural forces. Thus, culture will also affect a psychologist's cognitive processes, belief systems, values, sense of self, decision-making, and attitudes toward time, actions, and verbal and non-verbal behaviour (Wehrly, 1995). As most of the participants in this study originate from racially-privileged backgrounds, it is important that they continue to reflect on their culture and possible biases, stereotypes, worldviews, and attitudes and how these may be incompatible with cross-cultural clients. Thus, mere awareness of blind-spots and limitations is necessary but not sufficient; continued reflection of one's own culture is essential to being culturally sensitive in the therapeutic alliance. This is supported by Wampold (2011) who found that psychologists who were reflective of their own psychological processes, biases, and blind spots experienced more effective therapeutic alliances.

(b) Hindering attributes

The participants described a range of attributes that they experienced to hinder the establishment of a cross-cultural therapeutic alliance. Firstly, *being judgmental* was experienced as harmful to the alliance. Although this judgment was not always intended, some of the participants reflected on their choice of words and manner of expression and felt that it may have been misunderstood against their clients' cultural background. Hence, it appears that none of the participants intend to be judgmental, but without active consideration of how the client may perceive their expression may lead to the client feeling judged.

Secondly, *arrogance* was described as a hindrance. This, again, speaks to the issue of power in the therapeutic alliance. If psychologists radiate an element of arrogance, the client may feel uncomfortable with expressing any thought or feeling that may impinge on that psychologists' perceived position of power (Vasquez, 2007). Thus, as some of the participants described, to remain 'human' and as one that is equal to the client will allow for a therapeutic alliance to be developed more comfortably.

Thirdly, psychologists' *assumed competence* was described as a hindrance to the alliance as one cannot assume one knows what the client is explaining, particularly if the client is culturally different. Essentially, psychologists who limit their engagement in continuous learning and who do not explore their curiosity will limit their cultural competency. Cultural competency and continued development are required psychologists are

to meet their ethical obligations to all clients, regardless of background (Conner & Walker, 2017; Skovholt & Jennings, 2016).

5.6.2. Specific factors

The specific factors of therapy are described in terms of the techniques or interventions utilized by the participants in their attempts to establish strong cross-cultural therapeutic alliances.

(a) Facilitating techniques

Most of the participants did not utilize empirically-tested techniques specifically for cross-cultural clients. However, they expanded on three techniques that they found useful in establishing cross-cultural therapeutic alliances: firstly, *flexibility in one's approach*; this included being flexible when coming to an agreement about the tasks and goals of therapy by being interactive and collaborative with neither the psychologist nor the client having the 'final say' (Wampold, 2011). It was noted by Vasquez (2007) that some non-Western clients may be uncomfortable with non-directive styles of therapy, such as psychoanalysis. This notion was experienced by some of the participants who felt that it was necessary to adjust their style to suit the comfort of the client. Again, it emphasizes certain cultural groups' knowledge about psychology, whereby some clients may feel that psychologists offer practical advice or actually 'fix' them. Thus, more directive approaches, such as solution-focused therapy or cognitive-behavioural therapy, might be more in line with the clients' expectations.

Secondly, *psychoeducation* was perceived to be a useful therapeutic intervention that increased the client's knowledge and skills, as well as provided the client with a sound expectation of what to expect and to gather an understanding of the client's existing knowledge of psychology. Assuming that the client's cultural background depicts their existing knowledge or perception of therapy might lead to ruptures in the alliance if those assumptions are incorrect (Sue & Sue, 1990).

Thirdly, most of the participants made specific use of their *basic counselling skills*, which included active listening, summarizing, clarification, and empathic responding, to ensure that they maintained an accurate understanding of the client and to ensure that the client was aware that the psychologist was actively interested in understanding their cultural differences and their source of distress (Naidu & Ramlall, 2016). This is supported by Wampold (2011) who found that sophisticated interpersonal skills, appropriate affective and

verbal expression, and a curiosity to understand the client as beneficial to the therapeutic alliance.

(b) Hindering techniques

The specific factors that the participants experienced as hindering the alliance centered on the following: firstly, *direct confrontation* was experienced to offend older clients; particularly when the client comes from a culture where explicit respect to elders is highly valued. Older clients from a collectivist culture are typically viewed persons of wisdom and prestige, whereas elders from an individualistic culture are typically seen as dependent and are given less control and power (Pethtel & Chen, 2010). Thus, a younger psychologist from an individualistic culture confronting an older client from a collectivist culture may be perceived as challenging, rude, and disrespectful (Zhou, 2007). One of the participants explained his experience with confronting an older Black African woman about her parenting style, this was perceived negatively and there was an alliance rupture. Thus, psychologists working cross-culturally should be cognizant of culturally-acceptable manners of addressing elders.

Secondly, *inaccurate interpretation* was experienced to affect the *bond* between client and the psychologist. An interpretation is a psychoanalytic concept that focuses on the verbal communication by the psychologist of an unconscious conflict that seems to have emerged in the client's communication (Kernberg, 2016). Making inaccurate interpretations was based on erroneous understandings of the clients' distress, misunderstanding cultural perspectives, and assuming to be 'on the same page'. Before making psychoanalytic interpretations, psychologists need to ensure that they are interpreting clients' dialogue through the client's cultural lens.

Thirdly, *blunt questioning* was experienced to create tension with certain clients whose culture values sexual privacy. During initial interviews and assessments, awareness about the appropriateness of specific questions may benefit the therapeutic alliance in the long run. One of the participants highlighted his experience with asking an older, African woman about her sexual history; he experienced her perception of him as disrespectful and intrusive. In some cases, then, it may be beneficial to spend extra time on developing the *bond* in the alliance prior to discussing more intimate details. Again, the context of practice is imperative as many government psychologists do not have the option of extra time.

Lastly, the psychologist's' *rigidity in structure* was experienced as detrimental to the therapeutic alliance. Inflexibility in the use of theoretical orientations, self-disclosure,

boundaries, and style of thinking was experienced as unfavourable to exploring the world of a cross-cultural client and developing a therapeutic alliance based on openness, cultural sensitivity, and genuine interest. Research by Ackerman and Hilsenroth (2001) supports the participants' experiences through their finding that over-structured therapy and rigidity leads to a poorer perception of the therapeutic alliance.

These results echo Strupp's (2001) finding that the outcome of therapy is influenced by both specific and non-specific factors of therapy, specifically the personal qualities of the psychologist and the positive feelings that arise as a result of those characteristics; as well as the *task* components of therapy which include the techniques and interventions used by psychologists that characterize certain therapeutic orientations (Chatoor & Krupnick, 2001). Thus, the basis of forming cross-cultural therapeutic alliances requires the application of specific skills and qualities that psychologists have been trained to use. Some of the participants used these skills (as mentioned above) to facilitate, in some way, a 'natural unfolding' of the alliance. To facilitate a deeper bond in the alliance, attenuating these skills and qualities to accommodate feelings of acceptance and non-judgment were important in combating feelings of anxiety in relation to perceived cross-cultural differences and enacting a sense of neutrality as a way of diffusing these perceived differences.

5.7. Conclusion

This chapter aimed to provide an integrated discussion of the main findings in the current study. The discussion focused on exploring psychologists' experiences of establishing cross-cultural therapeutic alliances by placing them into the context of Bordin's (1979) Working Alliance Model and critically discussing their experiences and challenges therein. From the emergent experiences, it appears that the Working Alliance Model is useful for establishing the basic framework of a therapeutic alliance; however, when working cross-culturally, one has to consider the limits to this model and be mindful of the need to focus more on the *bond* than the *tasks* or the *structure*, depending on the type of client with which one is working. Culture is a complex phenomenon and not actively reflecting on its implicit and explicit effects on the establishment of the therapeutic alliance will leave many interpersonal dynamics unexplored. When reflecting on the psychologists' experiences, the following issues were discussed, namely: how cultural explanations may influence the agreement in the goals of therapy; how the

context in which one works affects the structure of therapy, and the level of anxiety of the psychologist due to the unexpectedness of the prospective client; the tendency for structure to be used for comfort in instances when psychologists are culturally uncomfortable (e.g., with boundary pushes); the need for greater structural flexibility; and the imperative role of psychoeducation in uncovering where the client is in terms of their understanding and expectations. Additionally, the topic of racial-matching in therapy was discussed with the argument being both for- and against it depending on the setting and perception of the client or psychologist and the perceived differences between the client and psychologist based on certain cultural factors (e.g., race, age, gender, and religion). Then, numerous challenges to the alliance were discussed, including communication barriers (i.e., both verbal and non-verbal); addressing the social construction of race and its place in therapy, stereotyping, and binary thinking; managing mental health stigma; and the role of power differentials in the cross-cultural dyad. Finally, this chapter discussed the specific (i.e., therapist techniques) and non-specific (i.e., therapist attributes) relational factors that were found to be most responsible for the facilitation and/or hindrance of the cross-cultural therapeutic alliance. All of these experiences were discussed critically in relation to current and past research.

CHAPTER SIX

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

6.1. Introduction

This final chapter aims to provide a short summary, conclusion, and limitations of this study, as well as some recommendations for future research and a personal reflection.

6.2. Study Summary and Conclusions

The aim of this research was to explore psychologists' experiences of establishing cross-cultural therapeutic alliances and to uncover the qualities and techniques that they perceived to facilitate or hinder the establishment of a cross-cultural therapeutic alliance. Eight (N=8) psychologists participated in the study (four (N=4) male; four (N=4) female) and the results of this study provided insights into the personal experiences of psychologists working within the multicultural South African context. Bordin's (1979) Working Alliance Model (WAM) provides guidelines for establishing a therapeutic alliance. WAM suggests that addressing the *goals*, *tasks*, and the *bond* within therapy is necessary and sufficient for a meaningful working alliance. The results of this study highlighted some of the limitations of this model, with data alluding to another dimension (i.e., the influence of cultural sensitivity, both subjective and objective), which was not conceptualized in Bordin's original model. Evidence from this study suggests that cross-cultural experiences meaningfully influence the establishment of a therapeutic alliance in the South African context.

In terms of having client-therapist *agreement on the goals* of therapy, the participants experienced cross-cultural difficulties due to conflicting worldviews, beliefs, and therapeutic expectations. Thus, when both the client and psychologist shared similar beliefs and agreed on the goals and treatment method, they experienced a more meaningful therapeutic alliance. This agreeability was further influenced by the client/therapist explanation for mental illness or the psychological distress. Thus, psychologists trained from the Western perspective experience more differences in opinion with regard to the etiology of the client's presenting problem and the best method in which to treat it. Psychologists in South Africa should, then, explore the client's causal explanation prior to implementing a mainstream understanding of their illness/distress; this may allow for the client to feel respected, comfortable, and empowered.

The *tasks* (also referred to as the structure) of therapy were experienced as an important component in maintaining the therapeutic relationship as one that is professional in nature. Establishing the structure of a relationship (i.e., times, dates, and payment) were perceived as 'unnatural' for many non-Western cultures as the majority of the participants spoke to the need for having greater structural flexibility with non-Western clients. In some cases, there was a sense of discomfort with the structural component of the therapeutic alliance as it requires professional rules and boundaries and formal requirements for conducting a service, but also calls for an implicit sense of being unstructured and value-free – a *task* that some cross-cultural dyads struggled to negotiate effectively.

The *bond* in therapy was perceived to be the most important aspect of the therapeutic alliance; however, the *bond* was also experienced to be the most challenging aspect in cross-cultural dyads. As the social construct of 'race' holds such a dominant role in both past- and present South African society, it was unsurprising that racial dynamics played a large role in cross-cultural therapeutic alliances. Racial-similarity in therapy provided an implicit sense of comfort and perceived lack of judgment from the client/therapist and it was perceived to be easier to be authentic in the therapeutic relationship. Cross-racial pairs did, however, create a greater sense of curiosity for the psychologist and it minimized an 'assumed understanding' of their client. Cultural differences (i.e., demographic, linguistic, and contextual) played a large role in the participants' perceptions of their clients and these cultural differences created challenges in their ability to establish and maintain culturally-acceptable therapeutic boundaries. Additionally, cultural differences lead to challenges with communication (both verbal and non-verbal), stereotyping the client (i.e., an 'us' versus 'them' style of thinking), difficulties with managing and minimizing a cultural-based stigma of psychology, and acknowledging micro-aggressions of power and dominance with non-white clients. Establishing a *bond* with a cross-cultural client was not experienced as a simple, linear process of understanding the client's concerns and providing them with warmth and comfort. Rather, it was experienced as a complex process that is comprised of many subtle cross-cultural dynamics which required ongoing self-reflection and active consideration within therapy.

The personal attributes and techniques that the participants used to facilitate this process of forming a *bond* with their cross-cultural clients shed light into the need to extend beyond the core counselling skills that were emphasized during psychological

training. The participants found that it was necessary to be aware of how empathy is displayed differently in each culture and to be explicit in their efforts to understand the clients' culture, even if this includes admitting to one's lack of knowledge or personal biases to ensure therapist genuineness. Also, ensuring that the techniques that one uses are conveyed in respectful manners (e.g., confrontation) and are culturally-accurate (e.g., interpretation); this was found to reduce cross-cultural alliance ruptures. Additionally, shifting the therapeutic focus from one's intrapsychic conflicts/processes, towards a family or community perspective was found to be useful for strengthening the *bond* in clients from collectivist cultures. Shifting perspectives, then, is at times the psychologists' responsibility if they wish to ensure a meaningful alliance that is relevant to the client's culture.

The results of this study illustrate how cross-cultural dynamics tend to complicate the processes of forming meaningful therapeutic alliances and how it is imperative for psychologists to allow flexibility within their therapy structure, worldviews, and their perceptions of psychology's relevance to non-Western cultures. Enforcing a model for a 'successful' therapeutic alliance that was developed for Western populations ignores the differences in social norms and cultural values that typically emerge in the therapeutic relationship. Ultimately, each experience is unique, and each alliance requires careful consideration about what is beneficial or detrimental to the establishment of the alliance.

The therapeutic alliance is an imperative component of effective therapy; thus, psychologists working cross-culturally should maintain cultural competency and continually reflect on the role of their own cultural worldviews in order to ensure culturally-competent and responsible care to the client.

6.3. Limitations

The limitations of a study refer to how the selected design or methodology may have influenced the interpretation or outcome of the research findings (Price & Murnan, 2004). The following study limitations are acknowledged:

6.3.1. Diversity of sample

This study is limited in terms of the sample's diversity. Six (N=6) of the eight participants were white. As noted in literature, the number of white psychologists practicing in South Africa outweighs the number of non-white psychologists (Sharp, Skinner, Serekoane & Ross, 2010). Due to the slow response rate, and with most responses being from white

practitioners, most of the participants were white despite the efforts to allow for representative racial diversity. Thus, the results of this study reflect largely a white, Western perspective of cross-cultural experiences. However, racial diversity was not a necessary criterion and therefore did not impinge the results of the study.

6.3.2. Setting of practice

All of the research participants practice within the private sector. This reduces the amount of diversity that they are exposed to due to socio-economic differences in racial groups. Thus, some of their cross-cultural experiences emerged from their time working in the public sector (i.e., psychology training, internship, and/or community service).

6.3.3. Data-collection method

The data were collected using face-to-face, semi-structured interviews. According to Szolnoki and Hoffmann (2013), face-to-face interviews have multiple advantages including a higher response rate, interview flexibility, and the ability for the participant to ask for clarity. A disadvantage, however, is the possible introduction of bias, as well as it being time-consuming for both the researcher and the participants. Due to the participants working within private practice, great effort was taken to ensure that the interviews occurred at convenient times that did not coincide with paying clients/patients. Resultantly, many interviews had to be declined and rescheduled and some interviews were shorter than originally anticipated due to time-constraints. Despite this limitation, the research achieved its aim in exploring experiences with establishing cross-cultural therapeutic alliances. The semi-structured nature of the interviews allowed the researcher to probe the participants' responses for richer information. However, bias may have been introduced in terms of which probes were used to elucidate richer information.

6.3.4. Generalizability of findings

Generalizing the findings of this study to other contexts is affected by the demographic make-up of the study sample. As the sample comprised of mainly white psychologists, the results may not be generalizable to non-white psychologists, as well as to white psychologists working in countries outside of South Africa due to South Africa's unique socio-political history. Also, the results of this study cannot be generalizable to all white psychologists practicing within the South African private sector as the training methodologies and exposure to diversity differ across institutions in South Africa. Samples

that have specifically included part of their training in district health or community placements may have greater exposure to cross-cultural therapy clients/patients.

6.3.5. Theory-driven VS Data-driven research

This study attempted to achieve a balance between the theory-driven approach and data-driven approach. The core assumption of a theory-driven approach is that data is given meaning when it is interpreted in relation to an existing theory (Wallender, 1992); this study utilized Bordin's (1979) Working Alliance Model to place the collected data into a context. Conversely, a data-driven approach to research focuses on gathering larger amounts of data and then generating a theory from that data (Wallender, 1992). A limitation of a theory-driven approach is that the data is guided- and influenced by the theory. Consequently, utilizing this specific model may have hindered the exploration of other cross-cultural experiences.

6.4. Recommendations for Further Research

Based on the results of this study, the following recommendations are provided for conducting further research:

- *To explore psychologists' experiences of forming cross-cultural therapeutic alliances amongst district health psychologists.*

This study focused on psychologists who work within the private sector. The types of clients/patients seen were reported to be less diverse as seen in the public domain. Thus, it would be interesting to replicate this study within the public domain in order to compare the findings and uncover other experiences.

- *To explore Black African psychologists' experiences of establishing therapeutic alliances with white clients.*

The participants within this study were majority white. Thus, the experiences of psychologists from other racial groups were not well explored. As white psychologists' experiences were well explored, it may be interesting to elucidate the cross-cultural experiences of non-white psychologists in South Africa.

- *To explore client/patient experiences of having a cross-racial psychologist.*

This study focused on the psychologists' experiences, thus it may be interesting to explore the client/patients' experiences of forming a therapeutic alliance with a cross-racial

therapist. A study of this nature may offer a useful insight into the client/patients' experiences and allow for the comparison of each party's (i.e., client vs. therapist) perception of the cross-cultural therapeutic alliance.

- *To explore the experiences of being racially-matched in therapeutic dyads.*

This study focused on cross-cultural experiences. Some of the data suggests that being racially -matched in therapy has both positive and negative aspects and it may be useful to understand the therapeutic benefits or consequences of being racially- or culturally similar and its effects on the establishment of the therapeutic alliance.

6.5. Self-Reflection

I chose this study topic due to my own background being largely mono-cultural. When I moved from a majority-white, private school to a government, multicultural university, I experienced a 'culture shock' and had found myself holding many superficial relationships with individuals from different cultural backgrounds. Through many discussions with non-white and culturally-diverse students, I found that many of them typically remained close with members of the same culture group and I wondered how these feelings translated to the therapeutic alliance: a relationship devoted to being non-judgmental, emotionally-deep, and aiming to uncover unchartered psychological waters. The question I held was: if people struggle to form in-depth cross-cultural *social* relationships, how will they move past superficiality when it comes to *therapeutic* relationships? The results of this study provided me with useful insights about cross-cultural therapy and I hope that the information gathered will offer other therapists greater insight into the subtleties that occur within cross-cultural dyads and the effects that these may have on the establishment of meaningful therapeutic alliances.

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APPENDICES

Appendix A: Gatekeeper Permission Request

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

Date: 14 September, 2017

GATEKEEPER PERMISSION REQUEST

To the Chair of the DPPG, Mr. K. Swain:

I am a Masters student in Clinical Psychology at the University of KwaZulu-Natal (Howard Campus). I am required to do a research project as a part of my training. My research topic is "A qualitative understanding of the experiences had by psychologists whilst establishing cross-cultural therapeutic alliances".

This is a qualitative, explorative study and will involve the use of semi-structured questions in the form of a personal interview to obtain the information needed from eligible and consenting psychologists in the Durban area.

The study will utilize approximately eight (8) participants. All information collected from the participants will be done with informed consent and each participant can refuse participation and/ or withdraw participation at any point of the study. I am therefore, requesting your permission to use the Durban Practicing Psychologists Group database as a participant recruitment platform which will ensure the legitimacy of my sample.

Please feel free to contact me if you have any queries. Alternatively, you may wish to contact my supervisor **Mr. Sachet Valjee**, if you would like a reference or any other information.

Yours sincerely,
Name: Lauren Barker
Email: labarker93@gmail.com
Contact No: 072 933 8528

Permission Letter:
If you are willing to participate, may you draft a signed letter that acknowledges that you [as the Chair of the DPPG] have read the explanatory statement, understand the nature of the study being conducted, and grant permission for the researcher to utilize the DPPG database for participant recruitment purposes.

Yours Sincerely,
Lauren Barker.

Appendix B: <u>Gatekeeper Permission</u>

DPPG
DURBAN PRACTISING PSYCHOLOGISTS' GROUP

14 September 2017

RE: GATEKEEPER PERMISSION REQUEST

Dear Lauren Barker (Researcher) and Sachet Valjee (Supervisor)

This letter serves to acknowledge that I, Karl Swain, Chairperson of the Durban Practising Psychologists" Group (DPPG), have read your explanatory research statement regarding your proposed research entitled "A study exploring psychologists' experiences with establishing cross-cultural therapeutic alliances". I understand the nature of the study being conducted, and grant permission for you as researcher to make use of the DPPG database via the DPPG Secretary, Kirsten Clark (dppg123@gmail.com) for participant recruitment purposes.

Sincerely,

Karl Swain
DPPG Chairperson

Appendix C: Invitation to Participate in Research

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

INVITATION TO PARTICIPATE IN RESEARCH

To: Prospective Research Participant

My name is Lauren Barker. I am a Clinical Psychology Masters' student from the University of Kwa-Zulu Natal (Howard College Campus). I am required to carry out a research dissertation as per my training requirements. **My research area surrounds the importance of the therapeutic alliance. Specifically, I want to explore therapists' experiences of establishing cross-cultural therapeutic alliances.**

You are being invited to consider participating in this study that aims to uncover the experiences of psychologists whilst establishing a therapeutic alliance, specifically with cross-cultural clients; the techniques that you use in order to facilitate such alliances; your perception of desirable attributes; and exploring the challenges or obstacles that psychologists may face when working cross-culturally in South Africa. The results of this study may provide useful information to current and future psychologists regarding the challenges of establishing a therapeutic relationship with cross-cultural clients and the strategies they may use in order to surpass these challenges.

The study is expected to enroll 8 participants. The participants were sourced from DPPG based on your qualification and location. The study will involve me asking you a set of semi-structured questions about your experiences with cross-cultural clients and the ways in which you establish alliances with your clients. The interview will take place face-to-face or via Skype and should last about 30 – 45 minutes to cover the topic area.

All of the interviews will be recorded using an electronic device for the purpose of transcription and to ensure no results are fabricated. The study will not provide any direct benefits to you, but it will add to the existing literature and may benefit future psychologists practicing in a multicultural context, like South Africa.

Although there are no risks involved in the participation in this study, your participation is still voluntary and you may withdraw from the study at any time. All information provided by you will remain confidential and your identity shall be kept private by using a pseudonym.

There is no compensation for participating in this study. However, your participation will be a valuable addition to this research. If you are willing to participate in my research dissertation, you may contact me (details below) whereby you may suggest a day and time that suits you and I'll do my best to be available. If you have any questions please do not hesitate to ask.

I thank you for taking the time to review this invitation. I look forward to hearing from you.

Best Regards,
Lauren Barker

Cell: 072 933 8528
Home: (031) 764 7315
E-mail: labarker93@gmail.com
Psychology Clinic: (031) 260 7425.

Appendix D: <u>Interview Consent Form</u>

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

INTERVIEW CONSENT FORM

I, _____ have been informed about the study entitled *"a qualitative study exploring psychologists' experiences of establishing cross-cultural therapeutic alliances"* by Lauren Barker.

I fully understand the purpose and procedures of the study and have been given the opportunity to ask questions where clarity was required and I have been answered adequately.

I understand that my participation in this study will consist of taking part in a 45 minute interview with the researcher, Lauren Barker, a Clinical Psychology Masters' student from the University of Kwa-Zulu Natal (Howard College Campus).

I understand that I will be asked to describe my experiences as a psychologist, including my views about the therapeutic alliance; my efforts to establish a therapeutic alliance; and the challenges I have faced with establishing a therapeutic alliance with cross-cultural clients.

Possible benefits of participation include the opportunity to make a valuable contribution to the research literature on the therapeutic alliance in cross-cultural settings.

I understand that I may ask questions at any point during the interview and that I may refuse to answer any question.

I understand that my participation in this study is strictly voluntary and I may withdraw from the study at any time.

I give full permission for the interview to be electronically-recorded, and understand that verbatim transcripts will be made from the tapes.

I have been informed that all of the information I provide during my participation in this study will be kept confidential. In the reporting of results, my name and all other identifying information will be altered using a participant number. Only the researcher, Lauren Barker,

and her appointed research supervisor, Mr. Sachet Valjee, will have access to the data in its raw form (verbatim transcripts).

I wish to receive an electronic copy of the final dissertation ☐

I have read the above terms and understand the nature of this study and what is required of me. Therefore, I am willing to participate in this study.

YES ☐

NO ☐

Signature of Participant: _____ Date: _____

In the event of any problems or concerns/questions, you may contact:

1. **Researcher (Lauren Barker) – Cell: 0729338528 or labarker93@gmail.com**
2. **Project Leader (Mr. S. Valjee) – Tel: (031) 260 7613**
3. **HSSREC Research Office: University of KwaZulu-Natal, Westville Campus – Tel: (031) 260 8350**
4. **University of Kwa-Zulu Natal (Howard College Campus) Psychology Clinic: 031 260 7425 or psychclinic@ukzn.ac.za**

Appendix E: <u>Audio-Recording Consent Form</u>

AUDIO-RECORDING CONSENT FORM

This study involves the audio recording of your interview with the researcher, Lauren Barker. Neither your name nor any other identifying information will be associated with the audio-recording or the transcript. Only the researcher and her research supervisor will have access to the audio recordings and transcripts. Each interview will be password-protected and stored safely on a USB. The transcripts of your interview may be reproduced in whole or in part for use in the written products that result from this study. You may have access to the audio-recordings and transcriptions if you wish; and you may request this data to be withdrawn at any point.

By signing this form, I am allowing this researcher to audio-record me during the interview as part of this research. I understand that the data from the audio-recording will be transcribed; after which, it will be stored away safely.

I have read the above terms and provide my permission to be audio-recorded for the purposes of this study.

YES ☐

NO ☐

Signed:_____ **on the:**_____

Appendix F: Ethical Approval Letter

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI

Ms Lauren Barker 212504187
School of Applied Human Sciences
Howard College Campus

Dear Ms Barker

Protocol reference number: HSS/1580/017M
Project title: A study exploring psychologists' experiences with establishing cross-cultural therapeutic alliances.

Expedited Approval

In response to your application dated 01 September 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....

Dr Shenuka Singh (Chair)

Appendix G: Interview Schedule

Semi-Structured Interview Schedule

"Do you have any questions before we begin?"

General Questioning:

- How would you describe a therapeutic alliance?
  - ***Probe**: what do you think is the most important aspect of the therapeutic alliance?*

- How would you describe your overall experience of forming therapeutic alliances with cross-cultural clients?
  - ***Probe**: the first contact (telephonic, electronically, face-to-face)*
  - ***Probe**: first impression of client in initial session (thoughts, feelings)*
  - ***Probe**: based on your differences/similarities, how do you think the client first perceived you?*

Structured Question 1: Perception of Congruence

- What is your opinion on ethnic-matching in therapy?
  - ***Probe:** how does ethic matching help or hinder you in therapy?*

- When working cross-culturally, what are some of your views/experiences with the compatibility (congruence) of the relationship?
  - ***Probe**: based on cross-cultural factors in therapy, how do you view the congruence (agreement) between your: attitudes; values; personality agreement during goal setting?*

- When it comes to setting therapeutic boundaries (such as with payment, length and number of sessions, and even physical contact), how do you experience such processes cross-culturally?
  - ***Probe:** similarities/differences between therapist's boundaries' and clients' boundaries.*
  - ***Probe:** impact on the relationship.*
  - ***Probe**: payment, physical proximity, self-disclosure, bartering, gifts.*
  - ***Probe**: altering personal boundaries, boundary crossings, boundary violations.*

Structured Question 2: Therapist Attributes and Techniques

- What qualities/attributes do you feel contribute to the establishment of a positive cross-cultural alliance?
  - ***Probe**: why do you feel that [specific attribute] is beneficial for cross-cultural therapy?*

- What qualities/attributes do you feel hinder the establishment of a positive cross-cultural alliance?
  - ***Probe**: why do you feel that [specific attribute] is detrimental for cross-cultural therapy?*

- What therapeutic techniques do you perceive to contribute to the establishment of a *positive* cross-cultural therapeutic alliance?
  - ***Probe**: what is your experience with working with [specific technique]?*
  - ***Probe**: how do you think [specific technique] benefits the alliance?*

- What therapeutic techniques do you perceive to contribute negatively to the establishment of a positive cross-cultural therapeutic alliance?
  - ***Probe**: what was your experience with working with [specific technique]?*
  - ***Probe**: how do you perceive this technique to have hindered the development of a positive therapeutic alliance?*

Structured Question 3: Perception of Cross-Cultural Difficulties

- What are some of the challenges that you have faced whilst working cross-culturally?
  - ***Probes**: language, self-disclosure, racial attitudes, expectations about the role of the therapist, familiarity with objectives of therapy, mental health stigma across cultures, level of cultural knowledge, anxieties about addressing culturally taboo issues*
  - ***Probe**: how often do you come across cultural challenges when working with clients?*

- How have these challenges influenced your perception of the therapeutic alliance?

- [Have you experienced any cross-cultural alliance ruptures?] What do you think contributed to this rupture?
  - ***Probe**: when did this rupture occur? Was it repaired? If yes, how?*

Structured Question 4: Cross-cultural Relational Dynamics

- How do you experience transference and countertransference with a cross-cultural client?
  - ***Probe:** parenting styles, ways of communicating, relationship with community, attitudes to women/men, etc…*
  - ***Probe:** management of transference/counter-transference*
  - ***Probe**: negative reactions, positive reactions*

General Questioning:

- Do you have any other cross-cultural experiences that you wish to add [If yes, please explain].
- Did you find this interview useful and my questions appropriate?

Appendix H: <u>Participant Demographic Form</u>

DEMOGRAPHIC INFORMATION

Dear Participant,

Please complete the following form in order for me to document your demographics accurately.

Participant name: _____

Age: _____

Gender: Male ☐ Female ☐ Other ☐

Race: White ☐ Black ☐ Indian ☐

Coloured ☐ Other ☐ (Specify :_____)

Home language: _____

Marital Status: _____

Religion: _____

Highest Qualification: _____

Special Interest(s): _____

Years of Experience: _____

Setting of Practice: Private ☐ Public ☐

Appendix I: <u>Summary of Themes</u>

MAIN THEME	ORGANISING THEME	SUB-THEME
1. Conceptualizing the Therapeutic Alliance	1.1 Forming a connection	
	1.2. Establishing the structure	a. Maintaining the client-therapist relationship b. Expected self-disclosure c. Perceptions of physical contact d. Perception of cultural forms of appreciation
	1.3. Agreeing on acceptable boundaries ⟶	
	1.4. Expectations of mutual agreement ⟶	a. Understanding the scope of practice b. Role confusion
2. Differences in the Practice Setting	2.1. Private sector 2.2. Public domain	
3. Perception of Cultural Congruence	3.1. Initial anxieties 3.2. Experiences of racial similarity 3.3. Assumed cultural uniqueness 3.4. Perceived cultural incompatibility	
4. Influence of Observable Cultural Differences	4.1. Racial dynamics 4.2. Age differences 4.3. Gender dynamics 4.4. Religious affiliations	
5. Challenges to the Cross-Cultural Alliance	5.1. Different communication style 5.2. Language barriers 5.3. Respecting cultural explanations of illness 5.4. Stereotyping the client 5.5. Managing power dynamics	
6. The role of attributes and techniques	6.1. Therapist attributes ⟶	a. Facilitating attributes b. Hindering attributes
	6.2. Therapist techniques ⟶	a. The role of theoretical perspectives b. Facilitating techniques c. Hindering techniques

Appendix J: Transcription Example*

***Note:** This is a 6-page excerpt from a *verbatim* transcription. This is not the full transcription and acts only as an example of how the data was transcribed. Names of practice areas, residential areas, and institutions have been removed to secure the confidentiality of the participant.

Participant 2 (WF)

LB: Okay, so, when thinking about ethnic matching, how do you think being ethnically matched will help or hinder the therapeutic relationship?

P2: Okay! I get your question (enthusiastically). How it will affect… It would definitely help because there will be some understanding. Sorry, my mind is blank at this stage but I am thinking of something… No, I can relate by thinking of some of the Afrikaans clients and I think 'ah, thank God you're not with another therapist' because they will not know where you're coming from (laughing). So yes, there is that 'I can forgive you because I know where you're coming from' but ya, someone else wouldn't now. So from that experience I can say there is a value, um, but I don't think it has to be forced. Actually I have a particular case where a woman came, and it wasn't cultural syndrome issues but marital issues… She was referred by the GP in the same building and um, she wanted to get away from her husband who was cheating on her and abusing her, things like that. She told me she was skeptical with me being a white person. But she was, ya, one of those successful cases where she felt I understood her the best. We were ruminating at the end and she was telling me about her reservations that she had.

LB: So those cultural differences that she saw caused some skepticism but she gave you a chance and you worked through it and it came out quite successful.

P2: Yeah, she was quite surprised… To come back to your question in ethnic matching… The onus is on the therapist to be aware that the client might be uncomfortable and just to assume that because you're comfortable that…

(Pause); maybe that something I need to start working in because I always am always comfortable… For them, they don't know where I am coming from. We need to be aware that because we comfortable, they may not be. We need to facilitate referrals if needed. I am open to doing matching.

LB: **Okay thank you… So, we will move onto the next question. So when working cross-culturally using experiences you've had with your own clients, what are some of your perceptions of the compatibility of you relationship with the client?**

P2: Hmm…I think every therapist will say 'there are some people we can't work with'.

LB: **Do you feel its culture-based or more of the presenting issue?**

P2: Well I find I get more annoyed or more judgmental towards people of my own culture. I have had clients who were expressively racist and would assume that I agree on where they're coming from, now that was a big challenge where now it's not my place to defend my views because I am very client-centered about the client… But ya, where the things they'd say would offend me a lot and I'd try defend my brothers and sisters from different races. It's not about me, or us having an argument, it's about this person's experiences. The presenting problem may not be about race but it always seems to come through into the picture. So I find that challenging to manage.

LB: **So it's more your own cultural group who assumes similarity in beliefs and attitudes.**

P2: Maybe also when someone from a different culture… maybe we try to impose or cannot separate our boundaries. It comes from my [Area X] background.

LB:

P2: **When it comes to setting therapeutic boundaries with clients; such as with payments, lengths of sessions, and number of session's etcetera… how do you experience this process cross-culturally?**

LB: Let me think, from my side everything is the same regardless of cultural background but I have found myself falling in the trap of stereotyping when a person from a more laid-back cultural background comes late or doesn't cancel appointments; so, there is an element to ascribe the way people manage or handle the structure of therapy…. There is an element of putting people in race groups.

P2: **So with regards to physical contact in therapy, do you feel that culturally you feel a difference between the way you try do therapy and how other cultural groups perceive care or boundaries?**

LB: I have had no physical contact, well experiences where someone has tried to make physical contact with me or vice versa… And I don't do physical contact therapy. If they cry, I give them space, that's just my personal approach. Eye contact is a big factor… I know certain cultures avoid it to show respect and then I have had a black male deliberately fixing eye contact, and I thought 'what does this mean?'… But we are all different so I even asked my colleague 'is this his personality style' or 'is he challenging me'. How do I put this? So yes, there was an instance where a young Black boy wasn't making eye contact culturally, but he didn't babble as a child so it was a case of Autism Spectrum Disorder.

P2: **Um, let me think, you've mentioned that you haven't really had boundary crossings or violations that are culturally-based. Such as bartering or people bringing gifts.**

LB:

No, the boundaries have never really been pushed in my private practice.

P2: **Thank you for answering those questions. I am going to move on to the next theme which focuses on therapist's qualities and techniques you use when working with someone who is culturally different. So the first question would be: what qualities do you feel contribute to building a meaningful therapeutic alliance with someone who is from a different culture.**

LB: Okay, what qualities do I personally think… yeah okay, the one is being totally comfortable? Comfort with homosexuality, being genuinely comfortable and not something that comes later. Also, like I mentioned genuine interest. Also a

P2: client-centered approach…

LB: **So a client-centered approach is your main technique or orientation when working with clients**

P2:

Yes, yes, it's the genuineness of it. Like, I'd ask 'how does that work for you'.

So when you're not sure of something, you make sure you ask them.

I will even tell them. One older man was explaining to me how he used to bring cattle home, he was an old headmaster telling me his stories growing up and how the cattle got lost. He was really enjoying telling me the story, and I would

LB: say 'I cannot imagine that position, I have never been there. How did it feel'? It sounds like a cliché, but I tell them 'I'd really like to know how it feels, I have never been there'. Then they really have to explain how it felt. So yes that genuine interest. Like, 'make me understand!'

P2:

What sort of qualities do you think will contribute negatively when building a cross-cultural alliance? So, what things would a therapist bring into the therapy room that might hinder the alliance?

Okay, okay, interesting one. I think, um, the one thing might be a trained response but not being aware of our own biases and being blind of how they

LB: come into play. For me, I have to be aware of my feministic biases. So, I must be aware if a Black woman says 'my husband beats me', um, my response might
P2: not be in her best interest. Putting away my biases and bracketing it out so my response isn't influenced by my beliefs.

So we constantly have to reflect on ourselves in order to be aware of them?

LB: Yes, I think that is why I was impressed when you were saying initially that you come from a white background and that you can bracket it out. Also, a lack of flexibility, ya. A lack of tolerance, lack of flexibility that will contribute negatively.

P2:

Still thinking what will negatively impact the alliance, what techniques or orientations do you feel may actually stop the development of a good alliance?

I can't think of any one orientation. But I guess anyone who is rigid in their approach will hinder it. You don't have to be totally eclectic but you must be
LB: open to adjust your style to the patient. Hmm… psychoanalytic perhaps. I have applied psychodynamic with a bit of eclecticism to it. Maybe the principles of
P2: psychodynamic theories but I don't force it upon them. It almost feels too rigid and strict.

LB:

So your preferred approach focuses on flexibility and the individual.

Yes, something that is sensitive to your client.

P2: **So, moving onto the next theme which focuses on some of the cultural difficulties that you've faced and you've mentioned that you haven't faced many. What are some of challenges have you faced when working cross culturally while trying to form a relationship?**

LB: Okay, perhaps personal annoyance where we tend to stereotype its 'them not us'. So, it comes into play. Racism does emerge. But I am quickly able to pick it up and pack it away. But the challenges would be, I think we all, every single

P2: person is ethnocentric… so, that comes into play where we might dwell upon something that is not within the therapy.

LB: **So in terms of self-disclosure expectations, have you had any challenges with it culturally?**

P2: Yes I have had many Black people asking me 'are you Christian'. Maybe it's a form of conformation like 'do you know where I am coming from'. Like searching for some form of connection with me.

LB: **In those instances, do you disclose that?**

P2: Um, ya I will disclose it. Unless I feel my answer will clash with what they're saying and hinder their view of me then I will give a neutral response to not distract them from the therapy but ya, if it's just part of the session then I disclose and move on. Like if they're talking about church, they'd ask, I'd say yes, and they'd just carry on with their story. But if the disclosure would hinder the session I wouldn't lie but I would be deflecting it more.

LB: **So, in a way, cultural issues do play a part because they get some sort of comfort from knowing you're similar to them, like 'ah yes she's a Christian too'.**

P2: Yes, yes. You're right. I just had a memory of a Muslim male who I saw once, an old-ish male, when I was working at [Organization X] at that stage, people had brain injuries and the person just started crying and crying; he was angry at Allah. He said if he told someone from his own culture or religion that he'd be judged. So he went on about how Allah could allow this and so he had a religious crisis that didn't allow him to go to anyone in his family, not his kids or wife or anyone.

In that case your differences were beneficial for him.

Yes, yes, back to self-disclosure, I guess it can be beneficial but it depends on how you do it. Sometimes I reflect on the obvious, like I'd say 'I come from a different background so this is how I see it'. ***[End of Excerpt.]***