EXPLORING ETHNORACIAL MINORITY CLIENTS' EXPERIENCES OF OPPRESSION DURING COUNSELLING WITH WHITE COUNSELLORS

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ABSTRACT

Multicultural counselling and psychotherapy theory and research that focuses on ethnicity and race in cross-cultural counselling have pointed to concerns of oppression within counselling processes; however, an open exploration of oppression that may occur in session is not readily available from the perspective of clients. As such, this thesis research explores the lived experiences of oppression for ethnoracial minority clients who have engaged in counselling with white counsellors, with the aim of gaining a deeper understanding of oppression and power in counselling, and possible resulting harm. This research is positioned within feminist and multicultural lenses, influencing the interviews themselves and the interpretations of participant experiences of oppression in counselling. Philosophical hermeneutics was used as the methodology to inform data collection and analysis. Five participants were interviewed using a semi-structured protocol to explore their counselling experiences for the following domains of interest: oppression, power, and harm. Through the analysis process, four major themes emerged for oppression (i.e., Whiteness of Therapy, Therapist Cultural Positioning in Sessions, Microinvalidations by Therapist, Disconnection Between Therapist and Client), four for power (i.e., Relational Power Differences in Therapy, Power Over by Therapist, Client Disempowerment, Client Empowerment Through Resistance), and three for harm (i.e., Hindered Counselling Process, Impeded Psychological Wellbeing, Generalized Negative Beliefs). Implications are discussed with the hope of informing multicultural research and training to improve competencies of professionals working within cross-cultural contexts.

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CHAPTER ONE

Introduction

While there is growing cultural diversity among professionals within the field of counselling and psychotherapy in Canada, the majority of professionals are Canadian-born, heterosexual, females of European descent (Bedi, Sinacore, & Christiani, 2016; 2018). Comparatively, visible minorities and immigrants collectively comprise 44% of the Canadian population ("Data Tables, 2016 Census", 2017). This disparity in demographics continues to motivate a need to better understand cross-cultural exchanges in counselling (Domene & Bedi, 2013). This holds particularly true in the less explored context of white[1] counsellors working with clients who identify as an ethnoracial minority, where power dynamics may manifest in the form of oppressive practice. To this end, my research question is 'what are the lived experiences of ethnoracial minority clients who experience oppression in counselling sessions with white counsellors?'. Specifically, this research will focus on 'cultural oppression'—often described as a form of social control where beliefs, values, and ideals are imposed onto minority groups (Hall, 2005)—in the context of race and ethnicity. The purpose of this research is to better understand ethnoracial minority clients' lived experience with power and oppression in counselling, and how these experiences may have caused harmed to clients. This research is built on a constructivist-interpretivist paradigm; hermeneutic phenomenology was used as the methodology and findings were conceptualized using a feminist-multicultural perspective.

Defining Terminology

When examining the terminology used throughout counselling and psychotherapy literature, it is important to outline the differences between "race", "ethnicity" and "culture." Although these terms are often used interchangeably, they have different meanings (Arthur & Collins, 2015; Hays, 1996). Arthur and Collins (2015) describe culture as one's holistic identity and positionality (e.g., ability, religious affiliations, gender, etc.). Moreover, culture is thought of as a dynamic, multidimensional construct that is learned through social interactions with individuals and groups within similar social contexts (Arthur & Collins, 2015). Although race and ethnicity are distinct from one another and from culture, they both include a cultural facet

[1] Research tends to capitalize the term "white", while not capitalizing terminology for racial or ethnic minority groups within Western society, which can further perpetuate unequal power relations. As such, "white" is not capitalized in this thesis in an attempt to equilibrate power between dominant and minority racial and ethnic groups included in this study.

(Hays, 1996). There are many definitions for both race and ethnicity; however, race generally encompasses biological characteristics, historically and politically oppressive contexts, and cultural components (e.g., norms, behaviours), while ethnicity includes the origin of one's traditions and values that are passed down by ancestors (Harley, Jolivette, & McCormick, 2002).

In multicultural counselling and psychotherapy (MCP) research in North America the terms "non-white" and "white" have commonly been used when exploring race and ethnicity within cross-cultural counselling—which is described as counselling relationships where counsellors and clients are of different social identities from one another (Gonzalez, Biever, & Gardner, 1994). In modern Western society, the term white is used to describe a socially dominant racial identity possessed by those with visible "whiteness" (McDermott & Samson, 2005). Whiteness is a social construct that maintains white privilege (Suchet, 2007) and encompasses a set of socialization processes, power structures, policies, privileges, and life experiences that favour those classified as white (Helms, 2017). White at one time was considered an ethnicity, associated with those of certain European backgrounds. However, it is now primarily considered a race because white identity and whiteness have been extended to individuals of various ethnic groups, such as Italian and Irish immigrants (Bonnett, 1998; McDermott & Samson, 2005). Out of the conceptualization of white racial identity came the development of racial and ethnic minority identity (Rowe, Bennett, & Atkinson, 1994). Racial and ethnic non-dominant groups were termed "non-white" to create a distinction from the white socially dominant group (Madowitz & Boutelle, 2014).

Since white is associated with social dominance and non-white with non-dominance, using this terminology in research contexts perpetuates the idea that white is the ethnoracial standard and that people should be measured on a scale of whiteness (Madowitz & Boutelle, 2014). Applying this non-white label to ethnic and racial minority groups reinforces power hierarchies that favour white supremacy (Madowitz & Boutelle, 2014; Sue, 2015; Wendt, 2015). Due to the covert, subtle, and pervasive societal association between non-white and inferiority, this oppressive language can be experienced by ethnic and racial minorities as a microaggression (Sue, 2004; Wendt, 2015). Additionally, use of the term non-white in research can create further power differentials within the researcher-participant relationship by identifying participants, and the individuals they represent, as what they are not (Madowitz & Boutelle, 2014).

Alternative terms used in research, include "racially diverse", "ethnically diverse", "diverse racial backgrounds", "heterogeneous group", "REC" (race and/or ethnicity and/or culture) diverse groups, and "ethnoracial minority" (Chang & Berk, 2009; Madowitz & Boutelle, 2014; Wendt, 2015). Ethnoracial minorities have been defined in MCP literature as social groups that encompass individuals who identify as belonging to a racial, ethnic, and culturally non-dominant social group (Wendt, 2015). There has been some scrutiny regarding the term "minority", as it can homogenize diverse ethnoracial groups and may not accurately reflect the ethnic and racial landscape in Canada. However, alternative terms have not been presented in the literature. For the purpose of this study, participants who have different racial and ethnic identities from persons belonging to the white socially-dominant group of Western society will be referred to as an *ethnoracial minority*.

Counselling and psychotherapy are relational processes used to facilitate psychological change using cognitive, behavioural, developmental, somatic, affective, expressive, spiritual and systemic principles (CRPO, 2019; Sheppard, 2016). In this research, "counselling" and "psychotherapy", in addition to their derivatives—including "therapy", "therapist", "counsellor"—are used interchangeably to describe mental health services that participants engaged in. Research and the general public use these terms to describe similar professional practices, without much consensus on how they differ from each other and how best to define them (Domene & Bedi, 2013).

Defining the Problem

Oppression and discrimination contribute to the development of psychological issues—such as depression, anxiety, negative affect, low self-esteem, and distorted cognitions—among ethnic and racial minorities living in white Western society (Brown, 2003; Morrow, & Weisser, 2012; Nadal et al., 2014; Thompson & Neville, 1999). There has been rising concern that power inequalities leading to oppression may also manifest in therapy exchanges between white counsellors and ethnoracial minorities (DeVaris, 1994; Fiske, 1993; Gushue & Constantine, 2007; Maurer, 2016). For example, Maurer (2016) shows how white counsellors exert their power by imposing whiteness norms and values through using positive language to describe desirable client behaviours and negative adjectives to describe behaviours that are traditionally non-Western. Moreover, counsellors are often unaware of their own privilege and power that may contribute to unintentional oppressive practices with ethnoracial clients (Audet et al., 2014;

Audet, 2015). Multicultural competencies and respect for diversity are expected of Canadian counselling and psychotherapy professionals, as reflected in professional codes of ethics and standards of practice (CCPA, 2007, 2015; CRPO, 2011, 2016). Indeed, counsellors' potential for engaging in oppressive practice with ethnoracial minority clients, even if inadvertent, would be considered counter to the ethical principle of "do no harm" (CCPA, 2007; Audet, 2015).

Understanding the impact that dynamics comprising of racial and ethnic differences may have on clients and counselling processes is a priority for counselling psychology research, training, and practice (Audet, 2015). Social justice, feminist, and multicultural perspectives particularly emphasize the importance of cultural context in counselling practice, focusing on issues of power and oppression between individuals and within systems, as well as valuing individual diversity (Moodley, 2007). Although there is some research demonstrating the presence of oppression and power inequalities in cross-cultural counselling and how this impedes therapy (Houshmand, Spanierman, & De Stefano, 2017; Lee & Bhuyan, 2013; Owen et al., 2014; Wendt, 2015), much of this research examines clients' experiences with preconstructed ideas of oppression, rather than exploring their lived experiences (Owen et al., 2014; Owen et al., 2016).

Research has demonstrated disparities between client and counsellor perceptions within multicultural contexts, which is exemplified through findings from Dillon and colleagues (2016) that highlight the discrepancies between client's ratings of their therapist's multicultural competency (MCC) and therapist's self-reported MCC. As such, including ethnoracial minority clients as research participants may provide new knowledges regarding oppression and power in counselling, as their perception of oppression in sessions may differ from that of their therapists. My thesis research will use a qualitative approach to explore ethnoracial minority clients' experiences of power and oppression in counselling with white counsellors, in a manner that is both non-restrictive and holds ethnoracial minority clients as experts of their own experiences.

Personal Prelude

My volunteer experience as a crisis counsellor for survivors of assault helped shape my understanding of the social constructs of power and oppression influencing various social identities, such as gender, race, ethnicity, and sexual orientation. Furthermore, this counselling-orientated experience spurred my interest in exploring oppression and power for those of minority group memberships within a counselling context. Additionally, I have been involved in agencies that service vulnerable populations and minority groups, including inner-city youth and

families living in homelessness. These experiences exposed me to the oppressive experiences of many ethnoracial minorities, such as immigrants and refugees, which has shaped my passion for research within the context of race and ethnicity specifically.

Upon entering my graduate program, I developed a curiosity around how my own identity, as a white counsellor-in-training, will influence my interactions with clients who identify as ethnoracial minorities. Specifically, I wanted to develop my knowledge on how cross-cultural counselling exchanges between white counsellors and ethnoracial minority clients could further oppress and disempower these individuals. As such, I conducted a pilot study, in my Qualitative Research course, on the counselling experiences of an individual who identifies as an ethnoracial minority and had previous experience of being counselled by a white counsellor. From interviewing this participant, I learned that cultural oppression can occur in therapy, regardless of the counsellor's intentions, and that these experiences can leave clients feeling powerless within the counselling relationship and unable to exercise their own autonomy in improving their psychological well-being. I was saddened by the reality that individuals seeking support could be met with experiences that further perpetuate their oppression and psychological distress. Furthermore, I was dismayed by how this finding opposed the counselling profession's ethical principles of promoting client well-being, reducing harm, and providing equal care.

My interactions with participants who will be included in my research will be influenced by the intersectionality of my identities. I am a 25-year-old, educated, heterosexual, white, Canadian-born, cis female. I am aware of the aspects of my social identity that provide me with privileges and oppressions and recognize that I must maintain this awareness throughout my research endeavours. I acknowledge that I hold a level of power based on my positionality within society and this research study. As such, I will reflect on my positionality throughout the process and share power with participants, to ensure that the resulting knowledge is co-created.

Thesis Overview

In the next chapter, I introduce the research through a review of the current literature, which initially defines constructs of oppression, power, and harm and the position of ethnoracial minority individuals within mental health to indicate their vulnerability and stigmatization. Mainly, the literature review examines research on oppression and power within the cross-cultural context described in the presented study, with additional attention to harm and professional ethics. Chapter Three delineates the conceptual framework of a feminist-

multicultural perspective, which is used as the theoretical lens for constructing and conducting this study. In Chapter Four, the methodology is discussed, including the methodological framework of philosophical hermeneutics, the methods involved in data collection and analysis, and the trustworthiness of the research. Chapter Five describes the results, with the demographics and counselling context outlined initially and the interpretative analysis of interviews separated into the constructs of oppression, power, and harm. Chapter Six begins with a critical reflection on the research process and then discusses interpretations and meanings of the results based on the literature, with limitations and contributions outlined at the end.

CHAPTER TWO

Literature Review

The aim of this literature review is to present key knowledges regarding oppression and related power dynamics within cross-cultural counselling. As oppression and power are main constructs under examination in this research, I first describe these terms and associated constructs. The impact of oppressive experiences on mental health of ethnoracial minority groups is then discussed to highlight the importance of researching this population.

In the context of counselling, this review presents research on counsellors' cultural biases that can create power imbalances in counselling, the oppressive behaviours of counsellors in session that are representative of these biases, and how these behaviours shape client's experiences in counselling. Furthermore, I explore the harmful impact of oppressive experiences in counselling sessions and the conflict between oppressive practices and professional ethics. Lastly, I discuss therapeutic conditions, theoretical orientations, and multicultural approaches that help in mitigating oppression for ethnoracial minority clients.

Oppression, Privilege, and Power

Cultural oppression, which can lead to psychological and emotional distress (Hanna, Talley, & Guindo, 2000), has been described as a product of social hierarchies where inaccurate beliefs, ideals, and values are imposed onto members of social minority groups (Hall, 2005; Hanna, et al., 2000). To understand oppression, it is important to also examine the concepts of privilege and power, which are very much intertwined. Privilege is defined as unearned advantage in favour of dominant social groups, fostering these groups' entitlement for social benefits, while also remaining out of awareness for those who benefit from it (Black & Stone, 2005). Socially dominant individuals, groups, and systems bestow privilege onto those who possess (or are assumed to possess) socially desirable identities associated with race, ethnicity, gender, sexual orientation, age, socioeconomic status, etc. (Black & Stone, 2005; Israel, 2012).

Taking a deeper look at racial and ethnic privilege, McIntosh (1998) examines her own white privilege. She states that although white people learn about racism and the disadvantages of "non-normative" racial groups, they are often taught not to see their own privilege. Certain power is also associated with privilege, such that privileged social groups possess the power to assert their dominance over minority groups and maintain the systems of privilege and oppression (Johnson, 1978; Sagrestano, 1992). For example, white privilege acts as an

expression of power, as only those who are racially white are benefited and those of different racial and ethnic identities are further disadvantaged and disempowered (Black & Stone, 2005; Neville et al., 2000; Thompson & Neville, 1999).

Ethnoracial Minorities and Mental Health

Mental health is impacted by social and cultural contexts that are linked to power hierarchies, oppression, and privilege. Unequal distribution of power between different racial and ethnic group memberships and experiences of oppression is associated with greater vulnerability for mental health issues (Arthur & Collins, 2015; Brown, 2003). Forms of racial oppression include racial discrimination, internalized racism, racial microaggressions, and systemic oppression (Brown, 2003; Sue et al., 2007; Thompson & Neville, 1999; Williams & Williams-Morris, 2000)—defined as longstanding laws, policies, and practices that favour privileged groups and limit access to social systems such as healthcare (Leyland et al., 2016). Specifically, these types of oppressive experiences for ethnic and racial minority groups can lead to psychological impairments, including inadequate coping skills, inability to relate to others, distorted perceptions, negative affect, lack of behavioural control, feelings of distrust towards others, and low self-esteem (Houshmand et al., 2017; Thompson & Neville, 1999). While oppression experienced outside of counselling can lead ethnoracial minority individuals to seek counselling (Houshmand et al., 2017; Nadal et al., 2014), they can also be met with similar oppressive experiences in counselling—a process that is expected to help those who engage in it.

Clinical Barriers for Ethnoracial Clients

A variety of factors inhibit certain ethnoracial clients from accessing services, whether these barriers are related to client-held values or systemic and structural issues. Regarding the former, many ethonoracial minorities tend not to possess the same degrees of help-seeking behaviours as white individuals (Tracey, Leong, & Glidden, 1986). Specifically, certain cultural values and attitudes can impede seeking supports, including proscriptions against discussing personal issues with non-family members, beliefs of the "model minority" that creates denial of psychological issues, collectivist values and importance of family obligations, lower levels of acculturation, and low orientations towards positive social networks (Das & Kemp, 1997; Tata & Leong, 1994). Cultural and social stigma contributes to barriers as well, since many cultures typically hold negative views about mental illness and treatment. As such, stigma around having mental health issues can create fear of judgement from one's community or family and loss of

social supports, which is a predictive factor for help seeking behaviour (O'Mahony & Donnelly, 2007). Furthermore, spiritual beliefs and reliance on traditional health practices are seen as factors that influence willingness to access mental health care services, as these values represent a source of strength and resiliency (O'Mahony & Donnelly, 2007).

Due to the demographic landscape of professionals in counselling-related fields, cultural and linguistic mismatches may contribute to barriers experienced by ethnoracal minorities (Matthew and Hughes, 2001). Specifically, Graham, Bradshaw, and Trew (2009) discuss barriers within current mental health services for Muslim clients, including language barriers due to limited English proficiency and understanding, conflicts of cultural values and policies of agency, power imbalances between clients and service providers, cultural misunderstandings by service providers, and cultural insensitivity among service providers. Cost-related factors have also been shown to influence ethnoracial minority's access to mental health services, including lack of insurance coverage, employment opportunities and sufficient financial feasibility for services, in addition to factors related to knowledge about counselling and available resources (Matthew & Hughes, 2001; Graham, Bradshaw, & Trew, 2009).

Cultural Oppression and Power Dynamics in Counselling

Processes of cultural oppression have been described within MCP literature, including cultural stereotypes, colour-blindness, cultural countertransference, whiteness norms, and microaggressions. I address each process separately below by first briefly introducing the process and then examining it in the context of the cross-cultural client-counsellor dyad. Most of the current empirical literature does not explore ethnoracial minority client experiences of oppression and power in cross-cultural counselling from the perspective of the clients themselves. Of the studies that do include client's experiences of oppression and power, there are some that explore experiences of microaggressions (Constantine, 2007; Sue et al., 2009; Owen et al., 2014), therapist whiteness (Lee & Bhuyan, 2013), and effects of therapist multicultural orientation and humility (Owen et al., 2011; Owen et al., 2016). However, these studies explore client perspectives of predetermined constructs of oppression and power, such as types of microaggressions and forms of whiteness. As such, to the knowledge of the researcher, there are no studies exploring client experiences of oppression and power more generally and without confines, from the perspective of clients themselves.

Cultural stereotypes. Racial and ethnic stereotypes are automatic and generalized cognitive perceptions of members who identify as particular racial or ethnic groups, which tend to be limiting and devaluing in nature (Chang & Kleiner, 2003). As a result, racial and ethnic minority individuals who are perceived negatively by society can develop feelings of worthlessness and inferiority (Chang & Kleiner, 2003). Stereotypes mediate the power dynamics in therapeutic relationships by providing individual of dominant group status control over oppressed groups (De Varis, 1994; Fiske, 1993). For example, therapists can categorize clients based on their sociocultural identity and apply the same assumptions of behaviours, psychological issues, and appropriate treatment to everyone in that socially constructed group, which can oppress clients, disrupt the therapeutic relationship, and limit psychological improvement (De Varis, 1994). Additionally, therapists tend to pathologize behaviours, feelings, and thoughts of those within marginalized groups, based on their departure from "normal" standards for those living in a white Western society (Morrow, & Weisser, 2012; Wendt, 2015). As such, ethnoracial minority groups tend to be over-diagnosed with mental health illnesses and perceived as more emotionally disturbed by white counsellors (De Varis, 1994; Wendt, 2015).

Colourblindness. Cultural stereotypes can foster "colourblindness", which influences individuals to unconsciously behave in ways that align with their inaccurate beliefs about social groups and societal systems (Neville, Worthington, & Spanierman, 2001). Colourblindness includes attitudes, beliefs, and behaviours that express a blatant denial and/or distortion of racial oppression and the impact of race on one's life (Gushue, Constantine, & Roberts, 2007; Neville et al., 2001). Neville et al. (2000) has established three dimensions of colourblind attitudes, including the denial of white privilege, institutional and systemic racism, and overt racial discrimination. For example, individuals with white privilege are often unaware of how their racial status benefits them, which maintains their beliefs that racialized individuals are not impacted by their racial identity (Neville et al., 2001).

In a counselling context, many white therapists with colourblindness are unaware of their privilege and the oppressive experiences of their ethnoracial minority clients. Studies examining the occurrence and effect of colourblindness attitudes in therapy include counselling professionals as participants, as opposed to ethnoracial clients themselves. Gushue and colleagues (2007) demonstrate the connection between high degrees of racial colourblindness and lack of awareness of privilege and dominant social status in white counselling and clinical

psychologists. They suggest that racially colourblind attitudes can be detrimental to the counselling process as beliefs held by white counsellors can unconsciously impact the assessment, relationship, and treatment used with racialized clients, from the perspective of the counsellors themselves (Gushue, Constantine, & Roberts, 2007). Gushue (2004) demonstrates this relationship by showing that therapists with high colourblind attitudes rated "black" clients as more symptomatic than their white clients. Furthermore, white therapists with higher colourblind attitudes tend to feel less empathy towards their African American clients and attributes client problems to internal, rather than external factors such as discrimination (Knox & Burkard, 2004).

Cultural countertransference. "Cultural countertransference" is a therapeutic process where therapists' culturally-established values, theoretical counselling beliefs, biases about other ethnic groups, and feelings about their own ethnic identity unconsciously manifest within the therapist-client dyad (De Varis, 1994; Foster, 1998). Comas-Diaz and Jacobsen (1991) describe possible interethnic countertransference reactions that can influence therapists' behaviours towards clients, which include: denial of ethnocultural differences, over-interest in client's ethnicity, guilt regarding societal power differentials, pity for clients' political impotence, aggression towards client for arousing guilt, and unawareness of cultural value conflicts.

Cultural countertransference can unconsciously interplay within the therapeutic relationship and perpetuate societal power dynamics that favour the therapist (De Varis, 1994). For example, the values of white therapists tend to correspond with individualistic ideology of Western culture—where the "self" and individual responsibility are essential components of therapy— and can conflict with interconnectedness values held by clients from collectivist backgrounds (Lee & Bhuyan, 2013; Sue, 1978). These individualistic values that inform white counsellor's practice may steer ethnoracial minority clients away from solutions that better fit with their own collectivist values. The most salient component of cultural countertransference that creates the greatest degree of imbalance in the power relationship are the therapist's personally driven biases towards ethnic groups that are different from their own (Foster, 1998). The unconscious views therapists hold about their clients can impede the development of an authentic therapeutic relationship and compels therapists to behave in ways that reflect these negative perceptions (De Varis, 1994; Foster, 1998).

Whiteness norms. "Whiteness norms" are ideologies associated with characteristics of whiteness and imposed onto members of Western society (Guess, 2006). Whiteness has been discussed in literature as a set of practices and values, produced historically, politically, socially, and culturally, that promote Eurocentric ideology and white people's ability to racialize and dominate others (Diangelo, 2006; Frankenberg, 1993; Lee & Bhuyan, 2013). In the counselling context, many theories, techniques, and treatments that white counsellors use are rooted in the values and beliefs of Western society and tend to be individual-centered, with an emphasis on changing cognitions, emotions, and behaviours (Sue, 2015). Furthermore, Western counselling and psychotherapy typically holds the view that maladaptive development of the individual 'self' is a main factor contributing to mental health issues and prioritizes self psychology in counselling practices (Das & Kemp, 1997).

White therapists can unknowingly impose their therapy ideologies onto their clients because they often regard assumptions underlying certain disorders as culturally universal when this may not be the case (Maurer, 2016; Sue, 2015). Additionally, white therapists can unintentionally present their Western values as truths, providing a narrow view of the client's problems and giving therapists the power to decide "what is right" (Houshmand et al., 2017; Lee & Bhuyan, 2013; Maurer, 2016). Wong and Piran (1995) discuss common underpinnings within Western practice that may conflict with ethnoracial minority values, including assumptions of normal behaviour, dependence on linear thinking, focus on individualism, overemphasis on independence, neglect of client social supports, fragmentation by academic disciplines, use of abstract language, focus on individual change, neglect of history, and dangers of cultural encapsulation. For example, white therapists can impose whiteness norms that express what a "good" client is in Western society, persuading clients to perceive their issues and solutions in a manner that aligns with these societal perspectives (Lee & Bhuyan, 2013; Maurer, 2016). Due to the inherent power dynamics between therapists and clients, in the context of therapist's counselling expertise and ethnic and racial identity status, attempts for ethnoracial clients to resist whiteness are usually unsuccessful (Lee & Bhuyan, 2013).

Microaggressions. Another form of oppression elicited through therapist behaviours in cross-cultural relationships is termed "microaggressions" (Constantine, 2007; Houshmand et al., 2017). Microaggressions are generally described as subtle and common verbal and behavioural expressions of oppression that are intentionally or unconsciously expressed (Ratts et al., 2016;

Sue et al., 2007). Due to the subtle nature of microaggressions, this form of oppression tends to be out of awareness for perpetrators and can easily be expressed in counselling as a result (Houshmand et al., 2017; Owen et al., 2014). Owen and colleagues (2014) demonstrate a high prevalence of microaggressions by white therapists in cross-cultural counselling with non-white clients, with 53% of clients reporting microaggressions in session. Since microaggressions are innately covert to dominant social groups, they can unknowingly create similar oppressive situations for minority clients and contribute to unhelpful power dynamic in therapy.

Houshmand and colleagues (2017) developed an overview of racial microaggressions that can be expressed by therapists during sessions, which include microinsults, microassaults, and microinvalidations. *Microinsults* include moments where therapists are insensitive to their clients' culture by suggesting treatments and assessments based on whiteness values (e.g., emotion-focused therapies). *Microinvalidations* are missed opportunities by therapists to discuss cultural thoughts, feelings, and experiences of clients. Lastly, *microassaults* are more overt forms of racism that involve therapists acting or speaking in a discriminatory manner based on their clients' cultural identity (Houshmand et al., 2017).

Few studies have explored microaggressions from the perspectives of ethnoracial minorities specifically to identify the types of oppressive practices experienced as microaggressions (Constantine, 2007; Sue et al., 2009). African American counselling clients have identified microaggressions in a study by Constantine (2007). These include: colourblindness; overidentification; denial of personal or individual racism; minimization of racial-cultural issues; assigning unique/special status on the basis of race or ethnicity; stereotypic assumptions about members of a racial or ethnic group; accused hypersensitivity regarding racial or cultural issues; meritocracy myth; culturally insensitive treatment considerations or recommendations; acceptance of less than optimal behaviours on the basis of racial-cultural group membership; idealization; and dysfunctional helping/patronization. Furthermore, Sue and colleagues (2009) demonstrate microaggression themes as described by Asian Americans specifically, including alienation in their own land, ascription of intelligence, denial of racial reality, exoticization of Asian American women, invalidation of interethnic differences, pathologizing cultural values and communication styles, second class citizenship, and invisibility.

Harm and Ethics in Multicultural Counselling

Harms of cultural oppression and client disempowerment. From a MCP perspective, Wendt (2015) has highlighted a number of sources of potential harm, including microaggressions, institutional racism, victimization, discrimination, and social control, among others. Within MCP, cultural oppression is interconnected with harm, as many relational experiences of oppression involve dominant groups harming those from marginalized or subordinate groups (Hanna et al., 2000). Racial microaggressions in counselling have been shown to influence the therapeutic relationship, client satisfaction, and client-perceived cultural competency. In one study, African American clients who reported higher degrees of racial microaggressions by their white therapists experienced a weaker therapeutic relationship, were less satisfied with counselling, and perceived their counsellor to have lower cultural competency (Constantine, 2007). In another study, Owen and colleagues (2014) demonstrated that racially and ethnically diverse clients who report occurrences of microaggressions in therapy perceive a weaker therapeutic alliance, ultimately disrupting therapy outcomes and psychological improvements. More importantly, of those clients who reported microaggressions by therapists, 76% of them stated that their therapist did not address these incidents in therapy (Owen et al., 2014).

Much of the literature on oppression-related harm in counselling focuses on harm within the context of the counselling process, which includes negative impacts on client outcomes, psychological improvements, and therapeutic relationship. However, to the researcher's knowledge there have been no empirical studies conducted for the purposes of exploring client experiences of oppression-related harm associated with the impact on their lives outside of counselling.

Professional ethics. In Canada, the ethical guidelines for counselling and psychotherapy highlight the importance of respecting and attempting to understand clients' diversity (CCPA, 2015). Counselling professionals have the responsibility of attaining general cultural knowledge and discussing cultural-specific information with their clients (Arthur & Collins, 2015). In the Canadian Counselling and Psychotherapy Association's (CCPA) *Standards of Practice*, there are three ethical articles that speak to counsellors' responsibility in a multicultural context: A10 (*Sensitivity to Diversity*), B9 (*Respecting Diversity*), and D10 (*Sensitivity to Diversity when Assessing and Evaluating*). These ethical articles explicitly state the expectations for counsellors

to work towards understanding their clients' cultural backgrounds, not condone or engage in discrimination, and break down disruptive power dynamics (CCPA, 2015).

Cultural-related forms of harm may be subtle and therefore require directive inquiry that ethnoracial minority clients address themselves, such as using qualitative research designs where these participants are intentionally included (Wendt, 2015). A common critique in the code of ethics for mental health professionals in Canada is that guidelines for ethical, appropriate, and respectful behaviours for counsellors are not explicitly outlined (Pettifor, 2010). As such, there is a need for MCP research to develop information on therapist behaviours that create culturally oppressive harm for clients, and to inform education and practice.

Mitigating Oppression, Power, and Harm

The therapeutic alliance and relationship. The therapeutic alliance and therapeutic relationship have been recognized as the most important aspects of counselling and psychotherapy, in their influence on therapy effectiveness across theoretical orientations and therapeutic approaches (Vasquez, 2007). The therapeutic alliance represents the involvement between the client's reasonable self and therapist's analyzing self to establish an understanding of the purpose and goals for therapy (Hackney & Cormier, 2017; Vasquez, 2007). The therapeutic relationship encompasses the therapeutic alliance and conditions of therapist empathy, genuineness, and positive regard that help to create an authentic, safe space for clients (Hackney & Cormier, 2017).

Therapeutic alliance and relationship are thought to be a valuable component of multicultural counselling specifically. Comas-Diaz (2006) suggests that therapeutic relationships can be modified to fit client's interpersonal, developmental, and cultural needs, with attention to building trust and credibility and engaging in cultural empathy. Therefore, the more professionals are aware of the cultural values and perspectives of those they work with, the stronger the therapeutic alliance and relationship (Vasquez, 2007).

Therapist's multicultural orientation is believed to enhance the therapeutic relationship within cross-cultural contexts. Multicultural orientation can allow for culturally relevant explanations and suggestions to be provided, which ultimately establishes trust and safety, and deepens exploration (Owen, Tao, Leach, & Rodolfa, 2011). The component of trust within the therapeutic relationship seems to be a very important factor contributing to therapeutic

effectiveness for immigrants, in particular, because many newcomers tend to be distrustful of health professionals and the system (Vasquez, 2007).

Studies have demonstrated that therapist awareness and willingness to repair ruptures can prevent the deterioration of the therapeutic relationship and help maintain a positive outcome trajectory (Dillion et al., 2016; Owen et al., (2014); Owen et al., (2016). For example, clients whose therapists discussed the incidents of microaggressions had comparable ratings of therapeutic alliance to those clients who did not experience microaggressions (Owen, 2014). Owen and colleagues (2016) define this therapist quality of genuine openness and desire to understand their client's cultural identities as "cultural humility." Cultural humility incorporates therapist's willingness and ability to self-reflect on one's own cultural identities and their intersection with the cultural identities of others (Hook, Davis, Owen, & Deblaere, 2017). Cultural humility can equalize the power dynamics within the relationship by respecting the client's freedom to discuss their identity and experiences with oppression, while providing them the autonomy to decide what they are comfortable sharing (Owen et al., 2016).

In addition to cultural humility, cultural empathy has been described in MCP literature, explored using different word variations, including "inclusive cultural empathy" and "ethnocultural empathy" (Pedersen, Crethar, & Carlson, 2008; Rasoal, Eklund, & Hansen, 2011). Empathy is an important quality in the therapeutic relationship, and can counter intolerance, conflicts, and discrimination, while enhancing understanding, respect, and tolerance in both intra- and inter-cultural contexts (Rasoal, Eklund, & Hansen, 2011). Conventional or general empathy is the understanding of and concern for another's experience and involves feeling another person's inner feeling state (Pedersen, Crethar, & Carlson, 2008; Rasoal, Eklund, & Hansen, 2011). Ridley and Lingle (1996) first described cultural empathy as general empathy with the addition of a comprehensive understanding and acceptance of another's cultural context.

Inclusive cultural empathy fosters therapeutic relationships and is viewed as a learned skill for accurately understanding and responding to client's cultural context, using both similarities and differences between the counsellor and client (Pedersen, Crethar, & Carlson, 2008). Conversely, general empathy is typically understood as emerging from similarities between people. Rasoal, Eklund, and Harsen (2011) define ethnocultural empathy as containing all the qualities of general empathy, while specifying the relationship context in terms of cultural differences between the empathizer and the other person.

Theoretical orientations. Research has indicated that cultural differences exist in the realms of client's concepts of self-identity, perceptions of illness, and expectations of therapists. For example, certain cultures view the "self" as a collective, psychological issues as part of physical disorders, and therapists as experts and treatment providers (Portera, 2014). As such, certain theoretical orientations used within Western society may be incongruent with the perceptions, needs, and expectations of culturally diverse clients.

Studies have shown that "directive" or "active" psychotherapies tend to work better for ethnoracial minorities, as this therapist stance aligns with their views of mental health professionals and treatment. Directive approaches allow counsellors to offer their perspectives of the client's difficulties, provide suggestions for goals, and use direct interventions (e.g., interpretations, challenges, and psychoeducation) (Lin & Kim, 2004; Uzoka, 1983). Nondirective approaches allow clients to describe their presenting problem, direct their own goals, and involves use of nondirective interventions (e.g., reflections of feeling, empathetic listening, and restatements) (Lin & Kim, 2004). African American clients are seen to have lower attrition rates, greater verbal participation, and enhanced disclosures when engaging in psychotherapy with active therapists, in comparison to passive ones (Uzoka, 1983). Lin and Kim (2004) determined that Asian American clients report higher counsellor empathy and cultural competency, stronger working alliances, and greater session depth when engaging in directive counselling, in comparison to nondirective counselling. Furthermore, some studies indicate behavioural-constructivist or psychoanalytic methods may fit better for ethnoracial minorities clients (Portera, 2014). Specifically, cognitive behavioural therapy (CBT), culturally adapted or not, may be beneficial for many ethnoracial minorities because short-term, directive, solution-focused approaches tend to align with mental health and treatment perceptions certain ethnoracial groups may hold (Benuto & O'Donohue, 2015; Comas-Diaz, 2006).

Conversely, some research has also shown that more directive approaches may be ill-suited for some ethnoracial minorities, as certain groups and/or individuals within groups are unsettled by these therapeutic orientations (APA, 2003). Specifically, client-centred approaches that emphasize collaboration, client empowerment, and nonjudgement may be beneficial for this client population (Hurdle, 2002; Vicary & Bishop, 2005). Feminist approaches use interventions and skills (e.g., assertiveness training) designed to empower those within oppressed and marginalized social groups, namely women and ethnoracial minorities (Comas-Diaz, 2006).

Narrative approaches that involve processes of construction, deconstruction, and reconstruction of experience align with nondirective approaches in that they aim to be collaborative and non-hierarchical, and they are thought to be culturally sensitive in practice as narrative interventions tend to avoid blaming and pathologizing, focuses on strengths and values, and fosters therapist transparency (Laird, 2000). Furthermore, autobiographical interventions within Narrative therapy, such as journaling, storytelling, and rapping, may be more effective for ethnoracial minority clients specifically because these approaches align with collectivist cultural values (Heath, 2018; Sodhi, 2017)

Interpersonal psychotherapy, developed by relational theorists, can be culturally sensitive for clients who value interpersonal relationships and are orientated towards a collectivist lens, and is seen as particularly useful for Hispanic and Latino clients (Comas-Diaz, 2006). In line with interpersonal psychotherapy, family-centered and systems approaches are suggested when working with some clients from ethnoracial minority cultures who place a strong focus on extended families (Hurdle, 2002).

Multicultural therapeutic approaches. Cultural competencies are defined as sets of behaviours, attitudes, and policies that allows for systems, organizations, and professionals in the helping industry to work effectively in cross-cultural contexts (Hurdle, 2002). These competencies include self-awareness, awareness of clients' culture, and intervention strategies and techniques, and have been at the forefront of multicultural counselling in recent decades. These competencies have been endorsed by various ethical codes and standards in Canada and incorporated into earlier models for therapists working in cross-cultural contexts (Sue, 1978). Furthermore, studies have demonstrated that counsellor multicultural competency can influence client satisfaction of counselling, even when accounting for general competency of counsellors (Constantine, 2002).

Although these competencies have improved counselling practices with multicultural clients, the focus tends to be on implementation of appropriate interventions and techniques, rather than a comprehensive theoretical and practical framework for counselling. As such, a number of multicultural frameworks have been constructed using these cultural competencies, while incorporating an organizational structure based on theoretical, practical, and empirical foundations. Collins and Arthur (2010) termed their culturally informed therapeutic approach as "culture-infused counselling." Under this counselling perspective, cultural competency can be

broken down into three domains, including counsellor awareness of their own biases, accurate knowledge of client's culture, and ability to maintain a culturally sensitive working alliance (Qasqas & Jerry, 2014). Within the context of the working alliance, one can integrate their personal attitudes and beliefs, knowledge, and skills into therapy to co-construct goals and treatments that are culturally informed (Collins & Arthur, 2010).

"Intercultural counselling" originally constructed by Peavy in 1998, encompasses four domains of counselling between therapists and clients who are different in relation to their cultural identities (Peavy, 1998). For intercultural counselling, therapists must work with both their own cultural context and that of another, validate client's experience of oppression and marginalization, and work to help clients overcome these experiences. The process must be holistic and inclusive in nature and embody constructivist principles of respect of diversity, openness to interpretation, encouragement of cultural resonance, engagement, resistance to categorizing and pathologizing, emphasis on culture, collaboration, autonomy and empowerment, and use of culture-specific tools (Peavy & Li, 2003). Intercultural competencies are defined as skills, attitudes, abilities, and knowledge to create effective and appropriate relationship management with persons of different linguistic and cultural identities. These competencies have been constructed from Theories of The Person, the theory of Multiple Intelligences, Quality of Life theory, and the theory of Fundamental Human Needs (Portera, 2014).

Current Study

Cultural oppression ethnoracial minority individuals experience within Western society can create psychological distress, impede their mental health, and lead them to seek therapy. Unfortunately, these ethnoracial minority clients can experience oppression in therapy as well, with over half of ethnoracial minority clients having reported cultural oppression in sessions with their white therapist(s) in a study by Owen and colleagues (2014). Therefore, it is crucial to explore, in greater depth, ethnoracial client's counselling experiences of in-session oppression. Although oppression and power within the context of race and ethnicity has been a significant focus in the literature, there is limited discussion of clients' experiences of oppression, power, and harm in counselling. Moreover, much of MCP research focuses on oppression and cultural competency as perceived by the counsellor. Two studies have been published in recent years—those of Constantine (2007) and Owen and colleagues (2014)—exploring oppression in therapy

from the client's perspective. However, these studies explored preconstructed ideas and theories of oppression, such as microaggressions and whiteness, rather than exploring the client's lived experience. As such, MCP research could benefit from qualitative research approaches exploring oppression in cross-cultural relationships, as experienced by ethnoracial minority clients and without imposing preconstructed definitions of oppression. This research aims to further the counselling profession's knowledge of oppression in cross-cultural counselling, providing ethnoracial minority participants with the opportunity to share their voices and contribute to white counsellors' understanding of how they may (unintentionally) exhibit cultural oppression and harm clients.

CHAPTER THREE

Research Questions

The research questions of my study are: What are ethnoracial minority clients' lived experiences of:

1) *oppression* during counselling with a white counsellor?
2) *power* during counselling with a white counsellor?
3) *harm* that they may have experienced related to power and oppression during counselling with a white counsellor?

Conceptual Framework

A constructivism-interpretivism paradigm assumes that every individual has a unique perception of reality that influences the subjective meanings they construct for their experiences (Ponterotto, 2005). This conceptual framework is commonly used in MCP research, as it aligns well with the constructive process that occurs in counselling and psychotherapy itself (Morrow, 2007; Ponterotto, 2005). In this research, the meanings attributed to a phenomenon is typically co-constructed by the participant and researcher (Knox & Burkard, 2009; Morrow, 2007). Both objective information and subjective meanings behind a participant's experience can aid in the researcher's interpretation of the meaning given to an experience. The subjective meanings of a participant's experience of a phenomenon can be brought into awareness through research-participant activities, including interviews (Ponterotto, 2005). Current MCP research recognizes that participants' lived experience is conveyed through the researcher's interpretations of the participants' subjective reality, constructed by their social context (Morrow, 2007). Feminist and multicultural perspectives are both compatible with a constructivist-interpretivist paradigm and are suitable theoretical lenses that guide this research.

Feminist and Multicultural Frameworks

Feminist theory. In counselling and psychotherapy, feminist perspective asserts that people exist within a sociopolitical environment that privileges certain social groups and their psychological, social, economic, and political development, while oppressing others (Brady-Amoon, 2011). Feminism values the understanding of power dynamics and works to deconstruct social hierarchies in both practice and research (Brady-Amoon, 2011; Brown & Brodsky, 1992). Feminist thought has contributed greatly to critical discourse about oppression and power (Brady-Amoon, 2011), paving the way for research that focuses on these concepts that are at the

forefront of this research. Although feminism emerged in response to oppression of women, the second wave of feminism constructed the term 'intersectionality'. Intersectionality was constructed from the understanding that oppression exists within the interconnectivity of various social identities, and therefore oppressive experiences cannot be examined separately (Crenshaw, 1991; Enns &Nutt Williams, 2012). As such, a feminist perspective values the inclusion of oppressed groups across diverse contexts, such as gender, race, ethnicity, sexual orientation, age, and class (Brown & Brodsky, 1992). Within research, this perspective fosters a collaborative approach through the inclusion of minority participants and commitment to respect, equality, and shared responsibility for all research members (Brady-Amoon, 2011).

Multiculturalism. Multiculturalism emphasizes an understanding of non-dominant group identities, respect for diversity, and equality for those with marginalized social memberships (Verkuytem, 2006). This framework emerged as the fourth force of counselling, where cultural awareness and competency are essential for one's ability to practice in the counselling profession (Pedersen, 1991). Additionally, the MCP movement highlights the importance of exploring potentially harmful counselling practices that are culturally insensitive and oppressive (Wendt, 2015). The multicultural perspective incorporates demographic status, membership affiliation, and ethnographic variables, within the constructs of gender, ethnicity, religion, and class, among others (Gonzalez et al., 1994). Relevant to this research, a multicultural theoretical framework incorporates an exploration of cross-cultural exchanges, where the client and counsellor identify with diverse and differing social groups (Gonzalez et al., 1994).

Feminist-multicultural perspective. Both feminist and multicultural theories are established on ideologies that individuals from socially non-dominant groups (e.g., women, ethnoracial, LGBTQ, etc.) have different experiences than the dominant white Western European male's experience, and tend to be marginalized, misrepresented, and devalued (May, 1998). Additionally, feminist and multicultural perspectives recognize that women and ethnoracial minorities have been influenced by power, privilege, and oppression, and that Western society should value equality for all social groups (Brady-Amoon, 2011; May, 1998).

A feminist-multicultural perspective is suitable for this research, as feminism's concepts of power and oppression will be applied to explore harm in cross-cultural exchanges involving ethnoracial minority clients, which are themes within multiculturalism (Nutt Williams & Barber, 2004; Silverstein, 2006). Although this research aims to explore experiences specific to

ethnoracial identity, it is acknowledged that ethnoracial identity cannot be separated from other social identities. Therefore, one's holistic cultural context must be considered as well (Cole, 2009). Applied together, the two theoretical lenses of feminism and multiculturalism can create a more inclusive perspective of an individual's experiences with oppression, privilege, and power (Silverstein, 2006). Although this study aims to uncover knowledge on the lived experiences of oppression, power, and harm for clients who identify as ethnoracial minorities, the divulged experiences will reflect a certain intersection with participants' other identities, such as gender, immigration status, and socioeconomic status.

Research Methodology

To answer these research questions, I applied a qualitative research design to explore participant's lived experience. For counselling psychology research, qualitative designs have increased in use because they tend to be more congruent with the counselling field itself. Additionally, they are ideal for understanding complex psychotherapy processes in depth and conducting research that specifically explores the way in which people make sense of their experiences (Morrow, 2007). Phenomenology was used to orient this research, which involves exploration of how we experience phenomena and the meanings we attach to them (Clarke, 2009; Glesne, 2016; Morrow, 2007). Phenomenology is the investigation and interpretation of all components of a phenomenon, with the intention of understanding the nature of a person's whole experience (Glesne, 2016). The parameters that define the phenomenon under study include (a) ethnoracial minority individuals, (b) who have engaged in counselling with a white counsellor, (c) in which they felt oppressed in session. This phenomenon was unveiled through in-depth exploration of ethnoracial minority participant's lived experience, without relying solely on preconceived constructs and assumptions of this phenomenon (Chang & Berk, 2009).

Within phenomenology, a *philosophical hermeneutics* perspective, informed the data analysis process, to specify the way in which participants' experiences of oppression in counselling sessions was to be interpreted (Walsh, 1996). Traditional hermeneutics was developed by Wilhelm Dilthey as a philosophical discipline that functions to understand past meanings of texts through interpretations, born from interactions between interpreters and the interpreted (Agrey, 2014; Patton, 1990). Furthermore, hermeneutic theory argues that interpretations can only be made from the researcher's perspective, standpoint, or context, and therefore bracketing preunderstandings is not possible (Patton, 1990). Philosophical

hermeneutics is a modern form of hermeneutics that Hans-Georg Gadamer developed, which encompasses three main theses: "(1) to understand is in fact to interpret, (2) all understanding is essentially bound up with language, and (3) the understanding of the meaning of a text is inseparable from its applications" (Silverman, 1991). Gadamer emphasizes that interpretations are the creation of understanding based on previous and new meanings, rather than the recovery of pre-existing meanings (Agrey, 2014).

Within philosophical hermeneutics are the four key constructs of prejudice, fusion of horizons, the hermeneutic circle, and play. The understanding of meaning attributed to phenomena happens within the interpreter and transforms their own understanding; therefore, the meanings constructed are partially comprised of "prejudices"—which Gadamer defines as preconceived beliefs and understandings—held by the researcher (Klingle et al., 2018). Gadamer developed the concept of the "fusion of horizons", where the researcher's perspectives fuse with the participants' sense of the phenomenon to construct a new comprehensive understanding, shared between both the researcher and participant (Havercamp & Young, 2007; Walsh, 1996). The "hermeneutic circle" describes the interpretation process as iterative and endless, where the interpreter continuously moves between the parts and the whole of the text to produce meanings, rather than reproduce meanings (Aylesworth, 1991). "Play", for Gadamer, is intended to represent a metaphor for the understanding process itself, in which the player gets absorbed into the game, just as the interpreter becomes a part of the construction of meaning (Silverman, 1991; Walsh, 1996).

Philosophical hermeneutics explores one's experience through genuine curiosity, which aligns well with multicultural counselling practices where counsellors are encouraged to become aware of their own beliefs and assumptions, in addition to those of their clients (Havercamp & Young, 2007). Within this theory is the belief that regardless of the listener's desire to deeply understand the other, they can never fully know because they are separate beings (Klingle et al., 2018). Both philosophical hermeneutics and MCP recognize the limits to one's own knowledge and the need for the listener to suspend their assumptions momentarily to more closely approach the perspective of another (Klingle et al., 2018). However, this perspective also recognizes that researcher preunderstandings cannot be fully suspended and, as a result, enter the interpretation process and help to inform the co-construction of meanings of the phenomenon (Havercamp &

Young, 2007). As such, my knowledge of MCP and training in counselling will help interpret global meanings of participant experiences.

Method

Participants and Recruitment

Sampling. Purposeful heterogeneous sampling is used in phenomenology as it ensures that selected participants are "information rich cases" that exemplify the phenomenon and are diverse enough to provide unique meanings (Glesne, 2016; Havercamp & Young, 2007; Laverty, 2003). As such, this sampling method was used to recruit participants from a demographic of ethnoracial minority adults who have had counselling with a white counsellor, during which they experienced oppression. To participate in this study, participants had to self-identify as an ethnoracial minority, be in past individual counselling with a white counsellor, perceive themselves to have experienced oppression during counselling, be at least 18 years old, and be able to communicate in English. The inclusion criteria were defined to reflect the specific phenomenon under study, which explains the specificity of the participants required for adequate exploration of the phenomenon. It was required that participants' experiences of oppression in counselling occurred in the past to help ensure that exploration of their oppressive experiences did not interfere with their on-going counselling work and therapeutic relationship, if applicable. Additionally, participants had to be at least 18 years old to give their own consent to participate in the study and able to speak in English to limit potential language barriers.

Sample size. In qualitative research, the adequacy of data is based on "saturation", rather than sample size. However, up to eight participants were intended to be recruited, as this number generally facilitates saturation and deep descriptions (Morrow, 2005). This type of recruitment allowed sample size to depend on the availability of interested participants and the amount of time available to the researcher, as hermeneutic analysis can be intensive and time consuming. Based on these factors, six participants were interview in total; one of which was not included in the data analysis because their in-session experience did not meet the criteria of psychotherapy and counselling, despite having asked them during the screening process.

Recruitment. In addition to purposeful sampling of participants, this sampling strategy was utilized for recruitment sites as well (Creswell, 2015), including diverse counselling centers (both private practice and community-based), health clinics, and community centres in Ottawa, Ontario that provide access to ethnoracial minority clients. Gatekeepers at each site were

identified and contacted via email for permission to display the recruitment poster (Appendix A). If emails were not responded to by gatekeepers in Ottawa, each site was visited in-person to ask permission to display recruitment posters (e.g., post-secondary centres, community centres, clinics, counselling private practices, non-profit organizations).

Due to recruitment issues, the geographical location was expanded to include Toronto, Ontario and Montreal, Quebec and strategies were added to include social media and online advertisements. I created a Facebook page that was used as a landing page for individuals interested in participating in the research study, and included information about the study, eligibility criteria, and what participation would involve (Appendix B). The Facebook page was also used to reach out to Facebook groups and pages that were likely to have ethnoracial minority members and/or followers who fit the eligibility criteria and reside in Ottawa, Toronto, and Montreal. For example, many community associations for various ethnoracial minority groups have Facebook pages, where ethnoracial minorities can access information, services, and upcoming events, among others. These pages were identified, and the hosts/members were sent a Facebook message asking to post the recruitment poster and information about the study. An online advertisement through the Kijiji platform was created for all three city locations and included information about the study (Appendix B) and my contact information.

Lastly, snowball sampling was incorporated, through prospective participants, actual participants, social media, and online advertisement. Specifically, prospective participants who expressed interest in participating but did not meet the inclusion criteria were invited to forward a recruitment poster and study description to anyone they felt may be interested in the study. Actual participants who met the inclusion criteria and participated were invited to do the same at the end of their participation (i.e., end of the interview). A line stating "please feel free to pass along this information to anyone you feel would be interested" was included on the Facebook page and posts, and the Kijiji advertisement.

Screening. Individuals who responded to the recruitment poster were sent an in-depth study description (Appendix C) via email, to learn more about the study and their participation. If they were still interested in joining the study after reviewing the study description, I asked participants if they would like to either set up a phone call or be sent an email for screening purposes. The screening phone calls were guided by the screening text (Appendix D) and the screening emails were guided by an email template with the screening questions (Appendix E). If

individuals met the inclusion criteria and were still interested in participating in the study after completion of the screening process, they were asked to set up a meeting, either in person or via Skype, to discuss the study, obtain consent, and complete the data collection (i.e., background information questionnaire and interview).

Instruments Used

Background information questionnaire. A questionnaire was used prior to the interview to gather information relating to the participant's demographics, counselling experience, and racial and ethnic backgrounds (Appendix F). This questionnaire was used for the purpose of better understanding and contextualizing descriptions of participant experiences. Furthermore, general questions regarding their counselling experience (e.g., location, number of sessions, type of therapy, counsellor identity, etc.) were included to provide further understanding of their counselling context when analyzing interview transcripts. Additionally, this information was gathered to provide transparency for readers as the specific information regarding the participant's story could be used to better understand commonalities and differences among participants.

Interview protocol. A semi-structured interview protocol was used to guide the interviews (Appendix G). In line with phenomenology, a flexible data collection instrument is suggested as it allows for participants to guide interviews based on their unique experiences and answers to questions. A semi-structured protocol allows for exploration of participant's stories that may not have been included in the protocol, to ensure the data are rich and specific to each participant. Since the purpose of this study was to explore oppression in counselling that ethnoracial participants experience, this type of instrument aligns with this objective.

The questions are based on MCP literature and aimed to elicit responses pertaining to: (a) experiences of oppression with white counsellors; (b) experiences with power in counselling sessions; (c) the perceived harm from these experiences. The protocol is divided into sections based on the three domains of interest of oppression, power and harm, where each section begins with a broad open-ended question regarding the construct of focus. Following the initial question, sequential questions are considered probing questions to be asked depending on participant responses to the initial question and natural direction of the dialogue, which were incorporated into the conversation at varying times across interviews. The questions included were constructed with the intention of eliciting deep descriptions of meaning (Morrow, 2005).

The questions included are open-ended to promote deep responses and open exploration (Havercamp & Young, 2007; Polkinghorne, 2005) and are designed to receive concrete and detailed descriptions (Giorgi, 1997; Wertz, 2005).

The protocol is divided into the following five sections: (1) participant understanding of oppression (e.g., "What does oppression mean to you?"), (2) exploring their counselling context (e.g., "How would you describe your counselling experience in general?"; "Describe your relationship with your therapist"), (3) experiences with oppression in counselling (e.g., "What were your experiences of oppression in session with your counsellor?"; "What experiences do you have where your counsellor discussed your racial/ethnic identity?"), (4) experiences with power imbalances with white therapists (e.g., "How would you define power within your counselling experience?"; "Describe a time when you felt you did not have enough power in therapy"), (5) harmful impact of oppressive experiences in counselling (e.g., "How do you feel these oppressive experiences harmed you?"; "If you could change anything about your therapy experience, what would you change?"). The protocol is divided into sections to help guide the exploration of participant experiences and ensure each of the three domains is adequately discussed. Furthermore, the protocol starts with sections inquiring about broader contexts regarding participants' experiences with oppression in general and the counselling context in which they are describing as their oppressive experiences. These sections were designed to help ease participants into the discussion and foster reflection of potentially challenging and vulnerable experiences to share. Additionally, they were included to help situate the participant and obtain data regarding their unique understanding of oppression. Throughout the interviews, a couple of additions and modifications were added to the protocol based on participant experiences of oppression, power, and harm, and based on the flow of interviews. Questions that were added to the protocol are italicized and deleted questions have a strikethrough (Appendix G) to allow transparency.

Reflectivity practices. Philosophical hermeneutics acknowledges that the researcher's perspective cannot be removed from the interpretative process because researchers interpret from a lens constructed by preunderstandings of the phenomenon (Havercamp & Young, 2007; Laverty, 2003). As such, my own understandings of the phenomenon in question were incorporated into the data collection process, through continuous engagement in reflective practices (Laverty, 2003; Morrow, 2005). I maintained a reflective journal throughout my

research endeavours to facilitate my awareness of biases, assumptions, and pre-understandings, as well as emerging understandings of the phenomenon based on participant interviews and continued exploration of literature. Included in the journal were field notes taken after interviews and reflective notes taken throughout the data analysis process. Additionally, a written reflection of my preunderstandings of ethnoracial minority client's experiences of oppression with white counsellors was completed, and can be found in Appendix H. This was done prior to engaging in recruitment, data collection, and analysis to facilitate self-awareness and ensure transparency in the final report. A "Critical Reflection" section is included in the discussion section to help foster transparency—a characteristic of my research to create trustworthiness—and provide readers with an understanding of my personal experiences and assumptions that could have contributed to the interpretations made in the data analysis.

Procedures

Data collection. The meetings, consisting of the interview and completion of the background information questionnaire, were either conducted in person or online through Skype. Those participants who were geographically close to me, met with me in person, while those who were located farther away (i.e., Toronto or Montreal) had a Skype meeting with me instead. During the in-person meetings, the consent form (Appendix I), participants were invited to review the consent form, which was emailed in advance, and given the opportunity to ask questions. Both myself and the participant signed two copies of the consent form, one of which I kept and the other was given to the participant. For the online Skype meetings, participants were sent the consent form in advance to review. Those who were able to sign, scan, and email the form to me were emailed a copy with my signature added. For those who were unable to email a scanned consent form with their signature, the form was reviewed at the beginning of the online meeting and verbal consent was obtained. After participants provided voluntary informed consent, I asked them to complete a background information questionnaire to obtain context for participant descriptions of the phenomenon, which took approximately 10 minutes (Appendix E).

After completion of the questionnaire, one-on-one interviews, following a semi-structured interview protocol (Appendix G) were conducted to collect detailed first-person accounts of experiences of the phenomenon under study (Ponterotto, 2005). The use of a semi-structured protocol allowed for flexibility in the ordering of questions and opportunity to follow up on novel aspects of participant's experience that emerged (Wertz, 2005). Therefore, follow-up

questions and probes (e.g., "Describe a specific instance where…") were included throughout the interviews to unveil concrete details of participant's experiences and facilitate deep reflection (Wertz, 2005). Interviews were audio recorded and a pseudonym was assigned to protect participant anonymity and confidentiality. Participants had the option of choosing their own pseudonym, and one participant decided for theirs to be chosen for them. Field notes were written during and after the interviews to note participants' nonverbal expressions (e.g., tone, facial expressions, etc.) and to record my initial impressions of the interview.

One interview was conducted for each participant, approximately 60-90 minutes in duration (Knox & Burkard, 2009). Attention was given to establishing rapport with participants—through skills acquired during my counselling program (e.g., attentive listening, paraphrasing, reflection of feeling, minimal encouragers)—to produce the trust and comfort necessary for eliciting deep and detailed descriptions (Polkinghorne, 2005). Although counselling skills can be helpful in qualitative counselling research, these skills are not directly transferrable (Polkinghorne, 2005); therefore, I engaged in literature on the goals and skills required for qualitative interviewing prior to the participant interviews.

To aid in reducing distress that can arise from reflection and discussion of oppressive experiences, procedures for addressing participant's emotional state was implemented (Knox & Burkard, 2009). As a counselling psychology student, I utilized skills learned through my courses and practicum to recognize participant's emotional distress and paused or stopped the interview when required. To maintain clear boundaries, all participants, including those who did not express any emotional distress, were provided counselling resources for their consideration. Since only participants located in Toronto and Ottawa responded to recruitment and participated in the study, resource lists for Ottawa (Appendix J) and Toronto (Appendix K) were created.

Data analysis. I transcribed interviews verbatim to allow for in-depth analysis, and I highlighted information-rich non-verbals in the left-hand margin of the document (Polkinghorne, 2005). The analysis process involved analysis of the "whole text", which included the interview audio-recording, transcript, field notes, journal reflections, non-verbal expressions, and the background information questionnaire (Fleming, 2003). Hermeneutic analysis includes the fusion of participant and researcher understandings—described as the "fusion of horizons"—and exists within the "circle of hermeneutics", where the researcher engages with the transcripts through a cyclical pattern of interpreting the parts and the whole of the text (Fleming, 2003;

Laverty, 2003). As such, my own preunderstandings from MCP literature and cultural positionality influence the interpretations of participant descriptions, as philosophical hermeneutics supports that our understandings of the phenomenon approach one another to create a new understanding. Fleming (2003) outlines steps, developed from Gadamer's philosophical hermeneutics, for constructing understandings of participant experiences, which were used to inform the analysis in this research. The steps below include both offerings by Fleming (2003) and my personal process that developed organically.

1. Understanding the Whole: Each interview transcript was read, while listening to the interview audio-recordings and referencing field notes. During this first read-through, the transcript was examined with the intent of identifying the fundamental meanings of participants' whole text, to gain an initial understanding of the phenomenon. Additionally, the left-hand column of the transcript was used to note significant descriptions participants offered, relating to oppression, power, and harm. These notes included wonderings about interview process and content, comments about experiences, and potential themes that were further reflected on and solidified in later stages of analysis.

2. Exploring the Parts: Notation of significant parts of the transcript, beginning in the first step, was continued in this step of the analysis process, with each transcript being re-read to identify sentences and paragraphs that highlighted the phenomenon. This process was done using a paper copy of the transcript, and each part was tied to one of the domains of interest of oppression, power, or harm. Each part was explored thoroughly and given a 'working' thematic label, which continuously changed with each read and was challenged by my preunderstandings, and against them as well. Throughout the process, parts that were connected across each individual transcript were examined together to solidify important thematic labels, merge parts, and nuance the meanings of the themes and subthemes that were reoccurring. All working subthemes were also clustered and placed under major theme labels, within each domain. Each transcript was read in depth three times and major parts were highlighted and notations were structured to include the domain, superordinate theme, subtheme, and paraphrase.

3. Returning to the Whole: Through an iterative process, these thematic labels were then related back to the initial meanings of the whole text, to expand the overall understanding and to widen and nuance the meanings of the parts themselves. This step engages the hermeneutic circle, as it requires that the interpreter move continuously between the parts and

whole of the text to construct deep understandings. Additionally, this step solidified and deepened significant themes and subthemes, and also helped to merge similar themes or subthemes and remove irrelevant ones. All major themes, subthemes, and interpretations were listed in a word document for each participant transcript. Steps 1-3 were completed for each individual participant.

4. Synthesizing a Comprehensive Understanding: Themes created from the analysis of individual participant data were further synthesized into main themes that reflected the variety of meanings, both shared between participants and separate from each other. Themes and subthemes between participants were merged to construct final themes across participants, with inclusion depending on the number of participants with shared subthemes and the significance of the subtheme. As such, some subthemes were only shared by a couple participants, but were included because they were either representative of the "wholes" of the participants' text or provided rich data for understanding the phenomenon. Quotes that reflected the synthesis of meanings of oppressive counselling experiences, chosen based on the degree of depth and nuance, were included in the final report.

A member check was not conducted, and therefore the interpretation output was a co-construction of the phenomenon based on what the participant shared in the interview and my hermeneutic engagement. There are advantages and limitations to follow up member checks (Birt et al., 2016; Carlson, 2010; Goldblatt, Karnieli-Miller, & Neumann, 2011) that have been assessed to inform this decision.

Trustworthiness

Transparency. My "social location" was included in the research as a means to contribute context to the study and provide readers with an understanding of potential assumptions and biases that could influence the interpretations of meaning (Morrow, 2007). *Reflectivity*, defined as self-awareness and appropriate action, was incorporated to manage subjectivity and biases (Morrow, 2005). In line with this practice, my preunderstandings of the phenomenon have been recorded (Appendix H) to facilitate transparency, through identification of pre-existing values, beliefs, and assumptions that may have influenced the interpretation of participant descriptions (Havercamp & Young, 2007). A self-reflection journal was used throughout the research process to record my emerging experiences, reactions, and assumptions (Morrow, 2005). Furthermore, self-reflectivity encourages the description of the process of how

interpretations are constructed (Laverty, 2003). To further facilitate transparency, the final report includes a critical reflection with an elaborate discussion on the research process from beginning to end.

Credibility. Credibility of the analysis was established by ensuring participant meanings were represented in the final understandings of the phenomenon. To allow readers opportunity to evaluate the credibility, interpretations in the final report were supported by contextual information and participant quotes (Goldblatt et al., 2011; Morrow, 2007). To establish accuracy of the data collection and help minimize power disparities, participants were able to review their transcript and make additions, elaborations, or corrections (Birt et al., 2016). All participants were sent their transcripts within a couple weeks of their interview; however, no participants made any alterations to the transcripts.

Confirmability. While philosophical hermeneutics encourages the inclusion of researcher beliefs and assumptions, I consulted with my thesis supervisor, Dr. Cristelle Audet, to assist with interpretations and provide alternative perspectives for my consideration at each of the four steps of analysis (Goldblatt et al., 2011; Morrow, 2005). I made Dr. Audet aware of my wonderings, interpretations, and personal reactions throughout the entire processed, which helped to delineate between interpretations based on personal biases and those based on my feminist-multicultural lens and counselling literature.

CHAPTER FOUR

Results

This study aimed to explore the experience of oppression for ethnoracial minority clients who have engaged in individual counselling with white counsellors, by asking "What are ethnoracial minority clients' lived experiences of (1) *oppression* during counselling with a white counsellor? (2) *power* during counselling with a white counsellor? (3) *harm* that they may have experienced related to power and oppression during counselling with a white counsellor?"

Five participants were involved in this study. Table 1 outlines each participant's background information, including their demographics and related counselling context. The information reported under "Other Social Identities" varies between participants based on the relevancy of the different identities for contextualizing their experiences and the verbatim quotes that illuminate the themes presented below. Of the five participants, three of them self-identified as female and two as male. The age range of the participants was between 20 and 70. While the average age was 33, most participants were in their early 20s. Regarding the counselling context, three participants engaged in counselling at post-secondary counselling centres, while Hotmot and JJ had experiences at a private office and hospital setting, respectively. The majority of participants discussed one counselling experience with one professional in which they experienced oppression. However, Lilly had experiences with three therapists and spoke to all three throughout her interview. Additionally, the types of professionals with whom the participants engaged in counselling or psychotherapy varied among participants, with Hotmot's counselling experience being with a psychiatrist. Hotmot's oppressive counselling experiences were included in this research because he defined his experience with the psychiatrist as "counselling."

Table 1

Participant background information

	Dolly	Lilly	Hotmot	Anica	JJ
Ethnoracial Identity	Canadian, Cuban, Russian, Jewish, Taíno 2nd generation	East Asian (Dubai; Singapore) 2nd generation	Canadian Mohawk	Turkish 1st generation	Jamaican Canadian 2nd generation

Other Social Identities	Early 20s Female	Early 20s Female Agnostic (formerly Christian)	Late 60s Male Agnostic (formerly Christian)	Early 20s Female Muslim	Early 30s Male Mentally disabled
Reason for Counselling	Depression Anxiety Life Transitions	Family religious/value conflicts	Alcoholism Social anxiety	Depression	Social anxiety Low mood
Duration of Counselling (approx.)	1 year	2 years (total)	3 years	3 months	6 months
Number of Sessions (approx.)	25	8 (1st counsellor) 1 (2nd counsellor) 1 (3rd counsellor)	18	5	5
Counsellor's Social Identities	Female Early 20s	Female 1st (Early 20s) 2nd (30s) 3rd (50+)	Male 50s	Female 30s American	Male 40s
Counsellor's Professional Information	Counselling Masters Intern (1 year)	1st (Masters; 1-2 years) 2nd (Masters; 10 years) 3rd (unknown; 25+ years)	Psychiatrist (30 years)	Clinical Psychologist (5 years at centre)	Psycho-therapist (5-10 years)
Theoretical Orientation or Approach	Cognitive Behavioural Therapy	Talk therapy/ Psychotherapy	Talk therapy	Talk therapy	Cognitive Behavioural Therapy

This section is divided into three subsections, where I present the major themes and their respective subthemes generated for the domains of interest, which were oppression, power, and harm. In describing the subthemes, I offer verbatim quotes from participants that instantiate the subthemes based on experiences and perceptions shared during interviews. Although participants were asked for offerings grounded in practical experiences, some participants occasionally went a step further to make speculations or else provide theoretical understandings about oppression and power in counselling. While this study explored lived experiences specifically, it became difficult at times to discern when participants' understandings were grounded in their specific experiences of sessions and when their understandings expanded beyond those experiences. This entanglement may also have been reflected in how participants expressed their understandings differently from one another. For example, JJ sometimes made speculations while remaining close to his practical experiences and Hotmot appeared to take a "storytelling" approach to reflect his experiences and views. Acknowledging that speculative or theoretical offerings may emerge out of or be inextricably intertwined with lived experience, and that both experience and speculation could be deemed equally valuable, I opted to include both forms; I indicate in the results when I perceived instances of participant speculation/theorizing. Lastly, it should be noted that subthemes for oppression, power, and harm were oftentimes difficult to present separately, as they are also inextricably intertwined. Tables 2, 3, and 4 provide an overview of the themes and subthemes related to oppression, power, and harm, respectively, that resulted from the analysis of interviews.

Oppression

Table 2

Themes and subthemes related to oppression

Theme	Subtheme
Whiteness of Therapy	Client Feeling Alienated
	Client Perceiving Whiteness-Based Lens
Therapist Cultural Positioning in Sessions	Relying on Faulty Assumptions
	Leaning Away from Culture
	Mirroring Sociocultural Climate
Microinvalidations by Therapist	Minimizing Client Experiences Related to Culture

	Dismissing Client Experiences Related to Culture
Disconnection Between Therapist and Client	Client Feeling Misunderstood
	Therapist Lacking Attunement to Client
	Observing Therapist Behaviour as (Counter)transference

Whiteness of Therapy

Participants expressed having experienced oppression in counselling with white counsellors through what they described as "the whiteness" of the therapy setting. Whiteness of therapy was reflected in participant feelings of alienation vis à vis and within therapy, and their perceptions that their therapists applied a white-based lens during therapy.

Client feeling alienated. All but one participant stated that, in a general sense, they felt alienated from Canadian whiteness due to their visible differentness from the dominant ethnoracial group. Participants similarly experienced alienation in their sessions and in the counselling setting as a whole, stating that they felt rejected for their ethnoracial minority identity. Client alienation from therapy stemmed from the inaccessibility of therapy through supply and demand issues, financial barriers, and stigmatization by their own cultures. Ultimately, through feelings of alienation, participants felt oppressed by the whiteness of counselling prior to entering counselling and while engaging in sessions.

JJ experienced feeling alienated both by his therapist and within the whiteness of therapy when the therapist used JJ's visible differentness to guide the discussion. JJ felt as if *"He's saying, you know, 'you're not Canadian' or 'you're (inaudible). You're lesser.'"* Furthermore, he attributed the oppressive experiences throughout counselling to his visible differentness by stating, *"I mean I feel like maybe if I wasn't black, he would treat me differently."*

Dolly also speculated about the whiteness of and alienation within therapy due to her differentness: *"Well I know before I realized how white a space therapy really is…" […] "I'm feeling alienated in white spaces."* Furthermore, Dolly expressed her views of alienation as being related to "*supply and demand"* of ethnoracial therapists where, "*There is a lot of people of colour who need therapy and not that many who become therapists. It's a very inequal scenario. Like the balance isn't there."*

For Lilly, alienation stemmed from perspectives surrounding stigmatization of mental health and counselling within her own culture. She perceived this stigmatization as a barrier for ethnoracial minority clients like herself to accessing therapy, therefore alienating her from therapy. She stated, *"I think, to be honest, that white people are a little more open to mental health,"* and later stated that *"mental health is not talked about in my culture."*

Hotmot also offered his views about the whiteness of therapy and noted that his Aboriginal and male social identities contributed to him feeling alienated within therapy and mental health. He described how he associates being a man and Aboriginal with being *"tough"* and aggressive, and reflected on certain vulnerability associated with seeking therapy. He spoke to this maleness and vulnerability by referencing Harley Davidson motorcycles, known to strongly reflect masculinity:

> *"Only vulnerable men go to psychiatrists. Real men don't see a psychiatrist." That's macho man. "Have you ever seen a psychiatrist, Harley Davidson?" Maybe because the guy battered his wife and he's only there for a couple weeks. "Real men don't go see a psychiatrist. They can handle their own problems. They're independent and tough." That's the Harley Davidson approach to psychiatry. Only vulnerable, gay men go. Overly sensitive men. That's a different thinking than nowadays*.

Client perceiving whiteness-based lens. All five participants experienced their therapists using a whiteness-based lens to inform their conceptualization of client problems, the suggestions they provided, and the therapeutic approaches employed. Many participants felt the suggestions given were incongruent with the cultural layers associated with their presenting problems, describing the experience as a *"disconnect"* between their therapist's perspective and their own.

To demonstrate the disconnect in conceptualization, Lilly explained that the problems she was having with her family were distressing to her because of the cultural significance of her collectivist value of family closeness. However, she felt that the therapist was attributing the family problems to Lilly herself, as opposed to cultural factors: *"Yeah…I think what she did was focus on me as an individual, rather than the external factors that influence the individual."*

Anica had a similar experience of oppression based on what she perceived as a whiteness lens that the therapist used to conceptualize sexual assault that she was discussing in session. In our interview, Anica stated that her view of sexual assault was connected to her Turkish

immigrant identity, whereas the therapist's view was based on her own white cultural identity: *"So, I felt uncomfortable there and I felt that she didn't understand me, because maybe in her culture or in her head, that's not considered assault."*

In terms of therapists relying on a whiteness-based lens when providing suggestions to address presenting problems, Dolly felt the solutions her therapist provided were incongruent with the cultural layers she saw as attached to her problems. Specifically, she described an incident where her therapist suggested that she assert her boundaries to resolve issues with her mother's intrusiveness; something that did not resonate for Dolly culturally. Furthermore, her therapist's whiteness lens extended to conceptualization as well, in that she did not see the actions of Dolly's mother as a violation the way Dolly saw it, but rather as an annoyance. Dolly used the following analogy to describe this experience:

> *I had a plastic hammer and a concrete wall. Like that I was being given solutions that just – it didn't matter how hard I tried, it just wasn't going to work. And I could tell that. It wasn't an even match*.

Whereas Dolly's experience regarded a specific therapist intervention, JJ perceived his therapist to be relying on a whiteness-based perspective when responding more generally to his issues. For example, JJ felt that his therapist would *"take sides"* with the *"white friends"* that JJ referred to when speaking about his interpersonal relationships. JJ elaborated by adding his beliefs about where the therapist's responses could be coming from:

> *Maybe he just had a perspective that's different than mine, because he's coming from that white European background. You know, they're conquerors, domineerers. So, like everyone else is like beneath them. So, maybe he has that kind of mentality.*

Some participants experienced whiteness-based approaches used in their therapy, describing the therapist's approach as individualistic or deficit-focused. In terms of applying an individualistic approach, Lilly described how the three therapists with whom she experienced oppression focused on her as an individual, which was different from her collectivist cultural values. This approach made her feel as though her issues were uncommon and that she was alone in her struggles. Such lack of normalization is reflected in the following:

> *Yeah. My parents came from a collectivist culture, whereas I know the culture in Canada is more individualistic, and so, the approach she went with was the individualistic*

> *approach. So, that kind of clashed a little bit and it didn't really sit well with me because I just thought, "She's probably not listening to me properly."*

Referring to a deficit approach, Hotmot first discussed a motivational approach by a therapist he *"really liked"*, who focused on his strengths rather than his weaknesses. He then compared this therapist's approach to his psychiatrist's deficit-focused approach that he experienced as oppressive:

> *She would say, "You're limiting yourself with possibilities. You limit yourself – you're just a poor man. You could have a wealthy girlfriend who is civil servant. She doesn't care about your economic – she cares about the fact that you are good man. You're good. You limit yourself. You say – you limit yourself in the way that you are holding yourself back. There're all kinds of possibilities" …She was very practical.*

He also drew a comparison between his psychiatrist's deficit-based approach that focused on his flaws and the assimilation of Aboriginals through the White Christian church that focuses on one's sins.

Therapist Cultural Positioning in Sessions

While participants identified whiteness in therapy as oppressive, they also spoke to oppressive ways in which their therapists positioned themselves within their cross-cultural exchanges in counselling. Therapists' unhelpful cultural positionings in the sessions included relying on faulty assumptions about culture, leaning away from cultural conversations, and mirroring the cultural climate within society.

Relying on faulty assumptions. All five participants experienced oppression in session through the therapist's reliance on cultural assumptions about the client's backgrounds, based on their visible differentness. Participants described their therapist's reliance on assumptions in varying ways, where some therapists made implicit assumptions while others did so overtly. To demonstrate the implicit use of assumptions, Lilly described her oppressive experience in therapy as *"ethnocentric"* and got the impression that the therapist was making judgements about her ethnoracial culture, specifically in relation to religion:

> *I thought at one point – because at that time I was still practicing Catholicism – and it seemed as if she was kind of questioning how somebody who's Asian could be Christian. She was very surprised. So, I think she had the expectation or the understanding that I*

> *can't be Christian because the way that I look, or because of just where my parents are from. So, that was kind of weird to me.*

In JJ's experience, the therapist made implicit assumptions about his ethnoracial minority identity based on visible differentness and used these assumptions to guide questions in the therapy. JJ felt this to be culturally insensitive because the ethnoracial minority identity his therapist assumed him to identify with was incorrect, essentially leaving his cultural identity unexplored in therapy.

> *Just like, "What would people do in the Islands, like in your situation?" He'd ask me like "What would be their perspective?" But I'm not from the Islands, so I don't really understand why he asked me that. […] Yeah it was kind of insensitive.*

For Anica, she felt her cultural beliefs and values were pathologized through the therapist implicitly assuming that how Anica felt and perceived her sexual assault was attributable to her cultural background:

> *Umm, she didn't specifically say "culture", but…she didn't ask. She said that…I considered this [to be] assault because of my personal beliefs or experiences. She didn't ask [me] this. She said this, maybe from what I told her. I don't know what I told her exactly that [made her say] this, but yeah, she did say that.*

For Hotmot, reliance on faulty assumptions was a primary experience of oppression in his counselling and illustrates his psychiatrist's persistent use of overt assumptions. Hotmot felt as though he was *"reduced to a socialized stereotype"* in that his psychiatrist was looking at a part of him, rather than seeing him as a whole person. When discussing the factors contributing to his alcoholism, Hotmot described his psychiatrist as hyper-focused on his Aboriginal identity as the main contributor:

> *I said, "I think you're off base with this." I said, "You're giving undue emphasis on this, on – you're not looking at the whole person." I said, "An addictions doctor would look at the whole person." [the psychiatrist] said, "That's fine to a point, but you must admit, statistically and sociologically." [I said], "Yes, I know the propensity, but you're looking at me as a case study. You're looking at my background. You're extrapolating from my background. This is the way I am."*

Hotmot went on to claim that his psychiatrist lacked specific knowledge related to addictions and, as a result, relied on assumptions and biases to guide his understanding of Hotmot's issues.

Leaning away from culture. Whereas the previous subtheme demonstrates when therapists relied on faulty cultural assumptions in sessions, this subtheme demonstrates therapists avoiding cultural aspects altogether. Three participants had experiences of their therapists leaning away from cultural conversations, such as not inquiring about cultural identity and not acknowledging cultural difference between them. Dolly described how when she discusses her culture, both inside and outside of therapy: *"Like for a lot of people it's not that they don't comment. They'll say, 'Oh we should change the subject.'"* Further, she expressed frustration when her therapist would avoid cultural conversations out of what appeared to be the therapist's discomfort and fear of being oppressive.

> *[White therapists] don't understand how to not – how to interact with [ethnoracial clients] without being labeled racist or bigoted or whatever. […] You need to be putting in more effort to understand the culture. What's right and what's wrong when talking about other cultures respectfully. Let people have those conversations and shoot down the ones that – the comments that are not appropriate, not acceptable. The ones that are oppressive*.

Lilly experienced this form of oppression through the therapist avoiding cultural conversations about her identity and not acknowledging their cultural differences, something that she wished her therapist had broached at some point in her therapy: *"Like it would have been a lot more comfortable on my end, because it seems as if we just never talked about it, or that it's there, the big elephant in the room, but it's never addressed."* Additionally, she described how she would have valued having the therapist acknowledge their differences: *"It would be nice for her to acknowledge that they have this sort of privilege and this sort of power and that they don't understand everything, or that you have to look at things from a different perspective."*

Similar to Lilly, Anica's therapist did not acknowledge the differences between their cultures, in addition to the perspectives and beliefs associated with their respective cultures. Furthermore, Anica stated that she would have experienced less oppressive feelings within the therapy if the therapist had discussed the differences in their cultural perspectives on sexual assault:

> *…if she said "Okay, according to my culture this is how I feel, but according to your culture or your thoughts, obviously this is how you feel. If she addressed that, I would be more understood. Even if she didn't feel what I felt or even if she didn't think what I*

> *thought. Just her acknowledging that my feelings are also – my feelings according to my background are also valid for me. Yeah that would be better*.

Mirroring sociocultural climate. All of the participants stated that they believed that their therapist's intentions were "*non-malicious*", attributing the oppressive interactions to lack of awareness and to cultural assumptions perpetuated within society. For example, Hotmot stated multiple times that he believed his psychiatrist's oppressive behaviours were not done *"In a malicious way."* Further stating *"…not that he had any hidden agenda that he is trying to, you know – I just, I don't think it was malicious."* All participants felt as if the oppressive behaviours were inadvertent, with many participants referring to their therapist as "*a human*" or "*still people.*" However, participants had slightly different experiences and perceptions of how their therapist's humanness created oppressive transgressions.

Although participants expected their therapists to be non-judgemental, some also recognized that therapists are not "*immune*" to cultural biases that exist within society. For Dolly, she clearly stated that she felt her experiences of everyday oppression were mirrored in counselling. Additionally, she went a step further to theorize about explanations for her therapist's oppressive actions and behaviours to the cultural climate within society:

> *I guess it's maybe I sort of expect the same oppression that I get in every day life…there to be some sort of mirror that in therapy – cause therapist isn't a closed off bubble where nothing I do in real life has any effect on what happens there. People are still people. They still have judgements even though therapists are supposed to be impartial, there is still going to be that level of what I feel in everyday life, being mirrored there.*

For other participants, mirroring of cultural climate was perceived in more severe ways, making inferences that these therapists were affected by "racist" thinking within the sociocultural context in which they live. When JJ was discussing how ethnoracial difference between him and his therapist seemed to influence power dynamics in sessions, he stated:

> *You know, especially like anti-black racism. It's so prevalent. I don't know how he would be immune from it; even his feelings, you know. 'Cause even the next person he meets, he can be really friendly towards them and he's not that with me. So, it's – it's like that dynamic.*

While most participants believed their therapist's intentions surrounding their oppressive actions were inadvertent and due to mirroring of the culture climate, Anica shared a slightly

different perspective. She suggested that her therapist may have been trying to rid Anica of the negative feelings she was experiencing because of her cultural beliefs that led her to perceive her experience as "sexual assault." As such, the therapist attempted to alter Anica's cultural beliefs surrounding sexual assault and suggested that what she in fact experienced was not sexual assault from the standpoint of a white lens. *"She didn't understand me obviously and she – she didn't think it was something that I needed to feel this bad about, which is why I guess she was trying to change my perception of the event."*

Microinvalidations by Therapist

Participants reported experiencing microinvalidations during their counselling with white counsellors. Microinvalidations were connected to therapist behaviours that, according to participants, minimized or otherwise completely dismissed key aspects of their culture.

Minimizing client experiences related to culture. Most of the participants described their therapist's minimizing issues, feelings, experiences, or perspectives that related to their cultural context or identity. When referring to minimization, participants used statements such as *"Downplaying the importance"* and *"Wasn't even a big deal."* They also offered minimizing statements that their therapist directed towards them in session, including *"You're over exaggerating. It's not that bad"*, and "*It's fine, you don't need to be making such a huge deal out of it."*

In terms of minimization of issues, participants described how their therapist told them that what they were experiencing was not as significant or severe as they expressed it to be. For example, JJ stated that the therapist *"Would just make you feel like your concerns weren't serious. They were just…you know insignificant. Like your problems."*

In the following interaction with her counsellor, Dolly described her therapist minimizing her feelings about a family issue connected to her ethnoracial identity and family culture:

> *"Oh, and does that make you feel…irritated or annoyed that she's going into your room?" and I was like "No! It makes me feel violated because she has access to everything. I have no privacy." And she was like "So, you're annoyed."*

Lilly offered an experience of her therapist downplaying the relevance of culture to her presenting problems:

> *For example, when I told them that my relationship with my mom wasn't very good, in my culture, it's not common to be estranged from your family. They're really close. You're*

> *supposed to be, I guess, to be respectful to your parents especially and your relations no matter what they do to you. They're still your family. That's sort of the mentality they go by but when I told her that she – [therapist name] said, "Well they're your parents and as you get older, you know, you get independence but it's not a big deal." That kind of thing*.

Dolly felt her counsellor invalidated her cultural perceptions and attitudes when she attempted to mitigate Dolly's negative beliefs and feelings towards her own culture. Specifically, Dolly had expressed her annoyance around mannerisms of her immigrant mother, describing her mother's shopping style as an example, and her counsellor minimized these negative perceptions and feelings:

> *I see that a lot with white people in general but that definitely was something that I experienced in therapy. Where people would be like, "Well, maybe let's not say that" or "Let's not talk about that in that way." Like when I would say, "Oh it pisses me off so much that like my mom is an immigrant…" So, I try to bring it up in therapy and they're like, "Umm, maybe let's not say that about your mom's shopping style" and I'm like, "No, no, it's very immigrant. It's very annoying."*

Dismissing client experiences related to culture. While minimizations took the form of the therapist acknowledging culture but to a lesser degree than the participants themselves, dismissals occurred when the therapist did not acknowledge or accept culture altogether. Participants shared instances of being dismissed in their sessions where they felt the therapist either rejected the "truthfulness" of their cultural experiences or asserted their expertise and knowledge over that of the participant.

In terms of dismissal of participant's cultural experiences, Anica stated that her counsellor rejected the cultural perspective tied to her experience of sexual assault that she brought forward in her session:

> *[My therapist] had this one way of determining what assault was and her definition was right. So, my definition was wrong, and my feelings were wrong. So, she felt as if my definition didn't match her definition, my feelings were invalid. That's how she made me feel.*

Anica also noted experiencing dismissal through the invalidation of her feelings. Specifically, she stated that she felt her therapist *"…thought that she knew my feelings better than me. Like the way she was speaking."*

Some participants also described dismissals as therapists asserting their expertise and knowledge over their own, which participants experienced as patronizing or condescending. For example, Hotmot experienced dismissal when he attempted to express his belief that social anxiety was at the root of his addiction, and the psychiatrist dismissed his beliefs while asserting that Hotmot's Aboriginal cultural background was the reason for his alcoholism. Hotmot made the comparison of the patronizing relationship between him and the psychiatrist, as one of child and an adult:

> *Well no. "This is the best for you." They often – it becomes the power of the medical community. You have the right to say to your doctor, whether it's psychological or physical. "I'd like to take a second opinion on this." The problem (inaudible) "No, my word goes." You have a right to a second opinion. It's like this autonomy with patients. Are we just children in front of them?*

Lilly also noted that her therapist being of an older age than her helped to create an experience of patronization, where the therapist dismissed feelings associated with Lilly's culture and family and implied that she knew better based on her having more life experiences.

> *I think it was more so with the older therapist, because of the age difference. I felt like…they kept on saying, "Oh you're very young. You have a lot more opportunities to take. You have a lot of time. You're still very young." And it seemed as if they were implying that because "I'm older than you, I have a lot more life experience than you. I have more firm opinions than you."*

Generally, participants expressed their dismissal experiences as feeling as though they were wrong or incorrect, and that their counsellors were right and knew best for the client. Lilly provided an analogy for the dismissal she experienced and how it felt: *"Kind of like the analogy of raising your hand in class and talking so confidently about your answer and then in the end the prof just says, 'You're wrong.' That's how it felt like to me."*

Disconnection Between Therapist and Client

Participants described a feeling of disconnection that emerged in their experiences of oppression and as a result of their oppression. Participants felt disconnected from their therapists

in experiences when they felt misunderstood, perceived their therapists to lack attunement, and were reacted to based on therapist transference and countertransference.

Client feeling misunderstood. All five participants felt their therapists misunderstood their concerns, feelings, or cultural perspectives and differences. Sometimes the perceived misunderstandings by the therapist led to participants feeling misunderstood in an oppressive sense, while other times it did not. For Dolly, she felt misunderstood and oppressed in her therapist's misunderstandings when she was already feeling vulnerable and dependent. Conversely, when Dolly was in a place of empowerment and her therapist misunderstood aspects of her cultural experience, she did not feel oppressed. When feeling misunderstood during instances of disempowering Dolly indicated *"It makes me feel worse and I need that help"*, compared to feeling misunderstood during instances of empowerment where she felt *"Yeah, I can do what I want. I don't need to have excuses about it [to my therapist]."*

> Anica explained feeling misunderstood because of the therapist's inaccurate paraphrases: *Like I'm expressing myself and she was saying, "Oh, this is what you meant." But that wasn't actually what I meant. I'm not sure if that was her intention, because I know that counsellors are really supposed to understand what you mean, so maybe they're supposed to paraphrase what you're saying. But I felt like, I didn't feel okay with it.*

Other participants attributed the misunderstandings to dissimilar experiences and perspectives between themselves and their therapist. For example, Dolly described feeling misunderstood culturally as it *"…felt like I'm throwing my experiences at you and you're just not understanding them."* Dolly felt as though the therapist could not understand the cultural layers of her experience and the issues she was bringing into counselling:

> *Once you get to that level [of cultural], that's when the problems start to arise. They just don't understand you anymore. They understand the divorce. We can always go back to that, but the way it is making you feel…they can't always understand that.*

Both Anica and Dolly described how feeling misunderstood ultimately contributed to them leaving therapy. Anica said, *"I didn't continue [with therapy] because I didn't feel like she was understanding me, and I felt that there were obviously cultural differences so maybe that was the reason she didn't understand me."* For Dolly, there was too big of a difference with her therapist's experiences for her to feel understood, which seemed to lead up to a tipping point in therapy:

> *…so, experiences don't have to be perfectly matched up, but when there is that big of a miscommunication, especially in a setting like therapy…it just doesn't work anymore. You can feel the block. You can feel yourself holding back and the other person's confusion and it just snowballs into this giant…problem and eventually you're just like "I don't even want to go anymore."*

Therapist lacking attunement to client. Three participants associated their oppressive counselling experiences with interactions in sessions that lacked genuine responsiveness from the therapist to their emotional needs or state as clients—in other words lacking attunement. Participants described their therapists' responses and the structure of counselling as inflexible and rigid. Through his oppressive experiences, Hotmot developed a view of the profession as consisting of people who are fake and not genuine: *"These people are kind of bogus. As an Indian would say, 'These guys are a bunch of bogus phoneys, making lots of money. Let's talk to real people, you know."*

Lilly described the therapists with whom she experienced oppression as being *"robotic"*, and felt they were not responding to her emotionally or organically. She explains this by comparing the therapists she had oppressive experiences with to those with whom she had more positive therapy experiences: *"Yeah. With the other therapists, I felt like they just had no emotion. They just had a script to follow and then that was it."*

JJ describes the therapist as having "lacked empathy" and had the impression that his therapist did not care about him: *"Yeah maybe that, didn't resonate. It was kind of like aloof. He didn't really care. You could tell he didn't care. So, it kind of affected how [inaudible] I wanted to be."* When JJ was discussing his perspectives on what professionals should be aware of when working with ethnoracial minority clients, he alluded to his own experiences with a therapist who was not very responsive:

> *Yeah, like be consolatory, be open, like agree with your client sometimes, even if what I'm saying is bizarre. Show me that I'm not just talking to myself, that I am actually having an effect on someone, like with my opinions*.

Observing therapist behaviour as (counter)transference. When speaking to experiences of oppression in session, three participants described transference-related experiences with their therapists, whether in the form of transference or countertransference. Therapist transference regarded when therapists appeared to prioritize their own needs over those

of the participant, while participants experienced therapist countertransference when their therapist appeared to react emotionally to their cultural experiences.

To demonstrate therapist transference, some participants described situations where therapists behaved or acted in ways that clearly put their own needs ahead of client needs, such as by taking personal phones calls in sessions, being inflexible with session rescheduling, and ending sessions early. For example, JJ said:

> *I didn't want to go to the appointments anymore, and I guess he is being billed to attend these appointments so he's getting mad at me for that. And you know sometimes I just can't do it. You know, I have a work commitment and I have to work, so the appointment doesn't work for me anymore, and he is being inflexible about the rescheduling of the appointment.*

Furthermore, JJ speculated about this type of treatment and attributed it to his cultural identity and the perceptions that his therapist thought lesser of him because of it: *"I mean I feel like maybe if I wasn't black, he would treat me differently. […] Maybe he just thinks I'm inferior or lesser of a person because of my ethnicity."*

Participants experienced therapist countertransference when their therapists reacted to them through their own personal emotions and experiences that seemed to be based in context beyond the session. Participants experienced countertransference when the therapist exhibited either defensiveness or personal sensitivity towards topics participants deemed culturally relevant. Lilly described her therapist's countertransference:

> *And they were a little bit defensive. Or at least [therapist name] was. Well, for example, I brought up the – the fact that my sister's a sex worker and then she kind of introjected and said, "Would you be interested in sex work?" or "Does she have sex with these men?" "Umm umm okay." And then I would answer, "Umm no she doesn't have sex with these men." And then she was like, "Well then why are you uncomfortable?" That kind of …idea.*

When such therapist reactions emerged in session, Lilly and other participants felt judged, which ultimately deterred them from subsequently disclosing vulnerable information as a means of avoiding judgement.

Some participants also experienced countertransference when they felt their therapists to be *"awkward"* or *"over-sensitive"* in their cultural conversations. For example, Dolly theorized

about her therapist's avoidance of cultural conversations and suggested it was based on the therapist's discomfort with conversations about unfamiliar cultures:

> *There's that level of awkwardness that comes with talking about anything that is "not white Canadian-ism" because they don't understand it and they understand that certain reactions and certain thoughts are racist, but they – they almost can't differentiate like, normal face value judgements and racism. […] But there's almost like a fear of saying [something about culture] and being labelled a racist that stops them from commenting on it…at all.*

Additionally, this verbatim demonstrates one of Dolly's points that white people, including her therapist, may have a fear of being labelled as oppressive, which inadvertently creates oppression.

Power

Table 3

Themes and subthemes related to power

Theme	Subtheme
Relational Power Differences in Therapy	Widening Power Between Therapy Roles
	Client Feeling Ethnoracially Inferior
	Observing Transactional Nature of Therapist
Power Over by Therapist	Mismanaging Client Expectations
	Leading the Session
	Disrespecting Client Autonomy
	Persisting in Cultural Viewpoints
Client Disempowerment	Feeling Unable to Assert Against Therapist Oppression
	Feeling Trapped in Therapy
	Maneuvering within Disempowering Therapy
Client Empowerment through Resistance	Creating Boundaries in Therapy
	Liberating Self from Therapy

Relational Power Differences in Therapy

Participants experienced power differentials within the therapy relationship with their white counsellor. Participants described a power differential inherent to therapy roles of the therapist-client dyad, within hierarchical structures related to ethnoracial differences, and due to a transactional quality within the therapy relationship.

Widening power between therapy roles. When asked about the power dynamics in counselling, all five participants highlighted an *"intrinsic"*, *"pronounced"* power imbalance due to associating the role of client with dependence and the role of therapist with expertness. Participants expressed that they felt disempowered in counselling due to feelings of vulnerability and dependency on the counsellor and the therapy process as a whole. Furthermore, participants felt that their therapist had more power than them due to the nature of their jobs as helpers or providers and to their expertise. When referring to the inherent therapy roles that work to imbalance the power within the relationship, one participant used comparisons like *"doctor-patient"* indicating patient as subservient in the relationship, and *"master-slave"* suggesting a submissive role of the client. Specifically, Hotmot said, *"…you have to realize that's the nature of the relationship. The analyst is there to help you. If you say, 'Oh, I'm going to stop you. Help me out.' That's the nature of the relationship. Master – slave relationship."*

Additionally, three of the participants believed that certain factors and experiences made them more vulnerable in their client role, widening the power gap between them and their therapist even further. For example, participants attributed their heightened dependency on both counselling and the counsellor to stigmatization of mental health within their culture—which tended to prolong their seeking of help—in addition to their uncertainty in themselves and their identity. Dolly stated:

> *I definitely feel that they… do have the power in the scenario because I'm asking them for help. So, intrinsically, that gives them the advantage of having a skill or a knowledge that I don't have and that I desperately need. Because I don't…I sort of have this bad habit of waiting till the last minute to go into therapy. Where I'm like, "If I have to deal with this for one more second, I'm going to explode." So, when I do end up in therapy, it's almost like I'm begging on my hands and my knees for help.*

To address the issues of stigmatization within her culture that deters people, including herself, from sharing their mental health issues and seeking help for them, Lilly stated:

> *I think to be honest that white people are a little more open to mental health. So, when I went to my white professor and I told her, you know, I was having a hard time because I was going through depression at that time, that I was going to drop out to take a break for a semester. I felt that I was more open with her because I knew she was more accepting towards mental health. Whereas if I were to approach an ethnic minority of a prof, I would feel a lot more embarrassed or ashamed… […] Mental health is not talked about in my culture.*

Anica experienced power and oppression similarly, in that she felt "*even less powerful*" and more "*vulnerable*" due to her uncertainty in her self-concept and doubt in her experiences. She also added that it seemed as though her therapist used her expertise and Anica's vulnerability to widen the power gap between them. Anica mentioned that *"…[the therapist] knew this. She knew I didn't feel powerful. So, I think during that last session, her trying to…force her thoughts, to my brain, my head, that made the power gap even more significant."*

Client feeling ethnoracially inferior. While all participants expressed having experienced power differentials inherent in the therapy roles, two participants specified the additional influence that ethnoracial differences had on the power dynamics within therapy. Theoretical and practical offerings by JJ and Lilly demonstrate this additional dynamic to the intrinsic power disparity.

Referring to white therapists, Lilly explicitly stated: *"I feel like it's a hierarchy and they're at the top and I'm at the bottom."* Further, she attributes the difficulties in equalizing power in the therapy to her ethnoracial identity and indicated that she felt incapable of changing the dynamic with her therapist:

> *Yeah. When I'm at the bottom, like as a pyramid, there's really nothing I can do to raise myself up. Everything that I do would only have them looking down on me. That's kind of the feeling that I got.*

JJ also believed his oppressive experiences were tied to the ethnoracial power dynamic within his therapy relationship, stating *"Maybe he just thinks I'm inferior or lesser of a person because of my ethnicity."* Furthermore, JJ stated that his therapist's white identity, influenced by European historical background and perspectives, contributed to JJ's perceptions of the ethnoracial hierarchy between them and the therapist's position of dominance.

> *Maybe he just had a perspective that's different than mine, because he's coming from that white European background. […] You know, they're conquerors, domineerers. So, everyone else is beneath them. So, maybe he has that kind of mentality.*

Observing transactional nature of therapist. When discussing power within the relationship, three of the participants described their counselling relationship as *"strictly transactional"*, where the participant felt they were merely a *"means to an end."* Participants wanted to be related to in genuine and authentic ways, but instead therapists were perceived as interacting from a transactional place, as a result of their position of power. Furthermore, the transactional nature of therapy interactions contributed to participant feelings of disempowerment. Specifically, participants perceived their therapist as viewing clients and the relationship as a source of financial and knowledge gain. All three participants felt that their therapists viewed them as meeting their financial means. For example, JJ stated: *"I mean, there was a reluctancy on my part to open up because he just seemed disinterested in even getting to know me at all. So, I was just a number, just a statistic for him, just a paycheck."*

When Hotmot discussed the transactional nature of his therapy relationship, he referred to himself as being seen as a *"case study"* and *"specimen"* throughout the interview, rather than being seen as a *"a whole person."* When describing the conversation between him and his therapist about what his alcoholism was attributed to, Hotmot said:

> *"Yes, I know the propensity but you're looking at me as a case study. You're looking at my background. You're extrapolating from my background. This is the way I am"—I am sort of a Skinner rat in front of him, sort of thing.*

Power Over by Therapist

When discussing power in therapy, participants clearly indicated times when they viewed their therapist as engaging in "power over" them. While therapist intentions in such instances could not be established in the interviews, participants perceived their therapist exercising power over them when mismanaging expectations, leading the session, disrespecting client autonomy, and persisting with cultural viewpoints.

Mismanaging client expectations. Four of the participants perceived the therapist exercising power over them when the therapist either did not explore their expectations related to the counselling or apply a collaborative stance in the counselling. In terms of expectations for therapy, participants felt disregarded from the therapy process when the therapist failed to

discuss and/or meet therapy expectations. For example, JJ described how he expected counselling to be an *"interactive"* process, where his therapist would provide him with strategies and observable progress:

> *Like you want to see progression when you go to these things. Like the situation is improving for you or he gives you advice that you can apply to your life and then you can practice it and by the next meeting, you can give him a progress report. That was what I was hoping for ideally, but you know, it wasn't that kind of situation*.

Dolly's experience of mismanaged expectations came in the form of the therapist not socializing her to counselling and what it typically entails, ultimately separating her from the therapy process. Dolly described not having an accurate understanding of how therapy worked nor having the opportunity to negotiate expectations with her therapist, which ultimately weakened her commitment to the process. She stated:

> *I don't even know what I thought. The only thing I knew about therapy at that point was lying on a leather couch in an office. Like a very stereotypical Freud kind of character, and I didn't really know. I was like "I guess I just go in and talk and they tell me what to do?" Which isn't really what therapy is about. They help you help yourself. They're never going to tell you what to do, but they're going to help you come up with the decision that you think is best. And I just didn't – I had no idea. I didn't understand that. So, the first – I want to say—the first three months was kind of rocky…and I ended up quitting and starting up again…in the fall of that year*.

When Lilly discussed experiences of being powered over during her first engagement in counselling, she stated that she originally held the expectation that counselling was a non-judgemental space. However, since the therapist had not identified or explored this expectation, Lilly experienced judgement from her therapist that she perceived as oppressive. Perceiving her therapist as judgemental created a new expectation that she would experience the same treatment in all interactions with her therapist and by all other therapists as well:

> *Mhm. I know the first time I saw [name of therapist], it was the first time I'd even been to therapy. So, my understanding was that therapy, or the therapeutic environment, is supposed to be judgement free, and I didn't really feel that with [name of therapist], so I thought that "Oh, they're going to judge me every time."*

Furthermore, Lilly's therapist did not use their power position to explore and repair her new expectation around judgement, which perpetuated negative beliefs and separated Lilly from the counselling process. Unfortunately, this expectation of judgement created fears for Lilly associated with disclosing suicidal ideations. Specifically, she did not feel safe to inform her therapist about her suicidal ideations as she expected judgement from her therapist and a potential referral to another counsellor who would be similarly judgemental. She stated:

> *'Cause I feel like their interventions would have been a lot more, I guess severe. I felt like in a way I was safer with the doctor or disclosing my [suicidal ideations] with the doctor, rather than the therapist. […] I thought I would be referred to somewhere else, or like seeing somebody else that's not them.*

Leading the session. When speaking to power over, three of the participants stated that they noticed their therapist exerting power by leading the direction of sessions without their involvement and collaboration. Therapists appeared to (a) be directive and inflexible in both the structure and focus of sessions, and (b) lead sessions based on their cultural biases and desired responses from clients. In terms of session structure and focus, JJ stated that his therapist *"always tried to control the conversation. He wouldn't just let me – you know stream of consciousness, just speaking my mind."* Additionally, if JJ ever brought up something outside of his therapist's structure and focus for their sessions, JJ's therapist would redirect the conversation topic back to *"How [JJ] evaluate[s] things. How [he] perceive[s] things"*:

> *Yeah, 'cause things can come up between the last appointment and current appointment and I want to address them because they're immediate for me and he's telling me, "Oh don't bring up this topic." Like if it's relevant to me, I want to talk about it.*

Similar to JJ, Lilly's therapist also would set the structure for sessions and redirect conversation towards specific topics:

> *So, I would go in and then she would just ask me the conventional greetings, like "Oh, how's everything?" And then she would always, always start with, "So last session you were talking about your sister's abortion," for example. And then she would say, "Tell me how you are feeling about that now." And I would tell her and then she would, I guess, build off from what I said, and we would go from there. […] And yeah, when I would speak something that was off topic let's say, she would say something like "Oh going back to this topic" or "Going back to the initial idea."*

In addition to her therapist's structured approach and narrowed topic focus, Lilly identified ways she saw her therapist as "leading" in the session, by asking questions in a way that suggested she was looking for a specific response from Lilly:

> *I thought that she was closed off a little bit, and it kind of gave me the impression that I was supposed to say things that she wanted to hear. So, for a little bit I went on with that and it wasn't very helpful at the end of the day, and she went along with it. […] The way she would ask questions would be a little bit leading. […] I just kind of wanted to please her in a sense. I didn't want to give an answer that was completely…unexpected.*

Hotmot's experience demonstrated his psychiatrist using *"ethnic stereotyping"* of Aboriginal people to lead the conversation and treatment direction. Hotmot speculated: *"I don't think it's done in a malicious way. It wasn't malicious. I don't think he had an anti-aboriginal—it seemed he was leading me somewhere and I said, 'Why?', 'How does a person's addiction have anything to do with their background?'"*

Disrespecting client autonomy. This subtheme has similarities to the previous subtheme of leading the session in that they both address therapist directiveness in the therapy that was experienced as "power over." However, this subtheme reflects times when participants perceived the therapist as using their position of power to determine the direction of therapy in a way that fulfilled their own needs and excluded the client with certain deliberateness. Disrespect for client autonomy included therapist eliminating choice in treatment direction and in topic focus, as well as in the opportunity for client needs to be expressed or met. In such instances, participants felt that their autonomy had ultimately been disrespected, and such was the case for four of the five participants.

As Hotmot described the inherent power roles in therapy, he perceived his psychiatrist as using his position of power to assert his conceptualization of and interventions for Hotmot's addiction. In doing so, the psychiatrist disregarded Hotmot's beliefs about his addiction and therefore his autonomy in deciding treatment. Hotmot said that all clients, including himself, have the right to assert their autonomy within their sessions and refuse suggested treatment made by professionals:

> *You have the right to say to your doctor, whether it's psychological or physical, "I'd like to take a second opinion on this." The problem (inaudible) "no, my word goes." You have a right to a second opinion. It's like this autonomy with patients.*

He elaborated with an analogy to describe the feeling and experience of losing autonomy and agency:

> *Well, I felt like I wasn't respected. I felt a lack of respect that I was placed in that role. You know "I'm the doctor. I'll tell you what to do." I would rather be seen as an autonomous, intelligent individual, you know. It was kind of like, you know—except with [name]. It's the whole profession. The doctors and the patients. You're the—if B.F. Skinner is there, I'm the white rabbit and he's attaching electrodes to me, you know.*

In terms of attempts to assert autonomy regarding topics to discuss in session, JJ described trying to bring up topics of concern to him and how his therapist would meet his own needs by saying *"I don't want to talk about this topic again."* Furthermore, if JJ brought up a topic of significance to him, the therapist would say, *"'Oh we'll talk about this in the next session' and the next session came, and he would never bring it up."*

Dolly reported that she was not provided the opportunity to share her interests in certain treatment options the therapist presented and to assert her autonomy in deciding therapy approaches. Specifically, Dolly felt that her therapist was withholding additional testing that Dolly had expressed interest in, which made her feel even more dependent on her therapist and powerless:

> *There have been a couple times where I would see a therapist and she would almost—she would recommend extra testing or "We could try something else" and I would always feel like, "Yes!" Like if we try something else maybe that's the one thing that can help me, and then…we would keep talking and I would ask her about it later and she would be like, "Oh well…we'll see in a couple of sessions if we still think it's a good idea. Maybe we'll talk about it later." And it's sort of like that—almost like that leading you with a carrot type of thing. [...] I don't think she was doing it on purpose…but it certainly made me feel…awful. [...] It's like…it almost made me feel the power gap was more.*

Persisting with cultural viewpoints. Four of the participants also saw "power over" during times when their therapist persisted in making cultural assumptions or exercising whiteness ideologies, almost to a point of being *"antagonistic"*. Hotmot experienced his psychiatrist as persistent in his cultural assumptions about him and his presenting issue of alcoholism. Specifically, the psychiatrist insisted that Hotmot's Aboriginal identity was the main reason for his addiction, while Hotmot believed that his alcoholism had more to do with social

anxiety. Hotmot challenged the psychiatrist on his conceptualization, but the psychiatrist, rather than adjusting his perspective to match Hotmot's, continued to assert his opinion about the root of Hotmot's alcoholism. Moreover, the therapist tried to persuade him to agree. Referring to his psychiatrist's persistence, Hotmot said: *"Yes, yes very. He mentioned it almost 3 or 4 times. 'You mentioned it again. I don't think [my alcoholism] has anything to do with my ethnic[ity], I think it has more to do with [my] personality.'"*

Similarly, Anica used the words *"attacked"* and *"force"* when describing her therapist's persistence in her whiteness-based perspective of sexual assault. She stated:

> *Yeah, so if she said, "Look I'm aware that we have cultural differences, so maybe I'm not understanding you clearly." So, if she said this, then I think I would be more comfortable, and I wouldn't feel attacked, because then I—if she had said this, she wouldn't be trying to force her thoughts and force me to think that way, I'm guessing. Which I don't think she was aware so…*

As a result of this invalidation of Anica's experience of assault and the therapist's insistence that Anica change her perceptions, Anica explicitly expressed regret in disclosing her experience:

> *And umm, so I—I just, talking about this is something that is even hard for me, even if [according to the therapist] it's not assault. For me it was hard because of the experience and I talked to her about it and then the way she saw it wasn't—she was trying to change my perception. So, I felt that I did a big mistake by even talking to her. […] Yeah, yeah. I regretted it.*

Client Disempowerment

Participants expressed having experienced themselves as disempowered within their power-related experiences of oppression. Participants felt disempowerment through their inability to assert or the therapist's rejection of their assertiveness, through their feelings of being trapped in oppressive counselling, and through their need to maneuver themselves within therapy.

Feeling unable to assert against therapist oppression. Participants described a range of experiences related to difficulties asserting their feelings to their therapist about oppression occurring in session, which can be represented on a continuum. Three of the participants—all female—indicated that they felt unable to assert their feelings about the inappropriateness of oppressive experiences in their therapy.

When asked about responding to oppression related to their therapist's whiteness-based conceptualizations and interventions, they all felt as though they could not directly confront their therapist. For example, Anica described oppression related to when her therapist used a therapy approach that did not fit her needs and made her question herself more. Anica did not assert this to her therapist due to self-doubt and uncertainty in her experiences: *"…I didn't tell her this: 'You're just making me question [myself]'. I didn't tell her this directly because, I don't know, I wanted to see where it was going, I guess."* Furthermore, she expressed doubt about her perceptions of oppression in session, which also contributed to her non-assertiveness: *"Yeah, she didn't [try to understand my experiences] —I don't know and then I thought about it and maybe it's normal, because she's a human. She doesn't have to understand me, but I still felt like I was feeling…wrong."*

These participants also struggled with assertiveness in the face of power as they feared their therapist's reactions. For example, Dolly expressed feeling afraid of how her therapist would respond if she pushed back against the oppression related to what she perceived as her therapist's avoidance of cultural conversations:

> *I can't bring it up and I obviously can't be like, "Why are you so weird every time I talk about race? Why does that make you uncomfortable?" 'Cause that's a great way to get thrown out of the office. I don't even know if they do that, but I'm too scared to find out.*

Furthermore, these participants did not assert themselves because they were waiting for their therapist to make a change themselves. When Lilly was describing her non-assertive response to in-session oppression, she stated:

> *Yeah, I didn't—I noticed [the oppression], but I kind of just thought it was an isolated incident, that's why I came back the next session and thought maybe it would be different, and then realized that it wasn't, but I kind of continued with the hope that she would I guess brush it off, or it would change, but it didn't until the end.*

On the other side of the continuum, Hotmot was very direct in asserting against power and oppression in session. He described having confrontational and assertive responses toward his psychiatrist grounded in his recognition and awareness of his human rights and respect for dignity within the counselling context. Hotmot said, *"'I think you're off base with this'. I said, 'You're giving undue emphasis on this—you're not looking at the whole person.' I said, 'an addictions doctor would look at the whole person.'"* Although he attempted to push back against

the in-session oppression and relational power dynamics, he felt defeated in his attempts as a result of his psychiatrist's persistence in asserting his own perspectives in response to Hotmot.

Feeling trapped in therapy. Four out of the five participants stated that they had a feeling of being trapped within sessions and in the therapy process as a whole. Feeling trapped in general seemed to stem from an accumulation of oppressive experiences and participants' struggles in asserting against them, due to their feelings of disempowerment.

In terms of feeling trapped in the sessions themselves, some participants stated that they felt stuck in their oppression because they were unable to escape the session. For example, when Anica was describing the oppressive event within her final session where she felt her therapist did not validate her feelings and experience of sexual assault from a cultural perspective, she stated *"I was just waiting for the session to end so I could, I don't know, go home and cry and find my own solution."*

Participants felt disengaged from and increasingly disinterested in their counselling, expressing that *"It felt like a chore or a burden"* and that they *"Don't even want to go anymore."* However, they felt certain obligation to continue the counselling. Lilly was explicit in her reasoning that continuing to attend counselling was not out of genuine satisfaction, but rather because she felt trapped in the process due to a sense of obligation:

> *Yeah, and I guess the reason why I would take up another session when she asked was because I thought that I had to complete the number of sessions given to students. I thought it would be wasteful if I didn't use them all. That kind of idea. So…*

Moreover, Lilly and Dolly stated that they felt trapped in their counselling due to a fear of losing the help they needed and a perception that their counselling options were limited. For example, Dolly wanted to leave counselling, but did not see it as a viable option due to her disempowerment:

> *So, when I do end up in therapy, it's almost like I'm begging on my hands and my knees for help. And then, once you've sort of experienced that…need for assistance and need for someone to help you and you find that someone and they are flawed in that they don't respect your identity, it's sort of like "Well, now it's too late. I need you." So, I just sort of […] you do sort of have to…ignore it and sweep it under the rug, and you're almost afraid to bring it up because you're afraid to destroy a relationship that you so greatly need.*

As a result of their disempowerment, participants felt dependent on counselling or obligated to continue, which ultimately left them feeling stuck in the oppression and the counselling process itself.

Maneuvering within disempowering therapy. Related to disempowering therapy dynamics, two participants felt compelled to adjust themselves and what they brought into therapy. These participants described such "maneuvering" as repositioning themselves within therapy around the therapist's needs. They relied on this strategy because of their disempowered position and perceptions of being limited in their abilities to change their oppressive situations. They also repositioned themselves as a means of avoiding further oppression while trying to keep therapy alive.

Repositioning looked different for each participant. For Dolly, *"It's almost like maneuvering your identity around [the therapist's] needs"* and that she could *"map the landmines"* and position herself in a way that avoided future oppression based on that map. Furthermore, she described maneuvering herself within her therapist's whiteness by censoring parts of her ethnoracial identity:

> *It felt like…the side of my life that I could talk about in therapy and there was the side of my life that I couldn't talk about in therapy. Because if I did, I would just be wasting my own time. Going there and trying to talk to someone and getting nothing in return. Well it's like, "Oh I guess I better focus on the stuff that I can talk about" and I was like, "Kay now I feel like an imposter at a country club." This is not who I am. This doesn't encompass my full identity and my full life, but it's all I can do here right now.*

Furthermore, she stated how invisibilizing aspects of herself that resulted from "maneuvering" was unsustainable and ultimately unhelpful:

> *…if I could only get therapy for part of my life, and even the parts that I could get help for, it never could get deep enough because after a while, my identity can no longer be separated from the – my ethnicity, my experiences. My problems can no longer be separated from the fact that…I am not white, and you are so uncomfortable with that. That I'm never going to be able to fully realize my issues and problems…because we just can't go that deep, 'cause you just get uncomfortable and I have no help*.

. Lilly engaged in maneuvering based on her impression that her therapist was expecting her to behave in certain ways or say certain things. She felt compelled to meet her therapist's

needs surrounding expertise by demonstrating progress in her mental health to appease the therapist. Referring to her therapist she said, *"I just kind of wanted to please her in a sense,"* but that *"it wasn't very helpful at the end of the day."* She also responded to questions in therapy in a manner to indicate to her therapist that she needed help, feeling as if she had to maintain certain disempowerment and the therapist's role as expert helper:

> *I felt like the way I had to talk had to be in a way that I had to phrase my sentences that made me seem like I was the one wanting help…or I had to be the one reinforcing the idea that I was there for help, and they were there to provide the help.*

Client Empowerment through Resistance

Participants spoke about how they responded to negative power dynamics in counselling with white counsellors, referring to ways they resisted oppression and power imbalances and to a resulting sense of empowerment. Empowerment resulting from resistance occurred by clients creating boundaries in the therapy and engaging self-liberation.

Creating boundaries in therapy. Four participants stated that they felt they needed to create boundaries within sessions as a means to mitigate power imbalance within the therapist-client dyad. As a result of in-session oppression, these participants made conscious decisions about their disclosures around culture in order to protect themselves from further oppression. They created boundaries in two different ways in response to oppressive interactions: (a) by explicitly setting boundaries with the therapist on conversations pertaining to cultural aspects related to their issues; and (b) by setting covert boundaries by choosing to limit their disclosure and openness around culture to proactively prevent new experiences of oppression.

Hotmot responded to oppression related to his psychiatrist's misconceptualization of his relationship with alcohol by overtly placing a boundary on the psychiatrist's ability to discuss the influence of culture on Hotmot's alcoholism. Specifically, he stated:

> *The thing was – he mentioned it 3 times and I was like "Let's end it. I think you're going in the wrong direction. I'm not comfortable with this. Someone can be an addict regardless of his or her ethnicity." And he might say, "Well, yes I know" or maybe he'll do the statistics. "Let's look at the sociological." Maybe there is – I just felt – and I didn't think he was doing it in a coercive way or even a sadistic way. I was very pleasant. I said, "Let's agree to disagree and let's not discuss it again."*

In contrast, rather than create overt boundaries with his therapist to prevent judgement and resulting feelings of oppression, JJ chose to be more cautious in his self-disclosure and openness with his therapist. For example, when JJ described how he responded to the oppression he experienced in session, he said:

> *I mean I was reluctant to open up and be free to talk and speak my mind. I felt like, I go to psychotherapy to be free and open and not be judged and I feel like I was being judged and that was kind of the issue.*

This verbatim helps illustrate how JJ and other participants put limitations on how much of themselves they brought into their sessions. In more severe instances of caution surrounding openness and disclosure, Lilly intentionally withheld suicidal ideations from her therapist due to the distrust and discomfort felt in session. Ultimately, while in therapy, she sought out her family doctor to discuss her suicidal thoughts.

> *Well…I guess on a physical term…[I] was not acknowledging certain symptoms that I had leading up to…it took me going to the family doctor and actually disclosing to him – because I felt more comfortable with him – and disclosing the suicidal ideations to him and then that's when I went to the hospital and got help.*

Liberating self from therapy. Although participants attempted to mitigate in-session oppression themselves, many participants felt defeated in their attempts. As such, participants decided that completely removing themselves from therapy was their only option for truly ending the oppression in counselling. Taking matters into their own hands, all participants stated that they ultimately responded to and resisted continuous oppression by ending therapy altogether.

In the face of oppressive therapy, some participants committed themselves to finding alternative solutions to therapy as a way of developing independence and self-sufficiency from therapy and to empower themselves. Lilly fostered self-sufficiency through resources with clear intention to improve independently of her therapist and not have to stay in or return to. She said, *"Yeah, on the positive end, maybe I just think about what I could do so I don't have to see [therapist]. […] Just to be more independent and not rely on them – on therapists."* She empowered herself by using this independence from therapy to help improve her mental health to the point where she could liberate herself from oppressive therapy.

Hotmot also relied on alternative resources to be less dependent on and ultimately leave therapy. For example, rather than continue with his psychiatrist who saw his alcoholism in a misinformed and rigid manner, Hotmot turned to friends and family for support and to external resources for self-improvement and progress. He said, *"'I've got a good social network. Close friends. Family'. I don't need – it's sarcastic, but it's actually true, 'Why should I pay somebody to be my friend?', you know. A psychiatrist, a counsellor, a social worker. They're paid."* He also mentioned the positive resources outside of counselling that he turned to:

> *This was a positive thing, in terms of self-confidence and that. The thing was – this was a positive thing – in terms of competence and that. It was mostly drinking in bars and talking – [I'm] engaged and talkative usually with these people, and actually I took a Dale Carnegie course. […] It's kind of an old American thing, rooted in sales. It's not about social work – it's public speaking and presenting. It's really a business. It's all about self-confidence, public speaking.*

Furthermore, Hotmot's negative experiences inspired him to become an independent thinker different from his psychiatrist:

> *I certainly took the power. I said, "I'm through with it. I know you're a doctor. You're an MD. (inaudible) It's not really doing [me] any good." That became, me sort of branching out and saying, "To hell with this. I'm going to use my power and (inaudible) to become an independent thinker. Go back to University."*

Additionally, Hotmot specifically stated that he felt that leaving therapy and relying on external resources *"…was liberating in a way. Like I said, liberating. I said, 'You don't need this. You're an intelligent guy. I apply myself.'"*

Harm

Table 4

Themes and subthemes related to harm

Theme	Subtheme
Hindered Counselling Processes	Weakened Therapeutic Relationship
	Worsened Symptoms
	Premature Termination
	Diminished Help-Seeking
Impeded Psychological Wellbeing	Weakened Interpersonal Relationships

	Doubt Surrounding Self and Identity
	Internalized Shame
Generalized Negative Beliefs	Client Loss of Faith in Profession
	Oppression Generalized Beyond Therapy

Hindered Counselling Processes

In terms of harm resulting from oppression in counselling, participants identified ways the counselling process was impeded, including a weak therapeutic relationship, a worsening rather than improvement of symptoms, premature termination, and barriers to seeking subsequent help.

Weakened therapeutic relationship. Four of the participants stated that their therapeutic relationships never fully formed or otherwise worsened over time as a result of the in-session oppression they experienced. All participants had certain feelings of distrust toward their therapist, such that they felt unsafe in therapy and fearful of judgement or oppression, which ultimately affected the therapeutic relationship. Harm to the therapeutic relationship occurred at the onset of therapy, or else either suddenly or gradually within the course of therapy.

For some participants the therapy relationship felt superficial, awkward, or distant at the onset. When asked about trust within the relationship, Dolly expressed that her therapeutic relationship was superficial, which she felt impacted how deep she and her therapist could explore her issues. She stated, *"I feel like there was a surface level. There was a foundation that was built, but the hard – the deeper we tried to go with the relationship, the more and more it just crumbled apart."* Lilly described the therapists she had oppressive experiences with as *"distant relatives"* with whom she never developed a relationship. Further, she described them as *"…still people, but I'm not close to them. I don't know them very well. I know of them, but I don't know them personally."*

Participants also described a gradual weakening of the therapeutic relationship over time, resulting from the accumulation of oppressive experiences in therapy. JJ described the effects on his relationship after experiencing numerous oppressive and power-over interactions where the therapist directed the focus in therapy conversations while disregarding JJ's attempts at directing focus. Referring to the therapy relationship, he said:

> *It was good at first but then it gradually, you know. That's why I only had the 5 or so meetings. Because the meeting would come up and I wouldn't even want to go meet him. Because it's just so unpleasant being near him. […] It just deteriorated over time.*

Hotmot's experience of a weak therapeutic relationship involved a sudden shift in trust from a relationship rupture that arose out of the psychiatrist asserting a whiteness-based perspective of addiction in an Aboriginal context. When asked about his experience of harm as a result of oppression in session, he stated, *"All of a sudden I started feeling a lack of trust with him"* and *"Well, I felt like I wasn't respected. I felt a lack of respect that I was placed in that [dependent, subservient] role."*

Worsened symptoms. When discussing harm resulting from their oppressive counselling experiences, all participants described not only feeling as though the symptoms they had initially presented in the therapy did not improve, but that they had worsened. Worsening symptoms were observed both immediately after sessions and gradually over the course of therapy.

Participants who reported feeling worse immediately after the session itself stated things like: *"I leave the session worse than I go in*" or "*I go in depressed and anxious and I leave even more anxious."* Lilly described feeling more anxious and depressed—two issues that she was attending therapy for—immediately after her sessions. She stated:

> *Instead of alleviating my symptoms, I felt like they were only being amplified sometimes. So, especially when I go home and think about it, I have the tendency to ruminate or to really overthink things. And that was – that would be a really common thing for me to think about.*

For Dolly and Anica, symptoms that initially brought them to therapy gradually worsened over the course of their counselling, where they described feeling more depressed and anxious overall, and having more relational and self-esteem issues than when they started therapy. Dolly stated that her struggles with identity that made her attend therapy got worse as a result of the oppression she experienced in session that protectively led her to invisibilize parts of her ethnoracial identity:

> *…it almost felt like trying to fit in [to therapy] was contributing to my anxiety, to my depression, to my identity issues. And I was like, "Kay I need to stop doing that because it's not going to help me feel better and I'm not getting the help I need in therapy anyways. I'm already feeling worse in my everyday life. Something's got to give, so it*

> *might as well be everything. So, we're not doing any of that anymore." […] And it made my identity crisis worse.*

Some participants attributed worsening symptoms to the approach their counsellor used. For example, Anica felt her counsellor's exploratory approach was inappropriate for her anxiety and depression, in that it worsened her existential anxieties associated with "meaning" and uncertainty in her identity. Anica stated:

> *…she was always questioning the stuff that I said. Umm, in a sense that made me think "Okay, what is meaning?", but then umm I didn't really have the answers to what she was asking because that's what I was questioning also. […] … She was making me question them more, which was my initial problem.*

Participants who felt worse in their distress and other symptoms, whether directly after sessions or gradually over time, indicated a sense of aversion to the therapy process. This is perhaps best explained by Dolly, where she appeared to experience relief at the conclusion of each session:

> *I feel like I'm not doing anything when I do go. I almost feel better…leaving than I do going in, but not because I'm getting something out of it, but because I'm finally glad I get to leave that place, because it's over, it's done with. I don't have to worry about it for another week.*

JJ had a similar experience, but emphasized how counselling in itself became a new source of stress in his already stressful life, ultimately worsening his anxiety and distress:

> *Just that it was very disconcerting for me because I go to psychotherapy to almost escape from everyday life's stressors and then it became a source of stress just to go to the appointment.*

Premature termination. Four of the participants identified their premature termination of the counselling as harmful. Most of these participants indicated that their experiences of oppression eventually forced them to terminate therapy, viewing it as the only way out of the oppression and harm they experienced. For example, Anica terminated therapy specifically because of the severity of oppression she experienced in her final session:

> *Overall, I don't think it helped me much. That's why I only went 4 times…I didn't continue because I didn't feel like she was understanding me, and I felt that there were obviously cultural differences, so maybe that was the reason she didn't understand me.*

When discussing harm, Dolly stated that the oppression she faced, and having to reposition herself within whiteness as a response to that oppression, resulted in her terminating therapy:

> *Yeah. I definitely talked about how it's a lot harder to convince yourself to do therapy and fully commit yourself to it if you don't have that full understanding, because after a while of not being understood, you just don't want to go anymore. You feel like it's pointless. Like I said, you feel like you're going and only bringing a part of who you are in and you need help with everything, and it definitely can be harmful in that it can almost end up forcing you out of [therapy] that you very much need to be in.*

Participants also recognized that terminating unfinished therapy created further harm in that they still needed help for their mental health issues that were left unaddressed in therapy. For example, although Anica left therapy as a result of feeling her therapist could not understand her culturally, she questioned whether she may have had faster and longer-term improvements had she continued with therapy or sought counselling elsewhere:

> *Yeah, I think though that this is kind of harmful because…a counsellor or a psychologist is the one who is more knowledgeable, so maybe they – if I did go, maybe I would be feeling better now or then. I don't know if [premature termination] was helpful. […] So maybe if I went to a counsellor, I would be getting over it in – I don't know – 6 months, but now it's taking me so much longer and I don't even know if I'm getting over it; not just that case [of sexual assault], but my overall depression.*

Diminished help-seeking. All participants expressed inhibitions to seeking help subsequent to their oppressive therapy experiences. Impediments to seeking subsequent help had to do with fears of re-oppression and the belief that therapy is unhelpful. Participants experienced such impediments as harmful, as they acknowledged their desire and need for obtaining help but felt their oppressive counselling experiences deterred them from doing so. Lilly stated*, "After I finished seeing her, I just took a long break I guess of not seeing a therapist, even though I probably needed it back then, because I didn't want to be exposed to that type of setting."* She further explained how oppressive therapy negatively impacted her willingness to seek out help:

> *It makes me harder – it makes it a little bit harder to seek help…or wanting to seek help – well I know I want to seek help, but it makes me feel like there's no point sometimes. I'm just wasting my time.*

Participants described different timeframes during which they contemplated resuming therapy. Dolly and Lilly discontinued therapy for a brief period, as both eventually returned to counselling within a year after terminating and were engaged in positive counselling experiences at the time of their interviews. The remaining participants stated that their oppressive counselling experiences impacted their help-seeking behaviour to such an extent that they never returned to therapy. For example, instead of returning to therapy, Hotmot relied on external resources and personal relationships for the issues he was still struggling with after his final counselling experience. He reported that he informed the psychiatrist with whom he had experienced oppression, that he was seeking therapy elsewhere, but in fact had no intention of engaging in counselling again.

> *…That's the kind of practical advice that I like that I wasn't getting from [name of therapist] in the end. So, I said – I sent him a phoney letter. I didn't write it. It said, "I'm seeking therapy somewhere else." Forget therapy.*

Dolly speculated that people might avoid therapy altogether because they lack knowledge of how therapy can be helpful. She implied how having been socialized to counselling and possessing a certain understanding of the counselling process allowed for her return to counselling, even after experiencing oppression:

> *Yeah and I definitely feel like that could be something that would keep you out of therapy if you were sort of – I've read the studies. I've looked at all the data and therapy does work. It does. But if you don't understand that and you have those experiences [of in-session oppression], I can absolutely see why you would avoid therapy like the…burning plague.*

Impeded Psychological Wellbeing

Participants stated that, beyond worsening symptoms related to their presenting issues, the harm they experienced as a result of oppression in counselling sometimes impeded aspects of their psychological wellbeing in new ways, whether associated to their initial problems or new problems altogether. They reported weakened social relationships, challenges to their sense of self and identity, and internalized shame.

Weakened social relationships. When discussing long-term harm and the negative effects of oppressive counselling outside of sessions, four out of the five participants stated that their social relationships were weakened as a result of oppression. Participants used words such as *"isolated"*, *"alone"*, and *"withdrawn"* to describe the impact of their counselling experiences on their social relationships. Lilly expressed how her therapist's individualized focus, based on whiteness ideologies, did not foster feelings of normalcy surrounding her issues relating to her ethnoracial identity and her transition to University. She stated how this lack of normalization made her feel withdrawn and detached from social relationships:

> *Yeah, it made me feel very lonely because it made me feel like I was the only one not adjusting well. My other friends as well are first generation immigrant children and they're adjusting well, so maybe there is something wrong with me.*

Both JJ and Hotmot sought therapy to address issues related to social interactions and interpersonal relationships, and neither felt these issues were properly addressed in therapy. For example, Hotmot's therapist dismissed his views that his addiction was related to his social anxiety, and JJ's therapist disregarded his attempts at directing the session focus to social relationships. In both instances, the participants felt these experiences of oppression negatively impacted their interpersonal relationships and made them distance themselves further socially. Specifically, JJ stated, *"It affected my social relationships even more than they already were. I became more withdrawn and despondent."*

Doubt surrounding self and identity. Three participants stated that they experienced impaired wellbeing by internalizing therapist invalidations of their experiences, feelings, and perspectives, some of which were tied to their culture. Internalizing the therapist's invalidations created self-doubt and confusion, both related to their ethnoracial identity and their overall identity. In terms of overall identity, Anica elaborated on how her therapist's invalidation created confusion surrounding how she perceived herself and who she felt she was, referring to this experience as questioning her identity:

> *I mean, I think at the time it did, because I was already trying to find myself and I was trying to…I was thinking about my thoughts and why I – why I was thinking about things the way I did. So, I was already questioning this, so her behaviour did make me question this even further. So, at the time – at that time, yes it did make me question my identity a*

> *little, I guess, but I think I was already questioning it, so I'm not sure how big of an effect it had on top of my questioning. […] Yeah, I'm not sure how much it added, but it did.*

Self-doubt and confusion were particularly the case for participants who entered therapy with identity issues related to their ethnoracial culture as a main presenting problem. For example, when Anica's therapist specifically minimized her culturally-informed views on sexual assault, it led her to question herself and how she perceived the issue:

> *Yeah. That made it more intense because, when my counsellor, when the counsellor said those things, I was thinking, "Am I really making a big deal out of this?" She really did make me question myself, which is not what I needed at the moment, because even if it is my cultural background that made me feel this way, I can't change it. It is what it is. I did feel that way.*

Dolly's description of her therapist's avoidance of exploring cultural aspects of her problems had specific implications for how she perceived her ethnoracial identity. Dolly described how she temporarily abandoned her ethnoracial minority identity to assimilate into an identity of whiteness. She stated:

> *Umm, there was definitely a time where I was trying to mute that part of my identity almost. Where I was just like, "I'm just going to pretend I'm white because it's a lot easier to get through this garbage fire…of therapy and this – and all the difficulties in my life if I just pretend that I don't have to deal with the problems." 'Cause in the end, it almost seemed that because we couldn't talk about them, it almost seems like my identity and my race and my ethnicity were the problem. Instead of the problem being tied to them. So that's sort of – because like I said before, I was also having problems with my identity at that time. And it…like really fucked up my perspective for a while and then I slowly had to realize it's not who I am that's creating the problem, it's—their inability to separate who I am and my problem and deal with them.*

Furthermore, Dolly expressed that because her therapist was unwilling *"To go into those deeper experiences [of culture]…because [she] can't understand them"*, she started to attribute her issues to her culture, seeing her ethnoracial identity as the problem that needed to be solved.

Internalized shame. In addition to internalizing therapist invalidations that impacted ethnoracial identity, three participants experienced internalized shame. Therapist's lack of cultural understanding and invalidations led participants to believe negative aspects of

themselves that their therapist's actions demonstrated. Participants stated that their oppressive counselling experiences made them feel *"bad"*, *"ashamed"* and *"inferior"*, indicating an overarching emotional experience of shame.

When Dolly reflected on in-session moments of cultural invalidation and misunderstanding, she expressed having felt shame in these instances, which led her to believe that she was incapable of managing her issues associated with transitioning to University and cultural aspects of her family dynamic:

> *There was definitely a little bit of shame in that…I don't know if it was her intention, but she made it out to seem like I should be able to deal with this on my own and it wasn't that big of a deal. So, you do kind of feel that little bit of shame when you can't handle it on your own. And that's not good for anyone. Like very unhealthy and just a little bit of embarrassment because—like it's kind of embarrassing when you're not fully understood, and you feel like you're not making your point made.*

Furthermore, Dolly's verbatim expressed that she felt inadequate in not being able to be understood by her therapist, ultimately suggesting that she placed the responsibility of misunderstandings onto herself.

JJ, who also experienced shame in response to oppressive experiences in session, added an impactful description of how he internalized his therapist's criticism. He said, *"It's like an internal negative voice you hear in your head. Oh—you just hear the therapist in your head saying you're a bad person."* JJ mentioned other statements throughout our interview that pointed to far-reaching impacts of internalized shame, such as *"Well, it made me have inferiority"*, *"You know, inferior. Like 'I don't matter.' Lesser of a person"*, and *"I don't measure up. I'm less of a person. Everyone's better off. You know the saying that the grass is greener on the other side. It seems like my life in comparison to other people's lives isn't great."*

This experience of internalized shame ultimately diminished their self-esteem. Participants had entered therapy with poor self-esteem, in addition to their main presenting problems, and described a worsening of self-esteem as a result of internalized shame. For example, JJ stated that he *"Had self-esteem challenges"* and that *"It didn't improve, so it probably worsened"* as a result of oppression he experienced in session.

Generalized Negative Beliefs

Participants described developing negative beliefs about their therapist and counselling experience as a result of oppression in session that they then carried forward into new experiences. Generalized negative beliefs included losing faith in the counselling profession as a whole and overgeneralizing the potential for oppression to individuals beyond their therapist. Participants felt that such generalizations were ultimately harmful to them in that they deterred them from subsequent meaningful interactions with professionals and other individuals.

Client loss of faith in profession. As a result of their oppressive experiences in session participants felt a level of distrust towards the therapists with whom they experienced oppression. This distrust was generalized to the counselling field at large, with participants developing negative beliefs about the unhelpfulness of counselling and expectations of similar treatment in future counselling situations. For example, Lilly stated that she did not want to seek out another therapist because her experience *"… just kind of made me not trust therapists anymore."*

Participants also generalized their negative beliefs about counselling to other professionals as well, including doctors and psychiatrists. Lilly generalized her beliefs about counsellors being judgemental and her fear of disclosure to the entire medical professional:

> *I'm afraid to go to my doctor sometimes. I know they have the same, I guess, policy confidentiality of the patient or client, and I'm afraid of oversharing. […] Yeah, my family doctor, he's a male, but I still feel uncomfortable talking about certain things because I have the idea that "Oh, this person is a medical professional and they're going to judge me."*

In Hotmot's interview, he described his experience of harm as impacting his beliefs about the integrity of the psychiatric profession that his therapist belonged to, ultimately generalizing his beliefs to all psychiatric professionals. Specifically, he mentioned his general belief that the profession is disingenuous in its motivations for financial success and hypocritical in their ethics of 'do no harm'. For example, he said, *"I'm starting to lose faith in the whole profession, you know […] all became a bias against the psychiatric profession […] because they're making money hand over fist and they're not doing their job, you know."*

Additionally, participants felt harmed in their loss of faith and trust because it deterred them from seeking help for their mental health issues and getting assistance from potentially effective counselling services. For example, Lilly stated:

> *Yeah, I know I see my family doctor regularly and he oversees my medications, and he told me that it's best to pair the medications with therapy. And even though I know it's good for me to have therapy, it makes me not want to go because there is always that anxiety of "What if I end up with a not very good therapist?"*

Furthermore, Lilly's generalization of distrust and negative beliefs to other counsellors created feelings of hopelessness in finding solutions for her issues:

> *I know that's something that I said before, but it just made me not want to come back to therapy. It made me just kind of believe I'm going to be depressed forever or I'm just going to rely on my medications, which I'm kind of doing now. But…yeah it just kind of made me feel like…I don't know, like I don't have any hope in therapy or it's not worth going.*

Oppression generalized beyond therapy. Four participants stated that they felt harmed by in-session oppression in that they found themselves expecting people other than their therapist to also be oppressive towards them in their lives outside of counselling. Specifically, they began to expect the same mistreatment, lack of care, misunderstanding, and judgement from "all people." For example, Lilly felt that because her therapist was judgemental, those with whom she had close relationships with would also be judgemental, which impacted her trust with others: *"I feel like their attitude kind of applies to everybody. Even if I'm close to other people, it made me not want to share a lot of things with my friends, or my sister."*

Lilly stated that she also generalized the belief that her therapist was unable to understand her to other people in her life, such that if her therapist could not understand her then no one would be able to understand her:

> *Oh, I thought at that time that maybe she just doesn't understand. Or – because she's not me, she doesn't understand or—because of that I generalize to everyone else. "Nobody understands me." That kind of thing. […] Yeah so, I think I overgeneralized at that time.*

Anica generalized her experience of oppression to others, regardless of their ethnicity or race. Specifically, when discussing the impact of feeling misunderstood by her therapist and feeling oppressed, she generalized this expectation to all people:

> *I just had something against counselling, but I didn't have anything against white people or—I just formed his idea in my head about people in general. Maybe they aren't going*

to understand me if they haven't experienced it the way that I did. That's the idea that I got, but not specifically against or towards a race. Just in general about people.

CHAPTER FIVE

Critical Reflection

In line with the research methodology of philosophical hermeneutics used in this study, I ensured that a research journal was kept of all thoughts, ideas, feelings, and wonderings that emerged throughout the entire process, starting at the beginning phase of forming a research topic, up until the final edits. I had been forming this research topic prior to entering my counselling psychology program at the University of Ottawa, during my work supporting various marginalized groups. Once starting the program, I discussed areas of interest with my supervisor, Dr. Cristelle Audet who specializes in social justice and ethics in counselling, and reviewed literature that aligned with my interest of oppression in counselling.

Through continuous engagement with the literature and conversations with Dr. Audet, I learned that there was research on oppression in counselling for those identifying as diverse ethnic and racial minorities, but the majority of studies were focused on therapist's perspectives of oppression and/or preconstructed ideas within oppression. As such, I landed on exploring ethnoracial minority client's lived experiences of oppression in counselling with white counsellors, from the perspective of the client's themselves. My research questions expanded to include the domains of power and harm, as power is connected to oppression and harm provides insight into the impact on the client in terms of counselling process and mental health.

Terminology. Terminology became a point of tension early on in the research process, as many studies used oppressive language to describe the types of clients I was including in my study, that being "non-white." As a white researcher and counsellor, I felt it important to use appropriate language with participants and to present research that critically examines the current terminology used and to offer something different. I spent time researching the etiology of definitions of race, ethnicity, and culture, as well as non-oppressive language for classifying "non-white" clients, which eventually led to the selection of "ethnoracial minority". Although I decided on this label from the available terms used in Canadian literature, I recognize that it has shortcomings in that as a collective, ethnoracial "minority" individuals are in fact not a minority of Canadian demographics. I encourage future researchers to continue reflecting on terminology they use in their work and implications it may have in terms of power and perpetuating oppression.

Participant recruitment. During the recruitment phase of this research, I recognized some difficulty in finding recruitment sites to willingly display my poster, as well as individuals to participate. I recruited throughout various types of organizations, centres, and clinics across Ottawa. After several weeks of recruiting by email and in-person visits, without any responses from potential participants, I started to worry about whether the intended number of participants would be reached in the available time frame for this research. A conversation with a gatekeeper at one of the recruitment sites helped to provide insight into why I was experiencing difficulties finding participants. This sparked reflection on the challenges for many ethnoracial individuals to discuss sensitive topics within mental health, let alone the vulnerabilities of oppressive experiences associated with topics of mental health. Additionally, this suggested the value of psychoeducation and counselling socialization for ethnoracial minorities, to help clients feel included and informed in the treatment and process, which emerged as a subtheme, being mismanaged expectations, of "power over."

After a couple months of recruiting, three participants had responded to the posters throughout Ottawa recruitment sites and were interviewed. At this point, I decided to expand my recruitment location to Toronto and Montreal and incorporated additional recruitment strategies of snowball sampling, email distribution lists, Facebook pages, and Kijiji advertisement. Although all these were included in my ethics revision, mainly snowball sampling and Kijiji advertisements were utilized. These new strategies resulted in an influx of interested participants; however, due to time and resources, only 5 participants were included, which was less than originally expected, but has been shown to still allow for saturation.

Participant interviewing. Every interview was very different. I noticed that although I used the semi structured interview protocol, I ended up following the participants in where they were guiding the discussion, which I felt allowed for lot of rich data. My interview style changed depending on the talking style of each participant, which influenced my use of questions, paraphrases and active listening. I noticed that the in-person interviews were both longer, being 90 – 120 minutes in length, and provided more in-depth descriptions of experiences, while the online Skype interviews that were completed with two participants, appeared more challenging to elicit in-depth reflections. Noteworthily, one participant's interview style was very different than the others, in that they took a more storytelling approach, and used references to reinforce

and add details to their experiences. Regardless of style, length, and depth, I felt that all interviews and participants provided valuable information and data.

I noticed my own frustration and irritation forming while interviewing some participants. Upon reflection, I realized that this reaction emerged for various reasons, including feeling like participants were getting off track, answering questions in an unexpected manner, and/or resistant to reflection and expansion of descriptions. Perhaps my emotional reaction to participant styles and responses was a result of preconceived expectations, ideologies, and standards that may be linked to my own white lens. Additionally, I may have unintentionally used my own language in paraphrases during the interview and offered new understandings based on personal learning from research and prior interviews with other participants. However, I feel I used tentative language when offering potentially new information in interviews, giving participants the opportunity to reject or accept and elaborate. These were things that I tried to reflect on during and after each interview, and I adjusted myself while engaging in the interviews and during future interviews. The transcription process was very helpful as it allowed for further reflection on my own reactions and the impact on the participant-researcher relationship, and also helped build awareness of areas to keep in mind during following interviews.

Analysis. I felt drawn to particular offerings within the transcript that initially caught my attention during the interview. For example, the first participant provided metaphors to emphasize aspects of their oppressive experiences that felt powerful to me both during the interview and while reading transcripts. Furthermore, I wrote field notes after each interview that acted as reflection points for understanding the main parts of the participant's interviews, which may have influenced the lens in which I used to analyze each transcript. The interpretations of each interview may have influenced the analysis of subsequent interviews through the types of descriptions that pulled my attention, the way I interpreted them, and the labels used to describe them. Additionally, my knowledge based on the current MCP literature influenced the types of themes and subtheme labels I used, and how I clustered subthemes. I initially intended to find one "whole" for each interview, but during the process, I felt it more appropriate to reflect on the main aspects of each interview while writing the field notes and after each transcript reading, as transcripts were complex.

Results and Discussion. In entering the writing stage of the results, I started to become anxious about the number of subthemes and themes, and I felt disorganized in how similar some

were to others. Throughout the writing process, themes and subthemes were merged and reorganized, which helped to create a feeling of organization and clarity. However, some of my worries remain as I feel that some subthemes and themes share similarities but are too different to be merged or removed all together. Throughout the process of delineating the results, I was able to draw links between the subthemes, themes, and constructs, with links becoming more concretized as I moved into writing the discussion and implications sections. This process highlighted for me some of the observations offered in MCP literature that power and oppression are inextricably linked, but opted to keep subthemes that may appear to overlap in favour of demonstrating the complexity and nuance of oppressive counselling experiences.

Philosophical hermeneutics was chosen because I believe that due to the subjective nature of reality, I as a researcher am unable to take an objective stance at any point of this process. The "fusion of horizons" is a main component of this methodology and, as such, I aimed to position myself within a shared space of understanding by approaching participant narratives while holding some of my preconceptions and the literature I have been steeped in. Ultimately, this process fostered the creation of a new understanding of the phenomenon under study, rather than an uncovering of participant understandings. A concern was that interpretations made could be based primarily on current literature and the type of results that I was expecting to find. However, through continuous reflection and discussion with my supervisor, I feel I was able to recognize moments where preconception, based on my assumptions and literature, may have influenced the interpretations, in order to remain as close to participants' experiences as possible.

Many findings were similar to the preconceived ideas and assumptions that I reflected on prior to the study (see Appendix H), but there were also findings that I did not anticipate. For example, with respect to power dynamics, I anticipated participants would primarily reference ethnoracial differences within the therapist-client dyad. However, participants felt that inherent disparities of power within client-therapist relationship was the main component of the power dynamic, and that ethnoracial hierarchies influenced their perceptions of oppression and created difficulties in resisting oppression and power. Furthermore, while I expected miroaggressions to be a part of participant experiences, I was surprised to hear that dismissals, minimizations, and feeling misunderstood were at the core of their oppressive experiences.

Main Findings and Discussion

In this section, I discuss main findings related to the themes and subthemes presented in Chapter Five, grounded in the experiences that participants shared about their therapy with a white counsellor. Specifically, I organize the findings according to oppression, power, and harm. I situate the findings within current literature in the context of counselling ethnoracial minority clients, and indicate instances when findings are similar to or build upon the literature.

Oppression

When oppression is discussed in the MCP literature, it is often in the form of microaggressions, such as therapists applying treatment that is culturally insensitive, using stereotypes, making assumptions, pathologizing cultural values, invalidating interethnic differences, denying racism, minimizing cultural issues, accusing hypersensitivity to cultural issues, and being patronizing toward clients (Constantine, 2007; Sue et al., 2009). While some of the participants reported experiencing similar microaggressions, they were able to further nuance the nature and form that microaggressions took. In this regard, they referred to ways that the general whiteness of therapy, how the therapist positioned themselves vis-à-vis cultural difference, and in-session microinvalidations all contributed to their experiences of oppression in therapy.

Whiteness of therapy. While all participants experienced oppression prior to their engagement in therapy, they continued to experience oppression in the therapy setting as they clearly remarked on the whiteness of the therapy industry. For example, some participants noted a paucity of ethnoracial minority therapists in the field, not having the financial means to secure a therapist that could be a "better fit" (Graham, Bradshaw, & Trew, 2009), and stigmatization of mental health and counselling within their own culture as reflecting the whiteness of therapy. These observations led participants to feel alienated in the therapy context—a finding reflected in the work of O'Mahony and Donnelly (2007), who discuss how alienation may serve as a barrier that further distances ethnoracial clients from seeking mental health services. That ethnoracial minority clients are oppressed before they even enter the counselling room and continue to feel alienated within the whiteness of therapy could render them more vulnerable to the oppressive experiences that may occur in the therapy.

Participants noted that, once in therapy, therapists applied a whiteness-based lens when both conceptualizing presenting problems and providing interventions. In terms of conceptualizing presenting problems, therapists did so in many instances through whiteness

norms and ideologies. Clear examples of this include Anica who wanted to address a sexual assault and Hotmot who wanted to address alcoholism, where in both instances the therapist promoted their own understandings of the issue without creating space for the client's understanding. Whiteness norms and perspectives manifesting within therapy when assessing client problems have been reported in the literature (Lee & Bhuyan, 2013), and have been attributed to the whiteness lens of both the individual therapist and society at large—both of which shape the approaches to counselling and psychotherapy (Houshmand et al., 2017; Lee & Bhuyan, 2013; Maurer, 2016; Sue, 2015).

One approach that participants considered culturally insensitive regarded how their therapist tended to overemphasize individualistic values (Constantine, 2007; Das & Kemp, 1997; Wong & Piran, 1995). Overemphasis of individualistic values at the expense of collectivist values that clients may possess is not new, and the lack of acknowledgement in this area has been a source of criticism by multicultural counselling literature (Sue, 2015). Criticism has equally been directed at how Western psychology itself is a largely white endeavour that promotes individualistic, person-centered approaches that overshadow the cultural roles of family and community in client wellbeing (Das & Kemp, 1997; Wong & Piran, 1995). Indeed, participant experiences were consistent with theoretical-based literature indicating that the values encompassed in Western practices of counselling and psychotherapy can often conflict with client cultural values and needs (Sue, 2015; Wong & Piran, 1995). However, these findings offer empirical evidence for culturally insensitive approaches of whiteness used within oppressive therapy conditions. Perhaps oppression and disempowerment arising from "white interventions" was best reflected in Dolly's "plastic hammer and concrete wall" metaphor, where the plastic hammer represents the intervention and the concrete wall represents the problem.

Another approach that participants deemed culturally insensitive, occurred when therapists overemphasized weaknesses, creating oppression by making participants feel as though their culture-based problems were their fault. This deficit-based focus also created the sense that aspects of their problems linked to ethnoracial identity were "abnormal", and that they needed to change their behaviours and parts of themselves, rather than therapist's seeing participant issues and behaviours as common within the context of their culture. This aligns with Sue's (2015) recognition that theories, interventions, and approaches within Western psychotherapy often emerge from whiteness beliefs and values about what constitutes "healthy"

human development. It moreover points to therapists problematizing—that is, regarding aspects of the client's cultural values and behaviours as needing to be "fixed", based on behaviours that are deemed "normal" within white Western society (Wong & Piran, 1995). Rather, participants wanted more normalization of their culture-based problems and for their therapist to use strength-based approaches or interventions.

Therapist cultural positioning in sessions. Experiences of oppression also arose when participants noticed unfavourable ways in which their therapist seemed to relate to and engage culture in sessions. Unfavourable positionings emerged when therapists relied on faulty cultural assumptions, leaned away from cultural conversations, and replicated unhelpful societal views on culture—all of which have been identified in the literature as microaggressions that negatively impact the counselling experience for ethnoracial minority clients (Gushue, Constantine, & Roberts, 2007; Gushue et al., 2004; Gushue et al., 2007; Knox & Burkard, 2004). All three cultural positionings could be understood as a lack of cultural humility, defined in the literature as the willingness to understand a client's cultural identity and ability to reflect on the intersection of the therapist's and client's identities (Owen et al., 2016). According to Owen and colleagues, among other empirical research (Dillion et al., 2016; Owen et al, 2014; Owen et al., 2016), cultural humility can serve to prevent negative client experiences surrounding culture that could result in relational strains and ruptures, as well as repair such ruptures.

Many participants believed that their therapist's oppressive behaviours and actions in therapy were not malicious in intent, but rather a result of the cultural climate in which they live. Specifically, participants expressed their belief that their therapist was unconsciously affected by racist attitudes held within white Western society, which was found by Bronstein (1986) as well. This is also consistent with Lee and Bhuyan's (2013) observations from their study on client negotiation within whiteness that the clinical setting often mirrors the broader social context.

Microinvalidations by therapist. Participants experienced microinvalidations when counsellors either minimized or dismissed certain thoughts, feelings, and behaviours associated with cultural identity and experiences that were important to the participants. Consistent with the literature, minimizations generated the feeling that the issues presented in therapy were not as severe as the participant perceived (Constantine, 2007, Houshmand et al., 2017; Sue et al., 2009) and that their culture was not a significant contributor to the issues—in effect implying that they are engaging in "cultural hypersensitivity" (Constantine, 2007).

Compared to minimizations, participants experienced dismissals as a rejection of specific aspects of experiences that they saw as related to their culture, seen as a form of microaggressions by Constantine (2007) and Sue et al. (2009). These instances left them sensing that their culture-specific feelings and beliefs were incorrect. Dismissal also took the form of therapists asserting their expertise over their clients' experiences, which generated feelings of patronization also reported in the literature (Constantine, 2007). However, patronization in this study is different from what Constantine (2007) reported, as participant's feelings of being patronized came from their therapist's use of a whiteness lens to dismiss cultural experiences, while Constantine (2007) reported clients perceiving patronization through unnecessary help from therapists. Lastly, some dismissals took the form of therapists "denying racism", which ultimately negated in-session experiences of oppression (Constantine, 2007; Sue et al., 2009). What these microinvalidations have in common is that they are considered a form of microaggression that result in missed opportunities for therapists to explore culture with their client (Houshmand et al., 2017).

Disconnection between therapist and client. Participants described several ways they felt disconnected from their therapist in moments of oppression. Disconnection took the form of feeling misunderstood culturally, experiencing an absence of authentic therapist presence, and receiving therapist transference and countertransference.

There is much counselling literature on "cross-cultural misunderstanding", where therapists misinterpret client expectations and goals for therapy, cultural components of their problems, language, culture-bound values, and non-verbal and verbal communication styles (Keenan, Tsang, Bogo, & George, 2005; Sue & Sue, 1977). In this study, cross-cultural misunderstanding was most often reflected in the therapist conveying dissimilarity of experiences with participants, such that participants felt their therapist simply could not empathize with them on a cultural basis. This is similar to Chang and Yoon (2011) who report that clients of colour often feel that white therapists are unable to understand their experiences on a deep and emotional level, due to their inability to appreciate the impact of their ethnoracial identity on their experiences. This lack of understanding can be compared to literature that shows that a common therapeutic factor across ethnoracial groups in counselling is when counsellors possess a shared worldview (Fischer et al., 1998). Although previously demonstrated empirically, ethnoracial minority participants in this study added to literature on cross-cultural

misunderstandings, in the way that they explained that cultural misunderstandings felt oppressive when they felt vulnerable and in a position of disempowerment prior to the cultural misunderstandings.

Participants also reported that when there was an accumulation of cultural misunderstandings or when misunderstanding was "too great", a tipping point was reached where feeling misunderstood was no longer tolerable or acceptable and warranted a departure from therapy. This finding aligns with studies that show cross-cultural misunderstandings contributing to microruptures in the therapeutic relationship, which when left unresolved can create complete ruptures (Keenan, Tsang, Bogo, & George, 2005) and ultimately result in premature termination (Nelson, & Baumgarte, 2004; Sue & Sue, 1977).

Oppressive experiences in therapy were also associated with times therapists lacked attunement, described as engaging in manualized, robotic, or disingenuous interactions in counselling. Participants noticed in these instances that therapists were not responding to them in an authentic manner and that it felt dehumanizing, which contributed to the experience of oppression. Lack of attunement is described in the literature as "lack of responsiveness" to client offerings in session and is a common therapist quality seen in cross-cultural counselling with ethnoracial minority clients that indicates cultural ignorance (Worthington et al., 2000). Although these qualities can be seen across cultural contexts (Nelson & Neufeldt, 1998), the multicultural counselling literature emphasizes that therapists need to be responsive to their ethnoracial clients and adjust their communication style and approach to fit the client (MacDougall, 2002), in order for therapy to be effective.

A final site of disconnection through oppression in therapy regards moments of therapist transference and countertransference. Transference and countertransference can be considered a general therapy process in all cultural contexts (e.g., Bartoli & Aarti, 2009; Gelso et al., 1995; Gelso et al., 1999; Fuertes, Gelso, Owen, & Cheng, 2013; Redekop, Luke, Malone, 2017), where therapists react to client's transference and other client-specific phenomena due to unresolved conflicts of the therapist (Hayes, 2004; Rosenberger, Hayes, & Jeffrey, 2002). In this study, participants described instances of cultural transference and cultural countertransference related to their therapists avoiding their culture and expressing sensitivity to their cultural experiences, in addition to more general experiences, such as prioritizing their own needs and affective experience. With respect to cultural transference, Nagai (2009) outlines four types of

transferential interaction patterns within cross-cultural contexts, with one being the clinician "using" the client to meet their own needs, which was also the case for some participants in this study. Of concern is how some participants, in response to feeling oppressed, were compelled to respond in ways that met the therapist's needs and maintained the therapist's professional self-image. For example, Lilly felt compelled to meet her therapist's transference needs by indicating progress in her mental health, even though she did not feel this was the case.

With respect to cultural countertransference, the literature describes it as encompassing therapist's personal reactions to the client's culture or cultural background (Nagai, 2009). Participants in this study felt their therapist's reactions were personally driven at times, and took the form of defensiveness, judgement, emotional sensitivity, and avoidance of aspects of their ethnoracial identity. Furthermore, participants attributed much of the transference and countertransference reactions of their therapists to their own ethnoracial minority identity and the cultural differences between them and their therapists. Therapist cultural countertransference is often based on assumptions and stereotypes the therapist holds about the client's ethnoracial background and can influence the therapy process (De Varis, 1994; Foster, 1998). Specifically, Comas-Diaz and Jacobsen (1991) outlined "denial of ethnocultural differences" as a form of cultural countertransference, describing it as therapists applying assumptions of sameness across all ethnoracial minority clients or ignoring cultural differences between therapist and client (Comas-Diaz & Jacobsen, 1991; Foster, 1998). Therapist avoidance of conversations about ethnoracial minority's cultural background can also be considered as a form of cultural countertransference, which is unconsciously expressed from the desires to avoid negative effects of guilt associated with one's privilege and power and fears of appearing oppressive (Comas-Diaz & Jacobsen, 1991; Foster, 1998; Sue, 2011)—something that was offered by participants in this study.

Power

When discussing power in oppressive therapy, participants pointed to different power differentials between themselves and the therapist, times when they experienced therapists as exerting power over them, their responses to feeling disempowered, and ways they attempted to reclaim power through resistance.

Relational power differences in therapy. As with most clients, participants recognized a power difference between the therapist-client therapy roles, regardless of their specific cultural

context, where they saw clients in a dependent vulnerable position and therapists as knowledgeable experts. Such a power dynamic has been outlined by Foster (1998), where the referential power associated with the therapist role can be seen as an important therapy condition for fostering client change and growth (Foster, 1998; Guilfoyle, 2003; Sutherland & Strong, 2010). Power can inadvertently be used by therapists as a way to dominate and control therapy, and it is the therapists' responsibility to shift the dialogue of therapy into a more collaborative space where clients have power and autonomy (Guilfoyle, 2003; Sutherland & Strong, 2010). However, cultural aspects can widen this inherent power imbalance, with participants expressing their increased vulnerability due to cultural stigma prolonging help-seeking and uncertainty in their cultural identity and experiences. In this study, ethnoracial hierarchical structures seemed to enter the power dynamic in therapy, with cultural power dynamics in broader society influencing how clients may perceive power within the counselling context itself. Participants referred to this societal hierarchy based on ethnoracial identity in their power relationship in therapy, stating that it felt as if their therapists perceived themselves to be superior to them based solely on their ethnic and racial identity status. There are studies that speak to the parallel of sociopolitical relational structures within therapy (De Varis, 1994; Foster, 1998; Goldberg, & Hoyt, 2015; Sue, 2015); however, participants in this research described their perceptions of both the ethnoracial hierarchial structure in their therapy relationship and the influence of external social context on power structures.

Relational power was also experienced in the transactional nature of therapy, for some participants, in that they felt their therapists "used them" as a means to an end for financial gain and knowledge acquisition. They also experienced the transactional nature of therapy as dehumanizing and felt their therapist did not genuinely care for their wellbeing. This finding is important given that the therapeutic relationship is deemed an essential component of counselling across various cultural values and counselling approaches (McDougall, 2002). Transactional relationships can be seen in different therapy contexts, where therapists enter the process with preconceived ideas and beliefs of "appropriate" session structure, interventions, and approaches, regardless of their ethnoracial identity or their client's (Davis, 2019; Nelson & Neufeldt, 1998). Furthermore, these therapy qualities correspond with rigid or manualized approaches, which can exclude clients from the therapy process, diminish the counselling

relationship, and alter client perceptions of counsellor "humanness" (Henry, Strupp, Butler, Schacht, & Binder, 1993; Nelson & Neufeldt, 1998)

These transactional dynamics—which include other subthemes within "power over" and "disconnection"—seem counter to what the MCP literature proposes regarding the importance of therapist qualities for enhancing the therapeutic relationship, such as showing genuine interest in clients and providing cultural empathy (Fischer, 1998). For example, Relational Culture Therapy is built on the assumptions that psychological healing for minority groups occurs through relational connections, including the therapeutic relationship, and require that therapists relate to their clients more authentically (Comstock, et al., 2008; Jordan, 2001).

Power over by therapist. For participants, power over occurred when the therapist appeared to exert role- or culture-based power over them or the therapy process. Ways in which therapists exercised power over, rather than 'power with' or shared power, clients emerged when they mismanaged client expectations of counselling, controlled the session direction, disrespected client attempts at asserting autonomy, and persisted in asserting their whiteness ideologies and assumptions. Some of the experiences of "power over" outlined by participants can be thought of as general therapy processes, such as when the therapist is leading the session and mismanages expectations. However, these ethnoracial minority participants experienced these therapist behaviours and therapy processes through an ethnoracial lens and, therefore, the way in which the client interprets the therapist's behaviour may differ from white clients or clients with different cultural identities.

Participants reported they were not provided opportunity to formulate or share their therapy expectations or needs—an important condition for a positive counselling experience across all cultural contexts (Fischer, 1998). Ultimately, participants felt their therapist did not include them in the counselling process, which can be seen as the therapist exerting power to maintain their "expert" role (Guilfoyle, 2003). Although seen in other theoretical studies on power and oppression in cross-cultural counselling, this study offers empirical results that demonstrate the relationship between power and expectation management for ethnoracial minority clients working with white counsellors. Expectation management is an ethical responsibility of counsellors and psychotherapists within the informed consent process—a practice that should occur at the onset and throughout the therapy process (CCPA, 2007, 2015;

CRPO, 2011, 2016) to establish comfort in the therapy process and instill hope toward therapeutic change (Fischer, 1998).

Participants also experienced their therapist's control through them leading the session, using faulty cultural assumptions and whiteness ideologies to direct focus and structure in therapy. Lee and Bhuyan (2013) similarly found that the white therapists in their study dominated the therapy process and perpetuated client disempowerment through their assertions and maintenance of whiteness ideologies within the therapy conversation. As seen in this study, ethnoracial clients' attempts to assert autonomy by taking more control over the session direction were usually unsuccessful because of the rigidity and structure the therapist imposed. In this way, participants felt their autonomy was disrespected, leaving little space for clients to express their own understandings in therapy. Promoting client autonomy and respecting their right to self-determination are core professional values (e.g., CCPA, 2007, 2015; CRPO, 2011, 2016) (Lee & Bhuyan, 2013) that may need to be considered more closely when working within ethnoracial diversity.

Of particular concern in this study is when therapists, rather than listen or adjust to their ethnoracial minority client's offerings, actually dismissed or pushed back against client attempts at asserting their perspectives. Also, of concern is that therapist persistence—whether in excluding the client in the structuring or focus of therapy, in exercising whiteness ideologies in therapy practices, or in dismissing client resistance to oppression—seemed to potentially lead clients towards assimilation (Lee & Bhuyan, 2013). These experiences are akin to what Todd and Wade (1994) among others (Reynolds & Hammoud-Beckett, 2018) have referred to as 'psychocolonization', where therapists colonize the world views of ethnoracial minority clients through their attempts at enforcing their whiteness-based ideologies and perspectives.

Client disempowerment. A consequence of relational power difference and "power over" was that participants ended up feeling disempowered within therapy. Participants had a range of responses to disempowerment. Some felt incapable of asserting themselves in the face of oppression, in which case the same power dynamics persisted. One participant directly confronted his therapist's views, though the therapist did not cede the client's perspective. This finding aligns with the work of Lee and Bhuyan (2013) who provide findings that demonstrate that, because of the inherent power dynamics in therapy, ethnoracial minority clients typically do

not assert themselves in response to oppression, and even if they do, their attempts at assertive resistance are usually unsuccessful.

All female participants were unable to assert themselves; they described feeling trapped in both their sessions and in the counselling process as a whole, unable to escape the oppressive situation that they were in. This was often sustained by a sense of obligation to stay in the therapy, out of fear of losing help while in their state of vulnerability and need. As such, they remained in the oppressive therapy. The trap could be described as being unable to assert against disempowerment because of disempowerment. Ultimately, this left participants to devise ways to maneuver themselves within an oppressive therapy setting they felt unable to leave, in order to avoid further oppression. Lee and Bhuyan (2013) also found this strategy in their study, where ethnoracial minority clients "position (and reposition) one's place as 'other' within whiteness" to seem like good clients who have acculturated to whiteness norms and values. Participants positioned themselves within their therapist's white cultural identity and the whiteness of therapy by invisibilizing ethnoracial aspects of their identity—similar to the acculturation strategy of assimilation unconsciously employed by "non-dominant" ethnoracial groups when in continuous contact with another culture (Berry, 1997). Furthermore, Berry (1997) describes assimilation strategy as the process of "non-dominant" individuals or groups abandoning their own culture to become involved in the "dominant" culture, while separation is the process by which "non-dominant" individuals hold onto their original cultures and avoid interacting with others.

Client empowerment through resistance. After experiencing continuous oppression in therapy, some participants attempted to reclaim power in two ways, by creating boundaries in session or by liberating themselves from the oppressive counselling altogether. Unfortunately, this meant the responsibility to resolve oppression fell on the client, rather than the therapist. Participants set implicit boundaries particularly on cultural conversations by bracketing cultural aspects of their issues that they anticipated would lead to oppressive responses by the therapist. Such boundary setting appears common among ethnoracial minority clients in cross-cultural contexts, as seen in both theoretical and empirical research. Specifically, ethnoracial minority clients tend to limit their disclosure about cultural values and experiences of oppression due to fears of being invalidated or misunderstood, or treated without empathy and cultural sensitivity (Bronstein, 1986; Chang & Yoon, 2011). Although non-disclosure was a form of resistance for

participants, it also had a harmful impact on the therapeutic relationship and counselling process, as participants felt unable to share valuable aspects of their struggles.

At a certain point, participants recognized that they were unable to continue limiting themselves and being dismissed by their therapists in their resistance attempts, that they felt their only remaining option was to leave counselling. Ethnoracial minority clients can experience psychological liberation through dis-identifying with and disengaging from the beliefs imposed by their therapists, a strategy that participants in this study also seemed to employ to liberate themselves from therapy where whiteness-based oppression was enacted (Hanna, Talley, & Guidon, 2000). Participants saw this act as empowering, as they turned to resources that fostered agency and self-sufficiency, such as external social networks and self-improvement programs.

Harm

Participant experiences of harm included the ways that oppression harmed the therapy itself as well as harmed clients, where participants reported perceiving themselves as "worse off" after having gone through therapy. Such worsening is antithetical to the purpose of therapy, which in the most general sense serves to assist individuals toward positive change and improvement.

Hindered counselling processes. The therapeutic relationship has been deemed one of the most important factors for fostering effective, culturally sensitive therapy (Collins & Arthur, 2010; Fischer et al., 1998; MacDougall, 2002; Owen, et al., 2004; Vasquez, 2007). Moreover, therapeutic conditions of unconditional positive regard, genuineness, and empathy advocated in Person-Centered Therapy have been identified as important to establishing and fostering a strong therapeutic relationship cross-culturally (MacDougall, 2002; Patterson & Joseph, 2007; Torrey, 1986). In this study, many participants reported losing trust in their therapists primarily as a result of feeling misunderstood culturally, which they saw as interfering with therapeutic conditions and weakening the therapeutic relationship necessary for positive change (Clark, 2010; Patterson & Joseph, 2007; Wilkins, 2000). That impediments to trust occurred gradually over the course of therapy and in other instances quite suddenly suggests that loss of trust in the face of oppression may occur differently for different clients. Also noteworthy is that the therapists spoken about in this study seemed to fail to be aware or acknowledge in some manner that their clients were feeling oppressed, precluding any opportunity to repair trust-related strains or ruptures to the therapeutic relationship.

Particularly concerning was that, counter to the objectives of therapy, participants not only did not see improvements in the symptoms that brought them to therapy but felt that their symptoms in fact worsened. These experiences resonate with the work of Wendt (2015) and empirical studies (Constantine, 2007; Owen et al., 2014; Owen et al., 2016), who describes how potentially harmful therapy in a multicultural context can contribute to increased distress for clients, as well as extensive and enduring harm to clients psychological wellbeing—a subtheme addressed later on. A potentially important distinction in how symptoms worsened regards how they intensified either right after sessions or else gradually over the course of counselling.

Equally disconcerting is that all participants eventually experienced therapy itself as a source of stress or distress that ultimately influenced their decision to end therapy. While they did not feel ready to leave therapy, they believed ending the therapy was necessary to avoid their therapist's continued oppression. Studies have shown that premature termination occurs more readily among ethnoracial minority clients working with white counsellors when they experience racial microaggressions, mistrust, and misunderstandings (Chung & Bemak, 2002; Constantine, 2007; Terrel & Terrel, 1984; Whaley, 2001), such as the participants in this study. Participants also saw certain harm associated with premature termination in that the presenting issues for which they sought therapy remained unaddressed. In effect, the "choice" of continuing with oppressive therapy compared to leaving therapy before their issues were resolved seemed to create a double bind for them, a dilemma for ethnoracial minority clients that does not appear to be reflected in the current MCP literature. Ultimately, oppressive therapy experiences prevented them from seeking subsequent help, despite awareness that their issues remained unresolved. Some participants expressed fears of re-oppression by new therapists as the impetus for avoiding further help, a finding consistent with those of Vogel, Wester, and Larson (2007) and other literature (e.g., Nickerson, Helms, & Terrell, 1994) citing incongruent cultural values/norms with and mistrust of white mental health professionals as influential to help-seeking behaviours for ethnoracial minority clients.

Impeded psychological wellbeing. In the literature, psychological wellbeing is often conceived as stemming from or including positive interpersonal relationships, a sense of self, and feelings of self-worth, all of which are closely tied to mental health (Townsend & McWhirter, 2005; Trzesniewski et al., 2006; Von der Lippe & Amundsen, 1998). Unfortunately, participants identified weakened social relationships, doubt in their identity and sense of self, and

internalized shame as resulting from oppressive therapy. Much of the MCP literature on harm resulting from oppression discusses harm within and to the counselling process—such as worsening symptoms, dissatisfaction, and poor therapeutic relationship (Constantine, 2007; Owen et al., 2014; Owen et al., 2016), with little to no empirical studies that demonstrate long-term psychological harm. These impacts on psychological wellbeing, seen in this study, stemmed mainly from cultural differences within the client-therapist dyad that the therapist failed to acknowledge or else amplified overtly. While participants viewed these therapist behaviours as unintentional, they nevertheless served to reify cultural difference already experienced with others outside of therapy, further widen the gap of social isolation, and deepen social-related anxieties. Of particular concern is juxtaposing this finding with those of multicultural studies that demonstrate social support can be a protective factor against mental health issues and be a coping resource for improving psychological distress (Chen, et al., 2019; Karaca, et al., 2019; Stoltz, et al., 2012; Thoits, 1982; Wang, Xiong, & Yang, 2018).

A number of participants felt that their oppressive counselling in some ways hindered their self-concept and identity, mainly by fostering self-doubt related to aspects of both their ethnoracial minority culture and their identity as a whole. Self-doubt often emerged in response to therapist minimizations and dismissals of culture. Some participants bracketed cultural aspects of themselves to avoid further invalidation and to fit within the whiteness of therapy. While invisibilizing aspects of self is a common response to avoiding further oppression (Lee & Bhuyan, 2013), it had implications for how participants saw themselves through the therapist's eyes. In some instances, participants attempted to "join" the therapist in their whiteness, akin to processes of acculturation (Chae & Foley, 2010; Mossakowski, 2003). In other instances, participants began to see their ethnoracial identity as "part of the problem" and as something that needed to be fixed or reconciled. Problematizing ethnoracial identity can also have negative implications for developing or maintaining a cohesive ethnic identity and for mental health and self-esteem (Chae & Foley, 2010; Mossakowski, 2003; Smith & Silva, 2011).

A final impact on psychological wellbeing regarded experiences of internalized shame—encompassing feelings and beliefs of worthlessness (Jacoby, 2017) as conveyed or implied from their therapist's minimizing and invalidating behaviours. Feelings of shame have been shown to contribute to lower self-esteem and self-confidence (Jacoby, 2017), which participants reported in this study. That therapists can negatively impact client self-esteem through culturally

insensitive behaviour is significant given the link between self-esteem and mental health—which has also been reported within multicultural contexts (Karaca, et al., 2019; Kim, Hogge, & Salvisberg, 2014; Ni, et al., 2009; Wang & Castaneda-Sound, 2008).

Generalized negative beliefs. Given the oppression experienced in therapy, participants developed an expectation that they would experience similar oppression by not only other therapists but other professionals in their circle of care, which Vogel, Wester, and Larson (2007) discuss as a factor that can influence avoidance in help-seeking. Fears of oppression and judgement associated with past experience with mental health services also seemed to extend to the profession of counselling as a whole, as well as other mental health professions (Deane & Chamberlain, 1994; Kusher & Sher, 1991). Terrel and Terrel (1984) and others (e.g., Nickerson, Helms, & Terrel, 1994; Vogel, Wester, & Larson, 2007) have found that ethnoracial minority clients can develop and generalize mistrust resulting from oppressive counselling to the entire counselling profession, regardless of the ethnoracial identity of the therapist, and discontinue treatment completely. Similarly, while many participants felt they could have benefited from continued counselling, loss of faith in helping professionals and professions changed their help-seeking behaviours such that they sought out alternate resources unrelated to counselling. This raises a certain paradox that therapist cultural insensitivity made therapy so uncomfortable that clients themselves began to make assumptions about future therapists and therapy experiences. That oppression through therapist cultural assumptions about clients begets client assumptions about therapists suggests a potentially unhelpful cycle that could prevent ethnoracial minority clients from receiving meaningful assistance.

Lastly, some participants, particularly those who experienced weakened social relationships as a result of oppressive therapy, expressed an overgeneralization of oppression to "all people", including individuals with whom they had a relationship—whether family members or friends. Many stated that they expected the same misunderstanding and judgement experienced in their therapeutic relationship to emerge in their friendships and personal relationships. Most poignantly, one participant alluded to the possibility that if a therapist could not understand her, then perhaps nobody could, calling into question whether "being understood" by someone—regardless of their cultural background—was even possible. These findings have implications for MCP literature, as the available literature in this area has slightly touched on generalizations of experiences from oppressive therapy to white people, other therapists, and the

mental health profession (Nickerson, Helms, & Terrel, 1994; Terrell & Terrell, 1984), but not to "all people."

Limitations

This research explored ethnoracial minority clients' experiences of oppression in counselling with white counsellors. Due to the qualitative design of this research, the descriptions and results are not representative of ethnoracial minority clients as a whole. Although participants identified as different ethnoracial minorities from one another, which helps to provide some heterogeneity in terms of ethnicity and race, the results cannot be generalized to all ethnoracial minorities. Moreover, while all professionals that participants received therapy from were white, there was diversity in the type of professionals who provided the therapy (i.e., counsellor, psychologist, psychiatrist); in such a case, the results do not represent counselling professionals specifically, but rather help to inform the practice of counselling and psychotherapy itself by a variety of professionals, all of whom were deemed to provide therapy. Additionally, due to the methodology and time restraints, only five participants could be included in the study; having more participants could have created further heterogeneity in the participant sample in terms of age and gender. Furthermore, more participants could have allowed for saturation of data and additional offerings for experiences of oppression, power, and harm that the current sample provided. In terms of representation, the inclusion criteria that required individuals to not be attending therapy in which they felt oppressed during the time of the interview and be able to communicate in English, excluded those who might still be in counselling and immigrants or refugees with language barriers. Lastly, as a white researcher myself, and a counsellor, I may have been a representation of the oppression experienced for participants. I addressed this at the beginning of each participant interview directly, in hopes of mitigating some of the effects of this dynamics on the data collection process. However, this cross-cultural research context could have still influenced the way in which participants related to me, the offerings made by participants in interviews, and the interpretations of those offerings. Nevertheless, this study offers some insights into ways ethnoracial minority clients might experience therapy with white professionals, the implications of which are discussed next.

Implications and Contributions

The findings and interpretations offered in this study may help broaden current knowledge on ethnoracial minority clients' experiences of oppression, contribute to white

counsellors' understanding of power and privilege in cross-cultural contexts, and ultimately provide racialized individuals greater space to share their voice in therapy. There are a number of findings that could guide future MCP research, counsellor training and education, and clinical practice, discussed separately.

Future Research

Perhaps the biggest contribution of this study is that it captured the perspective of ethnoracial minority clients, which is a population that is underrepresented in the MCP literature. This creates opportunity for research that can ultimately inform existing MCP training and competency development that align with ethnoracial minority client's experiences. For example, various forms of microaggressions related to in-session oppression were identified. While some of these microaggressions are already represented in MCP literature (e.g., microinvalidations, using stereotypes, pathologizing culture), they could be further nuanced by considering perspectives of microaggressions from client experiences directly. Furthermore, therapists can broaden their own knowledge of microaggressions by learning about forms that have less attention in current literature—such as leaning away from culture by not giving clients opportunities to discuss culture in session. Additionally, therapists could develop deeper understandings of existing microaggressions, including the distinction between minimizations and dismissals within microinvalidations.

In terms of power, imbalanced relational power dynamics can be reinforced, in that therapists can exert power over clients through a variety of oppressive interactions, which in turn can maintain ethnoracial minorities' dependency on therapy and their position of disempowerment within it. Furthermore, this can be described as a "power trap", where clients experience a double bind because they feel unable to address the oppression with their therapists due to their disempowered position, and also cannot leave therapy or else they will not be getting the help they still need. Some clients can end up abandoning their ethnoracial minority identity to assimilate to the whiteness of therapists and mitigate oppression, which ultimately can lead to impairment of psychological wellbeing as seen in this research. Ethnoracial minority clients can respond to oppression and power in different ways, both through recoiling and resisting. As such, the MCP field might benefit from future research exploring how minority clients respond to oppression, based on their power position. Another implication to this contribution could be for

research to focus on developing strategies to help therapists identify, explore, and assess unhelpful power dynamics that interfere with the therapeutic process and client wellbeing.

Much of the MCP literature that focuses on the harmful impacts of oppression and power in cross-cultural counselling, primarily discusses 'harm' to the therapy process itself. In addition to these types of harm, this research also indicates the possibility of long-term harm beyond the direct counselling context, particularly the ways clients' psychological wellbeing and beliefs can be negatively affected by oppressive therapy. As such, there is a need for future studies to continue Wendt's (2015) research on potentially harmful therapies and explore the extent to which clients can be harmed.

Counsellor Training and Education

The feeling of being misunderstood was a significant piece in terms of oppression and was at the core of many experiences for clients, such as alienation from therapy, generalized beliefs, and self-doubt. Ethnoracial minority clients can feel misunderstood through a variety of interactions with their white therapists that create feelings of disconnect between them and their therapists, which can further weaken the therapeutic relationship and produce ineffective therapy. When therapists are attuned to their ethnoracial minority clients' experiences, especially the cultural layers within them, clients can feel understood by their therapists, which can reduce feelings of oppression and correct for oppression. The therapeutic relationship is a core component of multicultural therapies and competencies, and therefore fostering feelings of being "understood" in ethnoracial minority clients may be an important factor to be considered in terms of training culturally sensitive counselling professionals. Beyond this core, therapists could consider when ethnoracial minority clients may want cultural differences, identity, and even oppression to be broached in sessions. As such, attention could be placed on developing culturally sensitive micro skills and educating counsellors on ways to mitigate and repair oppression experiences through broaching cultural conversations and emphasizing cultural empathy.

Clinical Practice

Findings that surround ethnoracial minority clients' perspectives about the whiteness of therapy and observations regarding therapist positioning within culture, can aid in therapists' self awareness. Specifically, therapists can build their awareness of how they perpetuate whiteness in therapy through their use of particular theories, approaches, interventions, and suggestions.

Furthermore, therapists' cultural understandings of themselves and their clients can be widened such that they lean towards cultural conversations, rather than away, and recognize instances where they may be bringing in beliefs and assumptions from the greater society.

Core therapy conditions of congruence, unconditional positive regard, and empathy equally apply in cross-cultural contexts. While virtually universally accepted, it appears that not all therapists cultivate these conditions in therapy with intentionality, which may be especially helpful in cross-cultural encounters. Doing so could create much-needed safety and space for clients to voice their cultural concerns and wellbeing. Therapists would also do well to consider ways in which individualistic approaches may be counter to client culture to avoid pathologizing clients for the culture they identify with. Therapy approaches themselves can contribute to client experiences of oppression. Here, a collectivist lens and strength-based interventions may be particularly applicable. Foremost, collaboration between therapists and clients is valuable in establishing a shared understanding of needs, wants, and expectations of the client and ways in which therapists can best meet these. As such, counselling socialization and exploration of client expectations may be useful for creating a collaborative environment and shared understanding. Ultimately, the application of these tools in therapy practice could mitigate the far-reaching harm of oppression in counselling that impacts client lives beyond counselling, including self-doubt, social relationships, and self-esteem.

Final Remarks

Although there is current literature that explores the presence and implications of oppression and power differentials within cross-cultural counselling between ethnoracial minority clients and white counsellors, much of the research either examines preconstructed forms of oppression or negates client perspectives of these experiences (e.g. Houshmand et al., 2017; Maurer, 2016; Owen et al., 2014, 2016). Therefore, my research broadens the current understanding of oppression and power within cross-cultural counselling relationships to include client's lived experience with oppressive power and harm encountered as a result of these experiences. This addition to the current understanding of oppression within cross-cultural counselling can also contribute to established knowledge within multicultural counselling, influencing both training and practice associated with multicultural competencies.

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Appendix A

Recruitment Poster

Are you an Ethnic and Racial Minority?

Have you experienced oppression during counselling with a white counsellor?

If so, I would like to invite you to participate in a study exploring ethnoracial minority clients' experiences of oppression in counselling with white counsellors. This study seeks to gather stories from your perspective about oppression during counselling sessions to inform and improve cross-cultural counselling services.

To participate in this study, you need to:

a) Self-identify as an ethnoracial minority individual
b) Have been involved in past individual counselling/therapy with a white counsellor
c) Perceive yourself to have experienced oppression during counselling
d) Be at least 18 years old
e) Be able to communicate in English

I am looking for 8 participants on a first-come, first-served basis. Your participation will involve completing a questionnaire for background information and an interview of 60 to 90 minutes at a time and place that is mutually convenient. Your participation is completely confidential. You will receive $20 for your time and participation.

If you have any questions or are interested in participating, please contact me,

Whitney Reinhart, via email at **[email address]**

I am a Master's student in Counselling Psychology at the University of Ottawa. This research is supervised by Dr. Cristelle Audet (email address).

Appendix B

Information Text

Subject Line: Participants Needed for Research Study

Hello!

Do you identify as an **ethnoracial minority**?
Have you been in counselling/therapy with a **white counsellor/therapist**?
Did you experience power issues, like **oppression**?

If so, I would like to invite you to participate in a study exploring ethnoracial minority clients' experiences of oppression in counselling with white counsellors. To help inform and improve cross-cultural counselling services, I would like to gather stories from your perspective about oppression—however you define it—that occurred during counselling sessions.

To participate in this study, you need to:

a) Self-identify as an ethnoracial minority individual
b) Have been involved in past individual counselling/therapy with a white counsellor
c) Perceive yourself to have experienced oppression during counselling
d) Be at least 18 years old
e) Be able to communicate in English

I am looking for 8 participants on a first-come, first-served basis. Your participation will involve completing a questionnaire for background information and an interview, which combined should take about 60 to 90 minutes, and will happen at a time and place that is mutually convenient. Depending on your location, interviews can be completed over Skype. Your participation is completely confidential. **You will receive $20 for your time and participation.**

I am a Master's student in Counselling Psychology at the University of Ottawa. This research is supervised by Dr. Cristelle Audet (email address). If you have any questions or are interested in participating, please contact me, Whitney Reinhart, by email at [email address].

Please feel free to forward this information to anyone you think would be interested.

Appendix C

Study Description

Greetings,

My name is Whitney Reinhart and I am a Master's student in Counselling Psychology at the University of Ottawa supervised by Dr. Cristelle Audet. I am currently recruiting participants for my thesis research project. The purpose of my research is to explore ethnoracial minority clients' counselling experiences with white counsellors, where clients perceive themselves to have experienced oppression during the counselling. I view participants as experts on the topic under study and would be honored to learn from your experiences, if you are interested in participating in the study.

What is the purpose of this study?

The main objective of this study is to contribute to the current knowledge regarding ethnoracial minority clients' lived experience with power and oppression in counselling, and how these oppressive experiences may be harmful. My aim is to co-create knowledge with participants that will help make counsellors aware of potentially oppressive behaviours they may unintentionally engage in and could improve multicultural counselling practices for counsellors working in cross-cultural contexts, specifically with ethnoracial minority clients.

Who am I asking to participate?

The participants in this study need to meet specific criteria, that is: (a) Self-identify as an ethnoracial minority individual; (b) Have been involved in individual counselling/therapy in the past with a white counsellor; (c) Perceive yourself to have experienced oppression during counselling; (d) Be at least 18 years old; and (e) able to communicate in English.

What will participation involve?

Should you choose to join the study, your participation would involve approximately one to one and a half hours to answer some demographic questions for background information and complete an interview. During the interview, we would talk about your experiences with oppression, power, and possible harm during counselling with a white counsellor. The interview would be at a time and venue that is mutually convenient for both of us. You will be given the option to interview in a private room in the library, LMX resource center, or CRX building at the University of Ottawa. These locations are safe, confidential, and comfortable. If you are geographically located too far away from the principle investigator to attend an in-person meeting, you will have the option of having an online Skype interview. I would need to audio-record the interview, which would be transcribed by myself. You would receive a $20 honorarium for your time and participation.

If you voluntarily decide to participate in this study, it is important for you to know that you have the right to:

- Ask any questions about the study at any time
- Decline to answer any particular question at any time

- Stop the interview or the audio-recording at any time
- Withdraw from the study without suffering any negative consequences
- Inform me of feelings of distress and/or discomfort
- Review your interview transcript and make modifications or additions

Are there any risks involved in participating?

Talking about your experiences in counselling where you feel you have been oppressed by your counsellor may give rise to feelings of discomfort or distress. You have the freedom to refuse to answer any questions, to stop the interview at any time, and to withdraw your participation in this study. To lessen the risks of potential emotional distress, I will inform you of available and relevant support resources in your community.

Are there any benefits involved in participating?

Your participation in this study will provide you with the potential benefit of contributing to the current knowledge and understanding of oppression in cross-cultural counselling, in this case between ethnoracial minority clients and white counsellors, improving current multicultural counselling practice and training, and voicing your experiences with oppression in counselling sessions.

How will I maintain your privacy and confidentiality?

Your involvement in the study and what you share will be strictly confidential at all times. Only myself and my supervisor, Dr. Audet, will have access to the research data. The contents of your participation will be used only for informing this thesis research. Your confidentiality and anonymity will be protected through the use of a pseudonym, and only your pseudonym will be shown in the interview notes, transcript, thesis manuscript, and future publications. Quotes may be used, but no information that can identify you will appear in them. Confidential data collected during this study will be securely retained for the purpose of this research for five years.

Please contact me if you have any questions or are interested in being a part of this project. My e-mail is **[email address]**

My supervisor Dr. Cristelle Audet can be reached by email at [email address] or by phone at [phone number]

Thank you very much for your consideration,

With regards,

Whitney Reinhart

Appendix D

Screening Text

Hello, thank you for your interest in my study. My name is Whitney Reinhart and I am a master's student in Counselling Psychology at the University of Ottawa. The purpose of my study is to better understand the oppressive experiences of ethnoracial minority individuals who have been involved in individual counselling with a white counsellor. As such, I am looking for individuals who self-identify as an ethnoracial minority, who have engaged in individual counselling with a white counsellor that has now ended, and who feel they have experienced oppression during counselling sessions with their white counsellor. The results of this study will inform counsellors of ethnoracial minority clients' experiences of oppression in cross-cultural contexts and will help counsellors improve their multicultural competencies. Does this sound like something you might be interested in?

If not: Ok, thank you for your time and your interest. Good-bye.

If yes: Ok great. The individuals who participate in this project need to meet specific criteria to be eligible. So, before I go on, do you mind if I ask you some questions to make sure you are eligible to participate? Please know that you are free to say no, and to not answer any questions you don't want to answer.

If not: Ok, I understand, would you like to hear more information about what your participation would involve?

If yes: Participation includes a demographic questionnaire and an interview lasting approximately an hour and a half, which will include questions regarding your experiences of oppression within counselling.

If not: Ok, thank you for your time.

If yes: Ok, thanks. My questions are the following:

1. Are you 18 years of age or older?
2. Do you identify as an ethnic and racial minority?
    - An ethnic and racial minority is anyone who identifies as belonging to a racial and ethnic group that is not considered "dominant" in white Western society.
3. Have you completed personal/individual counselling/psychotherapy in the past? Has the counselling ended or is it still ongoing?

- Counselling is defined as having explored any difficulty or concern that was affecting your emotional wellbeing with a trained counsellor or therapist for at least one individual, face-to-face session.

4. Was the counsellor that you worked with racially white?
    - A racially white individual is someone who portray visible whiteness through skin colour and other physical features, and identifies within the socially dominant ethnoracial group within Western society
5. During your counselling/therapy with this white counsellor, did you perceive yourself to have experienced oppression, based on your ethnic and/or racial identity?
    - Oppression can be defined as any experience where beliefs, ideals, and values have been imposed onto those belonging to socially non-dominant groups, including social control, discrimination, prejudice, and assertion of power, among others.

If inclusion criteria are not met: Thank you for your answers. Unfortunately, this study is not a good fit since I am looking for participants that meet all the criteria for the study. Thank you for talking to me today. I appreciate your interest and your willingness to help me.

If inclusion criteria are met: Thank you. Based on your answers you meet the inclusion criteria for this study. Can I tell you more about the project? If you have any questions, feel free to ask me at any time. Your participation would involve meeting with me at a place and time that is convenient for both of us, so that we can discuss the study and your participation more fully. If you are located geographically too far away from me to attend an in-person meeting, you have the option of having an online interview using Skype. If you give your consent, we would then complete a background information questionnaire and an interview that combined would last approximately 60 to 90 minutes. Your participation would be completely confidential, and a pseudonym (made up name) will be used to protect your identity. The interview would be audio recorded and transcribed for analysis, which will be transcribed by myself. My thesis supervisor will have access to your transcript and my field notes; however, identifying information will be removed. At a later time, I will invite you to review your interview transcripts, so that if you want, you can provide feedback, additional information, or modifications by email. Do you have any questions for me so far?

Your participation in each step is completely voluntary. If you agree to participate, you have the right to stop the interview at any time and decline answering questions. Additionally, you have the right to decline to participate or to withdraw at any point during the project without any repercussions, however you will not be able to withdraw your interview responses once the study results are published.

You will receive $20 for your participation in the study. Does this sound like something you would like to participate in?

If not: Thank you for your time. I appreciate you taking the time to listen. Good-bye.

If yes: Thank you. I appreciate it very much. I will email you a consent form for you to review that we will discuss further in person. Would it be okay if we schedule a time to meet to go over the study consent form and if you agree, conduct the interview? What city are you located in? (if located in a city too far away from the principle investigator) Would you feel comfortable conducting our interview online over Skype? (If located in the same city as the principle investigator) Where would you like to meet? If you want, we can do the interview at a private room in the library, LMX resource center, or CRX building at the University of Ottawa. These locations are safe, confidential, and comfortable. When would be a good day and time for you to meet?

After scheduling: Great, what is the best way to reach you? Do you mind if I contact you by email about 1-2 days before the interview to confirm that you are still interested? If you have any questions or concerns, please do not hesitate to contact me. My email is [email address].

Thank you again. I am looking forward to meeting you and learning from your experiences. Have a great day.

Appendix E

Screening Email

That is great to hear that you are still interested. The purpose of my study is to better understand the oppressive experiences of ethnoracial minority individuals who have been involved in individual counselling with a white counsellor. As such, I am looking for individuals who self-identify as an ethnoracial minority, who have engaged in individual counselling with a white counsellor that has now ended, and who feel they have experienced oppression during counselling sessions with their white counsellor. The individuals who participate in this research need to meet specific criteria to be eligible. So, I need to ask you some questions to make sure you are eligible to participate. Please know that you are free to decline to answer any question you do not want to answer. The questions are the following:

1. Are you 18 years of age or older?
2. Do you identify as an ethnic and racial minority?
3. Have you completed individual counselling/psychotherapy in the past?
4. Was the counsellor that you worked with racially white?
5. During your counselling/therapy with this white counsellor, did you perceive yourself to have experienced oppression?
6. Has the counselling ended with this counsellor or is it still ongoing?

Thank you in advance for taking the time to answer these questions. Once I receive the answers to these questions, I will determine if you meet the criteria to participate and let you know. If you are eligible, we would then set up an in-person meeting at a time and place that is mutually convenient to complete the background information questionnaire and interview, which combined will last about 60-90 minutes. If you are unsure how to answer any of these questions, or if you have any additional questions regarding the study and your participation, please let me know.

I look forward to hearing from you!

All the best,

Whitney Reinhart

Appendix F

Background Information Questionnaire

Pseudonym: _____ Date: _____

1. Describe your ethnic (e.g. country of origin, country of ancestry, linguistics, nationality, religious affiliations, tribe) and racial (e.g. skin colour) background?
    a. What is your ethnoracial generation status (i.e., immigrant; first-, second-, or third- generation immigrant; refugee, etc.)?
    b. How culturally connected are you to your ethnic/racial background?

While this research focuses primarily on the "ethnoracial" social identity within cross-cultural counselling contexts, social identities do not exist in isolation from one another. As such, we are inquiring about intersectionality, to better inform the analysis of each participant's experiences. You have the right to decline answering any questions.

2. How old are you?
3. What is your gender?
4. What is your sexual orientation?
5. What is your level of education?
6. What are your religious affiliations?
7. How would you classify your socioeconomic status?
   Lower____ Middle____ Upper____
8. Is there anything else you would like to share about your social identity?

Consider the counselling experiences that you will be talking about today with me:

1. What was your initial reason for seeking counselling?
2. How long ago did you seek counselling?
   Month/Year of *first* session _____ Month/Year of *last* session _____
3. How many sessions did you attend?
4. How regularly did you see your counsellor?
5. Where did you receive counselling?
   Post-secondary counselling center _____Private office _____Hospital _____
   Community organization: _____ Other:_____
6. How did you find your counselling center and/or counsellor?

    a. Did you have a choice of counsellor?
7. What can you tell me about the counsellor(s)' social identities (i.e. gender, age, race/ethnicity)?
8. What can you tell me about the credentials of your counsellor? This can include your counsellor's academic degree and professional licenses/certifications.
9. What can you tell me about the therapeutic approach used by your counsellor?
10. Approximately how many years of experience did your counsellor have?

Appendix G

Interview Protocol

The interview will begin with questions regarding the participant's experience with oppression in general, outside of the counselling context. Questions are divided into subgroups to structure interviews to allow an exhaustive exploration of each research question, which include participant's experiences with oppression, power, and harm in counselling sessions. The interview will be semi-structured. As such, each section will begin with a broad open question (e.g., What can you tell me about...) regarding the construct of focus (i.e., oppression, power, harm) to allow participants to express their experience, without constricting their descriptions. The interview protocol should be read with the understanding that the probing questions following the initial question serve as prompts, if needed, to obtain pertinent information about the phenomenon, based on the perspective of the researcher and the literature. These follow up questions may be incorporated into the interview at varying times, depending on what the participant offers after the initial questions and where they direct the conversation.

Participant Understanding of Oppression

- What does oppression mean to you?
- How would you define oppression?

Exploring their Counselling Context

Thinking back to the counselling experience you had with a white counsellor:

- What can you tell me about what brought you to counselling and what you were hoping to get out of counselling?
- What topics did you and your counsellor discuss in session?
- In a general sense, how would you describe the counselling experience you had?
- How would you describe your relationship with the counsellor?
- How did you feel about the ethnoracial difference between you and your counsellor when you first met? How did you feel about it later in the counselling?
- How was your ethnoracial identity discussed during the counselling, if at all?
- How was ethnoracial difference between you and your counsellor approached in session, if at all?

- What was the conversation(s) like for you?
- How would you wish the counsellor had approached ethnoracial difference?

Exploring Experiences of Oppression in Counselling

- What can you tell me about your experience of oppression in counselling? Can you give an example?

Prompts:

- What did the counsellor do or express (verbally or non-verbally) that made you feel oppressed?
- What was that experience like for you?
- How would you describe the dynamics between you and your counsellor before/after the experience?
- How did you respond or react? How, if at all, was the experience of oppression broached during the counselling?
- How do you feel the experience influenced: the counselling relationship? the counselling process? your progress with counselling goals/outcomes?
- *How do you feel communication influenced or was influenced by your experiences of oppression?*

Exploring Experiences of Power with White Therapists

- What can you tell me about your experience of power during the counselling?

Prompts:

- How would you describe power between you and the counsellor?
- Can you describe a time when you felt you did not have enough power during the counselling? What do you think enabled this? How did you feel?
- Can you describe a time when you felt empowered during the counselling? What do you think enabled this? How did you feel?
- In what ways, if any, do you think your counselling experience was influenced by ethnoracial difference (i.e., white and non-white)?

- In what ways might power and oppression in your everyday life have influenced power and oppression during the counselling?

Exploring Harm in the Context of Oppressive Experiences in Counselling

- What can you tell me about harm related to having experienced oppression during the counselling?

Prompts:

- In what ways, if any, do you feel oppression caused harm to the counselling?
- ~~In what ways, if any, do you feel oppression may have harmed you in the short-term?~~
- ~~In what ways, if any, do you feel oppression may have harmed you in the long-term?~~
- How would you describe the impact of the oppression on: your well-being *(e.g., symptoms)?* reaching your counselling goals? satisfaction with counselling? your life outside of counselling?
  - *How do you feel your experiences of oppression impacted your sense of self and identity?*
  - *How do you feel your experiences of oppression impacted your interpersonal relationships?*
- *How did your experiences of oppression influence your perceptions of the counselling profession?*
- What would you say was the most harmful about oppression within your counselling experience?

Wrapping Up

- In what ways might you have experienced power and oppression differently/similarly had you been working with a counsellor who was an ethnoracial minority?
- If you could change anything about your counselling experience, what would you change?
- What, if anything, would you want white counsellors to know about working with ethnoracial minority clients?
- Is there anything else you would like to share about your experience?

Appendix H

Preunderstandings

In line with hermeneutic phenomenology, my assumptions and beliefs regarding ethnoracial minority clients' oppressive experiences with white counsellors will help to construct interpretations and bridge the gap between participant narratives and MCP research and practice. I am entering this research with assumptions and beliefs that are primarily informed by training in feminist anti-oppressive counselling, involvement with vulnerable populations (e.g., homeless families, inner-city youth, assault survivors, etc.), exposure to research and readings on social justice and multicultural counselling, as well as my research experiences from my pilot study in Fall 2017. I recognize that my assumptions and beliefs will evolve throughout this research process; however, after extensive reflection, my preunderstandings are as follows:

1. Current racial inequalities are a result of social and historical influences on systemic and institutional policies and practices that allow certain groups to maintain and assert dominance over other groups. Oppressive experiences in counselling for ethnoracial minority clients are ultimately a result of these social hierarchies. White counsellors may unknowingly assert their power over socially inferior, or non-dominant, ethnoracial groups in counselling sessions, by engaging in oppressive practices and behaviours.
2. Based on a literature search on MCP research, constructs of oppression in cross-cultural counselling contexts have been identified as key components of oppression in counselling for clients of non-dominant ethnoracial groups. These constructs include racial microaggressions, whiteness norms, cultural stereotypes, cultural countertransference and interethnic countertransference, colourblindness. Oppressive behaviours of white counsellors, expressed through racial microaggressions and imposition of whiteness norms, are a product of cultural stereotypes, countertransference, colorblindness, and whiteness ideologies. I believe that these constructs of oppression, identified by previous studies in the MCP field, are involved in oppressive counselling practices for ethnoracial minority clients when being counselled by white counsellors. However, it is also my understanding that ethnoracial minority clients' lived experiences of oppression in counselling may not fit within these assumptions or may extend beyond these confines.
3. White counsellors can overtly and/or covertly assert their power as the "expert" through language by making suggestions that are built off Western ideas of how to properly

behave as a client and citizen within Western society. Ethnoracial minority clients are overdiagnoses with mental health problems within Canada, and often their behaviours are pathologized rather than seen as potentially connected to their cultural identity. Additionally, the current language and multicultural discourse within multicultural counselling research can be pejorative, including terminology such as "minority", "non-white", and "culturally competent." As such, this language use can be adopted in the clinical setting and contribute to inadvertent oppressive behaviours of counsellors. Furthermore, as a white researcher interviewing ethnoracial minority participants, the language I use may inadvertently maintain and expand the power imbalances between sociocultural identities within the researcher-participant relationship, which may impact the descriptions that the participants express to me.

4. There are inherent power dynamics between clients and counsellors, which combine with sociocultural power hierarchies among ethnoracial minority persons and white persons, in addition to other social identities. Without white counsellors recognizing sociocultural hierarchies and identity statuses connected to privilege and oppression, systems of oppression, privilege and power are maintained within the counsellor-client dyad. Additionally, the intersection of ethnoracial client oppression and white counsellor privilege, in addition to power dynamics within the counselling context, make it challenging for ethnoracial minority clients to resist and challenge counsellors who engage in oppressive practices.
5. Counselling approaches and theories used in Western society are typically seen as Eurocentric in nature and having emerged from Western values, which may influence white counsellors' behaviours in session inadvertently. From MCP research and graduate courses on theories and counselling practices, it is apparent that many of the approaches and educational training of counselling professionals are a product of Western values and beliefs. As such, white counsellors may not recognize their use of Eurocentric therapy approaches and inclusion of Western values, which may be perceived by some clients as oppressive.

Appendix I

Informed Consent Form

uOttawa

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Faculté d'education | Faculty of Education

Consent Form

Exploring Ethnoracial Minority Client's Experiences of Oppression during Counselling with White Counsellors

Whitney Reinhart, MA student
Principal Investigator
Faculty of Education
University of Ottawa
Email: [email address]

Dr. Cristelle Audet, Ph.D.
Thesis Supervisor
Faculty of Education
University of Ottawa
Tel: [phone number]
Email: [email address]
Office: [room location]

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Whitney Reinhart, under the supervision of Dr. Cristelle Audet.

Purpose of the Study: The purpose of the study is to explore ethoracial minority client's past experiences of oppression in counselling sessions with a white counsellor. The resulting knowledge will inform counselling professionals of potential behaviours that can be oppressive, disempowering and possibly harmful for clients, and improve counsellor competency when working in multicultural contexts.

Participation: My participation will consist of completing a demographic information questionnaire with the researcher, which includes questions about my social identities (e.g. age, gender, ethnicity, race, sexual orientation, etc.) and previous counselling where I perceived myself to have experienced oppression. The researcher will also interview me on my experiences of oppression in counselling with a white counsellor. The questionnaire and interview combined should take approximately 60-90 minutes. The interview will take place at a mutually chosen time and place that ensures my comfort, safety, and confidentiality. I have the option of having an online meeting via Skype, if I am geographically farther from the principle investigator. I have the right to choose what information I would like to share and refuse to answer any questions. The interview will be audio-recorded and transcribed by the principle investigator. I will be given opportunity to review the transcript of my interview and provide feedback, make additions, or remove information within a 2-week period by email.

Funding Source: This research project is being funded by the Social Sciences and Humanities Research Council of Canada (SSHRC).

Risks: My participation in this study will entail discussing experiences where I felt I was oppressed, lost power, and as a result may have felt possibly harmed in past counselling sessions, which may result in me feeling uncomfortable and/or emotional. I have the freedom to refuse to answer any questions, to pause or stop the interview at any time, and to withdraw my participation in this study at any time. While I may or may not experience any discomfort and/or distress during the interview, the researcher will provide me with a list of support resources when the interview ends.

Benefits: My participation in this study may provide me with the potential benefit of contributing to the current knowledge and understanding of oppression in "cross-cultural" counselling (counselling relationships where counsellors and clients possess different social/cultural identities) between ethnoracial minority clients and white counsellors, improving current counselling practice and training, and voicing my experiences with oppression occurring in counselling sessions.

Confidentiality and anonymity: I have received assurance from the researcher that the information I share will remain strictly confidential. I understand that the contents will be used only for informing this thesis research described in the "Purpose of the Study" section. My confidentiality will be protected through the use of a pseudonym and non-disclosure of my identity or the identity of others I mention to any person(s) by the researcher. A pseudonym will be used in the notes taken during the interview, interview transcript, thesis manuscript and future publications. Any details in the interview recordings that could reveal my identity will be changed during the transcription process. Quotes may be used by the researcher, but no information that can identify me will appear in them. Lastly, only the researcher and her thesis supervisor will have access to the interview notes and transcripts.

Conservation of data: The data collected through audio recordings of interviews, transcriptions of interviews, demographic questionnaires, and notes taken during the interview will be kept in a secure manner. Specifically, electronic files will be double locked, in that they will be kept in password protected files on a password protected computer, or on a USB with password protection and stored in a locked cabinet along with material data. The data will be securely safeguarded for five years after data analysis is completed, after which time all material data will be shredded and electronic data will be erased.

Compensation: I will receive a compensation of 20 dollars for my time and participation in this study. If I choose to withdraw from the study after consenting to participate, I will still receive this compensation.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed. However, results based on the data cannot be withdrawn once the results are published.

I understand that information obtained through the interview, the background information questionnaire, and correspondence with me will be used by the researcher for the sole purpose of

this research. I acknowledge that the results of this study may be disseminated through conferences and publications.

Acceptance: I, _____, agree to participate in the above research study conducted by Whitney Reinhart as part of her master's thesis requirements, at the Faculty of Education, University of Ottawa under the supervision of Dr. Cristelle Audet. If I have any questions, I may contact the researcher or her thesis supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: *(Signature)* Date: *(Date)*

Researcher's signature: *(Signature)* Date: *(Date)*

Appendix J

Resource List - Ottawa

Resource	Telephone/Webpage	Description
Ottawa Distress Center	613-238-3311	24-hour general crisis intervention.
Mental Health Crisis Line	613-722-6914	24-hour crisis line.
Mental Health Mobile Crisis Unit, Ottawa Hospital	613-722-6914	Direct intervention for mental health crisis.
Royal Ottawa Mental Health Center	613-722-6521	In / out-patient services. Many programs related to mental health.
Wabano's Centre for Aboriginal Health	613-748-0657	Free walk-in counselling for First Nations, Inuit, or Metis clients
The Walk-in Counselling Clinic	613-722-2225	Free walk-in counselling (multiple locations)
Ottawa Community Immigration Services Organization	613-725-0202	Counselling and mental health support for immigrant and refugees
E-Mental Health	www.ementalhealth.ca	List of resources in Ottawa
City of Ottawa, EAP	613-580-2424, ext. 23816 613-580-2458 (crisis line)	Free short-term counselling to City of Ottawa employees
Ottawa Carleton Immigrant Community Centre	613-249-0006	Free counselling services for immigrants and refugees

Appendix K

Resource List - Toronto

Resource	Telephone/Webpage	Description
Woodgreen Community Services	416-572-3575	Free walk-in counselling clinic. Free counselling for adults, families and seniors
Toronto Distress Line	416-408-4357	24-hour crisis line.
Rainbow Health Ontario	www.rainbowhealthontario.ca	Province wide online service directory for LGBTQ
Anishnawbe Health Toronto	613-748-0657 (crisis line) 416-920-2605 (walk-in)	Mental Health Crisis Management Services and 24/7 crisis line for Aboriginal clients Walk-In Counselling Services
Toronto Rape and Crisis Centre (Multicultural Women Against Rape)	416-597-1171 416-597-8808 (crisis)	Counselling for sexual assault and abuse. Crisis line
Gerstein Crisis Centre	416-929-5200	Crisis Intervention for those in Toronto. Telephone support, community visit and residence.
Mental Health Helpline	1-866-531-2600	Helpline for referral and recommendations for counselling.
Polycultural Immigrant and Community Services	416-233-005 x1237	Free short-term counselling
Access Alliance Multicultural Health and Community Services	416-324-8677	Counselling services for immigrants, refugees and their communities