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Experiences of South Asian Canadian mental health professionals: Insights from a Reflexive Thematic Analysis

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Experiences of South Asian Canadian mental health professionals: Insights from a Reflexive Thematic Analysis

by

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Abstract

Despite the growing South Asian population and demand for culturally relevant mental health services in Canada, the perspectives of South Asian mental health professionals remain underrepresented in existing literature. This gap hinders the development of culturally responsive therapeutic practices and impedes the professional development of South Asian Canadian trainees. Thus, this study addressed the research question "What are the experiences of South Asian Canadian mental health professionals working with South Asian clients?" Sub-questions explored their experiences of working with South Asian clients compared to clients from other cultural backgrounds, the impact of cultural identity on therapeutic relationships, the interventions and theories guiding their practice, and their experiences with education and training in the field. Using semi-structured interviews with eight South Asian Canadian mental health professionals, representing ethnic backgrounds from India, Pakistan, and Sri Lanka, this study employed Reflexive Thematic Analysis (RTA). Key co-constructed themes included the dual role of shared cultural identity as both an asset and challenge in navigating therapeutic dynamics, the influence of the therapist's multicultural and/or religious identity, culturally adapted interventions highlighting collectivism, family, and spirituality, and systemic gaps in education and training. These findings have significant implications for counsellor education, clinical training, and therapeutic practice, highlighting the need for culturally responsive training, supervision, and professional development. These insights can also inform the development of more effective and inclusive mental health interventions, contributing to improved services for South Asian Canadians.

Keywords: South Asian Canadians, mental health professionals, counsellor education, Reflexive Thematic Analysis

Preface

This thesis is an original work by the author, Durr-e Sameen. This project received research ethics approval from the University of Calgary Conjoint Faculties Research Ethics Board [REB24-0871]. Research in this thesis was completed by the author in collaboration with the principal investigator, and research supervisor, Dr. José Domene (Professor, University of Calgary). No part of this thesis has been previously published.

Acknowledgments

First and foremost, I extend my sincerest gratitude to my supervisor, Dr. José Domene, for his insightful guidance, continuous support, and heartfelt encouragement throughout this process. Your dedication to your students is evident in every interaction, and I feel profoundly fortunate to have had your mentorship. My graduate student experience would not have been the same without you.

I am deeply thankful to all the participants of this study, whose generosity in sharing their stories, knowledge, and time was essential to bringing forth this research. Your contributions enriched the depth and meaning of this work in ways that words alone cannot capture. As I prepare to step into my role as a practicing psychologist, I am heartened to know that I will be joining a compassionate and supportive community of South Asian mental health professionals who share and celebrate parts of my cultural identity.

Finally, I am eternally grateful to my loved ones for their patience and encouragement throughout my academic journey. Your belief in me has been a constant source of strength, and your sacrifices have made my pursuit of this milestone possible.

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Chapter 1: Introduction

South Asians, a heterogeneous pan-ethnic group delineated by multiple national, linguistic, cultural, and religious origins, currently represent the largest visible minority group in Canada, constituting approximately 7.1% of the overall population (Statistics Canada, 2021). Studies indicate that South Asian Canadians report unique mental health experiences compared to other Canadians, such as higher rates of anxiety disorders and psychosocial stress (Islam et al., 2014; Inman et al., 2014; Tummala-Narra & Deshpande, 2018). Current research increasingly identifies mental health as a highly prevalent yet stigmatized concern among this population (Islam et al., 2014). These emerging research trends underscore the evolving landscape of mental healthcare needs within this community. However, while providing valuable insights into the broader mental health concerns of South Asian Canadians, the extant research often neglects to consider the nuanced experiences and perspectives of mental health professionals themselves. That is, there is a noticeable paucity in current empirical research regarding the experiences of South Asian mental health professionals practicing with South Asian clients in Canada.

While studies highlight a recent increase of ethnic minority individuals entering mental health professions in the United States (Hipolito-Delgado et al., 2017), there is an absence of such exploration into the diversity of mental health professions in Canada. This highlights the need for educators, supervisors, training programs, and policymakers in Canadian mental healthcare fields to better understand their diverse student body. Additionally, as cultural responsivity becomes increasingly integrated into mental health training programs (Faber et al., 2023), it becomes imperative to understand how South Asian professionals experience and perceive their practice with culturally similar clients. Responding to this need, I explored the

experiences and perspectives of South Asian Canadian mental health professionals in navigating their therapeutic work with South Asian clients.

Researcher Positionality

In this section, I discuss my positionality and its significance in shaping my research as a Pakistani Canadian woman completing a counselling psychology program. I reflect on how my cultural background, gender, and bicultural identity may have influenced my engagement with participants and the interpretation of their narratives. The section concludes with an emphasis on the importance of reflexivity and transparency throughout the research process.

As a cis-gender Pakistani Canadian woman currently training to become a psychologist, I recognize the role of my positionality and personal experiences in shaping my research interests and in influencing my engagement in the research process. I was born and raised in Pakistan until my family immigrated to Canada when I was eight years old. Growing up within the diverse landscape of Pakistan, my first language was Urdu, followed by Punjabi, which also influenced the cultural traditions I practiced. My Pakistani-Punjabi cultural background and Islamic faith have deeply informed my worldview and interpersonal interactions. Having been raised in Canada from a young age, I have navigated the complexities of a bicultural identity, blending my South Asian heritage with Canadian cultural norms. This duality offers me a unique perspective on the experiences of South Asian Canadians, which is further influenced by my gender identity as a woman. In South Asian cultures, gender roles and expectations can profoundly influence individuals' mental health experiences and their willingness to seek support (Soorkia et al., 2011). As a woman, I am particularly attuned to the gender-specific challenges that South Asian women may face, including issues related to family dynamics, societal pressures, and gender-based discrimination.

Considering my background with South Asian cultures, traditions, languages, and gender roles, I recognize that my interpretation of the narratives shared by my participants may have been influenced by my existing knowledge-base. Additionally, my education in counselling psychology and practicum experiences of working with South Asian clients may have introduced certain assumptions or expectations into the research. Thus, it was important to acknowledge my perspectives and assumptions to ensure transparency and reflexivity throughout the data collection and analysis procedures.

As an "insider" to this cultural and professional community, sharing a similar identity with participants was helpful in establishing rapport and trust, leading to potentially deeper insight into the cultural nuances and systemic challenges they experience (Asselin, 2003; Chammas, 2020). For example, sharing an identity with my participants may have enabled a sense of comfort to express and explore their experiences without censoring or filtering due to a shared understanding. Additionally, my positionality encouraged me to consider employing a methodology that promotes active collaboration and reflexive engagement with my research participants in order to honour the underrepresented voices of South Asian communities. However, I remain cognizant that my positionality may have influenced what my participants chose to share and the overall relationship that I developed with them. I also acknowledge the possibility of expecting shared experiences with my participants simply due to our shared identities, similar to the process of over-identifying with clients in clinical practice. As a result, I might have been more likely to interpret thematic patterns that encapsulate certain challenges that I have personally experienced in my practice.

On the contrary, due to the diversity that exists within the South Asian Canadian population, I also considered the intersectionalities to which I am an "outsider," including

gender, national identity, immigration status, and language. This was important as participants may have withheld or limited their personal views due to potential assumptions about me as the researcher based on my own gender, national identity, immigration status, and language. Thus, I was committed to maintaining reflexivity throughout the research process by authentically exploring phenomena without narrowing the conversation based on my pre-existing understandings or assumptions. The strategies I utilized to maintain reflexivity in the research process are further elaborated in Chapter 3.

Structure of Thesis

In Chapter 2, I review the relevant literature and theoretical background underlying the current study and highlight the sub-questions, which are guided by the overarching research question. Following this, in Chapter 3, I outline the methodology used to address the sub-questions, including participant inclusion criteria, participant demographic information, and the steps taken in data collection and analyses. Chapter 4 presents the findings, including within-case analyses based on each participant's responses and cross-case analyses for all sub-questions. Finally, in Chapter 5, I discuss the findings in connection to existing research, strengths and limitations of the study, directions for future research, and implications for education, training, and practice.

Key Definitions

South Asian Canadians

Although some definitions of South Asia include individuals from Afghanistan, Iran, Bhutan, and the Maldives islands (Shariff, 2009; Singh & Bhayana, 2015), in the present study, South Asian Canadians refer to Canadian individuals who were either born in Bangladesh, India, Nepal, Pakistan, and Sri Lanka, or are descendants of immigrants from these countries. This was

established to maintain a degree of cultural similarity among participants, as South Asians embody vastly diverse identities and characteristics. According to Statistics Canada (2021), the term South Asian Canadian can be further categorized by nationality, such as Pakistani Canadian, Indian Canadian, and Sri Lankan Canadian. Despite sharing various cultural and historical characteristics, South Asians speak a range of languages, some of which include Urdu, Hindi, Punjabi, Sindhi, Nepalese, Bengali, Tamil, and Telugu, and practice several religions, including Islam, Hinduism, Jainism, and Christianity (Shariff, 2009).

Mental Health Professionals

In this study, the terms *mental health professionals*, *therapists*, and *counsellors* are used interchangeably to refer to individuals providing mental health care, acknowledging that while these terms may carry distinct meanings or professional designations in different regional or institutional contexts, they are treated synonymously for the purposes of this research. Qualified mental health professionals in the current study refer to those with graduate-level education, who hold a minimum of a master's degree in a mental health field and are either licensed by a provincial regulated body, such as the College of Alberta Psychologists, or certified with a national certification body, such as the Canadian Counselling and Psychotherapy Association. Mental health professionals in Canada use a variety of titles, including registered psychologist, provisional psychologist, psychological associate, registered psychotherapist, registered clinical counsellor, and registered clinical social worker. In the present study, the definition of mental health professional does not include religious leaders, mental health coaches, or family school liaison counsellors who are not licensed by a regulatory or certifying body, as well as those with different training backgrounds, such as psychiatrists, settlement workers, or school staff. Professionals who only provide mental health support services to individuals outside of Canada

are also excluded from the present study. The purpose of these exclusions is to maintain a focus on standardized and regulated mental health practices within Canada, creating some degree of consistency across the participant sample. These exclusions also ensure that participants have similar training backgrounds and regulatory oversight.

Chapter 2: Literature Review

Chapter 2 provides an overview of current literature related to the mental health experiences of South Asian Canadians in addition to their perceptions and experiences of seeking support. In this chapter, I discuss ethnic matching within therapeutic work and the preference for same-ethnicity therapeutic dyads among South Asian clients. Following this, I review the existing literature on diverse representation within mental health professions and its importance for South Asian Canadians, after which I address counsellor training and education as well as cultural responsivity in mental health. Finally, a review of the rationale leading to the present study is outlined and the primary research question and sub-questions are highlighted.

Mental Health Among South Asian Canadians

South Asians are one of the fastest growing groups in Canada, currently representing the largest visible minority group in the country (Statistics Canada, 2021). The 2021 Canadian Census reported approximately 2.57 million people of South Asian descent in Canada, with projections exceeding 5 million people by the year 2041 (Statistics Canada, 2021). Despite some similar cultural characteristics, this pan-ethnic group consists of individuals with ancestral backgrounds from Bangladesh, India, Nepal, Pakistan, and Sri Lanka, who come from various distinct cultural groups within those countries, speak numerous languages, practice various religions, and exercise diverse traditions. South Asian Canadians report unique mental health experiences compared to other Canadians, often due to experiences of discrimination, acculturation stress, and cultural stigma surrounding mental health (Inman et al., 2014). For example, one study conducted in the United States found that stress related to acculturation, trauma, and discrimination was linked with depression, anxiety, and substance use among South Asian Americans (Tummala-Narra & Deshpande, 2018).

Despite the prevalence of mental health concerns among this group, South Asian Canadians report the highest proportions of unmet mental healthcare needs and perceived barriers to mental healthcare compared to eight other ethnic groups in the country (Gadalla, 2010). Previous research suggests that even when South Asian Canadians disclose psychological symptoms to their primary care physicians, these symptoms are often unrecognized and untreated due to being presented somatically (e.g., sleep irregularities and gastrointestinal problems) rather than emotionally (e.g., depressed mood; Lai & Surood, 2008). Additionally, a systematic review of quantitative literature found that South Asian communities were more likely to somaticize or display physical symptoms in response to their psychological distress compared to other cultures in Western populations (Chandra et al., 2016).

In addition to shaping the way that South Asians perceive their mental health concerns, cultural factors also influence the type of support that they seek or expect from mental health professionals. For example, Comas-Diaz (2016) indicated that, in some South Asian cultures, counsellors, therapists, and psychologists are viewed as "healers" who teach and "fix" clients through advice and directiveness. Additionally, studies conducted in the United States indicate that, despite the higher risks for depression, self-injury, and suicide, South Asian Americans report negative attitudes toward seeking professional mental health support (Arora et al., 2016). While these studies clearly underscore several mental healthcare concerns among South Asians, it is important to note that most of the existing research was carried out in the United States, rather than specifically addressing Canada's multicultural landscape, highlighting the underrepresentation of South Asian Canadian voices.

Ethnic Matching in Therapeutic Relationships

Researchers have identified several cultural factors as potential reasons for help-seeking problems among South Asians, including societal stigma, avoidance of shame, discomfort with self-disclosure, family reputation, emotional restraint, and social conformity (Loya et al., 2010; Sue & Sue, 2003). Previous studies from the United States and the United Kingdom have attributed South Asian clients' preference for receiving mental healthcare services from professionals of the same or similar background to these cultural factors (Netto, 2006; Soorkia et al., 2011). This concept of matching therapeutic dyads based on culture, ethnicity, or race, is rooted in social psychology, suggesting that sharing a similar worldview fosters a sense of likeness, contributing to a stronger and higher quality therapeutic alliance (Ertl et al., 2019).

Some studies have suggested that ethnic matching enhances the effectiveness of therapeutic intervention due to the use of cultural scripts, shared ethnic-specific perceptions, and mutual channels of communication (Field & Caetano, 2010), while others do not indicate significant results related to therapeutic success. For example, a meta-analysis of 52 studies indicated that ethnic minority clients prefer a therapist whose ethnicity matches their own, although this match does not necessarily enhance counselling outcomes (Cabral & Smith, 2011). One possible explanation for the inconclusive findings regarding outcomes is that, while sharing an ethnic identity may increase a professional's sensitivity and understanding of the client's cultural context, therapists may also be influenced by their own pre-existing values, prejudices, and assumptions as "insiders" to the culture (Pandya & Herlihy, 2009). Additionally, as it is unlikely and impractical to establish exact ethnic matches in counselling due to the heterogeneity within South Asian cultures and even among different individuals from the same culture, it is important for mental health professionals to be aware of the diversity that exists across different

individuals who are South Asian (Jacob & Kuruvilla, 2012). Further, contrary to some South Asian clients' preference for South Asian mental healthcare providers (Meyer et al., 2011), other studies indicated that some clients may prefer a therapist from a different ethnic/cultural background due to the stigma related to discussing private habits, relationship conflicts, sex life, and emotional experiences (Ibaraki & Hall; Zane & Ku, 2014).

Following this trend, one study examined therapeutic dynamics among 236 ethnically matched (i.e., South Asian therapists and South Asian clients) and non-matched dyads (i.e., White therapists and South Asian clients) in the United Kingdom (Khan, 2006). Results indicated that clients rated working alliances in matched dyads as significantly better than the non-matched dyads (Khan, 2006). Importantly, the study also emphasized the need for qualitative research among South Asian populations to further understand the subjective experiences of culturally similar therapeutic relationships (Khan, 2006).

Contributing further to this research gap, a majority of existing research exploring ethnicity and mental health focuses primarily on the client's experiences of therapeutic dyads, particularly among White British or American, Hispanic, Black, or Chinese Asian individuals (Cabral & Smith, 2011). For example, one study in the United Kingdom found that clients' core beliefs may be effectively challenged through a strong therapeutic alliance if the therapist utilizes a sensitive approach, engages in reflexivity regarding their own cultural positioning, and demonstrates a thorough understanding of their clients' culture (Yon et al., 2018). However, this study addressed "minority ethnic clients" as one group, without specifically exploring the nuances across diverse cultural identities in the sample.

Bhatt (2015) attempted to address this critical gap in research by qualitatively investigating South Asian mental health professionals' experiences of providing ethnically

matched services in the United Kingdom. Results from this grounded theory study suggested several key themes, such as therapists feeling more empowered when working with clients from their own ethnic background, as well as some concerns related to negotiating cultural and professional expectations. Bhatt also highlighted the need for further support for the South Asian mental health professionals working in ethnically matched dyads, such as mentorship from a South Asian supervisor or educator. Although this study offered valuable insight into the experiences of South Asian therapists in the United Kingdom, it did not explore South Asian mental health professionals' processes of navigating the tension between their Western and South Asian values and norms.

The Role of Culture in Mental Health Services

The role of culture in mental health care practice has been reported to foster meaningful therapeutic relationships, thereby increasing effective outcomes (Mosher et al., 2017; Yon et al., 2018). For example, one study reported that ethnic minority clients in the United States were more satisfied with their counselling experience if their therapist identified with the same ethnicity, which resulted in lower rates of dropout than clients with Caucasian therapists (Huang & Zane, 2016). Another study conducted among 102 ethnic minority clients in the United States found a significant correlation between being able to discuss culturally specific issues and client satisfaction and outcomes (Meyer & Zane, 2013). Further, minoritized clients reported a preference for their therapists to be knowledgeable about their culture's prejudices and values (e.g., shame related to mental health, importance of family; Meyer & Zane, 2013). Meyer and Zane's findings suggested that cultural understanding is an important factor for ethnic minority clients and that it may potentially influence their perception of mental health professionals as well as their openness toward help-seeking. However, it is important to note that this study did

not consider the perceptions of mental health professionals providing culturally responsive care, nor did it differentiate between sub-groups of ethnic minority clients (i.e., South Asian).

Researchers in the United Kingdom have attempted to study the perspectives of mental health professionals as participants, highlighting the need for further research and cultural training (Patel, 2014). Although Patel's study provided information regarding ethnic matching from a White British perspective, there remains a lack of attention toward mental health professionals from an ethnic minority background. Collectively, it appears that most of these findings tend to address ethnic minorities as a whole or address populations from the United States or the United Kingdom, disregarding the unique cultural nuances of the South Asian dyads of mental health professionals and their clients in Canada. This lack of representation not only impacts the accessibility of mental health services for South Asian Canadians, but it also contributes to a broader narrative of systemic disparities (Faber et al., 2023).

Diversity in Mental Health Professions

Previous research conducted in the United States and the United Kingdom has found that ethnic minority individuals are increasingly entering mental health professions (Hipolito-Delgado et al., 2017; Rees et al., 2011). This diversification of the student body in Western countries has the potential to benefit South Asian clients who report feeling more comfortable with therapists who share their ethnic background (Meyer et al., 2011). As mental healthcare training programs continue to grow, it becomes important for educators, supervisors, and program developers to understand the needs and contexts of their diverse students (Smith et al., 2017). However, it is important to note that, at present, there is an absence of such exploration into the cultural diversity of mental health professions in Canada.

Recent studies highlight a persistent disparity in the availability of mental health professionals for racialized groups in Canada (Islam et al., 2014; Peachy et al., 2013; Williams et al., 2022), which further emphasizes the challenges faced by South Asian Canadians in accessing culturally responsive care. According to the Angus-Reid National Survey, representative of 1,501 adults in Canada, 22% of South Asian respondents reported struggling to locate language-matched providers (Faber et al., 2023), indicating a significant barrier in their pathway to seeking mental health support. The dearth of diverse representation in mental healthcare fields in Canada exacerbates these challenges, as individuals from ethnic minority groups often seek mental health services from professionals who can communicate in their language, comprehend their cultural nuances, and share a connection with their community (Brisset et al., 2014; King et al., 2022; Thomson et al., 2015). These studies suggest that as the number of South Asian Canadians increases in both the general population and mental health professions, it becomes important to understand not only clients' experiences of ethnically similar counselling, but also professionals' experiences.

Counsellor Education and Training

The increasing ethnic and cultural diversity within mental health professions in Canada and other Western countries has raised critical questions about whether existing counsellor education and training programs are adequately preparing professionals to work with diverse populations. Researchers have long critiqued counselling and psychotherapy education for its foundations in Eurocentric and individualistic frameworks (Cabanas, 2018; Christopher & Hickinbottom, 2008), which often fail to reflect the relational, collectivist, and community-based worldviews held by many non-Western cultural groups (Georghe, 2022; Kirmayer, 2012; Milner et al., 2021; Moodley, 2007). Additionally, previous studies have demonstrated that mental health

professionals from marginalized backgrounds frequently experience a disconnect between their lived knowledge and the clinical frameworks they are trained in, leading to internal conflicts about reconciling professional expectations with culturally congruent practices (Bhatt, 2015; Goode-Cross & Grim, 2016). These critiques suggest that education and training programs risk producing therapists who are technically competent within dominant Western models but underprepared to navigate the cultural complexities of practice with racialized communities (Collins & Arthur, 2010; Comas-Díaz, 2016).

Existing research indicates that multicultural counselling education often remains limited in scope, focusing on broad cultural awareness or competency checklists rather than integrating deep engagement with culturally situated theories, practices, and healing traditions (Georghe, 2022; La Roche & Maxie, 2003). Researchers posit that such training tends to overlook the intersectional realities of race, migration, language, and systemic marginalization (Inman et al., 2014; Collins & Arthur, 2010), which shape both client experiences and the practice contexts of racialized professionals. Similar critiques have emerged in international contexts. For example, a recent study with Latin American therapists in the United States indicated that professionals felt unprepared to use culturally appropriate approaches when serving their community, citing a lack of representation in training content and faculty mentorship (Rivera, 2023). These findings reflect a broader structural inadequacy in counselling education, particularly for professionals who aim to integrate cultural knowledge into their therapeutic work.

Further compounding this issue is the absence of racially and culturally congruent mentorship and supervision models, which are vital for supporting racialized professionals as they navigate identity-based challenges in clinical work. Previous research indicates that mentorship by culturally similar faculty or supervisors plays a critical role in affirming

professionals' identities, enhancing their clinical confidence, and helping them navigate challenges related to biculturalism and systemic inequities (Alves & Gazolla, 2011; Constantine & Sue, 2007; Patel, 2014). In contrast, traditional supervision models often reflect dominant norms and may fail to address the unique positionalities and professional dilemmas encountered by racialized trainees (Collins & Arthur, 2010; La Roche & Maxie, 2003). The absence of racially congruent mentorship opportunities is increasingly recognized as a barrier to both professional development and retention of racialized therapists in the field (Patel, 2014).

Collectively, this body of literature underscores the importance of critically examining counsellor education and supervision systems, particularly their capacity to support South Asian Canadian mental health professionals in developing culturally responsive and ethically grounded practice. These insights provide a strong rationale for examining training and education as a key area of inquiry when exploring the professional experiences of South Asian therapists working within their own cultural communities in Canada.

Present Study

From this literature review, it becomes apparent that the experiences and perspectives of South Asian mental health professionals in Canada have not yet been adequately explored. Instead, a majority of the existing literature tends to emerge from other Western countries, which have a different multicultural landscape compared to Canada, and focuses primarily on other ethnic groups (e.g., Gelman, 2004; Goh et al., 2014; Goode-Cross, 2011; Hamilton, 2023; Ito & Maramba, 2002; Yoshida, 2013) or solely on the perspectives of clients (e.g., Cabral & Smith, 2011; Chang & Berk, 2009; Meyer et al., 2011). These gaps in Canadian research underscore the absence of research documenting the experiences and perceptions of South Asian Canadian mental health professionals. This is particularly relevant in the Canadian context, where cultural

diversity is a cornerstone of the society, and the South Asian population is expanding rapidly while increasingly seeking mental health support (Islam et al., 2014).

Furthermore, the absence of Canadian research hinders the development of culturally responsive and effective therapeutic interventions for South Asian clients in Canada. They also limit the ability of South Asian Canadian mental health trainees to receive culturally responsive professional development training and support that may enhance their therapeutic practice. Exploring the experiences of this population is not only academically pertinent to address gaps in current literature, but it also has strong practical implications for training, education, and policies, thereby contributing to the overall improvement of mental health services for South Asian communities in Canada. Thus, the current study aimed to address these gaps and limitations through the overarching research question: *What are South Asian Canadian mental health professionals' experiences of navigating therapeutic work with South Asian clients?* Within this primary question, five sub-questions guided the analyses in this study:

1. *How do South Asian Canadian mental health professionals' experiences of navigating therapeutic work with South Asian clients differ from their experiences with clients from other cultural backgrounds?*
2. *What have these professionals observed about their therapeutic relationship with South Asian clients compared to other clients?*
3. *What are the interventions or theories that guide these professionals' practice with South Asian clients?*
4. *How does the professional's own cultural identity show up in their work with South Asian clients compared to other clients?*

5. *What are these professionals' experiences with education and training in the mental health field?*

Chapter 3: Methodology

This chapter outlines the methodological framework used to address the objectives of the current research. I begin by discussing the rationale for employing a qualitative approach to this study in addition to the theoretical and philosophical underpinnings of the selected method. Then, I detail the stages encompassing ethical approval, participant sampling, recruitment strategies, data collection methods, and analysis procedures. Finally, the measures undertaken to ensure rigour and trustworthiness as part of methodological integrity in the research process are outlined.

Qualitative Research Design

A qualitative approach was deemed optimal for this study due to several reasons. First, researchers recommend employing qualitative designs for understudied areas to enable a comprehensive and nuanced exploration of specific phenomena as perceived by individuals (Hancock & Algozzine, 2006). Second, qualitative approaches prioritize the unique experiences of individuals rather than simply uncovering general truths or average results (Carroll & Rothe, 2010). This capacity for depth is essential in capturing the contextual nuances in therapeutic interactions within the Canadian South Asian community. Third, qualitative approaches empower participants to share their experiences in their own words (Palinkas, 2014), describe the meanings that they assign to those experiences, and offer their own interpretations, which foster a sense of inclusion and representation (Morse & Richards, 2002). This participatory element is vital in highlighting the diverse voices of Canadian South Asian mental health professionals, as it parallels the principle of cultural responsivity. Fourth, a qualitative approach allows for a holistic exploration of participants' experiences, considering not only the therapeutic process but also the broader sociocultural and systemic factors potentially shaping their experiences. Finally, the

descriptive findings derived from a qualitative approach to this research have direct relevance for informing culturally responsive professional development and practice.

Ontology and Epistemology

Within qualitative research paradigms, researchers are expected to define their ontological beliefs and epistemological positions (Madill et al., 2000). By identifying the methodological assumptions and philosophical approaches underpinning the research, Freeman and Sullivan (2019) argued that researchers are better able to understand and justify certain decisions made during the process. Ontology refers to the study of the nature of reality and the various paradigms through which the world can be understood (Hays & Singh, 2011). A relativist ontology rejects the notion of a singular objective truth and promotes the idea that there are multiple subjective realities, each dependent on contextual factors, and influenced by idiosyncratic interpretations (Braun & Clarke, 2013; Cohen et al., 2018). This ontological approach aligns with a social constructionist perspective, which emphasizes that reality is co-constructed through ongoing interactions and negotiations that are shaped by cultural norms, societal expectations, and institutional structures (Braun & Clarke, 2006). Within the context of the present study, relativism enables the acknowledgment of multiple truths and exploration of individual stories related to the experiences of South Asian mental health professionals working in Canada. Drawing on this relativist ontology, in this study I adopted an interpretive framework that acknowledges the subjective nature of reality and the roles of social and cultural contexts in shaping individuals' experiences and perceptions (Ponterotto, 2005).

From the initial stages of conceptualizing the study to the data analysis process, epistemology informs the description of data as well as the theorization of meaning (Cohen et al., 2018). In alignment with my relativist ontological stance, the epistemological approach of the

current research is grounded in subjectivism, which suggests that knowledge is constructed through individual interpretations and subjective experiences (Ponterotto, 2005). This paradigm perspective highlights the importance of understanding the world from the perspective of the knower, rather than striving for a universal truth (Braun & Clarke, 2006). Adopting a subjective epistemology allowed me to recognize that interpretations are co-constructed through the interactions between the mental health professional participants and their clients as well as between the participants and the researcher. Overall, this stance encouraged me to engage in reflexive practices and critically examine my own biases or assumptions throughout the research process.

Reflexive Thematic Analysis

Braun and Clarke's (2021) Reflexive Thematic Analysis (RTA) was selected as a particularly suitable approach for exploring the experiences of South Asian Canadian mental health professionals. RTA is noted to be useful for "identifying, analyzing, and reporting patterns (themes) within the data" (p. 79; Braun & Clarke, 2006). I selected this method due to its consistency with the interpretivist and social constructionist paradigm assumptions of the current study and the exploratory nature of the primary research question and sub-questions. Furthermore, consistent with the qualitative research design and social justice aims of this study, RTA also adheres to the ethical imperative of centering the underrepresented voices of participants (Morgan et al., 2024).

According to its developers, RTA involves the co-construction of themes by the researcher and participants as a result of interpretive engagement with the data (Braun & Clarke, 2021). This view challenges the idea that themes simply emerge or are found within the data, which would effectively deny the active role of researchers (Braun & Clarke, 2021; Freeman &

Sullivan, 2019). In this study, the co-construction process was facilitated by using a flexible interview protocol that provided space for participants to share the information that they thought was important and by implementing the member-checking procedure that I describe in the data analysis section of this chapter.

Within their RTA approach, Braun and Clarke (2019a) highlight the researcher's "reflective and thoughtful engagement with their data and their reflexive and thoughtful engagement with the analytic process" (p. 594). They further posit the importance of making deliberate decisions, remaining aware of how the researcher engages with the data, and acknowledging theoretical assumptions (Braun & Clarke, 2021). Therefore, as a South Asian Canadian myself, it was important to acknowledge my perspectives, assumptions, and existing knowledge to ensure transparency and reflexivity throughout the analytical process. In doing so, the RTA approach ensured that my analyses and interpretations were grounded in the participants' narratives and experiences, fostering a more authentic representation of their lived realities.

While I considered several alternative qualitative research methods, each was ultimately evaluated as less suitable for the specific objectives of this study. Similar to RTA, Interpretive Phenomenological Analysis (IPA; Smith et al., 2009) is an interpretive methodology that promotes researcher reflexivity. However, whereas IPA is useful for a detailed understanding of the individual lived experiences of participants, RTA has a larger focus on understanding a phenomenon at the group level. As the objective of this study was to explore shared patterns of experiences across South Asian Canadian mental health professionals as a group, RTA was a better fit for my research goals. Grounded Theory (Strauss & Corbin, 1997) was also considered as a potential method. This approach is designed to generate theories grounded in qualitative

data, which did not particularly align with the exploratory nature of my study. The current research sought to understand and describe existing experiences rather than to develop a new theoretical framework, thus emphasizing RTA as a more appropriate choice. Finally, to address the overall research objective, I also considered Discourse Analysis (Coyle, 2006) as a potential method. However, this method's emphasis on examining the nuances of language and power dynamics would deviate from the primary goal of identifying shared themes in participants' experiences. In contrast, RTA provides the flexibility to focus on thematic patterns while still appreciating the social context of participants' narratives.

Participant Demographics

Due to its foundations in interpretivist and constructivist paradigms, RTA does not adhere to the notion of achieving saturation or redundancy through a specific sample size (Braun & Clarke, 2019b). Instead, RTA emphasizes the depth, richness, and complexity of data and the meaning-making process of both the participant and researcher, rather than aiming for exhaustive representation. As such, a total of eight South Asian mental health professionals were recruited to participate in the present study. This number is consistent with the sample sizes used in previous RTA studies, where sample adequacy is determined by the analytical scope, depth of engagement, and the quality of data generated (Braun & Clarke, 2021; Sim et al., 2018). To support transparency around sample sufficiency, I drew on the concept of information power (Malterud et al., 2016), which proposes that the more relevant information each participant provides for the aims of the study, the fewer participants are needed. Information power is influenced by several factors, including the specificity of the research question, the quality of dialogue, and the analytic strategy. In this study, participants shared rich, in-depth narratives that directly aligned with the study's focused aims, and the analytic approach of incorporating both

within- and cross-case analyses facilitated detailed engagement with each account. Additionally, participants were selected based on shared professional and cultural criteria, which enhanced the relevance of their contributions. Overall, these considerations supported the appropriateness of the sample size for the interpretive goals of this study.

Each participant took part in an individual semi-structured interview with the researcher, with some also opting to share brief feedback on within-case analyses via email as part of the member-checking procedure to co-construct themes. To ensure confidentiality, all participants were offered the opportunity to choose their own pseudonym. Two participants selected their own pseudonym while others requested to be referred to with a randomized name. A summary of the participants' demographic characteristics is detailed in Table 1, including pseudonyms, reported gender, South Asian background, designation qualifications, practice settings, and years of practice experience.

Table 1

Demographic Information of Participants

Pseudonym	Gender	Background	Registered title	Work setting	Years in practice
Rita	Female	Indian	Clinical counsellor	Private practice	13
Shiv	Male	Sri Lankan	Psychotherapist	Private practice	4
Chandni	Female	Indian	Psychologist	Private practice	10
Ravneet	Female	Indian	Psychotherapist & art therapist	Private practice	20
Himani	Female	Indian	Psychologist	Private practice	10
Shahid	Male	Pakistani	Mental health counsellor	Community clinic	1.5

Alina	Female	Indian	Psychotherapist	Private practice	5
Rubina	Female	Pakistani	Psychotherapist	Community clinic	1.5

Braun and Clarke (2006) state that purposive sampling is beneficial for RTA research due to maximizing the information gathered from a smaller sample of participants. In the present study, I engaged in purposive sampling using a specific set of inclusion and exclusion criteria. Following approval from the University of Calgary's Conjoint Faculties Research Ethics Board (CFREB), participants were recruited based on the four key inclusion criteria. First, participants were required to self-identify as South Asian, although there was no limitation in terms of immigration generation (i.e., first-generation, 1.5 generation, third generation, etc.), as this information helped to contextualize participants' experiences. Second, they were required to have completed at least a master's degree in relevant mental health fields, such as clinical or counselling psychology, psychotherapy, mental health counselling, or clinical social work. Third, participants were required to be actively licensed or certified with a provincial or national credentialing body for mental health practitioners (e.g., British Columbia Association of Clinical Counsellors; Canadian Counselling and Psychotherapy Association; College of Alberta Psychologists; College of Registered Psychotherapists of Ontario; Nova Scotia College of Social Workers).

Two exclusion criteria also informed the participant recruitment process. Interested individuals who only worked with South Asian clients residing outside of Canada (e.g., providing telepsychology services) were excluded from the study as the socio-political contexts of those clients might vary significantly from the Canadian context. Furthermore, as I explained in Chapter 1, those working as mental health coaches, spiritual leaders, settlement workers,

school liaison counsellors, and psychiatrists were excluded from the study due to major differences in training and practice experiences.

Data Collection Procedures

Participants were recruited using several different strategies, including word-of-mouth through the professional networks of the researcher and research supervisor. Additionally, I sent invitation letters to the Canadian Psychological Association's Asian Section and Counselling Psychology Section, in addition to provincial regulatory bodies (e.g., College of Alberta Psychologists) and professional associations (e.g., Psychologists' Association of Alberta) across Canada. The invitation letters (see Appendix E) and digital advertisements (see Appendix F) included detailed information about the purpose of the study, inclusion criteria, a QR code to access an online screening form to determine eligibility to participate and contact information for prospective participants to indicate interest.

Managers and Directors of organizations serving in the mental health sector or in South Asian communities across Canada were also contacted to request support in promoting the study. Connecting with organizations served as a more deliberately inclusive form of recruitment. Additionally, participants were encouraged to refer the information about this study to other South Asian mental health professionals in their professional networks across Canada (i.e., snowball sampling).

Prospective participants who expressed interest in the study were invited to take part in a brief screening process via a secure online survey platform, Qualtrics, in which they answered questions to confirm whether they meet eligibility criteria (see Appendix A) and to offer participants the opportunity to ask questions about the research. In the screening survey, interested individuals were also asked to share their contact information so that the researcher

could reach out to schedule an interview for participation if they met the eligibility criteria. Respondents who did not meet the criteria (n = 2) were informed of their ineligibility and thanked for their time over email correspondence.

Interested participants who met the inclusion criteria were contacted by the researcher via email to schedule a time for an interview and received an electronic copy of the consent form (see Appendix D) to review prior to commencing the interview. At the start of each interview, I verbally reviewed the consent form with each participant, ensuring that they were clearly informed about the voluntary and confidential nature of the study, any risks associated with participating, and that they may choose to withdraw consent for participation at any time without penalty or obligation. Participants were also reminded that they could stop the interview at any time, refrain from answering a question, or ask for clarification.

Once participants confirmed understanding the terms of their consent and agreed to proceed, they were asked to digitally sign and email a copy of the signature page to the researcher. I then offered each participant an opportunity to select their preferred pseudonym or be assigned one and conducted individual semi-structured interviews, which took between 40 to 90 minutes to complete, with an average interview time of 54.5 minutes. According to Braun and Clarke (2013), semi-structured interviews are the preferred data collection method when the goal of the research is to better understand the unique perspectives of individuals rather than a generalized understanding of a phenomenon.

The interviews began with some demographic questions to collect information regarding the participants' South Asian cultural identity, gender identity, age, languages, type of licensure, professional title, practice setting, and years in practice (see Appendix B). Before proceeding to the interview questions (see Appendix C), I informed participants that they would be contacted

for an optional member-checking follow-up to review initial themes that were generated during the within-case data analysis if they wished to provide feedback for adjustments or clarification. They were reminded that their participation in this follow-up was voluntary and that they may choose to refuse at any time. Participants were informed that follow-up information may be collected through their preferred method, either by exchanging a text document of initial themes via email or a brief Microsoft Teams video call lasting up to 30 minutes to discuss their reflections. All six participants who chose to review the preliminary themes opted to convey their feedback via email.

To account for flexibility and accessibility concerns, all interviews were conducted virtually and recorded through a secure online video-conferencing platform, Microsoft Teams. One participant requested a voice-only recording, instead of a video recording, alongside automatic transcription. To facilitate the data analysis procedures, each interview was transcribed verbatim using Microsoft Team's secure transcription option and proofread manually by the researcher to account for software errors. As interviews were stored electronically, all data records were maintained digitally, with the exception of handwritten notes collected during interviews and printed transcripts. Digital files of the recorded interviews and transcripts were encrypted and stored under password protection, while hard copy data were stored in a locked space, only accessible to the researcher.

Data Analysis Procedures

Following data collection, data analyses were guided by Braun and Clarke's (2021) six-phase process of RTA. During Phase One of familiarization, I became immersed in the data by reading and rereading the interview transcripts (Braun & Clarke, 2006). As per Braun and Clarke's (2006) suggestion that researchers "develop a far more thorough understanding of

[their] data through having transcribed it," I double-checked transcripts alongside the video recordings to further ensure accuracy and facilitate this phase of the analysis.

As part of Phase Two, code generation, Braun and Clarke (2012) suggest becoming more engaged with the data by attaching initial labels (i.e., codes), which are influenced by the research questions and the theoretical stance of the researcher. During this process, it is important to provide equal attention to each transcript and to generate codes across the entire data with equal rigour (Braun & Clarke, 2021; Freeman & Sullivan, 2019). To ensure equal attention across all participants' data, I generated codes for each participant individually upon completing their interview, instead of analyzing all data collectively to generate codes. Additionally, RTA research often employs two approaches to coding, including inductive coding (i.e., reviewing data to identify ideas for codes) and deductive coding (i.e., using existing ideas to search specifically in the data; Braun & Clarke, 2021). As the current study investigated an understudied topic, coding followed an inductive approach.

Phase Three of generating initial themes involves reviewing all transcripts for each research question together, to merge duplicate codes and collate similar codes. Braun and Clarke (2021) describe themes as meaningful patterns and shared representations that address a central concept. Thus, I collapsed and clustered codes that "seem to share some unifying feature together so that they reflect and describe a coherent and meaningful pattern in the data" (Braun & Clarke, 2012, p. 63). During this stage, to remain vigilant against "positivism creep," defined as the pressure to identify a "true" model depicting participants' experiences (Braun & Clarke, 2022), I engaged in reflexive journaling and positionality reflection. This practice involved systematically documenting my thoughts, feelings, and reflections throughout the research process. By recording and considering my pre-existing assumptions, values, and beliefs, I was able to

continuously scrutinize how these personal factors may influence my interpretation of the data. Reflecting on my positionality also supported me in identifying and addressing any biases or preconceptions, thereby ensuring a more transparent and nuanced analysis. Ongoing self-reflection was critical for maintaining the integrity and trustworthiness of the research, as it fosters a deeper engagement with the data and promotes a critical approach to the analysis (Braun & Clarke, 2022).

Following the generation of themes, Phase Four of developing and reviewing themes involves checking preliminary themes against the coded data and dataset to determine whether to merge, split, or discard them. During this process of quality checking, Braun and Clarke (2012) suggest five key questions to consider: a) Is this a theme? b) If it is a theme, what is the quality of this theme? c) What are the boundaries of this theme? d) Are there enough data to support this theme? and e) Are the data too diverse and wide-ranging to be a coherent theme? By reviewing the Phase Three themes in the context of the above questions, I worked toward a final set of themes that clearly and accurately captured the coded data excerpts. I maintained flexibility by consolidating similar themes, segregating themes that represented concepts more appropriately categorized by sub-themes within a larger theme, and eliminated concepts that did not qualify as themes.

Additionally, to ensure the credibility of the themes in this stage, I facilitated member-checking procedures with participants interested in reviewing and providing feedback on the preliminary themes developed during the analysis of their responses. This process involved sharing the themes and subthemes I generated based on my interpretation of the data and inviting participants' input on whether these themes reflected their experiences and perspectives. By incorporating their feedback, I aimed to refine and validate the themes, ensuring that they were

genuinely co-constructed and resonated with the participants' views. This step occurred after the initial coding and theme development but prior to finalizing the thematic analysis in Phase Four, as this allowed for any necessary adjustments based on participant feedback.

During Phases Three and Four, some themes demonstrated conceptual adjacency or appeared to partially overlap in context. In determining the boundaries between both within-case and cross-case themes, I engaged in a reflexive, iterative process guided by Braun and Clarke's (2021) emphasis on participants' narratives and my ethical commitment to privileging their voices. Rather than applying rigid or a priori thematic boundaries, I considered whether a code or set of excerpts conveyed a distinct meaning, focus, or concern that participants explicitly emphasized. These themes were intentionally retained as distinct based on two key considerations. First, even when themes touched on similar phenomena (e.g., cultural identity, therapeutic dynamics), they highlighted different facets or implications emphasized by participants. These themes were retained as distinct due to the unique emphasis that participants placed on specific experiences within their narratives. Second, the decision to maintain thematic distinction was driven by a commitment to preserving the nuances of participants' meaning-making, informed by the way they framed certain experiences as meaningful, unique, or emotionally salient in our conversations. Each theme was constructed not only based on semantic content, but also with respect to the emphasis, tone, and relational positioning conveyed in their narratives and confirmed by their feedback. As such, where necessary, clarifying statements are inserted throughout the findings chapters to articulate how certain themes overlap yet differ from each other or to acknowledge that they are grounded in participant emphases. This approach aligns with the principles of RTA, which values researcher reflexivity and situated meaning-making over rigid thematic boundaries (Braun & Clarke, 2021).

When deciding whether to combine or separate themes, I also considered two questions: Do these codes reflect a similar central idea, or are they pointing to different layers of experience? If two groups of codes addressed related content but conveyed different emphases (e.g., therapeutic rapport versus cultural knowledge), I opted to separate them. This approach allowed me to attend to the nuances that participants prioritized, even if the themes appeared interrelated. I also documented by interpretive decisions, particularly when I felt conflicted between clustering codes under broader umbrellas versus naming them as distinct themes. Ultimately, my decision-making was guided by the principle of centering participant meaning rather than reducing complexity for coherence.

Next, Phase Five involved refining, defining, and naming each theme and subtheme across all participants, to ensure that they accurately reflected the coded data and contributed to the overall narrative of the research. This included writing detailed descriptions, assigning concise names, and analyzing subthemes to capture nuanced aspects of the data. Additionally, I analyzed subthemes to capture nuanced aspects of the data, ensuring coherence and clarity in how themes interrelated and addressed each sub-question. The findings from this analysis are presented in Chapter 4, with two to three themes being constructed for each sub-question being addressed in this research (n = 14). According to Braun and Clarke (2021), this thorough examination ensures that the final set of themes provides a comprehensive and insightful understanding of the data. Finally, Phase Six involved producing a summarized final report with a degree of flexibility as some themes, or their organization, are reworked on an ongoing basis (Braun & Clarke, 2021).

Rigour and Trustworthiness

To establish the methodological integrity of this study, I adopted Lincoln and Guba's (1985) trustworthiness criteria: credibility, transferability, dependability, and confirmability. These criteria are rooted in a constructivist paradigm and provide a framework for evaluating the quality of interpretive inquiry. I also drew upon Yardley's (2000) four dimensions of qualitative rigour, which include sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance, where they aligned conceptually with Lincoln and Guba's framework. The integration of these frameworks allowed for a multifaceted approach to methodological integrity, aligning with qualitative research principles that prioritize reflexivity, collaboration, and contextual awareness (Nowell et al., 2017).

Credibility refers to the extent to which the research findings are grounded in participants' experiences and meaning-making processes rather than an objective truth (Lincoln & Guba, 1985). To address credibility, I implemented member-checking procedures by inviting participants to review and refine preliminary themes, ensuring that their voices remained central in the analytical process (Levitt at al., 2017). This process involved providing a completed analysis at the individual, within-case level to corresponding participants to confirm that the researcher's interpretations reflect their experiences authentically (Morse, 2015). This step occurred before finalizing the cross-case themes to allow for any necessary adjustments based on participant feedback. Additionally, I maintained persistent observation (Lincoln & Guba, 1985) through prolonged engagement with participants' narratives to allow for a nuanced and contextually rich understanding of their perspectives. This is similar to Yardley's (2000) criterion of commitment and rigour, which entails deep engagement with the data to capture a thorough representation of the phenomenon. I ensured that the present study fulfilled this criterion through

detailed interviews and repeated engagement with participants' narratives, particularly during Phases One and Two of the analysis. By avoiding the practice of inter-rater reliability, which would only involve multiple researchers' interpretations, the current research rejected the assumption that there is an accurate reality in the data that can be captured through coding (Clarke & Braun, 2018).

Transferability refers to the potential for findings to be relevant beyond the immediate research context while acknowledging that qualitative research does not aim for broad generalizability in a statistical sense (Lincoln & Guba, 1985). Similarly, Yardley's (2020) criterion of impact and importance emphasizes the broader significance of research findings. To facilitate these principles, I highlighted gaps in existing literature, demonstrating this study's contributions to education, training, and practice while underscoring its relevance beyond the immediate research setting. Additionally, I employed thick description, providing detailed information about the research context and participants' backgrounds, experiences, and social environments (e.g., practice setting, field of work). By offering comprehensive descriptions, this study enables future researchers and professionals to access the applicability of its findings within different settings and populations.

According to Lincoln and Guba (1985), dependability ensures that the research process is conducted in a consistent and traceable manner, while Yardley (2000) emphasizes transparency and coherence as key indicators of trustworthiness. To address both criteria, I maintained an audit trail, recording methodological decisions and analytical choices to allow for external evaluation of the research's logical progression. Debriefing discussions with my research supervisor also reinforced dependability by providing opportunities to challenge my assumptions and refine the analytical process (Tobin & Begley, 2004). Transparency was also ensured by

remaining theoretically aligned with the interpretivist and social constructionist underpinnings of the study (Braun & Clarke, 2021), ensuring coherence between methodology and epistemology.

Confirmability acknowledges that, while interpretations in qualitative research are influenced by the researcher's positionality, they should remain grounded in the data rather than personal biases (Lincoln & Guba, 1985). I addressed this through ongoing reflexivity, supervision discussions, and member engagement. My use of RTA foregrounded the active role of the researcher in meaning-making, which I acknowledged explicitly throughout the analytic process. Rather than seeking neutrality or objectivity, I aimed to be transparent about the interpretive lens I brought to the data, while also considering Yardley's (2000) criterion of sensitivity to context (i.e., acknowledging and respecting the cultural and social influences shaping participants' experiences while also considering the researcher's positionality). To address this criterion, I endeavoured to engage with my participants in a sensitive and ethical manner, remaining mindful of our distinct social, cultural, religious, and political contexts.

During this process, maintaining reflexivity was foundational to each of these evaluative components as well as the overall integrity of the study. Through reflexivity (Nowell et al., 2017), I critically reflected on my own biases, assumptions, and preconceptions throughout the research process. To achieve this, I maintained a reflexive journal to document my reflections and insights, ensuring a continuous and transparent examination of my influence on the research. Practicing reflexivity during all phases of this research was important to ensure that I did not ask leading questions or influence the discussions during the interviews as this would reduce participants' freedom to express their experiences and thus fail to genuinely capture their lived realities. Combined with the collaborative process of member-checking, which positioned participants as co-constructors of meaning, this process ensured that the findings resonated with

their lived experiences rather than reflecting my imposed interpretations as the researcher (Levitt et al., 2017).

Chapter 4: Findings

The purpose of this chapter is to present the findings that were generated from the data through RTA. The chapter begins with an overview of the themes and subthemes co-constructed from the data analysis for each participant separately (i.e., the findings from the within-case analysis). Then, I outline the findings that I generated through a cross-case analysis of the overall data (i.e., the cross-case findings), which are described based on each sub-question of the study to address the overarching research question: *What are the experiences of South Asian Canadian mental health professionals working with South Asian clients?* In addition to using pseudonyms, all identifying information related to participants' place of employment and references to specific private practices, community clinics, practicum settings, and educational/training programs has been removed to protect confidentiality.

Within-Case Findings

In this section, I present the themes and subthemes co-constructed with participants through within-case analyses. While some themes responding to subquestions related to general experiences of working with South Asian clients, therapeutic relationships with South Asian clients, and the therapist's South Asian cultural identity appeared to share conceptual ground, they were retained as distinct to honour the participants' own meaning-making. For instance, themes related to rapport building and cultural resonance may seem thematically adjacent, but they reflected different emphases, with the former centered on process (how rapport forms), while the latter centered on identity (what the therapist brings). Distinguishing them was not about asserting categorical truth, but rather tracing the textured way that participants navigated their work and described their perspectives.

Participant 1: Rita

Rita is a 39-year-old woman from a Fijian Indian background, who has been practicing as a registered clinical counsellor for 13 years. She provides therapy and counselling services in both English and Hindi to adults and families in a private practice setting.

As reflected in the theme, *Increased Relatability Due to Shared Culture*, Rita emphasized that her background creates a strong foundation for establishing a connection with South Asian clients and attending to their distinct experiences with family, collectivism, and stigma. She described the nature of her therapeutic relationships with South Asian clients through the theme, *Cultural Familiarity as Rapport Builder*, indicating that their similarities build trust and safety, fostering quicker rapport. However, through the theme, *Challenges in Navigating Therapeutic Dynamics*, she also noted some complexities in navigating cultural influences, such as stigma and gender dynamics:

> Within our culture, it can sometimes be difficult to open up. There's stigma and there's shame and the idea of 'what will people think'... in situations where I am working with couples, there might be a very traditional patriarchal type of relationship where the man leads, and the wife brings in her husband for therapy. So, there might be a little bit of apprehension or maybe not as much respect for a female counsellor, because of the fact that I'm a woman who is trying to give advice on their relationship. (Rita).

Rita indicated that cultural norms around gender and authority, combined with internalized stigma toward mental health, influence some South Asian clients' openness and perceptions of the therapist's authority.

While *Cultural Familiarity as Rapport Builder* and *Increased Relatability Due to Shared Culture* may appear conceptually linked, I chose to separate them because they emphasize

distinct layers of the relational process. The former focuses specifically on how shared cultural cues facilitated the early establishment of rapport, while the latter reflects Rita's broader reflections on identity-based empathy and understanding in therapy. Though they overlap in content, separating them highlights the relational versus contextual functions of shared identity as described by Rita.

Through the theme, *Culturally Adapted Therapeutic Approaches,* Rita highlighted the importance of adapting Western theories to incorporate cultural nuances and traditional frameworks of understanding, such as balancing individual and collective needs, addressing internalized stigma, and accounting for acculturation factors:

> By traditional I mean you don't talk about your problems, you don't talk about your feelings, and you keep it within the four walls of your home. As a result of that, the individuals that I see who migrated here might appreciate more psychoeducation. I probably offer them more explanation and I might not be too quick to jump into the whole 'let's feel your feelings,' because that might be really unfamiliar (Rita).

She emphasized the significance of *Integrating Spiritual and Religious Beliefs* and *Including Family and Community* into her therapeutic approaches with South Asian clients, as these factors play a central role in shaping their worldviews, therapeutic goals, and healing processes.

Rita discussed her own cultural identity as both a strength and a challenge in her therapeutic work with South Asian clients. Through the theme, *Enhanced Empathy and Cultural Resonance*, she mentioned leveraging her cultural knowledge to relate to her clients' context, allowing for a richer connection and enabling them to feel more understood without overexplaining. In contrast, she noted key *Challenges in Sharing a Cultural Background*, such as preventing countertransference, personal projection, and over-identification with clients'

experiences, and balancing professional boundaries with cultural values related to respect in relationships.

> As a South Asian therapist working with South Asians, I have to be aware of the things that I might feel harden me or soften me, and I have to park it. So, a part of me that shows up knows that there are things that are being shared that I understand at a level that someone else who isn't South Asian might not understand. But it still doesn't give me permission to say I'm an expert on somebody's life or their cultural identity. (Rita).

In the theme, *Self-Reflection and Cultural Identity*, she described engaging in ongoing reflection to remain aware of personal biases and to avoid making assumptions about clients due to their shared background.

While sharing her experiences with training and education, Rita expressed that she experienced a lack of training tailored to the unique needs of South Asian clients, as demonstrated in the theme, *Gaps in Cultural Relevance of Training*. She reported needing to engage in *Self-Directed Learning* to acquire the cultural knowledge and skills necessary to work effectively with South Asian clients. In response to these gaps, through the theme, *Recommendations for Improving Training,* Rita suggested that integrating more culturally responsive frameworks in curriculum as well as South Asian mentorship and representation is important to support South Asian therapists.

Participant 2: Shiv

Shiv is a 26-year-old man from a Sri Lankan-Canadian background. He has been practicing as a registered psychotherapist for four years, primarily within a private practice setting. Shiv provides mental health services in English and Tamil to a diverse range of clients including families and individuals.

Shiv suggested that his familiarity with the cultural dynamics that are often present among South Asian clients (e.g., acculturation experiences, collectivist values, and perceptions of mental health) fosters a stronger therapeutic connection with them, as demonstrated in the theme, *Cultural Familiarity as a Therapeutic Advantage*. He described trying to understand why there was such a high demand for his services from the beginning of his work as a psychotherapist:

> Being a male within the therapeutic setting, there's kind of a higher demand because there just aren't that many males in the field. And then secondly, most of the individuals who were reaching out to me inquiring about therapy were Tamil. (Shiv).

He indicated that their shared experiences enhance South Asian clients' sense of trust and comfort, which may explain their preference for a culturally similar therapist.

Through the theme, *Therapist's Role in Navigating Cultural Expectations*, Shiv highlighted the therapist's responsibility to support South Asian clients in exploring emotions while balancing cultural pressures of collectivism. He noted that a critical component of his therapeutic alliance with South Asian clients involves creating a space for exploration and development to enable clients to navigate the tension between family obligations and individual emotional needs, fostering both cultural sensitivity and personal autonomy in the process.

When sharing his perspectives on effective therapeutic approaches for South Asian clients, Shiv underlined the importance of integrating *Multimodal and Culturally Adapted Interventions* that align with clients' cultural needs and expectations of therapy.

> Sometimes people from South Asian cultures hold therapists or doctors in a very high regard like we're experts and they want structured directions [...] It's like when they go to a doctor, thinking I can prescribe them a pill and they will get better. (Shiv).

He described practicing flexibility in his therapeutic style to accommodate client preferences for structured sessions.

In the theme, *Therapist's Cultural Identity as an Asset in Therapeutic Work*, Shiv indicated that he leverages his shared background with South Asian clients to enhance contextual understanding, build therapeutic connections, and navigate cultural barriers. However, he noted the importance of *Self-Reflection and Awareness*, emphasizing the risk of making assumptions or generalizing client needs.

> If a South Asian client comes to me, my responsibility as a therapist is not to identify them as a South Asian client and assume what they need. My responsibility is to see them as a client. Being South Asian could perhaps benefit me in understanding them, but I don't know that unless I speak to them, and they tell me. (Shiv).

Shiv shared that continuously exploring his own biases and recognizing the variability within South Asian cultures enhances his cultural responsiveness. While this theme and the previous theme, *Cultural Familiarity as a Therapeutic Advantage*, are closely related and both explore the impact of shared cultural background, they were separated to emphasize the distinction between process and positioning. The latter centers on how Shiv's shared cultural knowledge facilitates rapport and eases client engagement, while the former focuses on how Shiv positions himself in the therapy room, including how he reflects on and strategically draws on his identity. This separation allows for a more nuanced understanding of the dynamic interplay between client perception and therapist self-awareness of cultural similarity.

Through the theme, *Limitations of Culturally Informed Training and Education*, Shiv described the gaps in formal training for South Asian professionals, including a lack of culturally

focused support, mentorship opportunities, and culturally relevant education beyond general cultural competence courses.

> Experiences within therapy are shared differently and people approach therapy differently. So maybe having more seminars with diverse professionals from around the world can help us see how culture and politics and religion actually influence the way someone might conduct or perceive therapy based on their cultural background. (Shiv).

In addition to diverse representation, he highlighted the importance of *Self-Directed and Experiential Learning* for South Asian therapists, which he achieves through reflecting on his personal cultural knowledge and direct interactions with South Asian clients.

Participant 3: Chandni

Chandni is a 33-year-old, second-generation immigrant woman from a minority community in India. She has been practicing as a registered psychologist for three years and a registered clinical counsellor for ten years. She currently works in a private practice setting, providing counselling services in English and French to individuals, families, and couples.

Chandni emphasized that the cultural environment of South Asian clients shapes the therapeutic process, which is noted in the theme, *Influence of Cultural Context on Therapy*. She acknowledged the complexities of navigating diverse cultural practices, beliefs, and values amongst subgroups within South Asian communities:

> There's all these intense cultural pockets and the unique norms within that. So, sharing a cultural identity but then not sharing a lot of smaller practices or nuances of that cultural identity means we need to get up to speed on that... (Chandni).

Chandni further noted challenges in therapeutic engagement when newcomer clients and clients from multigenerational households hold different cultural orientations, which often clash with Western norms of individual autonomy.

When describing the nature of her therapeutic relationships with South Asian clients, through the theme, *Rapport Building Through Shared Cultural Understanding*, Chandni explained that their shared experiences and references (e.g., metaphors) helped build trust and connection. However, she also shared unique challenges of working with this population in the theme, *Challenges in Meeting Client Expectations*:

> Let's say they really want me to agree with them on how their daughter is an old spinster and should get married and I'm challenging that. A lot of them can feel disconnected because they're like, 'I thought I was seeing a brown psychologist, so you should be on my side.' (Chandni).

She explained that clients sometimes expect her to share their cultural assumptions, which potentially complicates the therapeutic relationship.

Due to the emphasis on family dynamics among collectivist communities, Chandni highlighted a *Family Systems Approach as a Cultural Fit* for South Asian clients: "Sometimes learning more about their religious norms around grieving or what they have done culturally is important because then we can situate this loss in that way." In the theme, *Adapting Interventions to Cultural Norms and Challenges*, Chandni suggested modifying interventions to address the limitations of Western therapeutic models. She emphasized the importance of adapting therapy approaches to consider cultural values, collectivist influences, religious beliefs, and community structures.

While exploring the role of her own cultural identity, Chandni indicated that, although she is second-generation herself, understanding and validating the unique struggles of South Asian clients (e.g., arranged marriages) strengthens their therapeutic connection, as presented through the theme, *Therapist's Cultural Identity as a Therapeutic Tool*. She also shared various challenges in the theme, *Complexities of Countertransference and Personal Boundaries*: "I really struggle with that older group of South Asian Canadians that just wants their children married off or an arranged marriage as soon as possible. That can bring up a lot for me and that's triggering." Within this theme, she addressed navigating personal triggers, balancing self-disclosures, handling client expectations due to their similarities, and working with older generations who hold more traditional values.

Upon reflecting on her education and training as a psychologist, Chandni indicated that programs often lack sufficient cultural responsiveness, which leaves South Asian therapists feeling underprepared to address the specific needs of their community. This is demonstrated through the theme, *Inadequacy of Cultural Responsiveness in Training*:

> I once raised the question at an EFT training about why we don't have any demos of non-CIS or non-white couples and the answer was, 'oh, it would be too complicated to show such a complex couple.' That's actually mostly who I work with, so I thought it was weird that they see it as harder but to me, it's just different. (Chandni).

She highlighted the limited representation in faculty and training materials, sharing her hopes for more culturally relevant case studies and peer consultation groups to support South Asian mental health professionals.

Participant 4: Ravneet

Ravneet identifies as a 45-year-old woman from a Punjabi, Indian background and works as a registered psychotherapist and registered art therapist. She has been practicing for nearly 20 years, primarily within a private practice setting, combining community-based approaches to healing with art-based interventions and Western therapeutic models. Ravneet provides mental health services in English, Punjabi, and, to a lesser extent, Hindi, to a diverse range of individuals, couples, and families.

When describing her experiences, Ravneet noted that her shared cultural background enhances her sensitivity to the distinct values, family dynamics, and collectivist influences that shape South Asian clients' experiences. This understanding, outlined in the theme *Cultural Understanding and Relevance,* fosters a stronger therapeutic connection.

> You're not going to fully understand your client's experience. However, you may be able to relate to some of their experiences because they mirror some of your own experiences as a racialized individual or whatever intersections or identities that you share with your client. So, the sense of familiarity within those spaces is interesting. (Ravneet).

While recognizing the existence of substantial intracultural diversity among South Asians, Ravneet mentioned that her familiarity with family expectations, community stigma, and bicultural identity struggles all facilitate empathy and therapeutic alignment, enabling her South Asian clients to feel understood on a deeper level.

Through the theme *Awareness of Challenges Unique to South Asians*, Ravneet highlighted the mental health stigma that often presents as a familial vulnerability among South Asian clients. She mentioned that clients' search for culturally safe therapeutic spaces may explain their preference for therapists with a similar cultural background. Although both themes

attend to Ravneet's cultural knowledge, they differ in focus and intent. *Awareness of Challenges Unique to South Asians* highlights her understanding of the social and structural stressors that specifically affect this population (e.g., stigma, intergenerational conflict, and gendered expectations). This theme is grounded in recognizing systemic and collective challenges. In contrast, *Cultural Understanding and Relevance* focuses more on how Ravneet uses this knowledge to inform her therapeutic stance and practice. It emphasizes the ways she intentionally aligns her interventions with cultural norms and expectations. Keeping these themes separate reflects the distinction between understanding context and actively practicing cultural responsiveness.

In the theme *Enhanced Therapeutic Relationships*, Ravneet defined her cultural connection with South Asian clients as a "bonding tool" that enables trust and comfort. She indicated making intentional cultural adjustments to build rapport, such as observing traditional respect hierarchies, to help clients feel at ease. However, she noted that some clients bring initial hesitations due to stigma, gender dynamics, and perceptions of her authority, through the theme *Challenges in Building Alliances*. Ravneet shared that balancing respect for cultural norms while establishing boundaries allows clients to feel both safe and respected in the therapy space.

In the theme, *Adapting Western Models to Respect Cultural Perspectives,* Ravneet addressed the need to modify Western models to align with collectivist values:

> Our cultural and spiritual roots have such wisdom around power, strength, and sovereignty, especially the Sikh idea of oneness. So, bringing in those ideas that we are all sovereign and creative beings and then taking examples from history […] can help us reframe different stories from the past to find a sense of power and strength in the present. (Ravneet).

She indicated that, by integrating family and community into her approaches and including familiar cultural practices such as faith-based rituals, she is able to create a more culturally resonant experience. Through the theme *Recognizing Limitations in Western Approaches to Healing*, she addressed how the individualism promoted in Western therapy can clash with South Asian cultural values, requiring more flexible, culturally responsive methods that incorporate traditional healing practices.

As noted in the theme, *Cultural Identity as a Therapeutic Tool,* Ravneet suggested that her background helps foster empathy and validation by using respectful cultural terms like "Auntie," or carefully self-disclosing a general understanding of clients' experiences. Through the theme, *Personal Reflexivity,* she highlighted the importance of ongoing reflection on her personal biases and privileges to remain aware of the intersectionality among South Asian identities and avoid assumptions.

Ravneet noted the existence of significant gaps in culturally relevant training in the field, as noted in the theme *Gaps in Training and Education,* underscoring that she has to rely on personal cultural experiences to fill these gaps. Reflecting on these limitations, she shared:

> I think it would benefit us to think a little bit innovatively and use cultural norms to re-imagine what therapy looks like. Just looking at indigenous ways of healing and looking at the ways South Asian communities have traditionally done healing, […] it shows that within our cultures, we already have systems of healing and systems of wellness. So, the question is how do we honor those and how do we recognize that they already exist for us? (Ravneet).

She highlighted the need for decolonized, culturally adaptive frameworks that integrate traditional and faith-based healing.

In the theme *Advocacy for Institutional Change,* she further called for systemic shifts in counsellor training and education, including mentorship opportunities, diverse faculty representation, and a culturally inclusive curriculum, to better support South Asian clients and emerging professionals in the field.

Participant 5: Himani

Himani is a 32-year-old woman from a Punjabi, Indian background. She has been working in several counsellor roles in the mental health field (i.e., Canadian Certified Counsellor, community counsellor at non-profit agencies) for approximately 10 years, including around five years as a psychologist. Himani provides counselling services to older adolescents between ages 16-18 years, adult individuals, couples, and families from various ethnic backgrounds within a private practice setting. As a second-generation Canadian Indian, she offers services in English and Punjabi.

Through the theme, *Cultural Competence and Shared Understanding*, Himani indicated that her shared cultural knowledge and experiences with South Asian clients create a heightened sense of comfort: “People usually seek me out for that cultural competence and are looking to work with someone where they don’t have to explain a lot of context behind some of their family dynamics.” When discussing the differences between working with South Asian and non-South Asian clients, she shared that South Asian clients often seek fast, prescriptive results, viewing therapy as transactional, potentially due to cultural beliefs around mental health. This is demonstrated through the theme, *Navigating Client Perceptions and Expectations of Therapy*.

In terms of her therapeutic relationships with South Asian clients, through the theme, *Enhanced Trust and Cultural Familiarity*, Himani indicated that their cultural similarities help build initial trust, which fosters a faster working alliance. While this theme overlaps with

Cultural Competence and Shared Understanding, it specifically emphasizes trust-building, which Himani underscored as an important factor in her meaning-making. She explained that South Asian clients feel more at ease in therapy due to cultural familiarity, leading to a faster development of trust and working alliance. Thus, this theme is distinct because it focuses on Himani's understanding of client perceptions rather than her internal experiences.

In the theme, *Navigating Boundaries and Family Involvement*, Himani reflected on some challenges, including managing family and community expectations in addition to setting boundaries with highly involved family members to protect client confidentiality: "Sometimes it's difficult when parents or first-generation immigrant folks don't fully understand those boundaries." She highlighted the importance of maintaining her professional boundaries while respecting the cultural value of family and collectivism.

When discussing effective therapeutic approaches with South Asian clients, Himani mentioned incorporating specific tools and techniques that align with the client's cultural background, religious beliefs, and individual goals, presented through the theme, *Culturally Adapted Client-Centered Approaches*: "I might ask clients what about their faith gives them guidance or hope, and then we'll utilize their words and how they relate to their faith or spirituality." She mentioned frequently integrating faith-based practices into therapy (e.g., prayer, stories, and mindfulness exercises) to connect with clients on a spiritual level, reflecting the importance of faith in many South Asian communities. While this theme overlaps with the previous theme of *Navigating Boundaries and Family Involvement,* they were constructed as separate because they foreground different therapeutic tasks. The former centers on intervention choices and spiritual attunement, whereas the latter emphasizes systemic and relational dynamics (e.g., negotiating parental involvement). Retaining both themes following participant

confirmation through the member-checking process reflects Himani's own prioritization of these areas.

Himani also emphasized the varying levels of client readiness for deeper trauma work, boundary setting, and emotional expression:

> Trying to create boundaries within some of those spaces can be so challenging for clients, because it can feel like they're not allowed to do that or that's disrespectful [...] that's not something all of us are taught to do. Sometimes, I'm doing a lot of normalizing because there's so much shame and stigma. (Himani).

She noted that a gradual preparation is required to address the client's unfamiliarity with therapy and internalized stigma in South Asian communities.

Through the theme, *Therapist's Cultural Identity as an Asset and Challenge*, Himani indicated that, while South Asian clients frequently seek and value her lived and learned cultural competence, they often hold certain perceptions of her beliefs and values. She shared that her religious attire facilitates a sense of shared faith and immediate connection with clients, while also enabling them to make assumptions regarding her views. Further, in the theme, *Self-Awareness and Reflection*, Himani discussed the emotional challenge of working with clients whose experiences closely resemble her own:

> There's an element of, 'oh, this story sounds a lot like mine,' so I have to work through some of those feelings or I'll notice it just stays in my heart a little bit longer. So, I have to work on surrendering that afterwards and grounding myself. (Himani).

She acknowledged the risk of assuming that all South Asian clients share the same experiences or perspectives, emphasizing the importance of recognizing intersectionality (e.g., gender, immigration status) and the diversity among South Asians. This theme's emphasis on the benefits

and complications of Himani's own cultural identity as a South Asian therapist differs from the previous themes in which she highlights how shared cultural knowledge creates ease and validation in therapy between South Asian professionals and clients.

Through the theme, *Limited Cultural Competence in Training,* Himani mentioned that her formal education lacked a focus on intersectionality, family-centered frameworks, and traditional healing practices, which led to her reliance on personal experiences and reflection. She highlighted the value of experiential learning and immersive programs that allow trainees to engage with different cultures and religions in authentic ways beyond theoretical knowledge. In the theme, *Lack of Representation in Educational Settings,* she indicated feeling isolated:

> One thing I really wish I had worked a little harder for during my training is probably building a community of therapists around me [...] It helps being able to bounce back and forth with ideas and experiences and to have more shared experiences as a South Asian therapist. (Himani).

To address this, Himani called for including diverse voices in training materials and workshops, integrating culturally responsive supervision models, and establishing peer and professional support networks.

Participant 6: Shahid

Shahid is a 38-year-old Pakistani man who immigrated to Canada in his youth. He has been practicing as a licensed clinical social worker for over a year, after a recent career change. Following a variety of practicum placements in community settings, he currently works at a community clinic that offers faith-based counselling services. Shahid provides mental health services in English and Urdu to individual clients who identify as Muslim.

As demonstrated in the theme, *Connection Through Shared Identity*, Shahid explained that sharing a background with South Asian clients, whether cultural, religious, or both, allows them to feel more understood and validated, creating a sense of comfort and connection. When describing the nature of his therapeutic relationships with South Asian clients, Shahid suggested that sharing cultural commonalities, such as language, facilitates deeper conversation: "They get that they don't have to overexplain certain things, and that they don't have to bridge the gap between certain issues because I already have lived experience." Shahid explained that this enables clients to express themselves more openly and honestly, reducing the need for frequent explanations of cultural context, as highlighted by the theme, *Cultural Familiarity as a Bridge for Communication and Trust*. While both themes highlight the advantages of shared cultural understanding, their distinction lies in how that understanding manifests for Shahid. The former emphasizes emotional validation and connection, while the latter focuses more on how cultural familiarity reduces barriers to communication and enhances trust-building.

In the theme, *Overcoming Challenges with Cultural Sensitivity*, Shahid also described challenges arising from South Asian clients' differing beliefs about therapy, generational gaps, and cultural expectations related to mental health. He suggested various cultural modifications to Western therapeutic approaches to emphasize client empowerment and honour their cultural and religious values, through the theme, *Adapting Western Approaches to Cultural Needs*.

> Sometimes we'll ask if faith is important for them or if they want to bring in their religious beliefs as a part of finding their solution. Then we can try to use faith-based stories or examples to help them make some meaning out of their experience (Shahid).

He described the importance of flexibility when employing client-centered techniques as well as integrating faith-based practices to encourage client-directedness.

Through the theme, *Clarifying Client Expectations About Therapy*, Shahid explained that he establishes clear boundaries and discusses expectations around the purpose of therapy and confidentiality: “There’ll be clients that, even though they’re seeking out help, they might not necessarily believe in therapy. So, how do you bridge that gap?” He described that this emphasis on psychoeducation helps to minimize the impact of barriers related to cultural stigma.

When reflecting on his own South Asian identity, Shahid suggested that sharing a culture with clients enables him to gain a deeper understanding of their family dynamics, expectations, and challenges, allowing him to engage clients more effectively. This is demonstrated through the theme, *Therapist’s Cultural Identity as an Asset*. This theme addresses Shahid’s reflexive awareness of how his background informs his practice, not just in terms of connection, as indicated in the previous theme, *Connection Through Shared Identity,* but in how he views his role and responsibility as a South Asian therapist working with South Asian clients.

Shahid also highlighted a particular challenge of navigating shared cultural identities with South Asian clients, through the theme, *Balancing Cultural Empathy and Objectivity.*

> One way my cultural identity might hinder therapy is thinking that I know exactly what they’re experiencing [...] So, I definitely have to separate myself because of the advantage I might have, because it does give me some extra insight into a South Asian client, as opposed to someone whose cultural background I’m unfamiliar with. (Shahid).

He underlined the importance of ongoing self-reflection to navigate potential assumptions and empathy based on shared experiences with clients, while recognizing the uniqueness of each client’s experience.

Reflecting on his educational journey, Shahid addressed the limitations of his formal training, which he believes did not adequately address the intersectionalities or cultural nuances

specific to South Asian clients, as demonstrated by the theme, *Need for Cultural Training for South Asians*.

> If a student goes through a course or training, they might think that they understand cultural competence enough to apply to the South Asian population. But it's actually not so simple – there's a lot more context and intersectionality to everybody's individual life. (Shahid).

He explained that this gap in training led him to rely on personal experiences and self-directed learning in order to better serve South Asian communities. To address these limitations, Shahid highlighted key curriculum changes that emphasize community-based learning, experiential learning with cultural organizations, and increased education on culturally adapted interventions.

Participant 7: Alina

Alina is a 28-year-old woman from an Indian background and practicing as a registered social worker and psychotherapist. She has been working in the mental health field for over four years, primarily within a private practice setting serving younger women clients from diverse cultural backgrounds. As a second-generation Canadian Indian, she provides psychotherapy with a strong emphasis on cultural identity navigation and values-based work.

Alina highlighted her ability to connect with South Asian clients through shared cultural knowledge and awareness of common cultural issues, as outlined in the theme, *Enhanced Cultural Understanding and Relatability*.

> There might be a level of common ground and relatability, but at the same time, I'm also constantly learning about their specific dynamics and what they're coming in with, and the kind of implications that has on them because of their identities. So, the within-culture diversity does make a difference for sure. (Alina).

While acknowledging that her lived experiences fostered a more authentic and effective therapeutic connection, she emphasized the importance of recognizing the intracultural diversity among South Asians. Through the theme *Trust Building Through Shared Cultural Identity,* she explained that South Asian clients felt more understood and validated, which enabled stronger trust in the therapeutic relationship. Both of these themes highlight the impact of Alina's shared cultural background in forming connections with South Asian clients. However, the theme *Enhanced Cultural Understanding and Relatability* centers on how cultural knowledge and awareness create a foundation for relatability, acknowledging intracultural diversity among South Asian clients. On the other hand, in the theme *Trust Building Through Shared Cultural Identity,* Alina specifically examined the role of shared identity in fostering deeper trust, focusing on the emotional and relational security it brings to therapy.

Alina also shared some challenges, as demonstrated in the theme, *Challenges of Cultural Assumptions and Biases,* in working with culturally similar clients: "South Asian clients may be coming in with the belief that 'my therapist will agree with me' just because we have this common ground of shared cultural identities, which sometimes makes it more difficult to challenge their beliefs." She explained that clients may assume she will confirm their cultural biases or beliefs due to their shared backgrounds, which she noted made it difficult to challenge potentially unhealthy views.

When discussing the factors that guide her practice with South Asian clients, Alina indicated modifying interventions to emphasize cultural relevance, such as incorporating values-based work and bicultural identity negotiation, as reflected through the theme *Culturally Adaptive Therapeutic Approaches.* She mentioned utilizing trauma-informed approaches to

address South Asian cultural contexts, including recognizing the diverse ways that clients express and cope with trauma.

In the theme, *Cultural Identity as a Tool for Connection*, Alina explored how leveraging her shared languages with South Asian clients supported rapport-building, fostering openness and authenticity. Through this theme, Alina explored the role of her own cultural identity as a South Asian therapist, which she interpreted differently from her experiences of working with culturally similar clients. She indicated that her familiarity with South Asian cultural and religious beliefs allowed for meaningful engagement by validating clients. This theme is separated from the previously described overlapping themes to distinguish between Alina's intentional use of identity in practice and her broader capacity for resonance. The theme, *Cultural Identity as a Tool for Connection,* focuses on how she consciously draws upon her background to establish relational depth and cultural safety, which is a strategic, therapist-driven process. The theme, *Enhanced Cultural Understanding and Relatability,* by contrast, captures the inherent familiarity she brings to sessions due to lived experience, including how clients respond to her without her having to take explicit action. Though they overlap, maintaining both themes helps illustrate the difference Alina perceived between doing and being in her culturally responsive practice.

Alina also identified two key challenges of navigating her own cultural identity in therapy. First, through the theme, *Hyperawareness of Cultural Identity*, she expressed a heightened curiosity about how her own cultural identity is perceived by non-South Asian and non-racialized clients:

> Maybe it's just worrying about the kind of assumptions that they're making, especially if you're someone who visually looks like you have different beliefs [...] Sometimes I'm

> feeling concerned that white clients might think that I just wouldn't get their experiences. (Alina).

Second, as presented in the theme, *Maintaining Professional Boundaries and Navigating Relatability,* Alina described the importance of clarifying her therapeutic role, as South Asian clients may perceive their relatability as friendship.

Reflecting on her formal education as a psychotherapist, Alina mentioned being inadequately prepared to work effectively with South Asian clients, particularly due to the lack of cultural responsiveness, as demonstrated by the theme, *Insufficient Preparation in Training and Education*: "It was such an uncomfortable environment when the professors would just look around at the racialized students in class as if only they should be somehow equipped to answer these questions. And there would be awkward silences everywhere." She described relying on personal experiences and client interactions to address training gaps and navigate challenges as a South Asian mental health professional, due to the lack of support offered to racialized students in her training program. In the theme, *Call for Structural Changes in Training*, Alina shared her desire for curriculum reform, culturally adapted evidence-based approaches, and mentorship support networks.

Participant 8: Rubina

Rubina is a 37-year-old woman from Pakistan who immigrated to Canada after living in Saudi Arabia for 10 years. After gaining work experience in social work and non-profit organizations, she has been registered as a psychotherapist for one year and currently works in a community clinic setting with a diverse range of individuals. She provides counselling services in both English and Urdu.

Rubina shared that her inherent familiarity with navigating complex family structures and relational dynamics, mental health perceptions, and generational differences facilitates her work with South Asian clients: “When I meet clients with relationship difficulties, I already know the uniqueness of their context and the many people who influence their life and their worldview or how they might view themselves in relation to their family.” As demonstrated through the theme, *Cultural Understanding and Sensitivity,* she emphasized her awareness of cultural stigma, which often makes it difficult for South Asian clients to seek therapy or openly discuss emotional distress. She observed differences in perceptions of therapy among South Asians, with younger generations more open to seeking support, while older generations view therapy as necessary only for major mental health concerns due to stigma.

When discussing the nature of her therapeutic relationship with South Asian clients, Rubina shared that *Cultural Familiarity Eases Initial Connection*: “There’s just so many things that they feel you understand as their therapist, and they don't need to explain everything from the beginning and justify themselves.” She observed that her clients feel more comfortable and understood with a therapist who shares similar cultural experiences, particularly when navigating family dynamics and societal pressures. However, despite the shared cultural background potentially facilitating rapport, Rubina acknowledged other critical factors contributing to a strong working alliance: “The similar culture helps in some way to understand their context and presenting concerns more, but maybe it doesn’t entirely predict the relationship you can build with a client, regardless of their cultural background.” Through the theme, *Empathy and Presence Over Cultural Familiarity,* she emphasized that despite the advantages of cultural similarities, the therapeutic alliance is primarily built on her ability to be present and empathetic, regardless of the client’s cultural background.

Rubina highlighted the importance of maintaining cultural sensitivity while adapting interventions to work with South Asian clients, as noted in the theme, *Tailored Interventions Based on Cultural Sensitivity*. Given the strong stigma attached to mental health diagnoses, she suggested adopting a cautious approach when discussing potential diagnostic labels with South Asian clients. Additionally, Rubina mentioned remaining open to integrating faith-based intervention approaches or coping mechanisms due to their importance for many South Asian clients.

In the theme, *Therapist's Cultural Identity and Empathy,* when exploring the role of her own cultural identity, Rubina indicated that her shared cultural experiences allow for deeper empathy with South Asian clients, which enhances their therapeutic relationship. She maintained that her ability to provide counselling in a South Asian language and understand the social context helps clients feel more understood and express their emotions more openly.

> Understanding our social roles and dynamics are important, because if a woman comes in telling me that her mother-in-law said or did something she's frustrated with, I would validate her emotions but I wouldn't say, 'well, tell her to stay out of your business.' (Rubina).

Rubina further posited that her understanding of gendered cultural expectations, particularly for South Asian women, enables her to sensitively approach issues such as marriage, family roles, and societal pressures.

When reflecting on her training in psychotherapy, Rubina highlighted inadequate cultural responsiveness education, through the theme, *Training Gaps in Cultural Awareness*. She mentioned that her training provided a strong foundation in relational therapy but lacked cultural context, particularly in understanding South Asian collectivist family structures.

> You can't learn a whole culture just by reading about it. [...] The theory helps for an overview but lived experience teaches you so much more. Something experiential like learning directly from a South Asian psychotherapist or training right inside the community is so much stronger. (Rubina).

Rubina further emphasized the value of having lived experience in the South Asian community compared to relying primarily on theoretical knowledge when it comes to cultural competence. She suggested that more culturally tailored supervision, such as shadowing South Asian therapists, would significantly enhance cultural awareness.

Cross-Case Findings

In this section, I outline the findings from cross-case analyses based on all participants' responses to each sub-question. Table 2 presents an overview of all the themes and subthemes that were constructed in this analysis process. The following sections provide a detailed description of each finding generated.

Table 2

Overview of Themes and Subthemes Based on Sub-Questions

Sub-Question	Themes	Subthemes
In what ways do South Asian mental health professionals' experiences of working with South Asian clients differ from their experiences with clients from other cultural backgrounds?	1. Diverse client demographics and needs within South Asian communities	a. Varying migration histories b. Generational differences c. Within-culture diversity
	2. Cultural influences on perceptions of mental health and therapy	a. Stigma toward mental health and therapy b. The role of family and collectivism
	3. Cultural familiarity as a therapeutic advantage	

What have South Asian Canadian mental health professionals observed about the nature of their therapeutic relationship with South Asian clients compared to other clients?	1. Strengthened trust and rapport-building through shared culture	a. Shared lived experiences b. Shared language as facilitator
	2. Navigating the intersection of culture and therapy	a. Family dynamics and boundary management b. Gender and power influences on therapy dynamics c. Balancing cultural expectations with therapy norms
What are the interventions or theories that guide South Asian Canadian mental health professionals' practice with South Asian clients?	1. Acknowledging the limitations of Western therapeutic models	
	2. Adapting therapy to fit cultural context	a. Incorporating family-centered approaches b. Cultural practices as therapeutic tools c. Balancing collectivist and individualist values d. Bridging cultural gaps through psychoeducation
	3. Integrating faith and spirituality into therapy	
How does South Asian mental health professionals' own cultural identity show up in their work with South Asian clients compared to other clients?	1. Therapist cultural identity as an asset for connection	
	2. Challenges of the therapist's cultural identity in the therapeutic process	a. Impact of visible cultural markers on client perception b. Managing client expectations of cultural alignment
	3. Self-reflection and emotional awareness in practice	a. Navigating personal assumptions and biases b. Balancing empathy with professional objectivity
What are South Asian Canadian mental health professionals' experiences	1. Gaps in cultural competence training	

with education and training in the field?	2. Advocacy for institutional reform and increased representation 3. The need for culturally responsive supervision and support networks

Sub-Question 1: Working with South Asian Clients

I identified three main themes across multiple participants' data in response to the first sub-question, *In what ways do South Asian mental health professionals' experiences of working with South Asian clients differ from their experiences with clients from other cultural backgrounds?* These themes include: (1) diverse client demographics and needs within South Asian communities (subthemes: varying migration histories, generational differences, within-culture diversity), (2) cultural influences on perceptions of mental health and therapy (subthemes: stigma toward mental health and therapy, the role of family and collectivism), and (3) cultural familiarity as a therapeutic advantage.

Diverse Client Demographics and Needs Within South Asian Communities. Through this theme, participants consistently explored the variety of migration-related, generational, and cultural factors that shape the therapeutic experiences of South Asian clients compared to clients from other backgrounds. They indicated that the South Asian population in Canada is diverse, including both locally born or raised South Asians and newcomers who have immigrated more recently, which results in substantial variability in their views on therapy and mental health. Some participants also emphasized that South Asian clients' needs vary across generations, noting that younger South Asian clients generally tend to be more familiar to Western therapeutic practices and may approach therapy with less hesitation. In contrast, the participants noted that older generations may experience greater reluctance, perhaps due to a higher level of stigma

associated with mental health. Additionally, participants emphasized the wide range of different cultural backgrounds that exist within the South Asian community, including regional and religious differences, which they indicated creates unique therapeutic challenges to consider. Under this larger theme, I generated three subthemes through the analysis process: (a) varying migration histories, (b) generational differences, and (c) within-culture diversity.

Varying Migration Histories. Through this subtheme, participants explored the differences in South Asian clients' approaches to mental health based on their immigration backgrounds. Participants indicated that South Asian clients who have lived in Canada for most of their lives, often second-generation immigrants, may have more exposure to Canadian culture and thus present different needs, such as navigating bicultural identity and developing a sense of belonging across two cultures: "For second generation South Asians in Canada, I think there's a bit of an identity crisis because [...] they're navigating wanting to be progressive but also having traditional norms" (Chandni). Some participants suggested that local clients may possess a greater willingness to engage in therapy but may still encounter a cultural barrier when reconciling Western therapeutic practices with traditional family values. Participants discussed that, in contrast, newcomers may present needs related to acculturation and adaptation while hesitating to approach therapy due to more traditional views from their countries of origin. Newcomer clients may have a more complex relationship with mental health due to the intersection of immigration stress and cultural differences, while local South Asian clients might approach therapy with a sense of familiarity and normalization, which can potentially influence therapeutic interventions and the speed of rapport-building.

Generational Differences. This subtheme explored how different generations of South Asian in Canada clients perceive and engage with therapy, reflecting participants' observation of

a shift in attitudes across time. Participants indicated that older generations may view help-seeking outside the family as a sign of personal weakness or failure, and there may be ingrained reluctance to share personal struggles in a culturally unfamiliar setting. Additionally, as this generation often prioritizes community reputation, older South Asian clients may fear judgment from their extended family or broader social circles. Participants explained that younger generations, who are often born or raised in Canada, tend to be more open to mental health discussions due to being influenced by Western cultural norms of individualism: “Some of the younger generations of South Asians who were born here or raised here are seeking therapy for things that I think the older generation wouldn't even consider going to therapy for” (Rubina). Participants noted that, as a result, some younger South Asian clients may be more proactive in seeking therapy and more comfortable engaging in the therapeutic process without the same fear of social stigma.

Within-Culture Diversity. In this subtheme, participants highlighted the fallacy of categorizing all South Asian clients under a monolithic cultural group. Participants described that South Asian populations consist of diverse linguistic, cultural, religious, and socio-economic backgrounds, which significantly affects therapeutic experiences. They indicated that different clients from the same South Asian country may have vastly different cultural practices, religious beliefs, languages, and traditions, which may sometimes be unfamiliar even for a South Asian therapist. However, one participant highlighted the sense of relatability despite this: “When I'm working with folks who are not Punjabi, and for example they’re Pakistani, there is still a sense of solidarity and [...] shared kind of commonality there or shared understanding of our connectedness” (Ravneet). Participants noted that the diversity within the South Asian population

requires professionals to be adaptive and flexible in their approach to provide effective interventions.

Cultural Influences on Perceptions of Mental Health and Therapy. A recurring theme across most participants was how cultural beliefs, including stigma and traditional beliefs about healing, shape South Asian clients' perceptions of therapy and their willingness to seek professional support. Participants indicated that mental health stigma is deeply rooted in South Asian communities, often due to the importance placed on family reputation and the fear of social ostracism. Through this theme, participants also discussed the role of familial and collectivist dynamics, expectations, and values in shaping clients' experiences of therapy, from seeking help to engaging in treatment. They mentioned that mental health professionals must understand and work within these collectivist frameworks to effectively support South Asian clients.

The concepts explored in this theme are further categorized into two subthemes: (a) stigma toward mental health and therapy, and (b) the role of family and collectivism.

Stigma Toward Mental Health and Therapy. Through this theme, participants suggested that many South Asian clients approach therapy with a sense of hesitation, shame, or reluctance, influenced by societal and familial expectations to maintain privacy. "Within our culture, it can sometimes be difficult to open up. There's stigma and there's shame and there's the idea of "what will people think", and so there's the importance of safety" (Rita). Some participants reported that this often inhibits clients' willingness to seek help and suggested that professionals working with South Asian clients must navigate these cultural perceptions with sensitivity and acknowledge the stigma:

> I'm doing a lot of normalizing because there's so much shame and stigma within some South Asian clients. There's the idea that it's not OK to go to therapy or there's something wrong with me or I'm crazy if I need therapy. (Himani).

Participants highlighted the importance of creating a safe, non-judgmental space where clients can express themselves without fear of social repercussions. They noted that this experience differs from working with clients from other backgrounds in which mental health may be less stigmatized or more openly discussed.

The Role of Family and Collectivism. This subtheme explored the central role of family and community values in South Asian clients' lives and mental health decisions. Participants indicated that some family members may be actively involved in the client's decision-making process or may hold different views on the treatment process, which may create challenges in the therapeutic dynamics. Participants emphasized that, while it may provide opportunities for therapists to work with family members through a more holistic approach, it may also require careful negotiation between the client's individualistic needs and the relational structures that are central to the client's identity: "It's a lot of collectivistic work no matter how Canadian identifying the client might be, because we exist in systems and within our communities [...] a lot of the work is still situated within family contexts" (Chandni). Participants underscored the importance of understanding and working within these collectivist frameworks to effectively support South Asian clients.

Cultural Familiarity as a Therapeutic Advantage. All eight participants emphasized the therapeutic advantage that comes with shared cultural understanding between therapists and clients. They consistently highlighted how their familiarity with the South Asian context,

including cultural values, complex family dynamics, religious practices, and social norms, helps create a more comfortable, trusting, and authentic therapeutic relationship with their clients.

> I have had clients say that they had some kind of trouble in connecting with a therapist from a different ethnicity. They say that they are now more comfortable with me because they don't have to explain so many of the little things because I already have so much of that lived experience. (Alina).

Participants indicated that sharing the same cultural background as their clients often offers professionals a deeper insight into family structures, relational dynamics, and community pressures. They explained that South Asian clients indicated feeling more understood, validated, and seen in therapy due to the therapist's familiarity with their culture:

> When I mention that I am South Asian too, there's this immediate comfort [...] They get that they don't have to overexplain certain things, and that they don't have to bridge the gap between certain issues because I already have lived experience. (Shahid).

Participants indicated that this played a significant role in minimizing some South Asian clients' hesitation around the therapeutic process.

While discussing the advantages of cultural familiarity when working with South Asian clients, most participants also addressed the nature of their therapeutic relationship, which is the focus of the second sub-question. As such, further reporting of the findings related to participants' therapeutic relationships with South Asian clients will be presented in the following section, addressing sub-question 2.

Sub-Question 2: Therapeutic Relationships

Through a cross-case analysis of the second sub-question, *What have South Asian Canadian mental health professionals observed about the nature of their therapeutic relationship*

with South Asian clients compared to other clients? I generated two themes. The first theme was strengthened trust and rapport-building through shared culture (subthemes: shared lived experiences, shared language as facilitator). The second was navigating the intersection of culture and therapy (subthemes: family dynamics and boundary management, gender and power influences on therapy dynamics, balancing cultural expectations with therapy norms).

Strengthened Trust and Rapport-Building Through Shared Culture. Through this theme, participants explained that their therapeutic relationship with South Asian clients is often strengthened by shared experiences such as mutual cultural understanding and language. They discussed how shared cultural and linguistic elements facilitate communication, which helps to reduce cultural barriers or misunderstandings that might exist between the client and the professional. Additionally, participants indicated that therapists are able to create an environment of trust and safety more quickly, as clients often feel more understood and comfortable in expressing their thoughts and feelings, leading to more open dialogue in therapy.

Within this overarching theme, there were two subthemes recurrent across most participants' interviews: (a) shared lived experiences, and (b) shared language as facilitator.

Shared Lived Experiences. In this subtheme, participants explained that South Asian clients feel more comfortable working with a therapist who has a personal understanding of their distinct challenges. Participants mentioned that clients feel more validated and less compelled to explain their socio-cultural contexts due to the professional's pre-existing familiarity with their cultural context, including family dynamics and community pressures, immigration and acculturation, cultural stigma toward mental health, and navigating bicultural identities. Some participants emphasized that this increased comfort plays a significant role in reducing clients' hesitation about the therapy process:

> It just becomes so much easier for clients to feel comfortable answering my questions and allowing themselves to dig deeper because they feel more comfortable being vulnerable around someone familiar who just might be able to understand them rather than always asking them to explain. (Alina).

Participants indicated that South Asian clients are generally forthcoming due to their perceived relatability with the professional's cultural background. They explained that, as a result, the professional's cultural insight helps bridge potential gaps in communication, providing a stronger foundation for rapport-building.

However, two participants also implied that, although rapport is built faster with South Asian clients compared to clients from other cultural backgrounds, it may not necessarily be stronger:

> Maybe the similar culture helps in some way to understand their context and presenting concerns more, but maybe it doesn't predict the relationship you can build with a client, regardless of their cultural background. It seems that as long as you're there for them and present with them, it seems to work with everyone. (Rubina).

These two participants indicated that certain elements of a therapeutic relationship, including warmth, empathy, and compassion, are consistent across all clients regardless of their cultural backgrounds. They further noted that the connection between therapists and clients develops gradually over the duration of therapy through consistency and presence.

Shared Language as Facilitator. This second subtheme reflected several participants' belief that using the same native language enables clients to express themselves more freely and deeply, creating a sense of comfort and security. According to participants, this makes the therapeutic process feel more familiar and secure for the client, leading to more authentic and

open dialogue. Several responses highlighted an additional advantage of conducting therapy in a South Asian language, noting the influence of colonialism on newcomer clients' perception of English as a privileged language:

> I'm inviting clients to speak in Punjabi and yet there is real hesitation to do that, because they really want to show that, 'I'm just as good as you are. I'm no different from you.' And yet, for me, I think in English and speak in English, but I certainly feel in Punjabi, and so, if I could just hear you in Punjabi, I would be able to feel you better. (Ravneet).

Participants addressed the subtle ways that internalized beliefs about using certain first languages may hinder clients' progress, reflecting the importance of adopting a decolonializing lens to facilitate effective therapy.

One participant mentioned that certain concepts or terms related to mental health may not have direct translations in many South Asian languages due to the differing historical and cultural understanding of mental health between Western and South Asian contexts: "There are certain words that just aren't as translatable ... because certain words we use to describe mental health don't even exist in some of these languages" (Rita). Rita explained that, while Western cultures utilize distinct vocabulary to address specific psychological experiences, these terms may not exist in the same form in many South Asian languages. She further indicated that even if they do, they may carry different connotations or not fully capture the nuanced meanings inherent in the Western understanding of mental health.

Navigating the Intersection of Culture and Therapy. This theme addressed a recurrent pattern among participants' responses related to the challenges that arise when cultural values intersect with therapeutic norms. Participants reported that South Asian clients may have specific expectations about how therapy should unfold, particularly around the involvement of family and

the role of the therapist. Participants noted that clients may expect their therapist to be directive in a way that reflects the authority structures within their families, which may contrast with the more collaborative, client-centered approach generally employed in therapy. Additionally, participants mentioned that traditional views on gender and power influence the therapeutic relationship between professionals and South Asian clients. They emphasized that these cultural and gendered expectations are crucial for professionals to acknowledge in order to maintain a safe and effective therapeutic environment.

Within this larger theme, three subthemes were identified: (a) family dynamics and boundary management, (b) gender and power influences on therapy dynamics, and (c) balancing cultural expectations with therapy norms.

Family Dynamics and Boundary Management. Through this subtheme, participants discussed how family plays a central role in South Asian clients' lives, which can create both challenges and opportunities for professionals. They explained that, due to the collectivist nature of South Asian cultures, family members often play a significant role in younger clients' decisions, including whether to seek therapy and how to approach it: "They can go back to their parents and say, 'I'm going to therapy,' but their parents might not understand what exactly therapy is" (Shiv). Participants suggested that professionals must cautiously navigate these familial dynamics, setting clear boundaries to promote autonomy and individual healing while still respecting the cultural importance of family in South Asian communities. Some participants highlighted that this can be particularly challenging when clients feel pressured by family members to conform to cultural norms that may not align with the clients' own view of the therapeutic process:

> You have to cater to the ideals of the whole family unit and the focus is on the family rather than the individual, which brings a lot more tension between parents and children and often that leads to coming to therapy where they have a different understanding of how the systems play together. (Shiv).

Further, participants mentioned that some South Asian clients might wish to involve their family members in therapy, a nuance that some Western-trained mental health professionals may not immediately recognize. They suggested that, in addition to clients themselves, South Asian professionals may feel more at ease when addressing such cultural nuances due to their familiarity with social and familial expectations within this demographic: “People usually seek me out for that cultural competence and are looking to work with someone where they don’t have to explain a lot of context behind some of their family dynamics and certain issues” (Himani). Participants indicated that their ability to understand these relational dynamics contributes to better engagement and culturally responsive interventions, which leads to a smoother overall therapeutic process.

Gender and Power Influences on Therapy Dynamics. Through this subtheme, multiple participants’ responses explored how the distinct gender roles within South Asian cultures can affect the therapeutic process. Some shared that traditional views of masculinity may make it difficult for South Asian men to be vulnerable when seeking therapy from women: “Because of the patriarchy and the fact that I’m a woman who is trying to give advice on their relationship, there might be more resistance” (Rita). Participants indicated that South Asian men may feel societal pressure to maintain strong, stoic personas, which can inhibit their openness in therapy, particularly with women professionals.

Similarly, many participants discussed how power dynamics within South Asian families and other social relationships may influence the way clients engage with professionals. They highlighted the challenge of managing client expectations due to cultural norms around respect for authority figures:

> Somebody might call me ‘ma’am,’ and in Punjab, that's quite normal to do for people in positions of power. But it can feel a little different when you're a therapist who’s trying to implement anti-oppressive practices...that power difference in that moment feels a little jarring. (Ravneet).

Participants emphasized that professionals must navigate these expectations carefully, finding ways to honour the client’s cultural context while minimizing power imbalances and promoting client empowerment.

Balancing Cultural Expectations with Therapy Norms. Through this subtheme, participants discussed how clients may expect their therapist to adhere strictly to South Asian cultural norms and practices and may assume that a shared ethnic background guarantees a deep, personal understanding of their experiences. Acknowledging that cultural identity is multifaceted, participants highlighted the importance of clarifying the limits of their own cultural familiarity and expertise. Additionally, some participants explained that South Asian clients may expect a directive interaction due to their perception of the therapist’s prescriptive role and their medicalized view of therapy:

> At the first meeting they come and say, ‘hey, I’m here, fix me. Tell me what I have to do.’ And the thinking is very much coming from a medical model, like, ‘I’ll give you the problem, you’ll give me the medicine, I’ll take it and then I’ll be fine.’ (Rubina).

Participants discussed how this expectation, which they observed as more prevalent among older generation South Asian clients, may not align with conventional Western therapeutic approaches that emphasize self-exploration and client autonomy. Several participants also indicated that this perception could challenge the therapeutic process if professionals try to use techniques that are perceived as culturally foreign or "too Western."

Collectively, participants noted that while their shared backgrounds foster trust and comfort, there are also notable complexities that arise from cultural expectations. They suggested that mental health professionals need to set boundaries to manage the client's expectations, while also transparently communicating their cultural competence and willingness to learn from the client.

Sub-Question 3: Guiding Theories and Interventions

Three themes were recurrent across multiple participants' data in the cross-case analysis of the third sub-question, *What are the interventions or theories that guide South Asian Canadian mental health professionals' practice with South Asian clients?* These themes include: (1) acknowledging the limitations of Western therapeutic models, (2) adapting therapy to fit cultural context (subthemes: incorporating family-centered approaches, cultural practices as therapeutic tools, balancing collectivist and individualist values, bridging cultural gaps through psychoeducation), and (3) integrating faith and spirituality into therapy.

Acknowledging the Limitations of Western Therapeutic Models. Several participants observed that standard Western therapeutic models often fail to resonate with South Asian clients. They mentioned that these frameworks, which focus on personal autonomy, individual rights, and self-expression, can feel foreign or misaligned with South Asian values that prioritize interdependence. Participants also shared that while some Western models, such as Cognitive-

Behavioural Therapy, Narrative Therapy, and Acceptance and Commitment Therapy, are effective in many contexts, these approaches do not fully account for the cultural nuances that are central to South Asian identities.

> It's more so switching my focus to the things that might be more relevant for South Asians. So, with narrative therapy, I would be focusing on the identity piece and then their relationship with these different identities... And with acceptance and commitment therapy, with values-based work, I'm really focusing on collectivist values that are just more specific to the South Asian population. (Alina).

Another recurring observation among participants was that South Asian clients were sometimes reluctant to engage in therapy when the framework emphasized personal responsibility or individual goals over family involvement and collective healing. Participants reported that this was particularly evident in cases where clients struggled to relate to the professional's emphasis on individual autonomy.

> I can't just guide someone in thinking from a Western standpoint or from an individualistic standpoint, like 'hey, you've got to do what's best for you'... We have to balance that in, but consideration of the family and community is important and if I don't take in those factors, that can hinder therapy. (Rita).

They discussed how this dissonance may lead to clients feeling a disconnection from their cultural reality or a lack of resonance with Western therapeutic goals, which would hinder therapeutic progress. Participants suggested that combining Western theories with culturally responsive approaches that integrate South Asian values, spiritual healing practices, and community-oriented frameworks, can provide a more holistic and effective treatment for South Asian clients.

Three participants also critiqued the overreliance on clinical terminology, noting that some conventional Western practices do not sufficiently account for cultural differences in the communication and conceptualization of mental health. Participants noted that when professionals rely too heavily on clinical terminology, it can further alienate or overwhelm clients who are already feeling uncertain about therapy. As one participant mentioned, the initial process of explaining the process and purpose of therapy is essential:

> There's an initial aspect of explaining what exactly therapy is, because a lot of clients don't necessarily come in with an understanding of therapy. You have to give them an idea of what we are going to do here, what the purpose of this is, and how it's going to be beneficial to them. (Shiv).

These participants underscored the importance of employing flexibility, adapting to diverse cultural worldviews by offering language that is both clear and culturally relevant, thereby fostering a more accessible and welcoming therapeutic environment.

Adapting Therapy to Fit Cultural Context. Participants consistently discussed how they modify their therapeutic practices to better align with the cultural needs and values of their South Asian clients. They noted that adapting therapeutic approaches to the cultural context of South Asian clients involves shifting away from structured universal frameworks, and understanding cultural values, such as respect for hierarchy, the role of extended family, and the interconnectedness of individual and collective well-being. Recognizing that family is a fundamental unit of support and influence in South Asian communities, participants highlighted the importance of integrating family-centered approaches to acknowledge the interconnectedness, rather than focusing solely on individuals. Additionally, some participants

mentioned integrating cultural practices into individualistic intervention models to enhance the effectiveness of therapy for South Asian clients.

Under this overarching theme, three subthemes were developed: (a) incorporating family-centered approaches, (b) cultural practices as therapeutic tools, (c) balancing collectivist and individualist values, and (d) bridging cultural gaps through psychoeducation.

Incorporating Family-Centered Approaches. Through this subtheme, a consistent observation from participants was the centrality of family, which influences how therapists should design interventions with South Asian clients.

> Trying to create boundaries within some of those spaces can be so challenging for clients, because it can feel like they're not allowed to do that or that's disrespectful. So, I find a lot of conversations with South Asian clients will be around indirect boundaries instead. (Himani).

Participants highlighted that decisions are often made collectively within the tight-knit family systems among South Asian communities, with family playing a critical role in clients' sense of identity and well-being. Participants indicated that, since clients perceive mental health as closely connected to the well-being of their family unit, adopting family-centered approaches is essential. Some participants highlighted the importance of acknowledging the multigenerational setup of South Asian households:

> With all my clients, I always make sure to ask who's in your household, not who's in your family, because a lot of my clients live in multifamily homes. So, sometimes that genogram will be huge, because we have multiple generations in one house, but they are all considered family. (Chandni).

Participants noted that treatment was most effective when professionals recognized and integrated family dynamics into the therapeutic process, ensuring that interventions resonated with clients' lived realities.

Cultural Practices as Therapeutic Tools. This second subtheme addresses a frequently discussed concept by most participants regarding incorporating traditional South Asian healing methods. Participants shared that incorporating such healing methods into therapy involves not only modifying interventions to fit cultural values but also considering how mental health challenges are perceived within this context. They suggested that integrating storytelling, rituals, songs, and other cultural practices that are meaningful to clients is an essential component of adapting interventions to fit their cultural context. In addition to traditional practices, they highlighted community-based coping mechanisms, such as drawing on support networks that promote well-being. Some participants reported inviting clients to share cultural stories or metaphors that hold significance for them, using these as tools to promote holistic healing.

> Consider someone who identifies as a woman and has gone through domestic violence, feeling like it's all her fault and like she has no power. Then you start talking about women in Sikh history who were generals, bodyguards and warriors in the political realm, and you say, 'well, those are the women that you come from, and those are the folks that you can seek inspiration from.' (Ravneet).

Participants indicated that this practice not only makes therapy more relatable but also validates the client's identity and acknowledges the importance of their heritage in the healing process.

Balancing Collectivist and Individualist Values. Through this subtheme, participants emphasized the importance of aligning interventions with values that resonate deeply with South Asian cultures, such as respect for elders, collectivism, and the importance of honour and duty.

Participants reported that, in South Asian communities, therapy often intersects with values related to family, social harmony, and communal identity, thereby highlighting the importance of interventions that reflect these values. One participant suggested supporting clients in navigating a personalized balance between their Canadian individualism and South Asian collectivism:

> It's that meaning-making and identity-seeking that a lot of the clients are looking for, so I ask them about their past and current relationship with the collectivist culture and what it means to them, and then do the same with the Western culture in terms of how that's added to their lives or how that's brought struggle. (Alina).

Some participants indicated that effective adaptation of interventions used with South Asian clients might involve guiding clients in resolving conflicts in ways that uphold these values or helping them navigate their struggles within the framework of their cultural norms.

Bridging Cultural Gaps Through Psychoeducation. In the final subtheme, participants explored the importance of psychoeducation as a key intervention for addressing the cultural gaps in South Asian clients' understanding mental health and therapy. Participants highlighted the critical role that psychoeducation plays in helping clients understand and relate to therapy by providing culturally sensitive explanations of mental health concepts, therapeutic processes, and the potential benefits of therapy. One example they frequently highlighted was the limited experience with expressing or labelling emotions among some South Asian clients, as it may not be culturally acceptable outside of close family circles. As one participant explained, this requires approaching emotional awareness in a sensitive, non-judgmental way, to allow clients time and space to feel comfortable with the process:

> It's not that I wouldn't bring in emotions when I'm working with people that I offer psychoeducation to, it's just that I might delay it and be more conscious of my timing [...]

> I'd probably offer them more explanation and I might not be too quick to jump into the whole 'let's feel your feelings,' because that might be really unfamiliar. (Rita).

Participants suggested integrating psychoeducation about mental health theories and concepts by providing clients with culturally relevant resources and using analogies or metaphors that resonate with their experiences, in order to empower them to engage with therapy more confidently and meaningfully. Participants indicated that this is essential not only for bridging the gap between unfamiliarity and therapeutic expectations, but also for motivating clients toward new ways of understanding their experiences.

Integrating Faith and Spirituality in Healing. Through this theme, most participants discussed the significance of integrating spirituality and faith into therapy when working with South Asian clients. They indicated that incorporating spiritual practices and traditions into the therapeutic process can help bridge the gap between the therapeutic environment and the client's worldview. Whether through religious rituals, songs, prayers, or incorporating concepts from religious texts, participants reported a profound impact when faith-based practices were woven into the healing process.

> Religion is so big with all Muslims and it's really helpful in many cases too, because if you're feeling down and if you're feeling like you have nobody in your life, you can say, 'you know, you have God with you and he's there,' and you can quote something from the texts.' (Rubina).

Some participants indicated that many clients view spirituality as a coping mechanism to understand life's challenges and as a resource from which they can draw strength and resilience. Participants suggested encouraging clients to engage in faith-based practices or exploring the spiritual dimensions of their challenges:

> Often times I'll just invite them to surrender to their higher power, whatever that might be for them. Or, if it's someone of my own faith, I'll bring specific prayers into it. Or if not, I might ask clients what about their faith gives them guidance or hope, and then we'll utilize their words and how they relate to their faith or spirituality. (Himani).

Participants noted that acknowledging spirituality in therapy can enhance healing by providing clients with a sense of comfort, purpose, and direction. Instead of trying to remove religious beliefs from the therapy space, participants suggested utilizing it to reinforce a holistic view of mental health. They highlighted that professionals who consider the spiritual context of the client's experience can create a sense of validation and safety, enabling clients to approach therapy with more openness.

Overall, to address the limitations of Western models, participants highlighted the importance of modifying therapeutic approaches to align with cultural values. They discussed the significance of incorporating family, community, and spirituality into therapy to enhance healing through a culturally responsive framework. Participants suggested that this combination of cultural sensitivity and flexibility allows for more effective and holistic intervention.

Sub-Question 4: Mental Health Professionals' Cultural Identity

In relation to the fourth sub-question, *How does the professional's own cultural identity show up in their work with South Asian clients compared to other clients?* a cross-case analysis of the participants' data yielded three overall themes: (1) therapist cultural identity as an asset for connection, (2) challenges of the therapist's cultural identity in the therapeutic process (subthemes: impact of visible cultural markers on client perception, managing client expectations of cultural alignment), and (3) self-reflection and emotional awareness in practice (subthemes: navigating personal assumptions and biases, balancing empathy with professional objectivity).

Therapist Cultural Identity as an Asset for Connection. A recurring pattern among most participants' responses was that the professional's cultural identity serves as a powerful tool for building a deeper connection with clients, especially when their cultural background aligns with that of their South Asian clients. Many participants reported that their personal experiences as South Asians enables them to more authentically validate and address cultural stressors that South Asian clients may experience:

> It kind of enhances the work at a deeper level of connection, because not only can you understand what someone's going through, you might have been through a version of that that you can relate to [...] It's just tapping into my own experience and then also pairing it with theirs and empathizing with them from that place. (Rita).

Participants indicated that this shared cultural framework helps professionals avoid the kinds of misunderstandings that can occur with therapists from different backgrounds, who might unintentionally overlook culturally significant issues. In addition to fostering a sense of solidarity and reassurance, participants mentioned that clients frequently reported feeling more understood and less judged, as their South Asian therapists could relate to their experiences in a meaningful way.

Additionally, some participants noted that their cultural identity enabled them to bypass certain barriers, such as reluctance or hesitation to seek therapy, as the shared background would normalize and legitimize the therapeutic process.

> My cultural identity is the biggest asset for me, firstly, because there's a general lack of mental health resources within my community, so it's an opportunity for me to put myself out there, and then, second, it's very useful to teach people from my culture about mental health and some of the ideas pertaining to mental health. (Shiv).

Participants expressed that the enhanced sense of relatability supports clients to feel more comfortable discussing sensitive issues, such as intergenerational conflict, immigration stress, or cultural guilt, with professionals who have similar backgrounds. They also indicated that this mutual validation could help combat the stigma around mental health and therapy that often exists within South Asian communities.

Challenges Related to the Therapist's Cultural Identity in Therapeutic Dynamics. Through this theme, some participants also highlighted the unique challenges of practicing with clients who share a similar cultural identity with therapists. Participants discussed challenges related to the professional's visible markers of cultural identity, such as religious attire, which could impact how clients perceived them. They suggested that this could either foster a stronger connection or cause discomfort, as some clients may feel the therapist is too different from them, leading to a disconnection. Additionally, several participants mentioned the potential conflict that arises when clients expect professionals to understand their experiences on a personal level due to their similar backgrounds and thus provide limited explanations of their contexts, which may potentially lead to misunderstandings.

Within this theme, two subthemes were identified: (a) impact of visible cultural markers on client perception, and (b) managing client expectations of cultural alignment.

Impact of Visible Cultural Markers on Client Perception. Three participants described the double-edged impact of wearing a headscarf on client perceptions. On one hand, participants indicated that clients may feel a sense of connection or trust due to the shared religious or cultural identity, reinforcing the idea of cultural alignment: "Sometimes I wonder if there's a sense of comfort that they get from that, because people do tell me that, 'I came to you because you also seem religious and that's something that's important to me" (Himani). Contrarily, these

two participants also cautioned that clients may view the professional as either “too traditional” or “too Westernized” compared to themselves, and project their own biases or assumptions onto the therapist, which could potentially lead to dissonance in the therapeutic relationship.

One participant also shared that non-South Asian clients may be particularly hesitant to discuss spirituality due to their assumption about the professional’s unfamiliarity:

> Because I'm wearing religious attire, they often might be wary about talking about religion [...] it sometimes takes them a couple sessions to share their belief systems and the role that's played in their life. They might believe in God or not but then because I look religious, they might assume I wouldn’t understand them. (Himani).

Participants further noted that clients may feel unsure about the professional’s ability to remain neutral or non-judgmental:

> I've had some clients come in and say, ‘Hey, I prayed too.’ I was like, ‘OK, that’s great,’ and little did they know that I'm probably not as religious as they think I am. So, really being aware of those pieces and being able clarify to the client that this space is about you and I'm not judging you for how you practice your faith. (Ravneet).

In these instances, participants underscored the importance of actively engaging in building trust and navigating the complexities of being both a cultural insider and a professional.

Managing Client Expectations of Cultural Alignment. In this subtheme, some participants explored how South Asian clients may expect their therapist to have a deep understanding of their cultural background, assuming that a shared cultural identity will automatically translate to shared experiences in multiple areas of life. This subtheme addressed the potential challenge that arises when professionals do not meet these expectations or when

clients expect the professional to not only understand but also to agree with their experiences and perspectives.

> Clients often think that I know exactly what boat they're in [...] while there's some overlap, sometimes it's a false commonality because my clients think we have more in common, or I have more shared experience with them, but I don't. (Chandni).

Participants indicated that this assumption could create challenges in the therapeutic relationship if the client expects the professional to have lived experiences or views identical to those of the client. However, one participant suggested that some clients may, instead, experience discomfort with South Asian mental health professionals due to fear of judgment: "Sometimes folks would rather not speak to a South Asian, because a shame-based response could come up quickly, because they think this person might judge them" (Ravneet). Overall, multiple participants suggested that mental health professionals must address these expectations by establishing a collaborative framework that validates the client's experience while clarifying the therapist's role as a guide, rather than a cultural mirror, throughout the therapeutic process.

Self-Reflection and Awareness in Practice. Through this theme, multiple participants addressed the importance of being self-reflective and aware of their personal biases when working with clients from similar cultural backgrounds. They explained that, although shared cultural identity often fosters therapeutic connection, professionals must also be cautious not to impose their personal views or assumptions onto their clients.

> Your personal identity as a therapist and how you understand yourself is very important. I think it's even more important when you're working with clients of your own culture, because you have specific ideas of what your culture is and how you identify yourself.

> But as a therapist, I have to first understand what is my culture, what are some things I like and don't like about my culture? (Shiv).

As several participants noted, self-awareness of the professional's personal identity and biases related to cultural stereotypes or traditional beliefs is important to ensure that the therapeutic process remains respectful and nonjudgmental. Additionally, participants discussed the potential for over-identification with South Asian clients, particularly if they share similar experiences, and being cautious of countertransference concerns.

Under this overarching theme, participants' responses were organized into two key subthemes: (a) navigating personal assumptions and biases, and (b) balancing empathy with professional objectivity.

Navigating Personal Assumptions and Biases. This subtheme reflects a recurring practice noted among multiple participants related to maintaining self-reflexivity when working with the complex intersections of cultural identity. Some participants indicated that professionals may hold certain beliefs about family structures or gender roles that are informed by their unique cultural experiences, which could inadvertently influence their approach to therapy. Acknowledging the diversity that exists within South Asia, several participants mentioned that self-reflexivity is not only necessary when working with clients from a South Asian country different than their own, but also when clients are from the same country as themselves:

> You have to tread carefully, because there is within-culture discrimination and within-culture lack of understanding as well. So, I never want to make an assumption about what someone else might be going through just because we have a similar cultural identity, because that's just one aspect of someone. (Rita).

Participants underscored the important practice of regularly examining their own values and how these may align or conflict with their clients' experiences or beliefs. Several participants indicated that without this self-awareness, mental health professionals may risk inadvertently replicating cultural norms or assumptions that the client is seeking to challenge or change.

Additionally, participants discussed that recognizing and unpacking their biases allows professionals to foster a more neutral, open space for clients to explore their own beliefs. Multiple participants suggested that professionals must intentionally explore clients' experiences and worldviews through their own words: "Not being presumptuous about their experiences and asking questions and learning as much as I can about what is important to them, is still helpful regardless of what my cultural identity is" (Alina). To address their presumptions, participants consistently emphasized the importance of attuning to clients' distinct needs through a lens of curiosity.

Balancing Empathy with Professional Objectivity. This second subtheme explores multiple participants' discussions regarding the delicate balance between empathy and professional objectivity. Participants explained that, while empathy is essential in building rapport, it is equally important for South Asian mental health professionals to maintain professional boundaries to avoid over-identifying with their South Asian client's experiences. They mentioned that therapists might feel emotionally affected by a client's account of familial pressures or cultural expectations, for example, which could bring up the therapist's own experiences or struggles related to their cultural identity. "There's a lot of feelings that can come up for me, just as a therapist. If someone's experiences are mimicking some of mine, there's an element of letting go of those stories that can be harder for me" (Himani). Several participants

described the importance of balancing their emotional engagement with therapeutic distance to ensure that it does not detract from the client's distinct journey or therapeutic goals.

Additionally, one participant highlighted the challenge of managing the intersection of their own experiences of privilege and marginalization. This participant emphasized that, in addition to cultural empathy, mental health professionals must recognize how their own experiences of privilege might shape their interactions with clients:

> I'm supposed to be the tabula rasa, this neutral being in the therapist space, just allowing the client to show up. But it doesn't look like that. Inevitably, who I am shows up right there in the room. All of my marginalizations and privileges are sitting there with my clients. (Ravneet).

Ravneet also explained that similar to working with clients from any cultural background, professionals must ensure that they do not inadvertently minimize the client's struggles or offer solutions based on their own privileges.

Overall, to mitigate the challenges associated with how their own cultural identity shows up in their work with South Asian clients, several participants placed considerable emphasis on engaging in ongoing self-reflective practices to examine their own identities, vulnerabilities, and emotional responses. They suggested that, by maintaining a balance between empathy and objectivity, mental health professionals are able to practice cultural sensitivity while upholding ethical principles of the profession, thus supporting both their personal growth and the well-being of their clients.

Sub-Question 5: Education and Training

Through a cross-case analysis of data from the final sub-question, *What are South Asian Canadian mental health professionals' experiences with education and training in the field?* I

generated three themes across multiple participants' responses. These themes include: (1) gaps in cultural competence training, (2) advocacy for institutional reform and increased representation, and (3) the need for culturally responsive supervision and support networks.

Gaps in Cultural Competence Training. One of the most frequently recurring themes among all eight participants was the lack of comprehensive cultural competence training in their formal educational programs. Participants indicated that their formal training did not adequately address the cultural nuances of working with specific racialized populations, including South Asian communities, and instead offered a one-time lecture or generalized diversity course.

> There was some education about being inclusive and active listening and trying to understand people's cultural contexts and intersectionalities. Basically, all these things that are generally applied to everyone. So, it was broadly covered, but there wasn't any specific adaptation or cultural knowledge building for working with the South Asian community. (Shahid).

Some participants compared this lack of specificity to a professional deficit, implying that South Asian cultures were either an afterthought or treated as a homogenous "ethnic group" rather than the wide range of multifaceted, diverse communities they truly are. Further, they indicated that this lack of tailored education left many therapists feeling underprepared to serve South Asian clients or to manage their own professional identity as a South Asian mental healthcare provider.

Several participants noted that the majority of their academic and clinical training materials were rooted in Western psychological models, predominantly developed by and for individuals from white, middle-class, and often Eurocentric backgrounds: "I think training therapists on culturally relevant approaches, or perhaps the influence of culture in our profession is very important [...] how we practice therapy right now is influenced by very Western ideas"

(Shiv). They explained that these materials, while foundational, do not reflect the diverse cultural realities of South Asian populations, who may hold different views on mental health, healing, and therapy.

Participants further described the lack of culturally specific case studies, research, or evidence-based methodologies that left them underprepared to implement standard therapeutic approaches that intersect with South Asian cultural norms. Some highlighted unique cultural factors that must be considered when working with South Asian clients, including stigma around therapy, caste-based discrimination, intergenerational or acculturation trauma, gender roles, family system dynamics, and faith and spirituality. To address these gaps, several participants mentioned that they supplemented their formal education through self-directed learning, personal experiences, client interactions, or external mentorships.

Advocacy for Institutional Reform and Increased Representation. Through this theme, multiple participants addressed the broader institutional barriers that South Asian Canadian mental health professionals may encounter throughout their educational experiences. They advocated for significant structural changes within mental health training programs to increase cultural representation, inclusivity, and sensitivity toward the needs of racialized students, including those from South Asian backgrounds.

Multiple participants discussed the lack of racialized faculty members in their programs, and the impact this absence had on their overall training. Participants explained that, without faculty who share similar cultural identities, have lived experiences of marginalization, or have worked directly with South Asian clients, it becomes challenging for students to feel truly represented within their academic environment.

> Part of what I would have wanted to see is instructors who come from different cultural backgrounds teach us from their own cultural experiences, because even just the representation of them being in front of the classroom is important. Then through that, they might bring in their own experiences and address the cultural piece of certain situations, and they might bring in more diverse perspectives... (Rita).

Some participants suggested that the absence of South Asian and other racialized faculty members perpetuates the marginalization of cultural perspectives, limiting the diversity of ideas and approaches in training. In addition to improving diversity representation in faculty, participants called for curriculum reform to include content that specifically addresses the challenges that racialized students experience in navigating the field of mental health. They advocated for programs to make a commitment to fostering more inclusive and culturally aware learning environments.

Some participants also highlighted the need for experiential and immersive learning opportunities, which they noted would better prepare emerging mental health professionals for working with culturally diverse communities. Participants expressed frustration with the predominantly theoretical nature of their training, emphasizing that this does not allow for meaningful engagement with real-life cultural complexities in therapeutic settings.

> Reading from textbooks is still important because it helps with developing critical thinking, but I don't think it translates well to cultural competence. It’s not just recall or purely knowledge, it’s also skill developing and skill practicing. It's like taking an introductory psychology class and thinking ‘I'm a psychologist.’ (Himani).

They mentioned that immersion in cultural settings, through practicum placements with South Asian or other racialized communities, may enable deeper understanding and contextual

learning. Participants reported that their experiences with self-directed learning led them to view experiential learning as a way to bridge the gap between theory and practice.

Need for Culturally Responsive Supervision and Support Networks. Multiple participants consistently discussed the critical role of supervision and mentorship in shaping the professional development of South Asian Canadian mental health professionals both in their education programs and in their subsequent practice. Participants expressed a desire for supervision that recognizes and integrates cultural factors in both the therapeutic process and the supervision itself. They indicated that supervisors who acknowledge the complexities of working with South Asian clients, as well as the personal and professional challenges faced by racialized therapists, would be particularly beneficial.

> If you have someone who's competent within the field and can give you the heads up about specific challenges or things to navigate, it could be so much more helpful. If your supervisors are telling you the kind of formats they've seen or the kind of patterns they've seen in this group within the culture [...] it could be a starting point. (Shiv).

Participants highlighted that supervisors who understand the intersection of cultural identity, race, and mental health are better equipped to provide guidance and support that addresses the unique challenges that South Asian mental health professionals may encounter with their South Asian clients, including countertransference, internalization, and identity-based hypervigilance that may arise during the therapeutic process.

Participants also reported that, in addition to culturally responsive supervisors, trainees may benefit from structured mentorship opportunities with experienced South Asian mental health professionals who could provide guidance and support in addressing cultural concerns during both educational and practicum training. One participant reflected on how his educational

experience may have been enhanced: “I wish I had a little bit of a networking system of therapists who are a part of a specific culture who could help you navigate working with certain cultures. There’s just not enough representation” (Shiv). Several participants emphasized the importance of shadowing South Asian therapists, engaging with real-life case studies, or participating in community-based activities during their training. They indicated that these experiences could help students better understand the intricacies of working with South Asian clients and provide them with tools to navigate cultural challenges effectively.

Additionally, many participants expressed feeling isolated throughout their training, due to the lack of safe spaces for racialized students to explore their personal identities in relation to their emerging professional roles. Some participants mentioned that, combined with the lack of cultural representation among their peers and faculty described in the Advocacy for Institutional Reform and Increased Representation theme, having limited support for personal exploration of what it means to be a South Asian mental health professional led to a significant sense of disconnection from the broader academic community. They also reported a desire for stronger peer connections with other students from similar cultural backgrounds as well as opportunities to connect with established South Asian professionals working in the field:

> There's so much more room and opportunity for schools to try to organize these kinds of spaces for racialized students to help build that sense of community, and to find mentorship and feel a level of support from people around us when we eventually go and enter the workplace. (Alina).

Participants indicated that developing mentorship and peer-to-peer connection opportunities may mitigate the absence of support networks that South Asian trainees might be more inclined to experience within a predominantly white academic environment.

Overall, participants emphasized that current education and training programs often overlook the cultural nuances of working with South Asian clients, leaving therapists feeling underprepared to serve the South Asian community. They suggested that addressing these issues through more inclusive training, diverse faculty representation, and tailored mentorship could better support both South Asian Canadian mental health professionals and their clients.

Summary of Findings

Analyses of the overall data revealed several key insights and challenges experienced by South Asian Canadian mental health professionals working with South Asian clients. Some prominent themes that were generated included the dual role of shared cultural identity as both an asset and challenge in navigating therapeutic dynamics, the influence of the therapist's multicultural and/or religious identity, culturally adapted interventions highlighting collectivism, family, and spirituality, and systemic gaps in education and training. The highlights from these key findings are discussed in the context of existing literature in the following chapter.

Chapter 5: Discussion

In this study, I explored the experiences of South Asian Canadian mental health professionals working with South Asian clients. Through individual semi-structured interviews and Reflexive Thematic Analysis methods, I identified multiple themes in relation to the study's five sub-questions pertaining to these professionals' experiences with South Asian clients compared to clients from other backgrounds, the nature of their therapeutic relationships, the theories and interventions that guide their practice, the influence of cultural identity on therapeutic dynamics, and their reflections on education and training in the mental health field. In this chapter, I critically examine the major findings by positioning them within the broader existing literature. Then, I discuss the strengths and limitations of the present study, while outlining potential directions for future research. The chapter concludes with implications for counsellor education, clinical training, and therapeutic practice.

Connections to Existing Research

The Successes and Challenges of Shared Cultural Background

A central theme that I identified from the data was the therapeutic advantage of cultural familiarity between South Asian therapists and South Asian clients. Participants explained that shared cultural knowledge, whether through mutual understanding of socio-cultural contexts or a common language, facilitates more effective communication and accelerates the development of a therapeutic alliance. This observation supports existing literature on cultural competence in therapy, which suggests that shared cultural background fosters trust and rapport by minimizing the need for clients to explain cultural nuances (Chang & Yoon, 2011; Meyer et al., 2011; Khan, 2006). As I found in the current study, clients' perceptions of a shared lived experience enable

them to feel validated and understood by their therapist, reducing barriers related to internalized stigma, which might otherwise discourage this population from accessing mental health support.

I also found that the feeling of mutual understanding between mental health professionals and clients is further strengthened through using a common language, which helps clients feel more comfortable expressing themselves in ways that might be difficult in English, particularly for those who may have internalized colonial notions of language privilege. Having a common language may facilitate the co-creation of meaning within the therapeutic relationship, while also destabilizing power dynamics and making the professional more approachable and relatable (Szoke et al., 2019). Reflecting previous research (Aggarwal et al., 2016; Benish et al., 2011), this highlights language accessibility as a critical component of enhancing culturally responsive treatment and client engagement with therapy.

These findings also align with social identity theory (Ellemers & Haslam, 2012), which posits that individuals tend to trust and feel more comfortable with those they perceive as part of their in-group. Social identity theory supports the possibility that South Asian clients may feel more validated and less judged when working with South Asian therapists, as cultural norms, values, and experiences are implicitly understood, reducing the need for extensive explanation and minimizing cultural misalignment. In addition to these advantages for clients, South Asian therapists themselves noted that their familiarity with the cultural context enabled them to integrate some of their own identity through traditional stories, humour, cultural references, and even self-disclosure. Participants mentioned that acknowledging their racial identity through self-disclosure, when used sparingly and intentionally, contributed to creating safety with their South Asian clients, which is emphasized by previous research conducted with minority clients (Pandya & Herlihy, 2009). The significance of such reciprocity is supported by multicultural

therapy researchers who advocate for greater focus on the mutual and reciprocal nature of the therapeutic relationship rather than solely on demographic characteristics of the clients (Cabral & Smith, 2011; Lee et al., 2022; Verdinelli & Biever, 2009) As such, the present findings suggest that shared cultural identity creates a safer therapeutic space, enhancing the connection between South Asian mental health professionals and their clients, while facilitating more active engagement with the therapy process.

However, it is important to critically evaluate whether cultural similarity necessarily implies a stronger therapeutic relationship. In the current study, while some participants emphasized that trust was established more quickly with South Asian clients due to cultural familiarity, others suggested that warmth, empathy, and compassion are fundamental to the success of a therapeutic relationship with any client regardless of their cultural background. Additionally, most participants highlighted that, although South Asian clients actively sought them out due to their similar identities, therapists themselves were able to develop strong working alliances with their non-South Asian clients as well. In alignment with a previous meta-analysis study of cultural adaptations of psychological interventions, this finding indicates that, although cultural competence can be an asset for connecting with clients, certain core therapeutic qualities such as emotional support and presence are crucial in establishing a solid therapeutic bond (Hall et al., 2016). This finding challenges previous assumptions that shared identity alone is a contributor to therapeutic success (Cabral & Smith, 2011). Instead, the current study reinforces the idea that mental health professionals must actively navigate cultural similarities and differences, ensuring that cultural/ethnic matching is leveraged as a tool rather than a guarantee of therapeutic efficacy.

Despite emphasizing these successes, I observed that participants also shared some challenges of navigating culturally matched therapeutic dyads. Echoing previous research on Black therapists' experiences of working with Black clients (Goode-Cross & Grim, 2016), many participants in the present study highlighted a sense of obligation and pressure to embody the position of an 'expert' to conform with clients' culturally-influenced perceptions of healthcare professionals. They suggested that South Asian clients may be accustomed to hierarchical relationships in help-seeking contexts, where guidance is expected rather than collaborative decision-making, which reflects previous studies (Shonfeld-Ringel, 2001; Soorkia et al., 2011). In line with prior research conducted among South Asian clients in the United Kingdom (Pandya & Herlihy, 2009), participants in the present study indicated that older and first-generation South Asian clients were more likely to seek prescriptive advice rather than collaborating with their therapists in comparison to younger, second-generation clients. This intergenerational variability in expectations about therapy poses challenges for professionals trained only in Western models of non-directive, client-centered approaches, requiring them to balance client autonomy with culturally responsive guidance.

In the present study, participants also discussed some South Asian clients' overestimation of the therapist's level of cultural alignment, which led clients to assume that shared culture implied a shared worldview, religious values, or even political opinions. Additionally, therapists themselves described feeling pressure to meet clients' expectations of cultural alignment, even when these expectations did not fully resonate with their personal values or individual approaches to treatment. Expanding on prior research which cautions that overidentification in culturally/ethnically matched dyads can obscure important individual differences (Goode-Cross

& Grim, 2016; Pandya & Herlihy, 2009), participants underscored that this misperception could also create unrealistic expectations and limit critical reflection in the therapy process.

These findings align with critiques of essentialism in ethnically matched therapy dyads (Nguyen, 2014), which caution against overgeneralizing shared identity as inherently beneficial. As such, in acknowledging the nuances of cultural familiarity, South Asian therapists in the current study highlighted the importance of considering intersectionality in understanding the multidimensional factors that shape the mental health experiences of South Asian clients (i.e., generational attitudes, stigma toward mental health, role of family, and migration histories). Collectively, these findings indicate that, while cultural familiarity can be beneficial to the therapeutic relationship, professionals must navigate these complexities with adaptability and reflexivity.

Negotiating Cultural and Professional Identities

While reflecting on their own cultural identity and its influence on therapeutic work, the mental health professionals who participated in this study addressed countertransference, internalized biases, and challenges in boundary management. Consistent with previous literature (Goode-Cross & Grim, 2016; Kokaliari et al., 2013; Nguyen, 2014; Rivera, 2023; Yoshida, 2013), many participants expressed concerns about overidentification and higher levels of emotional investment with South Asian clients due to increased relatability and shared struggles. Participants mentioned that, because of this dynamic, they navigated more permeable boundaries with South Asian clients. Prior research indicates that overidentifying with clients based on racial or ethnic similarity can lead to various negative therapy outcomes, including overemphasis on a client's cultural identity (Goode-Cross, 2011), feelings of intimacy (Kokaliari et al., 2013),

imposing assumptions instead of exploring individual experiences, or boundaries being challenged by clients (Nguyen, 2014).

In the present study, these concerns were further amplified by the likelihood of sharing the same social spaces (i.e., temples, community events, weddings), making it more difficult for therapists to negotiate professional boundaries with South Asian clients outside of the therapeutic environment. Indeed, one previous study found that, since relational boundaries are constructed differently in South Asian cultures, clients frequently perceived their South Asian therapists as kin-like figures (e.g., daughters or sisters), rather than strictly as professional service providers (Reddy, 2019).While participants in the present study recognized that these dynamics had the potential to strengthen their therapeutic bond, they also expressed ethical and emotional concerns about the blurring of mental health standards of practice that discourage such multiple-role relationships. Similar findings have been observed in past studies on culturally responsive ethical practice, where racialized therapists reported feeling conflicted between maintaining traditions that feel culturally appropriate while still adhering to Western professional norms (Comas-Díaz, 2016).

These findings underscore the complexities of boundary management for South Asian mental health professionals in Canada, who must navigate the tension between culturally embedded relational expectations and professional ethics. While previous studies exploring overidentification and boundary challenges have acknowledged the importance of taking measures to address these collusions and adopting strategies to mitigate them, researchers have not explicitly outlined those strategies (Costa & Dewaele, 2014). The current study expanded on this area, with participants emphasizing ongoing self-reflection as a necessary tool to address concerns of countertransference and overidentification. They suggested engaging in continuous

strategies such as critically examining their own biases, assumptions, and evolving cultural perspectives, as well as consulting with peers, mentors, or supervisors from similar cultural backgrounds. Without intentional reflection, participants warned that there is a risk of therapists inadvertently reinforcing cultural norms that clients are seeking to challenge or assuming that their personal experiences mirror those of their clients. This finding reinforces the importance of cultural humility in mental health practice (Hook et al., 2013; Lee, 2014), which emphasizes that self-awareness and openness to learning are crucial for effective multicultural therapy.

Bridging Spiritual and Clinical Healing Practices

A significant theme recurring across the findings was the central role of religion and spirituality in South Asian healing processes. Participants highlighted that faith was not just a personal belief system but an integral part of clients' identity, shaping their coping mechanisms, moral frameworks, and perceptions of mental health struggles. They noted that many clients turn to prayer, religious rituals, or guidance from spiritual leaders as a means of managing distress, often seeking solace in their faith before considering professional mental health support. Additionally, participants indicated that some South Asian clients actively seek out therapists who express sharing the same religious orientation as they anticipate these therapists to be more open to exploring spiritual forms of coping and healing. These findings align with existing research suggesting that faith-based interventions can be an essential component of culturally responsive therapy (Meyer & Zane, 2013), and that attending to clients' religious values and beliefs can positively influence treatment outcomes (Plante, 2014). In the current study, South Asian professionals viewed religious practices, such as reciting prayers or fasting, as complementary to therapy rather than separate from it. They encouraged the use of spiritual stories, faith-based metaphors, and songs to instill hope, support meaning making, and identify

positive coping strategies among South Asian clients who indicated openness to integrating religion into their treatment.

Although the findings of this study consistently highlighted the benefits of incorporating religion and spirituality into therapy within the South Asian context, at least for some South Asian clients, previous research has identified potential barriers to this practice. For example, one study reported that while some clients value discussing faith in therapy, the extent to which therapists integrate religious components can sometimes misalign with client expectations (Kellems et al., 2010). Specifically, Kellems et al. (2010) found that therapists with higher personal religiosity tended to emphasize religious goals for clients more than clients themselves desired, raising concern about potentially imposed values and treatment goals. Further, past research has found that therapists sometimes hesitate to bring up religion or spirituality with clients who do not share their religious identity (Bier, 2022; Winkeljohn Black et al., 2021). In the present study, South Asian professionals reported feeling comfortable discussing religion regardless of their client's religious affiliation or their own limited training in spirituality-based interventions, as they felt that they could incorporate theological concepts without needing to address a particular religion.

Even when mental health professionals do not avoid religion and spirituality in therapy, prior research has demonstrated various client-related barriers. For example, one study conducted in the United States, which investigated therapists' perspectives of integrating spirituality in treatment, reported that clients were often guarded or defensive regarding their own religious identities due to holding assumptions about the therapist's level of religiosity (Bier, 2022). Similarly, in the current study, some participants mentioned that clients may perceive their therapist to be more spiritual than themselves due to visible markers of their faith

(e.g., headscarf, turban), which then influences their level of openness and sometimes fosters a fear of judgment. Participants noted that they mitigate these concerns by allowing clients themselves to initiate conversations around religion rather than making assumptions about clients' comfort. These findings suggest that, while integrating faith in therapy can be a meaningful and culturally responsive practice, particularly within the South Asian context, it requires careful navigation to ensure that religious discussions are client-led and aligned with their therapeutic needs.

The Complexities of Balancing Individual and Collective Needs

Another key theme that was observed across the findings was the centrality of family and collectivism in South Asian clients' mental health experiences and the therapist's role in managing these needs. Echoing previous research, participants in this study described that the collectivist nature of South Asian cultures prioritizes interdependence, family duty, and social harmony, which can influence how individuals seek and engage with mental health services (Inman et al., 2014; Sue & Sue, 2003). In some cases, they noted that South Asian clients felt compelled to obtain family approval before seeking professional mental health support, which therapists believed could present a significant barrier to accessing care. Additionally, many participants reflected on the tension they experienced when clients struggled between meeting family expectations and prioritizing their personal wellbeing.

Unlike their therapeutic work with non-South Asian clients, participants found that therapy with South Asian clients often involved navigating familial obligations, social reputation, and cultural values of duty and sacrifice. Some noted that clients frequently sought guidance on family conflict, marriage decisions, and intergenerational disputes, often expecting their therapist to validate traditional family structures, which placed the mental health professional in a role that

extended beyond standard Western therapy models. Participants struggled with navigating dilemmas where they personally disagreed with the traditional cultural norms being reinforced within the client's family system, as these norms conflicted with the client's desire for balancing the Western components of their bicultural identity. This finding aligns with prior research, which demonstrates that South Asian individuals often experience conflict between Western ideals of self-actualization and South Asian values of familial duty (Tummala-Narra & Deshpande, 2018). In the present study, as they recognized the cultural weight of family loyalty and obligation, participants expressed internal conflict when advising clients on setting boundaries with family members. Others discussed feeling pressured to provide guidance that aligned with cultural norms rather than individualistic therapeutic goals. These findings reflect the broader challenges faced by racialized therapists working within Western mental health frameworks that struggle to balance individual autonomy with collective wellbeing.

Furthermore, several participants described how South Asian clients often held expectations that the therapist would assume a directive, authoritative role, akin to that of a family elder. Participants noted that clients sometimes approached therapy anticipating advice-giving or prescriptive guidance, rather than a collaborative and exploratory process. This expectation at times created tension around the therapeutic frame, requiring mental health professionals to clarify their role and navigate clients' culturally shaped assumptions about authority and expertise. Some participants described selectively adapting their approach to meet clients where they were, integrating culturally responsive practices while maintaining professional boundaries. These findings mirror existing research suggesting that racialized therapists often feel pressured to adopt dual roles that challenge the balance between culturally situated expectations and ethical boundaries (Comas-Díaz, 2016; Goode-Cross & Grim, 2016).

In alignment with previous research (Mosher et al., 2017), participants in this study reported that, overall, South Asian clients may benefit from interventions that integrate family perspectives rather than solely focusing on individual mental health goals. They emphasized interventions that account for the relational dynamics of larger family systems, often including family members in-law and multigenerational households. For example, several participants reported helping clients find indirect ways to set boundaries without explicitly rejecting family expectations. This strategy is supported by existing literature on culturally adapted family-oriented interventions suitable for South Asian populations (Chadda & Deb, 2013).

However, in the current study, South Asian therapists also highlighted challenges in setting boundaries when family members attempted to exert influence over the therapeutic process, such as dictating the topics that should or should not be addressed in sessions or deciding when therapy must be terminated without the client's input. In such cases, participants had to navigate validating the client's personal experiences and goals while also addressing the deeply embedded cultural values that shaped their therapeutic journey and relational experiences. Overall, these findings suggest that, while integrating family perspectives into therapy can enhance its cultural relevance, South Asian mental health professionals may also experience emotional and professional dilemmas in balancing family expectations with client autonomy, while managing their personal positionality.

The Disconnect Between Formal Training and the Realities of Practice

The South Asian Canadian mental health professionals in this study consistently described feeling underprepared to work within their own cultural communities by their formal education and training programs, reflecting broader critiques of Western dominated mental health frameworks. Notably, seven of the eight participants in this study received their formal training

in Canada, while one completed initial training in the United Kingdom followed by additional qualifications in Canada, underscoring the predominance of Western-based educational paradigms in their professional development. Similarly, a previous study that investigated the perspectives of Latin American therapists in the United States indicated that they felt ill-prepared to serve their own communities through a culturally appropriate lens (Rivera, 2023). In the current study, participants explained that Eurocentric models lack inclusivity and fail to meaningfully engage with the lived realities of racialized professionals and clients, which echoes prior research (Comas-Díaz, 2016; Tummala-Narra, 2016). For some participants, the mismatch between their training and lived reality as South Asian therapists led them to question the relevance of their training, particularly when they found themselves adapting or modifying interventions on their own to better suit the needs of their South Asian clients. Others spoke about the pressure to bridge these gaps independently, often developing culturally responsive approaches through improvisation, trial and error, or post-degree professional development (e.g., workshops and seminars designed specifically for working with South Asian clients).

Additionally, while participants acknowledged that their programs included diversity-related coursework, they described these courses as broad, perfunctory, and lacking depth in addressing specific cultural nuances. This aligns with critiques that many cultural competence trainings in Western mental health programs rely on generalized, one-size-fits-all approaches, often reducing racialized communities to simplistic cultural checklists rather than equipping trainees with meaningful, in-depth understanding (Smith et al., 2017). In the current study, many participants noted that their education often framed cultural competence as an “add-on” to single lectures or brief modules, rather than being embedded throughout the curriculum, which created a false impression that cultural competence was secondary to “core” psychological theories and

interventions, reinforcing the marginalization of non-Western worldviews. For participants in this study, this finding also meant that their own cultural background was treated as a "niche" area of expertise, rather than being recognized as an essential component of providing effective care. These findings reinforce the argument that cultural competence training must go beyond superficial awareness and instead focus on developing nuanced, context-specific skills that enable professionals to effectively engage with diverse communities (Patel, 2014). As participants noted, without this depth, South Asian therapists are left navigating complex cultural dynamics without institutional support, leading to increased professional strain and self-doubt.

Furthermore, participants emphasized the lack of South Asian representation in faculty, supervisors, and academic leadership within their graduate degree programs, an absence that was not merely a symbolic concern, but rather one with direct consequences for their educational and professional development. Many described feeling isolated or disconnected from their training environments, which aligns with previous research underscoring the evolving nature of therapists' professional identity as a key component of their overall professional development in counsellor education programs (Wagner & Hill, 2015). Participants in the current study also reported that they rarely encountered mentors or peers who shared their experiences of navigating the complex intersection between cultural norms and professional practice (e.g., managing countertransference, boundary complexities, self-reflection, and negotiating dual identities). This finding aligns with existing research highlighting how the underrepresentation of racialized faculty in mental health training programs contributes to a lack of culturally relevant mentorship and guidance for racialized students (Rees et al., 2011; Hipolito-Delgado et al., 2017). In fact, previous research examining counsellor supervision models in the context of therapy with sexual minority clients found that sexual minority trainees strongly benefitted from

open discussions with their supervisors regarding ways to minimize the negative impact of overidentifying with their clients (Chui et al., 2018).

One of the most discussed experiences among participants in the current study was the significant emotional and professional labour they undertook to compensate for the shortcomings of their training. Many described feeling responsible for their own cultural learning, engaging in self-directed research, attending workshops, and seeking external mentorships to fill in gaps. This expectation that racialized mental health professionals must independently acquire the cultural knowledge they need to serve their communities reflects a broader systemic issue in counsellor education and training programs. Previous research has shown that racialized therapists are often expected to be cultural brokers, translating Western mental health models for their communities while also navigating the racial biases embedded within mental health institutions themselves (Rivera, 2022).

Overall, participants extensively discussed the need for systemic reform in counsellor education and training in Canada, to ensure that professionals are equipped with the tools they need to provide effective and culturally responsive care. As part of discussing the gaps of their education and training programs, all eight participants outlined several specific recommendations for improving counsellor education, clinical training, and therapeutic practice in the South Asian context. A detailed exploration of these implications will be addressed later in this chapter.

Strengths, Limitations, and Directions for Future Research

One of the most significant strengths of this study is its contribution to an underexplored area of mental health research. While previous studies have begun to explore South Asian clients' experiences in therapy, far fewer studies have examined the perspectives of South Asian mental health professionals practicing with South Asian clients in the Canadian context. By focusing on

the lived experiences of South Asian Canadian therapists, this study provided new empirical insights into the professional, ethical, and emotional complexities that these professionals navigate. As part of recognizing the heterogeneity within this cultural group, the study actively recognized that South Asians are not a monolithic group, incorporating insights from participants with varied migration histories, generational backgrounds, linguistic and religious identities, and professional experiences. By doing so, this research avoided overgeneralized narratives about South Asian therapists. Moreover, the study moved beyond simplistic ethnic matching models, by illustrating how therapists' cultural identity interacts with their professional role in complex, sometimes conflicting ways.

By employing RTA, a methodologically robust approach that promotes researcher reflexivity, I was able to acknowledge my positionality as the researcher. Unlike positivist or structured coding methods of analyses, RTA was particularly well-suited for exploring the meaning-making processes of my participants. The study's inductive approach ensured that the findings remained rooted in participants' lived realities, rather than being forced into pre-existing theoretical frameworks. Additionally, the use of reflexivity as a core methodological tool strengthens the credibility of this study. As the researcher, I engaged in ongoing reflexive practices (e.g., positionality reflection, reflexive journaling, transparency in writing) and implemented a member-checking procedure, allowing for collaborative interpretations and meaning-making with participants. This aligns with best practices in RTA research, ensuring that findings are co-constructed and validated through participant perspectives (Braun & Clarke, 2021).

My insider positionality as both a South Asian individual and a counselling psychology graduate student also served as a key methodological strength. Being a member of this cultural

community allowed for deeper understanding, which fostered stronger rapport, trust, and openness in participant interviews during data collection. In fact, seven out of eight participants spontaneously initiated conversations about my own cultural background or made references to our shared culture on several occasions during the interview process. Existing research on insider-outsider dynamics in qualitative studies suggests that participants from minoritized groups may be more candid in discussing culturally sensitive issues when speaking with a researcher who shares their background (Dwyer & Buckle, 2009). In the present study, participants appeared to speak more freely about their experiences of navigating South Asian cultural expectations in therapy, possibly because they felt that I would inherently understand the nuances of these experiences without requiring extensive explanation of context.

Additionally, as a student in a counselling psychology program who has completed 500 practicum hours, I was able to interpret and analyze the data through a practice-informed lens. This professional background provided insight into therapeutic frameworks, ethical considerations, and training models, allowing for a multidimensional exploration of the challenges that therapists encounter in their practice. Unlike a researcher from outside of mental health practice who may approach the topic from a purely academic perspective, my dual identity as both a community insider and a mental health professional-in-training enabled a more grounded, practice-relevant analysis that captures the real-world complexities of therapy within the South Asian cultural context.

A final strength of this study lies in its practical relevance for counsellor education, clinical training, and therapeutic practice. The findings highlight gaps in education and training programs, challenges in boundary-setting, and the limitations of applying Western therapeutic models in South Asian contexts. These insights provide a valuable foundation for shaping future

training programs, supervision models, and clinical practices that better equip South Asian mental health professionals to work effectively with culturally similar clients.

When acknowledging the strengths of this study, it is equally important to address its limitations. First, this study focused on licensed mental health professionals with graduate-level training (e.g., clinical and counselling psychologists, psychotherapists, and clinical social workers). Although this decision promoted the recruitment of participants who had rigour in professional training and ethical considerations, it excludes the perspectives of other key professionals working closely with South Asian communities on mental health-related issues, such as spiritual leaders (who provide informal mental health support rooted in religious frameworks), youth workers or settlement workers (who work with South Asian youth or newcomers but may lack formal licensure), and traditional healers or ayurvedic practitioners (whose healing approaches may intersect with mental health practices). Future research should expand the scope of mental health professionals in the sample, incorporating a broader spectrum of professionals that South Asian clients may be likely to seek mental health support from. Similarly, future studies could examine how South Asian therapists collaborate with faith leaders and community healers when providing mental health treatment to clients.

Second, while I identified gendered expectations in therapeutic relationships as a theme in this study, I did not fully unpack how South Asian mental health professionals experience gendered power dynamics in their work. Some participants noted that, in comparison to female clients, male clients held different expectations of female therapists. However, I was not able to explore how South Asian male and female therapists experience therapy differently, primarily due to the limited representation of male South Asian Canadian mental health professionals in the participant sample. Additionally, the study's focus on broader themes of shared experiences

constrained the depth of exploration regarding gendered dynamics. Considering this limitation, future research should explore how gendered expectations shape professionals' authority, credibility, and rapport-building. Additionally, as only two out of eight participants in this study identified as South Asian males, it may be beneficial to examine how South Asian male therapists navigate their role, particularly in contexts where clients expect emotionally distant or directive approaches in alignment with their cultural views on gender and power.

Third, most of the participants worked in private practice settings, with only two from community mental health clinics. This distribution of workplaces may have shaped the themes that were generated, as private practice settings could potentially afford professionals greater flexibility in structuring their clinical boundaries, fees, and therapeutic approaches. Private practice settings also may allow clients to research and select their preferred therapist, which may not be as easily navigated in institutional settings with higher caseloads, bureaucratic constraints, and systemic pressures. For example, boundary management and cultural accommodation strategies might apply differently in hospital or community clinic settings where South Asian therapists may experience greater pressure to conform to standardized care models. These aspects remain largely unexplored, due to the composition of the sample in this study. Future research should aim to include a broader range of South Asian mental health professionals working in diverse mental health settings, such as hospitals, publicly funded institutions, or university counselling centres, as comparing their experiences across different work environments could offer a more comprehensive understanding of how institutional contexts shape therapeutic practice.

Finally, while the breadth of diversity within the sample was beneficial for highlighting shared and divergent experiences, it also introduced challenges in fully capturing the depth of

each subgroup's experiences. The South Asian sub-continent encompasses a wide range of ethnic, linguistic, religious, and regional identities, each of which may carry distinct cultural norms, migration histories, and approaches to mental health (Tummala-Narra, 2016). While I was able to recruit South Asian participants from various nationalities, faith backgrounds, and generational identities in this study, the nuanced variation in experiences suggests that future research could further narrow the sample criteria to explore subgroup-specific complexities in greater detail. For example, future research could compare the experiences of therapists from South Asian communities that are larger in Canada (e.g., India, Pakistan) with those from communities that are smaller (e.g., Nepal, Bangladesh, Sri Lanka), particularly regarding access to professional mentorship and clinical training.

Future studies could also specifically explore the perspectives of mental health professionals from one South Asian religious or linguistic background, such as Muslim South Asian therapists, Tamil-speaking practitioners, or Sikh-identifying clinicians, to investigate how faith, language, and regional identity shape professional experiences. Additionally, researchers could focus exclusively on first-generation or second-generation South Asian therapists, examining how acculturation, familial expectations, and professional identity formation differ across generations. By narrowing the scope of South Asian identities in future studies, researchers can delve deeper into the specific cultural and professional challenges that different subgroups face, rather than aggregating their experiences under a broad "South Asian" category.

Overall, this study makes an important contribution to understanding the experiences of South Asian Canadian mental health professionals working with South Asian clients. Its methodological rigour, emphasis on reflexivity, and focus on an underexplored professional group strengthen its impact. On the other hand, its limitations point to valuable directions for future research, particularly in broadening the scope of participants in non-private settings, underrepresented South Asian identities, and sub-group specific investigations. Addressing these gaps will be essential in developing a more inclusive, representative, and culturally responsive body of research that fully captures the complex realities of South Asian mental health professionals in Canada.

Implications for Education, Training, and Practice

The insights contained within the findings of this study hold important implications for counsellor education, clinical training, and therapeutic practice. Educators, supervisors, and professionals in the mental health field benefit from understanding the unique needs of their South Asian students and trainees, in order to contribute to their overall professional development. By increasing their understanding the experiences of South Asian Canadian mental health professionals, counsellor training and education programs can better prepare them for future work with clients.

Participants in this study overwhelmingly noted a lack of culturally specific education, with most programs offering generalized diversity courses. To address this, I suggest that counsellor education programs should move beyond surface-level cultural competency models and integrate case studies, evidence-based culturally adapted interventions, experiential learning (e.g., community-based practicum placements), and applied skills training specifically addressing South Asian cultural, familial, and religious considerations in therapy. Educational

programs also should provide guidance on ethical boundary management in culturally/ethnically matched dyads, as participants in this study highlighted the challenge of clients viewing them as kin-like figures or as experts from which they may seek directive advice. By encouraging therapists-in-training to set professional boundaries that still remain culturally appropriate, programs can acknowledge that rigid Western boundaries may not always be practical in collectivist contexts.

Counsellor training programs should develop specialized training on collectivist cultural frameworks, particularly in navigating family involvement, cultural stigma, and non-Western healing models, such as those that integrate community-based interventions and faith-based practices. Receiving training in spiritual competency may support trainees in comfortably engaging in conversations about faith in an ethical and non-imposing way. Further, training models should foster self-reflexivity in practice, encouraging professionals to critically examine their biases, emotional reactions, and potential overidentification with clients on an ongoing basis, without judgment, to maintain therapeutic objectivity.

In terms of the lack of South Asian representation among faculty, supervisors, and clinical mentors, participants also noted difficulty finding supervisors who understood their cultural background or could guide them in navigating the unique challenges of working with culturally similar clients. This gap resulted in limited opportunities for culturally informed mentorship, often leaving therapists to navigate ethical dilemmas without adequate support. To enhance training and professional development support in this area, programs should actively recruit and retain South Asian faculty and supervisors to provide culturally informed mentorship. As participants suggested, programs also should encourage peer mentorship networks where South Asian mental healthcare trainees can receive support, validation, and guidance from other

professionals with shared lived experiences. Similarly, by incorporating discussions on racial identity and cultural complexity into clinical supervision, programs can create a space where emerging South Asian therapists can explore the challenges of working within their own community while negotiating their professional and cultural identities.

The findings also reinforced that therapy with South Asian clients often involves balancing individual wellbeing with family and collective obligations. This suggests that Western therapeutic models that prioritize individual autonomy and self-actualization may not always resonate with clients who view their identity as interconnected with their family and community. As indicated by the findings of this study, to improve therapeutic effectiveness, mental health professionals should incorporate family-based interventions (i.e., flexible or indirect boundary-setting) where appropriate, recognizing that family approval and involvement often play a critical role in mental health decision-making among this population. To enhance client comfort and mitigate hesitation toward therapy and mental health, therapists working with South Asian clients also should dedicate time to clarifying the objectives, purposes, and expectations of therapy and their role as therapists. Furthermore, professionals should collaborate with South Asian clients to reframe therapy goals to align with their collectivist values, emphasizing themes such as relational harmony, duty, and balance, rather than focusing solely on individual self-empowerment.

Additionally, South Asian mental health professionals working with South Asian clients must develop culturally sensitive approaches to boundary management. Some strategies may include having transparent conversations about professional boundaries, acknowledging cultural expectations while reinforcing ethical guidelines, and explaining therapy dynamics for clients who are unfamiliar with therapy, such as framing the therapist's role as a compassionate guide

rather than a family member. Further, to bridge the relative absence of spirituality and religion in typical Western psychotherapy, professionals should adopt a client-led approach by inquiring about the role of faith in the client's life and exploring how religious beliefs intersect with their mental health journeys. Similarly, they should validate and incorporate faith-based coping strategies where relevant, such as using spiritual stories, mindfulness from religious traditions, or faith-based metaphors to support meaning-making.

Overall, by understanding how South Asian Canadian mental health professionals experience therapeutic practice with South Asian clients, the findings that were generated in this study contribute to enhancing culturally responsive care. The need for mental health services and counselling among this pan-ethnic group is indeed supported by current research (Singh & Bhayana, 2015; Tummala-Narra et al., 2012). Thus, findings from the present study clarify and inform best practices, improving both the experiences of South Asian clients seeking mental health services and South Asian counselling students to feel more understood and supported throughout their training.

Conclusion

In this study, I generated a rich and nuanced understanding of South Asian Canadian mental health professionals' experiences, offering valuable implications for research, education, training, and practice. The review of existing literature that I conducted highlighted the need for a detailed exploration of diverse mental health professionals' experiences in providing services to culturally similar clients. The findings of this study contribute to the gaps in existing research by distinctly exploring South Asian perspectives within the Canadian context and offering directions for future research based on the themes that were generated. Specifically, I generated several themes related to the successes and challenges of working with South Asian clients, including the

dual role of shared cultural identity as both an asset and challenge in therapeutic dynamics, culturally adapted interventions that highlight family, spirituality, and collectivism, as well as gaps in education and training. These findings facilitate greater awareness of intersectional perspectives of mental health professionals, particularly contributing to a broader understanding of cultural responsiveness in the field.

The implications of this research are substantial, as results may be utilized to enhance cultural responsivity among mental health professionals and training programs. By understanding specific barriers and facilitators of working with this cultural group, findings from this research have the potential to empower South Asian Canadian mental health professionals with practical insights for developing more meaningful and effective therapeutic relationships with their South Asian clients. Further, this research presented an excellent opportunity for these mental health professionals to express their personal experiences of practicing with culturally similar clients.

References

Aggarwal, N. K., Pieh, M. C., Dixon, L., Guarnaccia, P., Alegria, M., & Lewis-Fernandez, R. (2016). Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review. *Patient education and counseling, 99*(2), 198-209. https://doi.org/10.1016/j.pec.2015.09.002

Alves, S., & Gazzola, N. (2011). Professional Identity: A Qualitative Inquiry of Experienced Counsellors. *Canadian Journal of Counselling and Psychotherapy, 45*(3), 189-207.

Arora, P. G., Metz, K., & Carolson, C. I. (2016). Attitudes toward professional psychological help-seeking in South Asian students: Role of stigma and gender. *Journal of Multicultural Counseling and Development, 44*, 263-284. https://doi.org/10.1002/jmcd.12053

Asselin, M. E. (2003). Insider research: Issues to consider when doing qualitative research in your own setting. *Journal for Nurses in Professional Development, 19*(2), 99-103.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58,* 279–289. http://dx.doi .org/10.1037/a0023626

Bhatt, H. M. (2015). *Extending Counselling Psychology practices and theories when meeting a client's and a service user's therapeutic needs* [Unpublished doctoral dissertation]. City University London. https://ethos.bl.uk/OrderDetails.do?uin=uk.bl.ethos.681391

Bier, A. L. (2022). *Therapist Experiences with Religion and Spirituality in Treatment: A Qualitative Study* (Publication No. 29320785) [Doctoral dissertation, Rutgers University]. Rutgers University Electronic Theses and Dissertations.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.), *The handbook of research methods in psychology* (Vol. 2, pp. 57-71). American Psychological Association.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* SAGE Publications.

Braun, V., & Clarke, V. (2019a). Reflecting on Reflexive Thematic Analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2019b). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201–216. https://doi.org/10.1080/2159676x.2019.1704846

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Braun, V., & Clarke, V. (2022). Toward good practice in thematic analysis: Avoiding common problems and be(com)ing a knowing researcher. *International Journal of Transgender Health*, *24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Brisset, C., Leanza, Y., Rosenberg, E., Vissandjée, B., Kirmayer, L. J., Muckle, G., Xenocostas, S., & Laforce, H. (2014). Language barriers in mental health care: A survey of primary care practitioners. *Journal of Immigrant and Minority Health, 16*(6), 1238–1246. https://doi.org/10 .1007/s10903-013-9971-9

Cabanas, E. (2018). Positive psychology and the legitimation of individualism. *Theory & Psychology, 28*(1), 3–19. https://doi.org/10.1177/0959354317747988

Cabral, R. R. & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services. *Journal of Counseling Psychology*, *58*(4), 537-554. doi:10.1037/a0025266.

Carroll, L. J., & J. Peter Rothe. (2010). Levels of reconstruction as complementarity in mixed methods research: A social theory-based conceptual framework for integrating qualitative and quantitative research. *International Journal of Environmental Research and Public Health*, *7*(9), 3478–3488. https://doi.org/10.3390/ijerph7093478

Chadda, R. K., & Deb, K. S. (2013). Indian family systems, collectivistic society and psychotherapy. *Indian Journal of Psychiatry, 55*(2), S299-S309.

Chammas, G. (2020). The insider-researcher status: A challenge for social work practice research. *The Qualitative Report*, *25*(2), 537-552. https://nsuworks.nova.edu/tqr/vol25/iss2/16

Chandra, R. M., Arora, L., Mehta, U. M., Asnaani, A., & Radhakrishnan, R. (2016). Review: Asian Indians in America: The influence of values and culture on mental health. *Asian Journal of Psychiatry, 22*, 202-209. https://doi.org/10.1016/j.ajp.2015.09.011

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology*, *56*(4), 521–536. https://doi.org/10.1037/a0016905

Chang, D. F., & Yoon, P. (2011). Ethnic minority clients' perceptions of the significance of race in cross-racial therapy relationships. *Psychotherapy Research, 21*(5), 567-582. https://doi.org/10.1080/10503307.2011.592549

Christopher, J. C., & Hickinbottom, S. (2008). Positive psychology, ethnocentrism, and the disguised ideology of individualism. *Theory & Psychology, 18*(5), 563–589. https://doi.org/10.1177/0959354308093396

Chu, J., Leino, A., Pflum, S., & Sue, S. (2016). A model for the theoretical basis of cultural competency to guide psychotherapy. *Professional Psychology: Research and Practice*, *47*(1), 18-29. https://doi.org/10.1037/pro0000055

Chui, H., McGann, K. J., Ziemer, K. S., Hoffman, M. A., & Stahl, J. (2018). Trainees' use of supervision for therapy with sexual minority clients: A qualitative study. *Journal of Counseling Psychology, 65*(1), 36–50. https://doi.org/10.1037/cou0000232

Clarke, V., & Braun, V. (2018). Using thematic analysis in counselling and psychotherapy research: A critical reflection. *Counselling and Psychotherapy Research*, *18*(2), 107–110. https://doi.org/10.1002/capr.12165

Collins, S., & Arthur, N. (2010). Culture-infused counselling: A model for developing multicultural competence. *Counselling Psychology Quarterly*, *23*(2), 217–233. https://doi.org/10.1080/09515071003798212

Comas-Díaz, L. (2016). Racial trauma recovery: A race-informed therapeutic approach to racial wounds. In A. N. Alvarez, C. T. H. Liang, & H. A. Neville (Eds.), *The cost of racism for people of color: Contextualizing experiences of discrimination* (pp. 249-272). American Psychological Association. https://doi.org/10.1037/14852-012

Constantine, M. G., & Sue, D. W. (2007). Perceptions of racial microaggressions among black supervisees in cross-racial dyads. *Journal of counseling psychology, 54*(2), 142-153. doi:10.1037/0022-0167.54.2.142

Costa, B., & Dewaele, J.-M. (2014). Psychotherapy across languages: Beliefs, attitudes and practices of monolingual and multilingual therapists with their multilingual patients. *Counselling and Psychotherapy Research, 14*(3), 235–244. https://doi.org/10.1080/14733145.2013.838338

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Ellemers, N., & Haslam, S. A. (2012). Social identity theory. In P. A. M van Lange, A. W. Kruglanski, & E. T. Higgins (Eds.), *Handbook of theories of social psychology* (Vol. 2, pp. 379-398). Sage.

Ertl, M. M., Mann-Saumier, M., Martin, R. A., Graves, D. F., & Altarriba, J. (2019). The impossibility of client-therapist "match": Implications and future directions for multicultural competency. *Journal of Mental Health Counseling, 41*(4), 312-326. https://doi.org/10.17744/mehc.41.4.03

Faber, S. C., Osman, M., & Williams, M. T. (2023). Access to mental health care in Canada. *International Journal of Mental Health, 52*(3), 1–23. https://doi.org/10.1080/00207411.2023.2218586

Freeman, L., & Sullivan, C. (2019). Thematic analysis. In C. Sullivan & M. Forrester (Eds.), *Doing qualitative research in psychology: A practical guide* (pp. 161-184). Sage.

Gadalla, T. M. (2010). Ethnicity and seeking treatment for depression: A Canadian national study. *Canadian Ethnic Studies, 41*(3), 233–245. https://doi.org/10.1353/ces.2010.0042

Gelman, C. R. (2004). Toward a better understanding of the use of psychodynamically-informed treatment with Latinos: Findings from clinician experience. *Clinical Social Work Journal*, *32*(1), 61–77. https://doi.org/10.1023/b:csow.0000017514.64368.86

Gheorghe, C. (2022). Decolonization, polarization, psychoanalysis, privilege: Toward a cosmopolitan and culturally intelligent psychotherapist. *In Analysis, 6*(2), 128-133. https://doi.org/10.1016/j.inan.2022.10.002

Goh, M., Yon, K. J., Shimmi, Y., & Hirai, T. (2014). Experiences of Asian psychologists and counselors trained in the USA: An exploratory study. *Asia Pacific Education Review, 15*(4), 593–608. https://doi.org/10.1007/s12564-014-9347-4

Goode-Cross, D. T. (2011). Same difference: Black therapists' experience of same-race therapeutic dyads. *Professional Psychology: Research and Practice*, *42*(5), 368–374. https://doi.org/10.1037/a0025520

Goode-Cross, D. T., & Grim, K. A. (2016). "An unspoken level of comfort": Black therapists' experiences working with Black clients. *Journal of Black Psychology*, *42*(1), 29–53. https://doi.org/10.1177/0095798414552103

Hall, G. C. N., Ibaraki, A. Y., Huang, E. R., Marti, C. N., & Stice, E. (2016). A meta-analysis of cultural adaptations of psychological interventions. *Behavior Therapy*, *47*(6), 993-1014. doi:10.1016/j.beth.2016.09.005

Hamilton, A. (2023). Black therapists' experiences with their Black clients: A systematic review. *Journal of Marital and Family Therapy*, *50*(1). https://doi.org/10.1111/jmft.12678

Hancock, D. R., & Algozzine, B. (2006). *Doing case study research: A practical guide for beginning researchers.* Teachers College Press.

Hays, D., & Singh, A. (2011). Qualitative research: Paradigms and traditions (pp. 32-66). In *Qualitative inquiry in clinical and educational settings*. Guilford Press.

Hipolito-Delgado, C. P., Estrada, D., & Garcia, M. (2017). Diversifying counsellor education: A case study of U.S. students of colour. *British Journal of Guidance & Counselling*, *45*(5), 473–488. https://doi.org/10.1080/03069885.2017.1379597

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., Jr., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. https://doi.org/10.1037/a0032595

Huang, C. Y., & Zane, N. (2016). Cultural influences in mental health treatment. *Current Opinion in Psychology, 8*, 131–136. https://doi.org/10.1016/j.copsyc.2015.10.009

Ibaraki, A. Y., & Hall, G. C. N. (2014). The components of cultural match in psychotherapy. *Journal of Social and Clinical Psychology*, *33*(10), 936–953. https://doi.org/10.1521/jscp.2014.33.10.936

Inman, A. G., Devdas, L., Spektor, V., & Pendse, A. (2014). Psychological research on South Asian Americans: A three-decade content analysis. *Asian American Journal of Psychology*, *5*(4), 364-372. doi:10.1037/a0035633

Islam, F., Khanlou, N., & Tamim, H. (2014). South Asian populations in Canada: Migration and mental health. *BMC Psychiatry*, *14*(1). https://doi.org/10.1186/1471-244x-14-154

Ito, K. L., & Maramba, G. G. (2002). Therapeutic beliefs of Asian American therapists: Views from an ethnic-specific clinic. *Transcultural Psychiatry*, *39*(1), 33–73. https://doi.org/10.1177/136346150203900102

Jacob, K. S., & Kuruvilla, A. (2012). Psychotherapy across cultures: The form-content dichotomy. *Clinical Psychology and Psychotherapy, 19,* 91-95. https://doi.org/10.1002/cpp.736

Khan, A. (2006). *A portfolio of academic, therapeutic practice and research work including an investigation of the effect of ethnic matching on therapy process and outcome and the role of culture-sensitive factors in therapy with South-Asian clients* (Publication No. 27600355) [Doctoral dissertation, University of Surrey]. ProQuests Dissertations & Theses Global.

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149-164. https://doi.org/10.1177/1363461512444673

King, R. U., Este, D. C., Yohani, S., Duhaney, P., McFarlane, C., & Liu, J. K. K. (2022). Actions needed to promote health equity and the mental health of Canada's Black refugees. *Ethnicity and Health, 27*(7), 1518-1536. https://doi.org/10.1080/13557858.2021.1955092

Kokaliari, E., Catanzarite, G., & Berzoff, J. (2013). It is called a mother tongue for a reason: A qualitative study of therapists' perspectives on bilingual psychotherapy - Treatment Implications. *Smith College Studies in Social Work, 83*(1), 97–118. https://doi.org/10.1080/00377317.2013.747396

Lai, D. W., & Surood, S. (2008). Predictors of depression in aging South Asian Canadians. *Journal of cross-cultural gerontology*, *23*, 57-75. https://doi.org/10.1007/s10823-007-9051-5

La Roche, M. J., & Maxie, A. (2003). Ten considerations in addressing cultural differences in psychotherapy. *Professional Psychology: Research and Practice*, *34*(2), 180. doi:10.1037/0735-7028.34.2.180

Lee, E. (2014). A therapist's self-disclosure and its impact on the therapy process in cross-cultural encounters: Disclosure of personal self, professional self, and/or cultural self? *Families in Society, 95*(1), 15-23. https://doi.org/10.1606/1044-3894.2014.95.3

Levitt, H. M., Pomerville, A., Surace, F. I. & Grabowski, L. M. (2017). Metamethod study of qualitative psychotherapy research on clients' experiences. *Journal of Counseling Psychology, 64*(6), 626-644. doi:10.1037/cou0000222

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry.* Sage. https://doi. org/10.1016/0147-1767(85)90062-8

Loya, F., Reddy, R., & Hinshaw, S. P. (2010). Mental illness stigma as a mediator of differences in Caucasian and South Asian college students' attitudes toward psychological counseling. *Journal of Counseling Psychology*, *57*(4), 484–490. https://doi.org/10.1037/a0021113

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*(1), 1-20. https://doi.org/10.1348/000712600161646

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology, 41*(7), 884-901. https://doi.org/10.1002/jcop.21580

Meyer, O. L., Zane, N., & Cho, Y. (2011). Understanding the psychological processes of the racial match effect in Asian Americans. *Journal of Counseling Psychology*, *58*(3), 335–345. https://doi.org/10.1037/a0023605

Millner, U. C., Maru, M., Ismail, A., & Chakrabarti, U. (2021). Decolonizing mental health practice: Reconstructing an Asian-centric framework through a social justice lens. *Asian American Journal of Psychology, 12*(4), 333–345. https://doi.org/10.1037/aap0000268

Moodley, R. (2007). (Re)placing multiculturalism in counselling and psychotherapy. *British Journal of Guidance & Counselling*, *35*(1), 1-22. https://doi.org/10.1080/03069880601106740

Mosher, D. K., Hook, J. N., Captari, L. E., Davis, D. E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations*, *2*(4), 221–233. https://doi.org/10.1037/pri0000055

Morgan, B. E., Hodgson, N. A., Massimo, L. M., & Ravitch, S. M. (2024). The *Listening Guide*: Illustrating an underused voice-centred methodology to foreground underrepresented research populations. *Journal of Advanced Nursing*, *00*, 1–11. https://doi.org/10.1111/jan.16054

Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research*, *25*(9), 1212–1222. https://doi.org/10.1177/1049732315588501

Morse, J. M., & Richards, L. (2002). *Readme first: For a user's guide to qualitative methods.* Sage Publications.

Netto, G. (2006). Creating a suitable space: A qualitative study of the cultural sensitivity of counselling provision in the voluntary sector in the UK. *Journal of Mental Health, 15*(5), 593-604. https://doi.org/10.1080/09638230600900132

Nguyen, B. P. (2014). Identification: A qualitative study of the experiences of bilingual therapists with their monolinguals and bilingual clients. *Psychodynamic Practice, 20*(4), 340–355. https://doi.org/10.1080/14753634.2014.947168

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods, 16*(1). https://doi.org/10.1177/1609406917733847

Palinkas, L. A. (2014). Qualitative and mixed methods in mental health services and implementation research. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 851–861. https://doi.org/10.1080/15374416.2014.910791

Pandya, K., & Herlihy, J. (2009). An exploratory study into how a sample of a British South Asian population perceive the therapeutic alliances in family therapy. *Journal of family therapy, 31*(4), 384-404. https://doi.org/10.1111/j.1467-6427.2009.00474.x

Patel, V. (2014). Why mental health matters to global health. *Transcultural Psychiatry, 51*(6), 777-789. https://doi.org/10.1037/a002875799.x

Peachy, D., Hicks, V., & Adams, O. (2013). *An imperative for change: Access to psychological services for Canada*. Canadian Psychological Association. https://cpa.ca/docs/File/Position/An_Imperative_for_Change.pdf

Plante, T. G. (2014). Four steps to improve religious/spiritual cultural competence in professional psychology. *Spirituality in Clinical Practice, 1*(4), 288-292. http://dx.doi.org/10.1037/scp0000047

Ponterotto, J. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology, 52,* 126-136. doi.org/10.1037/0022-0167.52.2.126

Reddy, S. M. (2019). “If we’re not serving our own community, no one else would”: The lived experience of providers in ethnically similar therapeutic dyads at South Asian women’s organizations. *Journal of Ethnic and Cultural Diversity in Social Work, 28*(11), 1-16. doi:10.1080/15313204.2019.1570894.

Rees, P., Wohland, P., Norman, P., & Boden, P. (2011). A local analysis of ethnic group population trends and projections for the UK. *Journal of Population Research, 28*(2-3), 149-183. https://doi.org/10.1037/cou0000181

Rivera, E. P. (2023). Working with other immigrants brings the parts that I lost back to me: The experiences of Latin American immigrant therapists working with Latin American immigrant populations [Unpublished doctoral dissertation]. University of San Francisco. https://repository.usfca.edu/diss/656/

Shariff, A. (2009). Ethnic identity and parenting stress in South Asian families: Implications for culturally sensitive counselling. *Canadian Journal of Counselling*, *43*(1), 35–46. https://cjc-rcc.ucalgary.ca/article/view/58908

Shonfeld-Ringel, S. (2001) A re-conceptualization of the working alliance in cross-cultural practice with non-western clients: integrating relational perspectives and multicultural theories. *Clinical Social Work Journal, 29*(1), 53–63. https://doi.org/10.1023/A:1005258511296

Sim, J., Saunders, B., Waterfield, J., & Kingstone, T. (2018). Can sample size in qualitative research be determined a priori? *International Journal of Social Research Methodology*, *21*(5), 619–634. https://doi.org/10.1080/13645579.2018.1454643

Singh, M. D., & Bhayana, R. M. (2015). Straddling three worlds: Stress, culture and adaptation in South Asian couples. *Contemporary Family Therapy: An International Journal*, *37*(1), 45–57. https://doi.org/10.1007/s10591-014-9319-1

Smith, J. A., Chang, C. Y., & Orr, J. J. (2017). A phenomenological investigation: Microaggressions and counselors-in-training. *Journal of Creativity in Mental Health, 12*(2), 213–229. https://doi.org/10.1080/15401383.2016.1243076

Smith, J. A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* Sage Publications.

Soorkia, R., Snelgar, R., & Swami, V. (2011). Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain. *Mental Health, Religion & Culture, 14*(6), 613-623. https://doi.org/10.1080/14780880903121491

Statistics Canada. (2021). South Asians report lower levels of mental health than other visible minorities during the pandemic. https://www150.statcan.gc.ca/n1/daily-quotidien/200902/dq200902b-eng.htm

Strauss, A. L., & Corbin, J. M. (1997). *Grounded theory in practice*. Sage Publications.

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). John Wiley & Sons.

Szoke, D., Cummings, C., & Benuto, L. T. (2019). Exposure in an increasingly bilingual world: Native language exposure therapy with a non-language matched therapist. *Clinical Case Studies*, *19*(1), 51-61. https://doi.org/10.1177/1534650119886349

Thomson, M. S., Chaze, F., George, U., & Guruge, S. (2015). Improving immigrant populations' access to mental health services in Canada: A review of barriers and recommendations.

Journal of Immigrant and Minority Health, 17(6), 1895-1905. https://doi.org/10.1007/s10903- 015-0175-3

Tummala-Narra, P. (2016). *Psychoanalytic theory and cultural competence in psychotherapy*. American Psychological Association.

Tummala-Narra, P., Alegria, M., & Chen, C. N. (2012). Perceived discrimination, acculturative stress, and depression among South Asians: Mixed findings. *Asian American Journal of Psychology, 3*(1), 3–16. https://doi.org/10.1037/a0024661

Tummala-Narra, P., & Deshpande, A. (2018). Mental health conditions among South Asians in the United States. *Cross-Cultural Research in Health, Illness and Well-Being*, 171–192. https://doi.org/10.1007/978-3-319-91120-5_9

Verdinelli, S., & Biever, J. L. (2009). Spanish-English bilingual psychotherapists: Personal and professional language development and use. *Cultural Diversity & Ethnic Minority Psychology, 15*(3), 230. doi:10.1037/a0015111

Wagner, H. H., & Hill, N. R. (2015). Becoming counselors through growth and learning: The entry transition process. *Counselor Education and Supervision, 54*(3), 189–202. https://doi.org/10.1002/ceas.12013

Williams, M., Faber, S. C., & Duniya, C. (2022). Being an anti-racist clinician. *Cognitive Behaviour Therapist, 15*. Article e19. https://doi.org/10.1017/ S1754470X22000162

Winkeljohn Black, S., Drinane, J. M., Owen, J., DeBlaere, C., & Davis, D. (2021). Integrating spirituality as a multicultural component into time-limited psychotherapy: Two case studies. *Professional Psychology: Research and Practice, 52*(2), 121–129. https://doi.org/10.1037/pro0000369

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215–228. https://doi.org/10.1080/08870440008400302

Yon, K., Malik, R., Mandin, P., & Midgley, N. (2018). Challenging core cultural beliefs and maintaining the therapeutic alliance: A qualitative study. *Journal of family therapy*, *40*(2), 180-200. https://doi.org/10.1111/1467-6427.12158

Yoshida, A. (2013). *The perspectives of Asian therapists on the impacts of race and ethnicity with Asian clients and non-Asian clients of color ethnicity with Asian clients and non-Asian clients of color* (Publication No. 147041264) [Master's Thesis, Smith College]. Smith ScholarWorks.

Zane, N., & Ku, H. (2014). Effects of ethnic match, gender match, acculturation, cultural identity, and face concern on self-disclosure in counseling for Asian Americans. *Asian American Journal of Psychology*, *5*(1), 66–74. https://doi.org/10.1037/a0036078

Appendix A

Participant Screening Form

Thank you for your interest in this research. Please note that all prospective participants are asked the following questions to determine their eligibility for the study.

Inclusion criteria

1. What is your ethnic and/or cultural background (South Asian: Pakistan, India, Bangladesh, Nepal, or Sri Lanka)? _____

2. What kind of graduate level education/training have you completed (e.g., MSc, MSW, PhD, etc.)?

   _____

3. Which field of mental health do you practice in (e.g., clinical or counselling psychology, psychotherapy, clinical social work, or mental health counselling)?

   _____

4. Which provincial or national body are you licensed, registered, or certified with (e.g., College of Alberta Psychologists)?

   _____

5. Are you comfortable having an online interview for 60-90 minutes in English to discuss your experiences?

   Yes No

6. Please provide your name, phone number, and/or email address so that a researcher may reach out to you for participation.

   _____

7. I understand that by selecting the submit button, I agree to being contacted by the researcher for participation in this study:

   Submit Cancel

Appendix B

Participant Demographics Questions

Pseudonym: _____ Date: _____

To begin our interview, I will ask you a series of questions about yourself as part of describing the overall participant sample of this research. Please feel free to let me know if you wish to skip any questions.

1. What is your gender identity and preferred pronouns?

   _____

2. What is your current age?

   _____

3. How would you describe your ethnic and/or cultural identity?

   _____

4. Were you born in Canada?

   _____

5. How many years have you lived in Canada?

   _____

6. What is your professional title or qualifications/accreditation/certification? (e.g., registered psychologist, provisional psychologist, clinical social worker, etc.)

   _____

7. How many years have you been practicing as a mental health professional in Canada?

   _____

8. What setting do you currently work in? (e.g., university counselling centre, hospital/in-patient, out-patient, community clinic, private practice, etc.)

   _____

9. In which format do you provide counselling? (e.g., individual, couple, family, group, etc.)

   _____

10. What is your first language?
    a. Do you speak other languages?
    b. Have you previously provided mental health services in this language?

    _____

Appendix C

Interview Protocol

Pseudonym: _____ Date: _____

Start time: _____ End time: _____

The purpose of this interview is to explore your experiences of working as a mental health professional, particularly with South Asian clients in Canada. Before we begin, I would like to remind you that there are no right or wrong answers. During our conversation today, you may choose to skip a question, take some time to think about it, or withdraw from the study at any point without obligation.

Please feel free to share your experiences openly and let me know if my questions are unclear or if you want me to repeat something. Do you have any questions so far?

1) **How does your experience of working with South Asian clients differ from your experience with clients from other cultural backgrounds?**

2) **What have you noticed about your therapeutic relationship with South Asian clients compared to other clients?**
    i. Can you describe any specific challenges or advantages in building rapport with South Asian clients?
    ii. What have you noticed about the nature of your working alliance with South Asian clients?

3) **What have you noticed in terms of the interventions or theories that guide your practice with South Asian clients compared to other clients?**
    i. Which therapeutic approaches or interventions do you find most effective with South Asian clients? Why?
    ii. Are there any culturally specific practices or modifications you employ when working with South Asian clients? Describe them.

4) **How does your own cultural identity show up in your work with South Asian clients compared to other clients?**
    i. How do you navigate potential cultural similarities or differences with South Asian clients?
    ii. In what ways does your cultural identity enhance or hinder your therapeutic work?

5) **How would you describe your experience of counsellor education and training in Canada as a South Asian?**

   i. How did your training prepare (or not prepare) you as a South Asian mental health professional working with South Asian clients?
   ii. What kinds of supports or resources during your education or training do you believe may have potentially prepared you in this work?

6) **Is there anything else you would like to add that I haven't asked about, to help me better understand your experience?**

Appendix D

Informed Consent Form

Name of Researcher: Sameen Durr-e

Faculty, Department, Telephone & Email: MSc Student in Counselling Psychology, Werklund School of Education, University of Calgary, durre.sameen@ucalgary.ca

Title of Project: Experiences of South Asian mental health professionals in Canada

Supervisor: Dr. José Domene, RPsych, Professor, Werklund School of Education, University of Calgary, jfdomene@ucalgary.ca

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You are being invited to voluntarily participate in a research study. This consent form, a copy of which has been provided to you, is only part of the process of informed consent. Please take your time to carefully read and understand the information in this document. Feel free to ask questions to clarify the details mentioned here or to learn more about any information that is not included.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (REB*24-0871*).

Purpose of the study

This research aims to explore the experiences of South Asian mental health professionals (e.g., clinical or counselling psychologists, clinical social workers, psychotherapists, and mental health counsellors) who have practiced or are currently practicing in Canada. Specifically, this study is seeking to understand their experiences of navigating therapeutic work with South Asian clients.

What will I be asked to do?

You will be invited to participate in a one-on-one online interview for approximately 45-60 minutes to discuss your experiences with the researcher. The interview will be video- and audio-recorded on the secure video-conferencing platform, Microsoft Teams. We will begin by asking questions to gather some demographic information about all participants, followed by questions regarding your experiences as a South Asian mental health professional working with South Asian clients.

As a follow-up approximately 3-6 weeks after the initial interview, you will be contacted via email to review a draft of the analysis of your data, if you wish. You will be given the option to share your views on the final draft of the data analyses either through email or a brief online interview (30 minutes) via Microsoft Teams, which you are free to decline participating in.

Participation in this study is completely voluntary. You may choose not to participate in any parts of this study, and you may decline to answer any and all questions. You may withdraw from the study at any time without penalty or obligation, up until one week after the first interview. After that point, it will not be possible to remove your data from the study due to data analyses.

What type of personal information will be collected?

Should you agree to participate, you will be asked to provide your gender, age, ethnicity, academic major, and profession. Prior to beginning the interviews, you will be asked to provide your full name, telephone number, and email address. Your name, personal information, and recordings will be kept confidential, and you will be invited to use a pseudonym identifier. Only the primary researcher and the academic supervisor will have access to your name, telephone number, email address, this signed consent form, digital recordings, and transcripts.

Prior to recording the interview, you will have the option of creating a pseudonym with which you will be referred throughout the interview transcripts. This way, any quotes from your interview that are used in the final report or other publications will only include your pseudonym instead of your name.

Are there any risks or benefits if I participate?

You may find it interesting and helpful to discuss your experiences of navigating therapeutic work with South Asian clients in Canada. Your participation in this study may enhance our understanding of South Asian Canadian mental health professionals' experiences. Participating also may provide practical insights for developing more meaningful and effective therapeutic relationships with South Asian clients.

This study is not expected to pose any additional risks beyond what you would normally experience in your everyday life as a mental health professional. However, there is potential for participants to experience unpleasant memories or emotions during the interview. If any questions or topics bring up negative memories or emotions, you are encouraged to inform the researcher.

You may choose to take a break, reschedule, or stop participating at any time without obligation. If you need support and do not already have access to such support through your own professional network or EAP program, a list of appropriate community resources and services can be provided to you.

What happens to the information I provide?

Any digital video or audio files of the recorded interviews will be encrypted and stored under password protection for the duration of the study and deleted immediately after project completion. The transcripts and other documents created during the data analysis process will also be encrypted and stored under password protection for up to five years, after which they will be permanently erased.

Participants are free to withdraw until one week after data collection. After this point, withdrawal will no longer be possible since data analysis procedures will begin. Upon withdrawal, all the data you have contributed to the study will be permanently destroyed.

The information you provide will be used toward the completion of a master's thesis and potentially be presented at psychology conferences and published in a scholarly journal. No personally identifying information from participants will be included in any future presentations or publications. Additionally, any intermediary sources involved in recruitment (e.g., CPA Sections, personal networks, mental health organizations, etc.) will not be provided with any information about who does or does not participate in the study.

Signatures

Your signature on this form indicates that:

1) you understand, to your satisfaction, the information provided about your participation in this study, including potential risks, discomforts, and benefits, confidentiality, as well as the option to discontinue participation from the study at any time,
2) you consent to being audio and video recorded during the interview, and
3) you agree to participate in this study.

Please note that this does not waive your legal rights nor release the researchers or involved institutions from their legal and professional responsibilities. You are free to withdraw from this study at any time. Feel free to ask for clarification or for updates throughout your participation.

Preferred Pseudonym: _____

Participant's name: _____

Participant's signature: _____ Date: _____

Researcher's name: _____

Researcher's signature: _____ Date: _____

Questions/Concerns

If you have any further questions or concerns regarding your participation in this study, please contact:

Sameen Durr-e (Researcher)
MSc Student in Counselling Psychology
Werklund School of Education, University of Calgary
durre.sameen@ucalgary.ca

or

Dr. José Domene, RPsych (Supervisor)
Werklund School of Education, University of Calgary
403-220-3364 jfdomene@ucalgary.ca

If you have any concerns about the way you have been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at 403-220-6289 or 403-220-8640*; or email* cfreb@ucalgary.ca. *A copy of this consent form will be provided to you to keep for your records and reference. The researcher will keep a copy of the consent form.*

Appendix E

Invitation Letter

Dear ___,

My name is Sameen Durr-e and I am an MSc Counselling Psychology student at the University of Calgary. I am eager to invite you to participate in my thesis study exploring the experiences of mental health professionals in Canada with a South Asian background (Bangladesh, India, Nepal, Pakistan, or Sri Lanka). This includes those who have a graduate degree (e.g., MSc, MSW, PhD, etc.) in a mental health field, such as counselling or clinical psychology, psychotherapy, clinical social work, or mental health counselling.

As a participant, you will be invited to share your experiences through an individual online interview lasting approximately 60 minutes. You will be asked about your experiences as a mental health professional and your perspectives on working with South Asian clients. As a follow up, you will also be invited to share your feedback on the final draft of the data analyses by email or a brief interview (around 30 minutes). Your participation in the follow-up is entirely optional and you may decline to participate. Please note that your participation in this research will remain confidential and your information will be stored securely.

To determine your eligibility for participation, please complete the brief pre-screening survey [*hyperlink*], after which I will contact you to arrange an interview.

If you are interested in learning more or have questions, please contact me at durre.sameen@ucalgary.ca, or my thesis supervisor, Dr. José Domene, at jfdomene@ucalgary.ca. You can also view the attached poster for more information about the study.

Sincerely,

Sameen

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (*REB24-0871*).

Appendix F

Advertisement Poster

We're recruiting research participants:

UNIVERSITY OF CALGARY

SOUTH ASIAN MENTAL HEALTH PROFESSIONALS

About our study

We are exploring the experiences of South Asian mental health professionals who have worked with South Asians in Canada. You will be invited to participate in a 60-90 minute online interview.

Eligibility

- **South Asian** background (Bangladesh, India, Nepal, Pakistan, or Sri Lanka)
- **Graduate degree** (e.g., MSc, MSW, PhD, etc.) in counselling or clinical psychology, clinical social work, psychotherapy, or mental health counselling
- **Registration, licensure, or certification** with a provincial or national body
- Fluency in **English**

To participate, please use the QR code to complete a brief pre-screening survey to determine your eligibility:

For more information, please contact:
Sameen at durre.sameen@ucalgary.ca or
Dr. José Domene at jfdomene@ucalgary.ca

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study (REB24-0871).