South Asian Women and Psychotherapy: A Phenomenological Analysis

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Abstract

Despite being the largest racialized demographic in Canada, psychological service usage amongst South Asians is significantly lower than other groups. Lack of service usage may be tied to barriers to use or inequities in service provision. Underutilization of mental health services may be a particularly pressing issue for South Asian women, who are at greater risk of experiencing mood and anxiety disorders in comparison to men. Nonetheless, research examining South Asians' psychological service usage has been lacking. The current study aimed to qualitatively examine the lived experiences of South Asian women who have engaged with psychotherapy. The methodology of this study was guided by philosophical hermeneutic phenomenology. An intersectional theoretical lens was further employed to obtain a deeper understanding of how participants' intersecting identities shaped their lived experiences of psychotherapy. Semi-structured interviews were conducted with 6 participants across Canada to explore their experiences before, during, and after psychotherapy. Interview transcripts were analyzed using Braun and Clarke's (2012) six-step approach to thematic analysis. A total of 7 themes and 23 subthemes were identified. Themes included the following: a) barriers to psychotherapy, b) facilitators to psychotherapy, c) frustrations or missing elements, d) helpful elements, e) psychotherapy in the future, f) community context, and g) (not) talking psychotherapy. Results from this study provide insight into the clinical needs and overall mental health service (under)utilization of South Asian Canadian women. Implications for the delivery of culturally-responsive care are provided.

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Chapter One: Introduction

The South Asian community is currently the largest and fastest growing racialized demographic in Canada (Statistics Canada, 2022a). Moreover, South Asian women, in line with gender-based data across racial demographics, are disproportionately affected by mood disorders in comparison to men (Islam et al., 2014). To treat mood disorders, psychotherapy is considered a major treatment option (e.g., Lam et al., 2024; Yatham et al., 2018). Despite this, research demonstrates that the South Asian population significantly underutilises mental health services in comparison to other demographics (Gadalla, 2010; Grace et al., 2016). Service underutilization suggests the presence of inequities or barriers to accessing mental health services (Tiwari & Wang, 2008). Community-level barriers have been cited as amongst one of the greatest obstacles to service usage, and include challenges such as cultural beliefs, mental health stigma, and a lack of awareness or willingness to engage with mental health issues within the South Asian community (Islam, 2012). Gender role constructs within the South Asian community may also lend itself to gender-specific barriers or stressors (Islam et al., 2023). Indeed, South Asian women face higher degrees of psychological distress when faced with a lack of familial support (Masood et al., 2009). Nonetheless, few studies explore South Asian women's experiences of accessing and engaging in mental health services (Naeem et al., 2020), and no such studies have been conducted with South Asian women in Canada. Examining South Asian women's experiences of seeking and engaging in psychotherapy would inform the delivery of culturally-responsive care. More specifically, obtaining rich accounts of experiences before, during, and after psychotherapy would provide a deeper understanding of barriers and supports that affect service utilization. Thus, this study employed qualitative methodology to examine the following question: "What are the lived experiences of South Asian women who engage in psychotherapy?"

Personal Prelude

The current study has been consciously and unconsciously shaped over years by personal experiences, cultural understandings, and anecdotal accounts shared by others. Before all else, my positionality underscores all facets of my research: I am a second-generation, Eelam Tamil-Canadian woman. My family migrated from Northern Sri Lanka in the late 1980s in the midst of the civil war and an active genocide. As many other diaspora children, straddling the lines between one's ethnic and cultural background and one's 'Western-ness' was a disorienting

experience. This two-pronged tension was keenly felt while navigating my own mental health. On one end, the prevailing stigmatization of mental illness in the South Asian community made conversations around this topic relatively obsolete. On the other end, barriers to accessing care and the experience of microaggressions *upon* accessing care left me feeling at a loss. While these experiences had been isolating, one question lingered: how many other South Asian women had experienced something similar?

Although my experiences have shaped my interest in providing clinical care that fills in the gaps, my research interests did not always align with this objective. For many years, I have hesitated to discuss or examine my own experiences—to look at it through a magnifying lens—both out of a concern of conducting 'me-search' and the fear of opening up an emotional can of worms. Despite this, the urge to know more and understand the experiences of other women far exceeds any apprehension. Indeed, existing data call attention to service underutilization amongst South Asians in Canada, and there is scant research that examines the experiences of those that *do* access services. There is a clear need to conduct research that addresses this gap in the literature, and my hope is that this research will ultimately inform culturally-responsive clinical practice with South Asian women. Through this, I hope to bring light to topics that have gone unspoken and unheard both within the South Asian community and the field of psychotherapy at large.

Chapter Two: Literature Review

The aim of this study was to explore the lived experiences of South Asian women who engage with psychotherapy. I will begin this chapter by first defining the term 'South Asian' and the overall scope of the literature review, which is delimited to South Asians apart of the Western diaspora. Following this, I will explore existing literature examining South Asian mental health in Canada, as well as mental health service utilization by South Asians. I will then discuss potential barriers to service access, receptivity to psychotherapy, and gender disparities in mental health. Finally, I will review extant literature on South Asian women's experiences of psychotherapy and outline the present study.

Defining 'South Asian'

Geographically, South Asia is generally considered to be composed of the following seven countries: Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan, and Sri Lanka. As such, the term 'South Asian' broadly refers to individuals who are from, or claim heritage from, the aforementioned countries (Naganathan & Islam, 2015). Consequently, 'South Asian' may also refer to individuals from countries with historical South Asian migrant communities, such as Guyana, Trinidad and Tobago, and Fiji. This classification is also reflected in the Statistics Canada census (Statistics Canada, 2024b).

Nonetheless, while the 'South Asian' classification serves as a demographic data-gathering tool, individuals who fall within this category are not homogenous (Naganathan & Islam, 2015). As such, it is critical that research on South Asian populations utilize explicit definitions of the construct or distinguish between subgroups if such data have been collected. Given the specific locale of the research question, I explicitly focused this literature review on diaspora South Asian populations primarily located in Canada, with some additional data from other Western countries (including the United States and the United Kingdom) as a result of commonalities in lived experience (e.g., migration, societal norms, and culture). This was to avoid the homogenization of data or experiences that may not be relevant or applicable to the population of interest.

South Asian Mental Health in Canada

Despite greater rates of exposure to life stressors, racialized demographics in Canada on average do not report significant self-reported mental health inequalities in comparison to non-racialized populations (Public Health Agency of Canada, 2022). This finding is consistent with

the South Asian population in Canada. Indeed, a report for Statistics Canada by Stephenson (2023) suggests that the South Asian population has a lower prevalence of mood, anxiety, and substance-use disorders when compared to non-Indigenous and non-racialized populations. Nonetheless, another report by Grace et al. (2016) suggests that South Asian individuals experience higher rates of anxiety than White individuals. Such conflicting data may be in part due to conflations between various characteristics of South Asian individuals (Islam et al., 2014). In particular, an article by Islam et al. (2014) highlights different profiles of mental health for South Asian Canadian-born and South Asian immigrant populations using data collected from the Canadian Community Health Survey. For instance, despite no significant variance in estimated prevalence of mood disorders, South Asian immigrants reported higher estimated prevalence of anxiety disorders in comparison to South Asian Canadian-born individuals. Furthermore, South Asian immigrants self-report higher extreme life stress. In contrast, South Asian Canadian-born individuals report a higher prevalence of poor-to-fair self-perceived mental health. These statistics point to varying determinants of mental health for immigrant and Canadian-born South Asian individuals. Thus, when considering the mental health experiences of South Asian individuals in Canada, it may be imperative to gather data related to immigration.

Healthy Immigrant Effect

Differing statistics between immigrant and Canadian-born South Asian individuals, particularly in perceptions of self-reported mental health (Islam et al., 2014), points toward the presence of the healthy immigrant effect (Ng & Zhang, 2020). The healthy immigrant effect is a well-researched phenomenon that suggests that new immigrants are healthier than their Canadian-born counterparts; however, this effect eventually tapers off, with immigrants' health status converging with that of Canadian-born individuals (Vang et al., 2015). As evidenced by findings from Ng and Zhang (2020), the healthy immigrant effect has been found to be applicable to mental health. Using four cycles of data from the Canadian Community Health Survey linked to the Longitudinal Immigration Database, Ng and Zhang (2020) found that recent immigrants had higher self-reported mental health levels than Canadian-born individuals. However, established immigrants report levels of self-perceived mental health similar to Canadian-born individuals—thus, pointing towards a drop in mental health levels consistent with the healthy immigrant effect. Consequently, the healthy immigrant effect must be taken into

account when surveying the mental health of South Asian individuals—particularly those whose lives are marked by some form of migration.

Service Utilization and Barriers to Care

As previously mentioned, South Asians in Canada significantly underutilize mental health services when compared to other groups (Gadalla, 2010; Grace et al., 2016). This finding can be seen across racialized groups in Canada, despite racialized groups reporting higher degrees of psychosocial distress in comparison to non-racialized groups (Grace et al., 2016). Of relevance to the South Asian population, Grace et al. (2016) found that South Asian individuals were significantly less likely to seek out mental health consultations via a psychiatrist or a doctor than White individuals. Similarly, in a national study by Gadalla (2010) utilizing the Canadian Community Health Survey, South Asians had the lowest odds of seeking mental health treatment in comparison to other demographics. This is particularly striking given that 48% of South Asians who had experienced a major depressive episode also reported unmet healthcare needs—the highest across all demographics surveyed. It is important to note that the studies by Grace et al. (2016) and Gadalla (2010) did not stratify results by immigration status—consequently, it is unclear if there are differences in service underutilization for immigrants and Canadian-born individuals. Moreover, both studies by Grace et al. (2016) and Gadalla (2010) were quantitative in nature and did not parse out particular rationales for service underutilization. Given this, it is critical that service usage is examined qualitatively when investigating the mental health experiences of South Asians in Canada.

As discussed, underutilization of mental health services is poorly understood; however, it has been suggested that service underutilization may be linked to inequities in care or barriers to accessing services (Tiwari & Wang, 2008). In this regard, mental health services may not necessarily be ‘underutilized’ (i.e., implying personal responsibility) as much as there are barriers that may prevent or hinder service access for some groups (Audet, 2025). Indeed, one study by Gadalla (2010) found that South Asians reported the highest (33%) rate of availability barriers (e.g., lacking culturally-relevant care, long waitlists, no available care in the area) across all demographics. Consequently, analyzing barriers to service use may be one way to understand mental health service underutilization in the South Asian community. A considerable degree of research has examined barriers to care for the South Asian population, including community-level (e.g., cultural beliefs, mental health stigma, difficulties trusting providers) and structural

barriers to treatment (e.g., inequities in care such as financial obstacles, lack of culturally-appropriate care) (Islam, 2012; Islam et al. 2017; Tummala-Narra et al., 2012). The following section will review current research on barriers to care by examining both structural and community-level barriers for South Asian individuals.

Structural Barriers

Financial Barriers. Structural barriers to treatment exist as a result of the nature of systems (e.g., healthcare systems) or institutions external to an individual, and have been cited as potential obstacles to receiving care for South Asian individuals (Islam, 2012; Rastogi et al., 2014). For instance, a focus group study on clinicians working with South Asians patients in the United States identified financial barriers as a major obstacle to care (Rastogi et al., 2014). Financial barriers were linked to a lack of insurance, income, financial dependence (specific to South Asian women), or a lack of willingness to pay for psychological treatment. This is consistent with data from a study by Islam et al. (2017) examining South Asian health equity in Toronto, where a lack of affordable care was highlighted as a barrier to seeking mental health treatment. These findings are unsurprising given the exorbitant costs of psychotherapy for individuals without insurance. Affordability or a lack thereof may also restrict options for care (e.g., short-term versus long-term forms of therapy) which may further impact service utilization and psychological outcomes (Corscadden et al., 2019). Thus, financial barriers may be considered as a major structural barrier that underscores service usage.

Lacking Culturally-Appropriate Care. An additional structural barrier may be a lack of culturally-appropriate care for South Asian populations (Islam et al., 2017; Naeem et al., 2020). Culturally-appropriate care is evidence-based practice that integrates cultural specificities (e.g., cultural beliefs and modes of healing) in order to facilitate service accessibility and improved recovery outcomes (Naeem et al., 2020). Specific to the South Asian demographic, it has been suggested that therapeutic framing through the recovery model—which emphasizes individualism and personal autonomy—may not be effective for the collectivist skew of many South Asian cultures (Naeem et al., 2020). This can be clearly seen in a study by Naeem et al. (2024): utilizing a qualitative approach to better understand the mental health service needs of South Asian Canadians, it was found that participants (South Asian individuals, community leaders, caregivers, and clinicians working with South Asians; n = 42) viewed therapeutic techniques that urged South Asian clients to turn against cultural beliefs or values as ineffective.

In line with this, one qualitative study found that clinicians working with South Asian clients identified cultural and religious sensitivity as major facilitators to care (Rastogi et al., 2014). Furthermore, the availability of South Asian providers with knowledge of these cultural and religious beliefs may help ensure that mental health services are culturally appropriate for South Asian individuals (Islam et al., 2023). Thus, the integration of cultural beliefs and values in care may be critical to the provision of effective services for the South Asian population. The potential lack of this integration may therefore be an additional factor impacting service use.

Community-Level Barriers

Stigma. Community-level barriers to treatment have been named as one of the greatest obstacles impacting South Asian mental health in Canada (Islam, 2012). In particular, mental health stigma within South Asian communities has been frequently cited as detrimental to service access and psychological outcomes (Islam et al., 2017; Karasz et al., 2019; Prajapati & Liebling, 2022; Rastogi et al., 2014). For instance, one experimental study sampled South Asian (n = 99) and Caucasian (n = 463) college students in the United States to examine their responses to vignettes of a friend expressing depressive symptoms (Thapar-Olmos & Myers, 2018). Participants were randomly provided with one of four vignettes where the friend was depicted as either a South Asian male, a South Asian female, a Caucasian male, or a Caucasian female. South Asian participants responded with significantly stronger anger to the vignettes irrespective of race. Moreover, both racial groups attributed greater degrees of control and individual responsibility (i.e., towards mental health) to vignettes of the same race; however, this effect was found to be stronger for South Asian participants. In other words, South Asian participants in this study were both more likely to view mental health as a personal responsibility, and to respond negatively to depictions of a friend struggling with depressive symptoms. These results point toward what may be an underlying stigmatized perception of depression amongst some South Asians.

Courtesy Stigma. Stigma associated with mental illness in the South Asian community has been linked to existing cultural norms and beliefs, particularly that of courtesy stigma (Prajapati & Liebling, 2022). Courtesy stigma refers to the process through which family members associated with a mentally ill individual are devalued or discriminated against by the community. A systematic review of literature with South Asian service users in the UK found that—given the collectivist nature of many South Asian cultures—individuals are generally

reluctant to seek out care as to avoid damage to the family's honour or reputation in the community (Prajapati & Liebling, 2022). Indeed, seeking external care may be perceived as an internal failure of the family to provide support (Karasz et al., 2019). Such beliefs may hamper service usage, and lead to an overall reluctance or unwillingness to discuss mental health issues within the community (Islam, 2012; Rastogi et al., 2014). These findings are unsurprising given literature that suggests that South Asians attribute the origin of mental illness to life circumstances (e.g., personal, familial, cultural) as opposed to the biomedical etiology of illness favoured by Euro-North Americans (Karasz et al., 2019). Consequently, one's mental well-being may be perceived as falling within the duties of one's family, and the presence of mental illness may subsequently be believed to reflect the failings of a family to provide care. In turn, fears of courtesy stigma may lead to an outright denial or rejection of mental illness within the South Asian community (Prajapati & Liebling, 2022).

Dilemma of Trust. The presence of stigma within South Asian communities poses further consequences for decisions made when seeking out treatment. Specifically, there may be a 'dilemma of trust' that occurs when seeking out treatment (Prajapati & Liebling, 2022). Prajapati and Liebling (2022) define this dilemma as distrust or fear that leads to South Asian individuals experiencing difficulties confiding in either White or South Asian clinicians. Although research demonstrates that a match in ethnicity between clients and clinicians may be beneficial (Islam et al., 2017), findings with South Asian participants have demonstrated that stereotyping of providers may also occur (Moller et al., 2016). In a qualitative study with South Asian women in the UK (N = 82), participants typically described White providers as either not knowledgeable or culturally-informed (Moller et al., 2016). On the other hand, South Asian providers were seen as *too* involved in the community and therefore a liability. Put differently, South Asian providers could not be trusted as they were expected to be biased or to gossip within the community. These overlapping tensions are likely to play out into an ambivalence towards accessing services and may consequently contribute to service underutilization amongst South Asians.

Receptivity to (Western) Psychotherapy

Given the multiple barriers to care, it may be important to consider factors positively influencing South Asian clients' overall receptivity to care. A study by Rastogi et al. (2014) suggests that a factor underscoring South Asians' underutilization of services may be due to a

lack of understanding regarding psychotherapy, with psychotherapy further being perceived as 'Western.' Indeed, psychotherapy within the context of North America is traditionally conceptualized through Eurocentric or Westernized perspectives (Sue et al., 2019). Psychoeducation—an intervention involving the distribution of mental health knowledge to clients to increase understanding and coping skills—may potentially increase uptake of psychotherapy with South Asian clients (Rastogi et al., 2014). However, holistic psychotherapeutic approaches integrating Eastern healing practices or integrative elements may also be beneficial (Naeem et al., 2024; Sodhi, 2024). Holistic approaches may involve counselling components focusing on both psychological and bodily sensations, such as meditation, breathwork, and yoga (Mullan, 2014). In one study examining culturally-adapted cognitive behavioural therapy for South Asian Canadians, psychotherapists (n = 10) highlighted the potential value of holistic approaches utilizing components such as breathing exercises and mindfulness-based practices (Naeem et al., 2024). Such holistic approaches may be culturally responsive and attune to the spiritual or cultural values of some South Asian clients (Islam et al., 2023; Naeem et al., 2024). Consequently, it is likely that receptivity to psychotherapy may be variable depending on the approach to psychotherapy used.

Acculturation

An additional element influencing South Asian clients' receptivity to care may be acculturation levels (Miller, 2007; Shapoval & Jeglic, 2016; Sun et al., 2016). Acculturation is a phenomenon whereby individuals or groups experience cultural changes upon continued contact with another group (Ryder et al., 2013; Shapoval & Jeglic, 2016). Increased acculturation levels may correspond with greater receptivity toward psychotherapy (Miller, 2007; Shapoval & Jeglic, 2016; Sun et al., 2016). Although acculturation does not always correspond with a generational classification of immigration status (e.g., first- or second-generation immigrant), research suggests that acculturation generally increases over generations (Harris & Chen, 2023). Indeed, an "acculturation gap" may occur between first-generation parents and second-generation children (Harris & Chen, 2023). Differences in acculturation may be important given findings suggesting that the endorsement of Western values increases help-seeking attitudes to psychotherapy (Ahn et al., 2024). Generational differences due to Western acculturation aligns with findings indicating that younger South Asians are more likely to seek out psychotherapy independently when compared to older generations of South Asians (Rastogi et al., 2014). As

such, it may be critical to examine how different generations of South Asian clients access and engage with psychotherapy given potential differences in acculturation.

Gender Disparities in Mental Health

To examine the mental health experiences of the South Asian community, it may also be particularly important to investigate gender disparities in mental health (Karasz et al., 2019). Consistent with data across racial groups, South Asian women experience disproportionately higher rates of mood and anxiety disorders than South Asian men (Islam et al., 2014; Karasz et al., 2019; Lai & Surood, 2008; Stephenson, 2023). There is some evidence that suggests cultural conflict and differences in gender-based expectations contribute to disparities (Islam et al., 2023; Karasz et al., 2019). For instance, in a qualitative study on providers (N = 22) working with South Asian youth in Toronto, both male and female providers emphasized the need to consider how gender role constructs and their ensuing stressors impacted South Asian men and women in differing ways (Islam et al., 2023). Masood et al. (2009) note that South Asian women may be expected to bear the burden of traditional, familial gender norms, which may in turn contribute to gender-specific forms of distress. In the study by Masood et al. (2009), a nationally-representative sample of South Asian American participants (N = 164) completed measures related to psychological distress, psychiatric diagnosis, individual variables, and familial variables. South Asian women were found to report higher levels of psychological distress. In addition, variability in distress that South Asian women reported was significantly related to family factors. In other words, when faced with a lack of familial support, South Asian women were significantly more likely to experience psychological distress than South Asian men. Similar results can be seen in Noor's (2018) study, where South Asian women experiencing cultural conflict had higher rates of depressive symptoms only when they also had difficult familial relationships. Consequently, it is clear that the intersection of cultural values and familial relationships may be an important feature of South Asian women's mental health. In light of the higher rates of mood and anxiety disorders seen in this population, there is a pressing need to better understand how South Asian women navigate cultural norms and expectations when seeking treatment. Furthermore, it may be critical to examine the potentially differing ways in which South Asian women across the gender spectrum (e.g., cisgender, transgender, non-binary) respond to cultural norms and expectations.

South Asian Women's Experiences of Therapy

Despite a higher prevalence of mood disorders (Islam et al., 2014), there is a dearth of research that examines the psychotherapy experiences of South Asian women. One potential explanation for this lack may be in part due to service underutilization amongst South Asian women. This is evident in previous studies sampling South Asian women: in one UK-based study analyzing South Asian women's (N = 82) attitudes towards counselling (Moller et al., 2016), researchers noted that only 8% of participants had previously engaged in psychotherapy. Moreover, participants' average time spent in counselling was a mere 2.5 hours. Similarly, in another UK-based study examining the mental health needs of South Asian women (Kumari, 2004), many participants—although expressing a strong desire for confidential mental health services—had not directly accessed psychotherapy or other counselling services. These samples potentially point towards difficulties in participant recruitment due to service underutilization, possibly as a result of barriers to care or inequities upon receiving care (Tiwari & Wang, 2008).

Exploring the therapeutic experiences of South Asian women who do engage in psychotherapy may offer some understanding of barriers to or inequities in care. However, of the handful of studies that sample South Asian women who have engaged in psychotherapy, many home in on cultural contexts and differences that are of interest or emerge in counselling. For instance, both Guzder and Krishna (2005) and Tummala-Narra (2013), two studies that are respectively Canadian and UK-based, utilize vignettes to explore common psychological concerns of South Asian diaspora women (e.g., intrafamilial conflict, gender roles, acculturation). Moreover, although Jheeta (2023) employs a qualitative approach to examine the psychotherapeutic experiences of South Asian women (N = 7) in the UK, the study largely examines intercultural negotiation processes that occur within psychotherapy. Consequently, the aforementioned studies do not holistically explore the *phenomenon* of South Asian women engaging in psychotherapy. In other words, there is a paucity of studies that actively seek to understand why and how South Asian women access psychotherapy, their experience with psychotherapy, their therapeutic relationship(s), and their overall perceptions of psychotherapy itself. In particular, to my knowledge, there are no studies to date that examine the psychotherapeutic experiences of South Asian women in Canada. In light of the fact that South Asian Canadians underutilize mental services, it is critical that the experiences of those that have accessed services are explored. By doing so, we may be able to gain insight into factors

underscoring service underutilization, as well as the overall cultural-responsiveness of care received.

Current Study

There is a significant lack of existing research examining the experiences of South Asian women in psychotherapy. Given service underutilization (Gadalla, 2010; Grace et al., 2016) and the higher prevalence of psychological disorders in South Asian women (Islam et al., 2014), this is a critical gap in the literature. Currently, much of the research working with South Asian women has focused on barriers to service access, cultural contexts, and psychological needs—largely sampling participants who have not accessed psychotherapy. Therefore, these studies do not narrow in on South Asian women who *have* accessed and received psychotherapy. Despite the service barriers that may exist, it is crucial that research holistically examines the direct experiences of South Asian women who have engaged in psychotherapy. Through this, we may garner some knowledge into what precipitates access to services, the potential value of culturally-responsive care, and the factors that enable South Asian women to continue to engage with psychotherapy (Yasmin-Qureshi & Ledwith, 2021). Thus, this qualitative study will explore the following question: "What are the lived experiences of South Asian women who engage in psychotherapy?"

Chapter Three: Methodology

This study was conducted with the aim of exploring participants' lived experiences with psychotherapy. In this regard, I employed a philosophical hermeneutic phenomenological approach rooted in intersectionality. In this chapter, I will describe the methodology used within the present study, as well as the theoretical framework guiding this work. Following this, I will summarize participant recruitment and data collection processes. Finally, I will detail procedures and trustworthiness efforts involved during thematic data analysis.

Theoretical Framework

To guide this study, an intersectional lens was used to examine the multiple ways in which South Asian women experience psychotherapy. Originally coined by Kimberlé Crenshaw (1989), intersectionality takes into consideration how different facets of identity (e.g., race, gender, class, etc.) may intersect to produce varying experiences of discrimination and inequality. Crenshaw's use of intersectionality to examine the experiences of black women disrupted earlier, status-quo waves of feminism that had traditionally focused on the lives of privileged women (i.e., White, middle-class). As such, intersectionality acknowledges that different forms of identity align with varying historical and sociopolitical realities. Consequently, intersectional frameworks may be of use in research to examine how participants' lives are shaped by their identities, particularly when these participants experience discrimination due to a number of overlapping identity features. Moreover, the use of intersectionality not only serves to identify and understand oppression, but also to challenge its existence within larger socio-political and structural contexts (Rice et al., 2019). Through these means, intersectional research ultimately works to challenge power and injustice on a macro level—thus, advocating for equity and bringing to the fore the experiences of marginalized individuals (Rice et al., 2019; Sharma et al., 2021).

Within the context of this research, intersectionality may be particularly applicable when sampling South Asian women in Canada, who may be subject to forms of discrimination such as misogyny, racism, anti-immigrant sentiment(s), and classism. Given that my research question aimed to unravel how South Asian women in Canada experience psychotherapy, it was crucial that I took steps to examine this phenomenon with an intersectional lens. For example, the ways in which a bisexual South Asian woman approaches psychotherapy (e.g., an inability to discuss her sexual orientation with family influencing her choice to seek out a professional) differs to

that of a heterosexual South Asian woman's experience. Similarly, a South Asian, working-class woman accessing limited therapy through insurance differs from a South Asian woman who has the means to pay for psychotherapy out-of-pocket. Further instances where intersectionality may be particularly important include experiences in clinical sessions (e.g., the identities of both the client and the therapist may interact to impact the process of psychotherapy, such as a South Asian client and a White therapist) or outside of the session as well (e.g., stigmatization of mental illness in the community driving individuals to seek or not seek psychotherapy). Thus, an intersectional framework was employed to consider how different facets of participants' identities contributed to varying degrees of oppression, discrimination, or inequality both in and outside of psychotherapy.

Research Methodology

To conduct this study, I utilized a qualitative approach to explore participants' lived experience of psychotherapy. In particular, I employed philosophical hermeneutic phenomenology as my method of inquiry in this project. At its core, phenomenology is the study of experience or phenomena. Researchers utilizing phenomenology as a method thus aim to *describe* an individual's experience in order to capture the 'essence' of a phenomenon (Rapport, 2005). However, while phenomenology is concerned with describing the core essence of an experience, researchers utilizing philosophical hermeneutic phenomenology aim to *interpret* lived experience.

At its core, hermeneutics is the study of interpretation (Rapport, 2005). Diverging from a descriptive phenomenological approach, hermeneutic theorists emphasized the need for interpretation given that humans engage in 'being-in-the-world.' In other words, we not only directly conceive of things in the world, but we *know* them intrinsically in a-priori ways. These ideas were expanded upon by Hans Georg Gadamer to develop Gadamerian hermeneutics, also known as philosophical hermeneutic phenomenology. Specifically, Gadamer stressed two key aspects concerning truth: historicity and language. By historicity, Gadamer implied that our experience of truth is shaped by historically transmitted meanings. Consequently, our interpretations of experience are shaped not only by ourselves, but also by traditions and histories of meaning. Secondly, Gadamer posited that the language we use is intimately tied to representations, meanings, and traditions. Language is thus a tool that carries meanings and its associated histories. Combined, both historicity and language are key concepts facilitating the

interpretation of experience. Thus, the emerging ontological assumption of philosophical hermeneutic phenomenology is as follows: through 'being-in-the-world,' our experiences are directly tied with historical sociocultural contexts that are facilitated through language. Consequently, the meanings we construct are derivative of these experiences. Given that this study was concerned with understanding the lived experiences of South Asian women, philosophical hermeneutic inquiry therefore oriented the study's inquiry and analysis processes.

In interpreting experience, philosophical hermeneutic inquiry employs four constructs: play, prejudice, fusion of horizons, and the hermeneutic circle (Rapport, 2005). Play represents a metaphor whereby the interpreter is subsumed in a game—they engage in the process of interpretation but are also part of the interpretation themselves. Prejudice consists of an interpreter's prior understandings of a phenomenon which lends itself in part to the meanings the interpreter develops. Working hand-in-hand with prejudice, fusion of horizons describes the process through which the interpreter's understandings 'fuse' with participants' understandings to develop a new, mutual understanding or 'horizon.' Finally, the hermeneutic circle refers to the continuous process of the fusion of horizons, which implies that the interpretation process is never-ending. It is through these constructs that the epistemological assumptions of philosophical hermeneutic phenomenology materialize. Specifically, philosophical hermeneutic phenomenology emphasises that knowledge is gained through an interpretative, cyclical, and collaborative process between the researcher and the participants.

In sum, philosophical hermeneutic phenomenology acknowledges that a researcher's positionality and pre-understandings are inevitably tied to the meanings constructed in the interpretation process. Thus, in the process of exploring the phenomenon in question, the researcher must meaningfully consider their own hermeneutic prejudices continuously and throughout interpretation. It is then through a fusion of horizons (the merging of the researcher's and participants' understandings) that the knowledge extracted from the study comes into fruition. In addition, philosophical hermeneutic phenomenology also aims to interpret experiences within specific historic sociocultural contexts as opposed to merely capturing the 'essence' of that experience (e.g., using an interpretative phenomenological approach). Given that this study examined the phenomenon of South Asian women's experiences of psychotherapy through an intersectional lens, it was critical that the sociocultural contexts in which participants are embedded were accounted for in this study. Furthermore, as a South Asian woman myself, it

was inevitable that my pre-understandings (see Appendix A) would be 'tangled up' with participants' understandings due to my shared positionality. Consequently, by employing philosophical hermeneutic phenomenology, these features of the study were intended to be acknowledged and meaningfully accounted for during the interpretation process.

Participants and Recruitment

Sampling

In hermeneutic phenomenological approaches, purposive participant sampling may be used to collect data that offer rich and diverse renderings of lived experiences (Laverty, 2003). In this regard, participant samples are not intended to be generalized to greater populations, but rather provide detailed descriptions of a phenomenon in question (Creswell, 2013). A sample of between 3 to 15 participants may be used to achieve these aims when employing a phenomenological approach (Creswell, 2013). Using purposive sampling, a total of 6 participants completed this study.

To participate, individuals were required to meet the following inclusion criteria: a) be 18 years of age or older, b) identify as a South Asian woman, c) be a current resident of Canada, d) have previously completed at least one psychotherapy session, and e) not currently be in psychotherapy or counselling. Participants were required to be at least 18 years of age given the study's focus on adult women. Moreover, participants currently in psychotherapy were excluded in order to minimize harm or negative influence on their ongoing therapeutic experience. Finally, participants completing as few as one session of psychotherapy were included as these experiences were considered to be equally valuable to the aim of this study. Although one session of psychotherapy may not necessarily be construed as a fulsome psychotherapy experience, exploring these experiences may nonetheless provide insight into the processes underscoring service access and utilization.

Recruitment

Upon receiving ethical approval from the University of Ottawa Research Ethics Board (REB; Appendix B), I began my recruitment process by a) sharing study information (Appendix C) with South Asian community organizations and b) posting a recruitment advertisement (Appendix D) on social media sites such as Facebook and Instagram. I shared study information with community organizations (see Appendix E for invitation) that were located across Canada and that worked primarily with South Asian women. To advertise the recruitment poster on

social media, I created Facebook and Instagram landing pages designed for the purpose of this study. These pages provided potential participants with information about participating in the study, eligibility criteria, and contact information to participate or ask further questions. Interested participants that reached out were sent study information. Although snowball sampling (e.g., asking participants to refer this study to other eligible women who may be interested) was originally intended to be utilized, sufficient interest—beyond the maximum capacity of participation—was received from individuals prior to beginning the interview process; thus, snowball sampling was not employed.

Screening

Interested individuals who reached out to participate were screened via e-mail. Screening questions consisted of a confirmation of eligibility using the criteria previously mentioned. Participants who met eligibility were then sent the consent form (Appendix F) and a demographic questionnaire to be completed and returned by e-mail prior to the interview. They were also invited to book an interview time either in-person (if located in or near Montréal) or via Microsoft Teams at their convenience.

Instruments Used

Demographic Information Questionnaire

A demographic questionnaire (Appendix G) was provided to all participants prior to the interview in order to capture background information about themselves and their psychotherapy experiences (e.g., duration of psychotherapy, amount of sessions attended). The demographic portion of the questionnaire collected information on the following: participants' geographic location, ethnic and religious identity, personal or familial migratory history (if applicable), gender identity, sexual orientation, current employment, and household income range (to assess socioeconomic status [SES]). Household income ranges were measured using ranges derived from the Canadian census (Statistics Canada, 2025) which may be a salient measure of SES (Public Health Agency of Canada, 2016), particularly given that one-fifth of South Asian Canadians reside in multigenerational family homes (Statistics Canada, 2024a). Taken together, information gathered from the demographic questionnaire played an integral role in the intersectional analysis of study data (Rice et al., 2019). Participants had the option to correct, elaborate, or expand on the information provided in this questionnaire at the beginning of their interview.

Interview Guide

A semi-structured interview guide (Appendix H) was used to conduct the research interviews. Consistent with phenomenological approaches, flexibility with the interview guide was essential in ensuring that participants were able to narrate their psychotherapy experiences holistically—thus, allowing what was most important to them to arise and come to the surface (Laverty, 2003). Given that the aim of this study was to examine the lived experiences of South Asian women in therapy, taking a flexible, semi-structured approach was critical to foreground participants' narratives. Participants were also offered the opportunity to review the interview guide prior to their scheduled meetings.

I structured the interview guide in four sections to help build a comprehensive understanding of participants' psychotherapeutic experiences, as well as their prior and current perspectives of psychotherapy. First, the 'before psychotherapy' section explored participants' perceptions and understandings of psychotherapy and mental health before engaging with psychotherapy (e.g., "Prior to accessing services, what was your initial understanding of what psychotherapy is?"). In addition, I asked questions regarding participants' psychotherapy decision-making and help-seeking processes (e.g., "Tell me about how you located or found a specific psychotherapist"). Second, the 'during psychotherapy' section of the interview guide examined participants' therapeutic relationships and overall therapy process (e.g., "Tell me about your experience in psychotherapy"). Participants also had the opportunity to describe how their therapy experiences closed (e.g., "Tell me about how your therapy experience ended"). Third, in the 'after psychotherapy' section, participants were asked questions about their perceptions of psychotherapy overall while looking back at their experiences in retrospect (e.g., "How did you feel after psychotherapy ended? What thoughts did you have about it ending?"). Moreover, I inquired about participants' potential interest in engaging with therapy in the future and whether they would change aspects from their previous experience in therapy (e.g., "Tell me how psychotherapy might fit in your life in the future"). Finally, a debrief section was incorporated in the interview guide to ensure that participants felt that their experiences were accurately reflected (e.g., "Is there anything else that you would like to discuss that we have not covered?").

The overall structure of the interview guide was designed to help promote narrative flow and enable participants to guide me through their experiences as they unfolded. To this end, open-ended questions were used (e.g., "Tell me about your decision to seek psychotherapy")

throughout the guide to help ensure that the interview stuck as closely as possible to participants' understandings of their experiences (Alsaigh & Coyne, 2021). Probes were also used when needed to deepen my understanding of participants' experiences or to seek clarification.

Data Collection

Interviews with participants were conducted online via Microsoft Teams. Although participants based near or around Montreal had the option to complete an in-person interview, all participants in this study opted for a virtual meeting. At the beginning of the meeting, I verbally reviewed the consent form with participants. All participants in the study signed and returned their consent form and demographic information questionnaire via e-mail prior to their interview meeting. Participants had the opportunity to ask additional questions about the study or expand and elaborate on their demographic questionnaire at the beginning of the meeting.

After the introduction, I began the interviews by following the semi-structured interview guide. Interviews lasted between 50- and 90-minutes and were video- and audio-recorded with the consent of participants. Video recording was conducted solely to extract audio-recordings. This was due to the limited functionality of Microsoft Teams that did not allow for audio-only recording. Audio-recordings were extracted for transcription purposes following interviews and video-recordings were permanently destroyed in a secure manner. Following the completion of their interview, each participant was offered the opportunity to select a pseudonym for the study. In efforts to reduce any potential distress arising from the interview, I provided all participants with a resource list for support and crisis lines (Appendix I) located across Canada after their interview. Participants further received a $25 digital gift card as an honorarium. The digital gift card could be redeemed at a wide range of Canadian retailers such that participants could select a use for the honorarium at their own discretion.

Data Analysis

To analyze the data, I utilized Braun and Clarke's (2012) six-step approach to thematic analysis. The process of thematic analysis process first began with transcription and carried into the final written interpretative report of results. NVivo was used to support data analysis during the coding process, and the core principles of philosophical hermeneutic phenomenology (i.e., play, prejudice, fusion of horizons, and the hermeneutic circle) guided the overall analysis. I detail how I approached Braun and Clarke's (2012) six steps of thematic analysis below.

1. **Familiarization with the Data.** I transcribed all interviews verbatim using audio-recordings and a rough, generated transcript from Microsoft Teams. During the transcription process, I actively listened to the audio-recordings of the interviews. Listening to and transcribing the interviews allowed me to familiarize myself with the raw data and deepen my understanding of participants' experiences. In addition, I removed or corrected any errors and potential identifying information from the generated transcripts. While reading and re-reading the transcripts, I noted down any commonalities or patterns from interviews that stood out in my research journal. Once transcription was complete, participants were emailed their transcripts in order to provide them with the opportunity to remove, add-on, or edit any details. Participants had a period of two weeks to edit their transcripts. Two participants opted to edit their transcripts; both participants removed details and one participant edited passages for clarity.
2. **Generating Initial Codes.** With the finalized transcripts, I began the process of generating initial codes. This process involved examining the transcripts for meaningful, key features while highlighting and labeling interpretative codes in NVivo. Patterns and insights found in the previous step helped to guide this procedure. I made active efforts to integrate an intersectional approach to my analysis and generation of codes. Furthermore, I exercised reflexivity while developing codes by tracking my own biases and hermeneutic prejudices about the data. In support of my reflexivity process, Dr. Audet my thesis supervisor, acted as an auditor throughout the analysis. Specifically, Dr. Audet provided support by reading through a sampling of the transcripts and noting down her own interpretative codes. Dr. Audet's codes and insights were cross-compared with my own in order to help promote my reflexive engagement with the data.
3. **Searching for Themes.** Using the initial codes developed in the last step, I initiated the process of generating themes. To do so, I employed the narrative structure of the interview guide (i.e., before, during, and after psychotherapy) as a starting point to help cluster codes together. During this process, I identified potential relationships between codes and drew out a visual thematic map in my research journal. I sorted the labelled codes in NVivo into themes and sub-themes, which was informed by the visual map that I had created. The process of searching for themes and clustering codes was an iterative, reflexive process that involved moving back and forth between the texts and the

emerging thematic structure. Relevant quotes from the text were grouped by theme using NVivo.

4. **Reviewing Themes.** Upon developing a rough thematic structure, I reviewed the themes and subthemes through a continuous iterative process. This step involved revisiting the codes and themes for coherence and thematic distinctiveness. During the review process, some themes were re-grouped, split, or merged in NVivo. I actively reflected on my decisions throughout this process—including examining how the themes related to each other and the research question—and consulted with Dr. Audet to review my choices. Any revisions were made to reflect clarity and the relation of themes to the overall research aim.
5. **Defining and Naming Themes.** After reviewing the themes, I finalized the thematic structure. To finalize the structure, I explicitly named the themes and subthemes. Themes were named with two goals in mind: to capture the essence of the theme or subtheme, and to aid with intelligibility. Additionally, I created definitions of the themes that contained summaries of each themes' essence and meaning. I further consulted with Dr. Audet to help reduce my personal biases during the finalization process and to increase overall clarity of the themes.
6. **Writing the Report.** Returning to the transcripts and the codes, I began the process of consolidating results via a written report. Relevant quotes were pulled to help develop a cohesive and transparent narrative for each theme. During this process, I aimed to stay as close as possible to participants' experiences by engaging with direct quotations in the results. Dr. Audet provided feedback throughout the reporting process to ensure illustration of the results was concise and transparent. Results were then synthesized during the written interpretation. The interpretation of results was guided by the research question and aimed to meaningfully capture patterns in participants' lived experiences before, during, and after psychotherapy. I remained reflexive during this process, and continuously reflected on the theoretical underpinnings of the study to inform and ground my interpretation. The written interpretation of results was structured narratively to capture the complexity and richness of participants' experiences as they unfolded.

Trustworthiness Efforts

To ensure study rigour, I employed Lincoln and Guba's (1985) criteria for trustworthiness during the data collection and analysis process. The following constructs were utilized with regard to the overarching Gadamerian hermeneutic methodology of the study: 1) credibility, or the presentation of findings that accurately and truthfully reflect participants' descriptions; 2) confirmability, or the overall objectivity of the study; and 3) dependability, or the consistency of data over time (Alsaigh & Coyne, 2021). Given that the aim of this study was to capture deep descriptions of the specific experiences of South Asian Canadian women in psychotherapy and involved intersectionality and hermeneutic engagement, the transferability criterion (i.e., the degree of generalizability of study findings; Lincoln and Guba, 1985) was not considered relevant (Alsaigh & Coyne, 2021).

Credibility

To establish credibility, I incorporated participants' direct quotes throughout the study results in order to accurately convey participants' thoughts. Moreover, following their interview, participants were offered the opportunity to review their transcript and to add on, clarify, or edit any details such that their experiences were truthfully represented. I also paid particular attention to my own positionality as a South Asian woman and engaged in active reflexive processes throughout the study process. To this end, I maintained a reflective research journal to examine and monitor any biases that occurred while conducting the study.

Confirmability

Within the context of Gadamerian hermeneutic phenomenology, the pre-understandings of a researcher are considered to be 'wrapped up' in the research process. Consequently, as opposed to viewing confirmability as 'true' objectivity, hermeneutic studies may instead ensure that there is transparency in regard to pre-understandings and openness to the emerging study text (Alsaigh & Coyne, 2021). In addition to documenting my pre-understandings (see Appendix A), the reflective research journal was used to archive the influence of my positionality and potential biases or prejudices. Furthermore, I sought an auditor or "expert" (Alsaigh & Coyne, 2021) through active consultation with my supervisor, Dr. Audet, during the analysis process. Dr. Audet's feedback and expertise with qualitative methodology helped to ensure that the study text was explored with the necessary depth and quality to conduct a thorough analysis.

Dependability

Although dependability refers to the consistency or reliability of data over time (Alsaigh & Coyne, 2021), Gadamerian hermeneutic phenomenology posits that the interpretation process is never-ending (i.e., the hermeneutic circle). Specifically, the researcher and participants continuously move back and forth between their understandings to develop a fusion of horizons. As such, understandings of the phenomenon at hand may shift over time—particularly if participants in this study choose to engage in psychotherapy again. Nonetheless, the data collected in this study may speak to how participants understood their experiences within the timeframe of their interview and may thus be dependable within this context. Moreover, the data analysis is representative of my own understandings of the interviews and the literature at the time of analysis, ultimately resulting in what Gadamer refers to as a fusion of horizons.

Chapter Four: Results

Participant Contexts

The following section provides a brief overview of the study's six participants: Thurga, Kirat, Lena, Oshani, Meena, and Nasima. Each overview consists of details regarding the participants' demographic information, context for seeking out therapy, number of sessions attended, therapist cultural identities, and reasons for termination. A short description of their personal experience is further offered within each context. Participants' age, locations, occupations or education, and other potentially identifying information were generalized in order to protect their privacy. For a quick review of participant demographic information, a table is provided below.

Table 1

Participant Self-Reported Background Information

Participant Pseudonym	Age Range	Ethnicity	Religion	Generation Status	Location	Sexuality	Employment	Average Household Income	Approximate Number of Sessions Attended
Thurga	35-40	Sri Lankan Tamil	Hindu	Second-generation	Alberta	Bisexual	Employed (full-time)	$130,000 to $220,999	10 to 20
Kirat	25-29	Punjabi	Sikh	Second-generation	Ontario	Heterosexual	Student	$84,000 to $129,999	5 to 6
Lena	20-24	Rajasthani	Hindu	First-generation	Ontario	Bisexual	Student, Employed (part-time)	Less than $25,000	100
Oshani	25-29	Sri Lankan Sinhalese	Buddhist/ Spiritual	Second-generation	Ontario	Bisexual/Queer	Student	$25,000 to $51,999	30
Meena	30-34	Malayalee	Agnostic Hindu	First-generation	Ontario	Heterosexual	Employed (full-time)	$130,000 to $220,999	50
Nasima	30-34	Bengali	Muslim	First-generation	Québec	Heterosexual	Employed (full-time)	$52,000 to $83,999	10

Thurga (she/her)

Thurga is a cisgender woman in her 30s who identifies as Sri Lankan Tamil and Hindu. She reported having attended psychotherapy over several, nonconsecutive years for various presenting issues (over 10 to 20 sessions on a weekly basis) since she was a young adult. Thurga identifies as bisexual, and currently lives in Alberta, Canada. She accessed psychotherapy via insurance and through provincial services. She was born and raised in Canada. Thurga currently works in the mental health field and emphasized that her education and work experiences have shaped her knowledge and perceptions of psychological services.

Thurga reported first beginning therapy in her early 20s. She highlighted that her initial experiences were with "traditional" talk therapy, which she found to be largely unhelpful and akin to a "Band-Aid solution." Thurga expressed having difficulty finding providers with a shared cultural background in Alberta, and noted that her experiences with primarily White therapists resulted in several frustrating encounters. Much of our interview focused on Thurga's subsequent experiences with equine-assisted therapy, which she described as "profound" and grounding in nature. As the equine therapy was offered via a provincially-sponsored program, Thurga's experience ended following completion of a limited number of sessions.

Kirat (she/her)

Kirat is a cisgender woman in her late 20s who identifies as Punjabi and Sikh. She currently lives in Ontario, Canada, and is a university student in a psychology program. Kirat identifies as heterosexual, and was born and raised in Canada. She attended psychotherapy (5 to 6 weekly sessions) as a learning experience for her education and future career. Kirat was able to access services via insurance and sliding scale fees.

Kirat first attended psychotherapy about one year before our interview. Her therapist was a White male psychologist. She expressed that a psychodynamic modality was used in her sessions, which she found "jarring" as it had brought up some "raw" matters that she had not anticipated to come up in her therapy. Kirat further expressed that she felt that her therapist had some difficulty understanding the cultural context of her narrative, and noted that it felt as though he had jumped to conclusions. Ultimately, Kirat ended sessions as she found that she did not enjoy her experience and felt that it had rendered her a "more insecure version of [herself]" that she had not experienced in several years.

Lena (she/her)

Lena is a cisgender woman in her early 20s who identifies as Rajasthani and Hindu. She was born in India, and currently lives in Ontario, Canada. Lena identifies as bisexual and is currently a university student that is working part-time. She has attended psychotherapy non-consecutively for about five years (approximately 100 weekly or biweekly sessions), and has seen several therapists of varying demographic (e.g., race and gender) backgrounds. Lena was able to access psychotherapy through university services, insurance, and a community grant for low-income individuals.

Lena expressed that she first began to attend psychotherapy after experiencing extreme stress during her first year of university. She first connected with a qualifying psychologist at her university for a total of 10 sessions, and later found another trauma-focused therapist within her community once she completed her maximum amount of sessions at the university. Lena noted that her first two therapists were both White women, and that she later chose to intentionally seek out therapists who could connect with her cultural background. Several modalities were used throughout Lena's psychotherapy experiences, including internal family systems, cognitive-behavioural therapy, dialectical-behavioural therapy, and solution-focused therapy. All of Lena's psychotherapy experiences ended either due to running out of limited sessions or for insurance and financial reasons.

Oshani (she/they)

Oshani is a queer cisgender woman in her late 20s who identifies as Sri Lankan Sinhalese and Buddhist/Spiritual. She was born and raised in Canada, and lives in Ontario, Canada. Oshani identifies as having a disability, and is currently a university student in a psychology program. She reports having attended approximately 30 sessions of psychotherapy on a weekly basis over a span of several, nonconsecutive years. Her therapists were of varying demographic backgrounds. Oshani accessed psychotherapy through free services (e.g., psychotherapy offered through her university, community services).

Oshani described first attending psychotherapy when she was in high school after experiencing a crisis. Oshani reported that her initial rounds of psychotherapy helped to provide her with psychoeducation that gave her the "language" to understand herself and explain what she was experiencing to others. She later chose to seek psychotherapy several times while completing her undergraduate and graduate degrees. Most of her psychotherapists primarily employed cognitive-behavioural therapy, and one of her therapists utilized somatic therapy.

Oshani described resonating strongly with the somatic techniques offered by the latter psychotherapist. Her therapy experiences ended for several different reasons, including poor fit with a therapist, moving out of a city, and running out of limited sessions.

Meena (she/her)

Meena is a cisgender woman in her early 30s who identifies as Malayalee and Agnostic Hindu. She was born in Oman, and later moved to Canada. Meena currently lives in Ontario, Canada and identifies as heterosexual. She is employed on a full-time basis. Meena has attended psychotherapy nonconsecutively for 10 years, and has completed over 50 sessions. Sessions were primarily biweekly with some occasional monthly maintenance sessions. Meena accessed psychotherapy via insurance, out-of-pocket payments, and through her employee assistance program (EAP).

Meena originally attended psychotherapy for grief after experiencing parental loss. She continued to see her first therapist for about four to five years, during which she received cognitive-behavioural therapy. Meena spoke about how her concerns and needs evolved over the course of their therapeutic relationship. She described eventually feeling that her therapist struggled to understand the nuances of her cultural experiences. Meena sought therapy again through her EAP after her therapist went on maternity leave. Her experiences with the EAP were varied in quality, and she struggled to find a therapist who could "understand" her. Meena's psychotherapy experiences ended due to either personal life circumstances or running out of limited EAP sessions.

Nasima (she/her)

Nasima is a cisgender woman in her early 30s who identifies as Bengali and Muslim. She was born in Qatar and later moved to Canada. Nasima identifies as heterosexual, is employed on a full-time basis, and currently lives in Quebec, Canada. She attended biweekly psychotherapy on two separate occasions (10 sessions total), both of which were paid through her insurance plan. Her first therapist was an East Asian woman in private practice. Nasima's subsequent therapist was accessed via her EAP program, and her therapist was a young Bengali Muslim woman like herself.

Nasima initially chose to seek out psychotherapy after experiencing family struggles. She intentionally sought a therapist who "resembled" her more with regard to familial and cultural values. This experience ended after two sessions whereby Nasima felt that her sessions were not

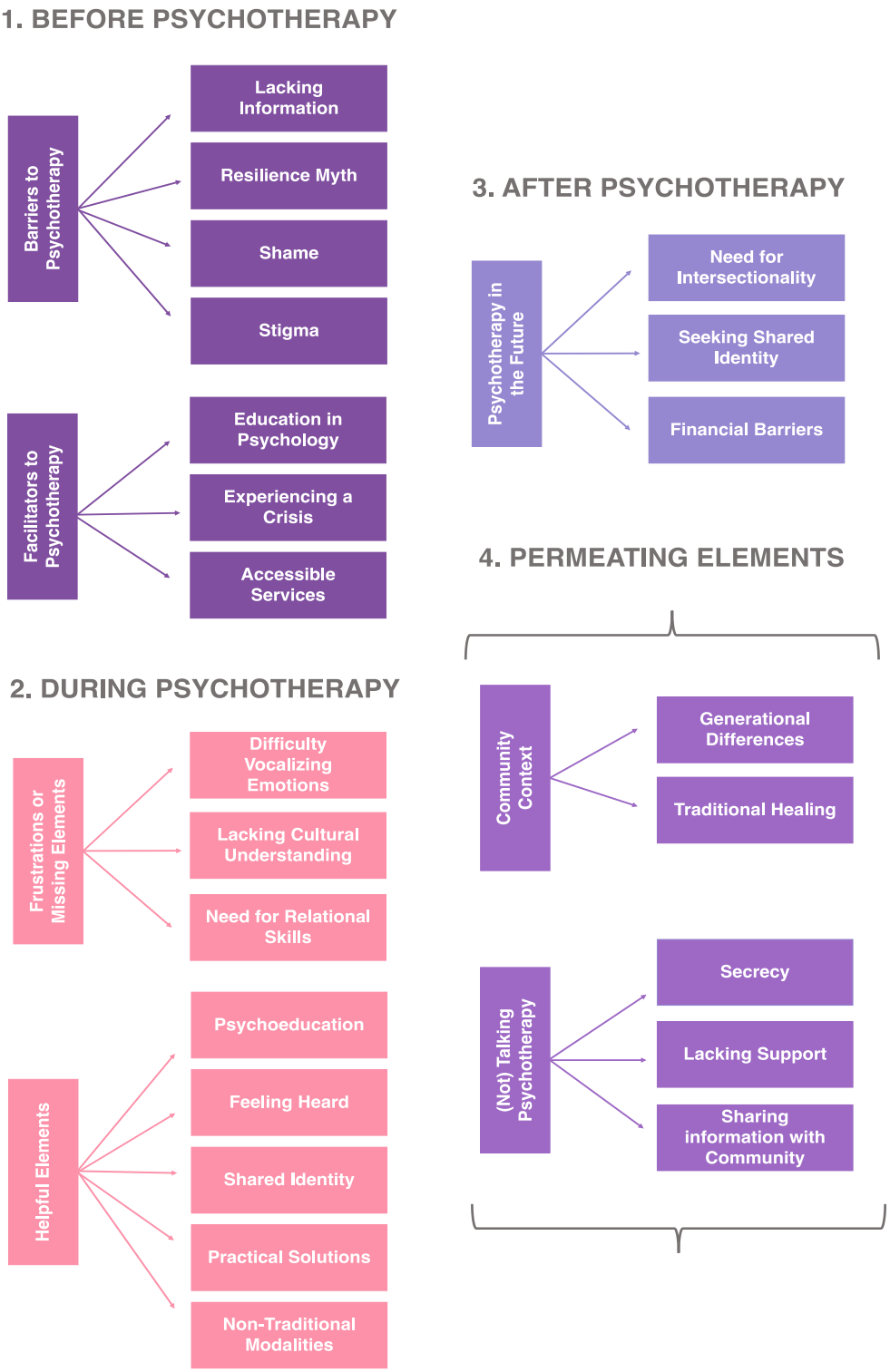
meeting her needs. Nasima later attended psychotherapy with an EAP-provided therapist. She was paired with a therapist whose identity resembled her own (i.e., religious and ethnic background). Nasima spoke about how their shared identities were highly valuable due to her therapist's ability to provide her with culturally-responsive solutions. This experience ended due to Nasima's EAP "trial period" running out, although she intends to continue psychotherapy with this therapist in the future.

Resulting Themes

A total of seven themes were generated from the transcripts during analysis: 1) *barriers to psychotherapy*, 2) *facilitators to psychotherapy*, 3) *frustrations or missing elements*, 4) *helpful elements*, 5) *psychotherapy in the future*, 6) *community context*, and 7) *(not) talking psychotherapy*. Themes 1 through 5 were categorized as occurring with one of three stages of the psychotherapy process (before, during, and after), and themes 6 and 7 were classified as permeating elements (see Figure 1). Permeating elements were themes present throughout several stages of the psychotherapy process. Intertwining philosophical hermeneutic phenomenology and thematic analysis, the following themes reflect commonalities in lived experience; however, descriptions of themes detail unique variations in these commonalities.

Figure 1

Themes and Subthemes



Terminology

Throughout the results, I refer to the professionals that participants worked with interchangeably as either their 'psychotherapist' or their 'therapist.' These terms encapsulate a wide range of professionals that participants may have worked with (e.g., social workers, psychologists)—all of whom provided participants with psychotherapy. The decision to use 'psychotherapist' and 'therapist' was taken as all professionals worked with participants under the scope of psychotherapy. In addition, I aimed to increase the overall intelligibility and clarity of the text through the use of these umbrella terms.

1. Barriers to Psychotherapy

Subthemes within this theme reflect barriers to participants accessing psychotherapy. Barriers were classified as any potential contextual obstacle that may have impeded participants from accessing psychotherapy or viewing psychotherapy as a viable option prior to their attendance. For most participants, several of these subthemes intersected. The subthemes are as follows: *a) lacking psychoeducation, b) resilience myth, c) shame,* and *d) stigma.*

1a. Lacking Information. Prior to attending psychotherapy, several participants highlighted lacking information related to mental health or psychotherapy while growing up or within their communities or families. For instance, Thurga articulated how community conversations around mental health were generally absent, and that growing up much of her understanding regarding mental health was received through Tamil movies depicting self-harm behaviour and suicidality. She described how media messaging on mental health impacted her own behaviour growing up, stating "I started doing shit [self-harm] like that when I was in like, elementary school for a boy." Thurga emphasized that, despite representations of mental health in media, community conversations on mental health were absent: "We don't talk about it. It's just a movie. It's fantasy." To this day, Thurga noted that she struggles to discuss her career in mental health with her mother as she is unaware if "there's language to explain that [her career] to [her] mom in Tamil."

On a similar note, Lena expressed that what she understood about mental health was what she "read about in textbooks or watched in movies" and that mental health "(…) wasn't really something that was part of my life or that I understood." She noted that, prior to beginning university, she had not personally known anyone who had previously attended psychotherapy.

Interestingly, both Lena and Meena noted that they had family members with psychiatric diagnoses that were treated with medication and no further treatment. For Lena, the reality that her family member had been taking anti-depressants for several decades demonstrated that "psychotherapy [was] not really seen as even an option to go to" in her family. Expounding on this, Lena highlighted that her family's choices were rooted in "not really knowing or understanding (…) what it is like to go to a therapist, and also not just that, but just not even wanting to entertain the idea of doing that." Indeed, several participants spoke about lacking information related to psychological services either personally or within the community. As expressed by Nasima, "I first didn't quite understand the different types of options for mental health, like help out there. Like what is psychotherapy? What is a psychologist? What is a counsellor?" Similarly, Meena noted that within her community, there was "(…) no concept about therapy, psychotherapy, counselling sessions, no formalness around it."

Expanding on the topic of treatment, Meena reported that she felt that her family members lacked an understanding of psychiatric disorders despite two of her aunts having been diagnosed with schizophrenia. She expressed the following:

> (…) [B]asically there is schizophrenia running in the family and the idea around it was that it was caused by someone and not that it was, you know, something that just developed or like there was no real understanding around it. There's no understanding of does she—do they need therapy? They're just on medication. The medication's poorly managed. Everyone's like ignoring it.

As Meena describes, the predominant narrative regarding the onset of her aunts' diagnoses was that they "fell into this trap of getting schizophrenia" as opposed to a biological manifestation of the disorder. Consequently, similar to Lena's family, Meena felt that this lack of psychoeducation contributed to her family members not being aware of (or not willing to be aware of) other mental health treatment options that were not pharmaceutical medications.

1b. Resilience Myth. All participants articulated growing up with an internalized narrative of the 'resilience myth'—a belief that it was necessary for them to conquer or display strength over suffering in their life as opposed to seeking out external support. Given the presence of the resilience myth, participants spoke about how experiencing poor mental health or having to seek out support could be perceived as a deficiency within their communities or families. Kirat described this process occurring within her own community:

> I think if you say you're going to therapy, people will think you're weak or like there's something... like it might reflect on your family that they can't help you deal with something or that you don't have the skills to deal with something that you should be able to deal with on your own, or almost like if you're going to psychotherapy, you're not like meeting the standard of what you should be or what you should be able to deal with, unless there's something wrong with you.

In viewing struggles with mental health through this resilience myth lens, Lena described how she previously engaged in a process of "othering," whereby poor mental health or experiences with psychotherapy only "happen[ed] to other people" or "people with mental illnesses." As such, Lena emphasized how her own subscription to the resilience myth ultimately resulted in her having difficulty processing her own declining mental health—a reality that would contribute to the crisis that led her to seek out psychotherapy.

Meena described hearing this narrative of the resilience myth from others in her community, whereby it was preferential to perceive an individual as not being in need of services, or as being simply "fine." Similarly, Thurga discussed her own personal experiences of this form of denial in her community: "It's like *chumma iru*[1], you know, like there's nothing wrong with you. Just stop, or like stop talking about it or like stop crying about it." Thurga attributes this response to what she feels is a "cultural upbringing" that emphasizes suffering in silence: "You hide your feelings, you cry in silence or you cry—yeah, like it's just like you do—that's just what I experienced growing up."

For Nasima and Oshani, coming up against the resilience myth represented failure. Nasima emphasized that, culturally, "[t]here's very, very strict ways that you need to follow or need to be, and you need to do certain things." Ultimately, straying from these strict norms constituted a form of failure, which Nasima highlighted as having the potential to "break[sic] your own identity." In Oshani's case, experiencing poor mental health resulted in them feeling "guilty" and as though "I had done something wrong or like, failed my parents or something like myself."

1c. Shame. Intimately related to the resilience myth were several recollections of shame-based experiences related to mental health or psychotherapy. Nasima, Thurga, and Oshani all highlighted how seeking out support could be viewed as an inherently shameful experience—an

[1] Chumma iru [Tamil] = "Just stop"

experience that was often seen as for 'others' and not themselves. In considering therapy, Oshani described experiencing strong feelings of shame: "I was super like, I don't know, I guess ashamed was the right word (…) yeah, I just felt like what kind of person would go to therapy or like talk to someone like, yeah, I think I felt a lot of internal, like stigma or shame to go."

Thurga highlighted the notion of shame as having a powerful presence within families and communities. She described, "(…) even if you mentioned like a psychiatrist, it's like, 'Oh, like, oh no, we can't have that in our family.' Like it's just a shame-based experience." Thurga further recollected an anecdote of a friend's brother who had been recently diagnosed with bipolar disorder. In this anecdote, she expresses how shame may manifest in a form of denial, such that the reality of a psychiatric diagnosis is dismissed:

> (…) The only reason he [the brother] got that diagnosis was because he had to be hospitalized because he was just acting like, really off. But then her [the friend's] mom, like, when I talk to that friend's mom she'll just pretend like that's not going on. She'll just be like, "Oh, like, he's back home." Like, just like try to hide the fact that there's something going on.

Both Nasima and Thurga expressed how shame may also be embedded within cultures. Nasima spoke about how shame was an omnipresent reality for many South Asian individuals and highlighted that, given this, "(…) there's always going to be elements of things that we find shameful in ourselves, in our experiences and different things." For Thurga, the interconnection between culture and shame lay in the realities experienced by those in her community. As a Sri Lankan Tamil woman, Thurga described how her community's history of experiences with "ethnic cleansing (…) and the civil war" strongly overlapped with shame related to mental health. In particular, Thurga expressed how these feelings of shame were navigated through "acceptable vices" such as "alcoholism or (…) consuming things that aren't traditional therapy."

1d. Stigma. Several participants described the presence of stigma related to mental health within their communities. Specifically, participants emphasized how experiencing mental illness or poor mental health could be perceived as an individual short-coming due to the stigmatization of mental health. As Lena expressed, merely discussing one's mental health could potentially cast them in a negative light:

> Mental health was sort of almost taboo. It was like, oh, why are you talking about mental health? What is wrong with you? Like you know, that something has to be wrong with

> you in order to talk about mental health. And um, there was a weird disconnect of knowing and understanding that mental health is a thing personally for myself, but still this disconnect of ever it being OK to seek help for something.

In contrast, Thurga described fantastical narrativizations of mental illness within her community. She recalled hearing stories from her mother about "(…) the crazy guy in the town village that they had to tie up." Within these stories, Thurga spoke about hearing about mental health "(…) in a very like, a fantasy type like storytelling. It's like this bestiality type of thing like, 'Oh, that's—they turned into like a monster'." In this essence, individuals with mental illnesses are 'othered' as almost nonhuman beings—thus, cast off from the rest of the community in a figurative and literal sense (i.e., being tied up). On the other hand, those who were not narrativized were discussed in jest or only in quick passing. Thurga spoke about how individuals were written off as "(…) *avan vanthu paithizham*[2] or whatever. Like it was just almost like it's a joke or like, 'Oh that family member we don't talk to because there's something wrong with him'." In both of these instances, stigmatization of individuals with mental illnesses ultimately cast them as either spectacles or pariahs.

For Kirat, stigmatization of mental health inevitably extended to stigmatization of psychotherapy itself. In particular, she described how psychotherapy was viewed as "(…) a waste of money, waste of time, not the way to get results. So probably like the result of stigma." Expanding on this, Kirat spoke about how psychotherapy was viewed as a "White thing," and that "(…) Western ways of doing things are often like looked down upon too, like in general, and there's just like different ways of doing things or ways of being." Consequently, within this notion, the "Western" way of seeking support (psychotherapy) was conceived critically as both inadequate and not intended for the community.

2. Facilitators to Psychotherapy

The following subthemes describe elements of participants' experience that may have promoted or encouraged a decision to seek out psychotherapy, including *a) education in psychology*, *b) experiencing a crisis*, and *c) accessible services*.

2a. **Education in Psychology.** Nearly all participants described having completed, or being in the process of completing, courses or degrees in psychology. Several of these participants (Thurga, Kirat, Lena, and Meena) briefly expressed that their education contributed

[2] Avan vanthu paithizham [Tamil] = "He's crazy"

to their understanding of mental health or psychotherapy before their attendance. For instance, Lena noted having a "little bit" of an understanding about psychology due to having taken a course, and Meena spoke about how having a bachelor's degree in psychology resulted in her being "exposed to a lot of conversations around therapy." In regard to her understanding of psychotherapy, Kirat stated "I guess once I started studying psychology, obviously, thankfully, I feel like I have more of an understanding. I think the more I learn, the more questions there are, too."

On a similar note, Thurga spoke about how her education and career in the mental health field largely informed her understanding of and perceptions toward psychotherapy: "(…) [I]t's made it easier to transition versus someone who may not be in the same field of practice." In regard to those who may not have had the same career or education experiences, Thurga posits the following: "They just like maybe… [have] some level of resistance or 'What is this really about?' Or you know, the taboos like influencing [them] or their historical family dynamics influencing that." On this note, as Thurga states, having an education and career in mental health may enable someone to "transition" into psychotherapy with greater ease, particularly when coming up against potential barriers such as a resistance towards or a stigma of psychotherapy.

2b. Experiencing a Crisis. For most participants, their first foray into psychotherapy occurred after experiencing some form of a crisis. Specifically, participants expressed attending therapy after feeling overwhelmed during some form of a major struggle or, alternatively, feeling that they had exhausted their options in attempting to cope alone. As Oshani stated, "I always said I was fine until I wasn't and I was in a crisis, and then I was like, 'Oh, I don't really know what to do.'" Oshani's crisis involved feeling academic stress during her high school years, during which her parents sought out therapy for her:

> I remember when my parents were kind of helping me get access to therapy, it was kind of like... I think the messaging was kind of like fix her or do something or like, you know, it's come to this point. It was kind of like—yeah, crisis management—it's like, "Oh, we don't know what to do."

Similar to Oshani, Thurga described seeking out therapy when she found that her life was "falling apart." In particular, Thurga spoke about how she sought out therapy after finding her emotions spilling out into other facets of her life. As Thurga mentioned, "I realized a lot of like, my childhood traumas and things like that were affecting my current relationships, so romantic

or non-platonic and just like having issues with anger." In this effect, therapy was seen by Thurga as an "emergency" route to take during moments of crisis.

For Meena, the crisis that resulted in her "needing therapy desperately" was the loss of a parent. Prior to attending psychotherapy, Meena described feeling "very isolated" while processing her grief, and spoke about the necessity of having a space to simply "speak and be heard." Meena further expressed how her husband supported her during her period of grief by filling out forms for her to attend psychotherapy.

Both Lena and Nasima described feeling lost and unable to chart a way forward during their moments of crisis. Lena recalled feeling "emotionally out of control" while experiencing stress in her first year of university, and described how she "(…) would be sitting in lecture and just start crying." She reported that "I did not understand what was going on with me because in the past I had just kept all these emotions like, you know, bottled up inside or I didn't feel them." Upon seeing her "academic performance plummet for the first time ever," Lena chose to seek out psychotherapeutic services. Similarly, Nasima spoke about "feeling really helpless" once her brother's substance use issues started "escalating." She reports that, as the eldest daughter, she was largely expected to "fix" her brother's substance use issues—an expectation she described as having "internalized." Nasima expressed that the stress of the situation grew beyond her own ability to cope alone, which resulted in her "throwing up" and experiencing panic attacks. As expressed by Nasima:

> I know it shouldn't get to that extreme place for someone to get the help that they need, but I feel like in my situation there was uh, it was like it got to this really heavy, heavy place and I've seen that with other people in my community that we don't get the help that we need until it becomes too much for one person to bear. And then we're like, OK, you know, this justifies, you know, going to see someone or spending money from our pocket to like, you know, get the help that we need.

Thus, feeling on the brink of collapse allowed Nasima to feel a sense of justification in seeking therapy (i.e., being willing to pay for services). In addition, she emphasizes how her situation resembles a pattern that she has observed within her own community, whereby support is sought only after an individual is no longer able to shoulder their struggles alone. Nasima further highlighted that her first experience with psychotherapy enabled her to seek services again before a crisis escalated: "It was another crisis, but it was less of a bigger crisis this time

around. (…) [N]ow I'm not feeling like myself and now I can auto, kind of, identify that like, you know what, before it gets to that place, let's speak to someone, you know."

2c. Accessible Services. All participants described having previously obtained some psychotherapeutic services through accessible means. For instance, Meena and Nasima reported having accessed psychotherapy via employee assistance programs (EAP) offered through their jobs, and Thurga described having received equine-assisted group therapy via provincially-covered services. Kirat, Oshani, and Lena all expressed having accessed services through free or reduced-cost means via their universities. Oshani spoke about how she was able to receive free services through a student therapist at her university. She noted that, at the time, she was under her parents' insurance and had not wanted them to know that she would be attending psychotherapy. Given this, Oshani described that attending free sessions offered by a student therapist was her "only option" as she could avoid filing any insurance claims that could potentially flag her parents' attention.

For both Kirat and Lena, their universities played a major role in increasing the accessibility of psychological services. At Kirat's university, sliding scale services were offered (i.e., services accessed along a pay scale adjusted to a client's financial means) to students. She described having the option of sliding scale services as a "big reason" to start therapy due to the reality of therapy being costly. Similarly, Lena accredited her first psychotherapy experience to having occurred when it did due to having been a student at a university with a comprehensive health services network. She recalls that "(…) it was very easy to get sort of an intake appointment and be connected with a therapy provider at the time. So, I had no issues at all." The ease of this process was particularly reassuring to Lena, who described experiencing several worries: "I mean, I was concerned about money and I had so many questions, but it was all very smooth, um, especially the getting connected and starting it part." Thus, the simplicity of seeking support (e.g., through a structured intake process) helped facilitate Lena's psychotherapy journey.

3. Frustrations or Missing Elements

This theme captures elements from participants' psychotherapy experiences that were desired but ultimately missing, or were issues that they noticed about the therapy process. The subthemes are as follows: *a) difficulty vocalizing emotions*, *b) lacking cultural understanding*, and *c) need for relational skills*.

3a. Difficulty Vocalizing Emotions. Three of six participants in the study recalled having a difficult time discussing their emotions in psychotherapy. All three participants attributed some part of their difficulties to an overall inexperience with sharing or discussing their emotions with others. For Kirat, these difficulties manifested within her first session whereby she felt an expectation to immediately divulge her feelings without any natural build-up: "(…) so it jumped right in and I feel like there was an assumption of trust. Like I didn't feel like I trusted this person yet, but this person was kind of like, well, why are you here?" Kirat described experiencing strong discomfort with having the "onus" on her to talk, and highlighted how this sense of discomfort was amplified by her inexperience with sharing feelings with others:

> It's always like, what's underneath? Like, what does that make you feel? Which for me, as someone who's been raised to, like, not talk about your feelings, don't show any feelings to like—that's my issue is I can't, like I can't just like explain that or feel that. I think I need to like start up here and work down, which maybe I should have expressed, but at the time I didn't really realize or think of that. I was just kind of like, felt bad that I couldn't or that I was confused.

Consequently, the expectation for Kirat to rapidly disclose her emotions conflicted with her own ability to do so. The inability to meet these felt expectations ultimately led her to experience feelings of self-blame. Kirat further highlighted how her inexperience was closely related to her cultural upbringing: "(…) our culture is very like, you don't talk about your problems. So, it can be hard to like—if you haven't talked about it, to understand it yourself or like to know how to describe it." Given this, Kirat reported struggling to "name emotions or to recognize what's happening inside" during her psychotherapy sessions. She highlighted how patience from her therapist during her sessions may have been beneficial, or additional tools (e.g., a feelings wheel) to help support her with naming her feelings.

Like Kirat, Oshani also spoke about how mental health was seldom discussed in their family. They described how they "didn't really have an understanding of how to talk about my mental health in everyday, like scenarios—I didn't feel like I could talk about it." In addition, they expressed that they struggled to articulate the intricacies of their emotional experiences to their therapist, particularly in regard to discussing their own feelings of shame related to attending psychotherapy. They stated that they "didn't really know how to explain [their feelings]" which resulted in their therapist being "(…) really confused as to like, why I felt the way I did." In later

rounds of psychotherapy, Oshani also pointed out the constraints related to having limited sessions with a therapist. They described themselves as a "(…) type of person that takes time to trust someone or feel like [they] can open up about things." Oshani noted how limited sessions thus interfered with their ability to open up to and "develop a relationship" with a therapist: "(…) when I know that it's capped, I just automatically feel defeated and I remember just feeling like, what's the point? Like there's nothing I can get."

Nasima's difficulty with vocalizing certain issues was closely related to feelings of shame. Here, she spoke about struggling to reconcile the importance of discussing certain issues with her feelings of shame:

> I'm like, why is it that you're not speaking of something that I do know that could feel very shameful to you and that could, you know, I'm just like, I was just analyzing a little bit from this perspective that like, why is it that even I, after the sessions, I'm like, why didn't I talk about this? Or why didn't I bring it up? It's important.

Nasima further highlighted that, despite her trust in her therapist, she was unable to disclose issues that she deemed shameful—an experience she considered to be common within South Asian communities. As examples, Nasima described having observed these feelings of shame with her friends who, while open to speaking about other issues in their life, may always have "something really hidden" that she felt "could be very core to their challenges." Thus, for Nasima and others in her community, shame-bound topics were difficult or nearly impossible to broach in psychotherapy.

3b. Lacking Cultural Understanding. Thurga, Kirat, and Meena all spoke about instances during psychotherapy where they felt their therapist(s) lacked cultural understanding. For Thurga, these instances were particularly felt while living in Alberta. Specifically, Thurga expressed having a difficult time finding practitioners who were South Asian or understood the South Asian experience in Alberta. In her experiences of what she referred to as talk therapy, she described feeling unable to "fully reveal [her] inner, darkest feelings" for fear of judgement. Her struggles articulating her feelings were particularly exacerbated with White clinicians: "I always felt guarded, especially with a White practitioner. I felt like I had to police myself constantly." Thurga shared experiences that contributed to her guardedness, including perceiving her therapist as dismissive of her experiences during sessions. She specifically highlighted instances of this occurring in couples counselling sessions:

> I'm talking about for example, in couples counselling, my issues with my partner and they're [the therapist] like, "Well, I don't really get like why that's like an issue." Like you could see like just even like the mannerisms or like the behavior change, even if they're not verbally saying things, you could see that it's [the therapy] like unwelcoming, not a good fit. They don't—how could they possibly understand if they have this level of privilege. And I don't know, like I've talked about my experiences with racism, just like in [Alberta], just for like—with me in general. And it's like they just don't get it.

Within this example, Thurga emphasized sensing nonverbal cues from her therapists that indicated to her that they were unable or unwilling to understand her experiences—particularly when she had brought up in session racism that she had endured. She further highlighted her therapists' White privilege as an obstacle to understanding her experience.

Kirat believed that her therapist was unable to understand the cultural nuances of her experience. She based this on how her therapist construed her mother as "always controlling" and "one-dimensional." Kirat expressed this narrative disregarded the "cultural piece" that she felt was intimately related to her mother's actions: "I'm like, every mom is like this in my culture and there's a reason why. And to me that adds a lot of like depth." Interestingly, Kirat emphasized feeling that her own "bias" may have played a part in her rendering of her therapist. Specifically, she spoke about feeling that her therapist was "very cold" and authority-like—an experience which had "(…) reminded [her] of all the White men in authority who [she] had maybe negative interactions with."

Like Kirat, Meena spoke about her therapists lacking a cultural understanding of experiences she brought up in therapy. In particular, she described experiencing difficulty explaining the cultural pieces underlying familial dynamics: "You have to be very respectful and gracious [to family] and just like there's a very strong hierarchy in South Asian culture that I felt like wasn't quite understood by a lot of the therapists I spoke to." Meena expressed feeling that her therapists were unable to provide her with tools to navigate these familial issues with cultural nuance. Instead, the therapist(s) largely focused on what she could control—an approach Meena described as "not something [she] could always use practically."

3c. Need for Relational Skills. Three participants described desiring a need to build skills related to interpersonal or familial relationships. However, all three participants felt that their therapists were often unable to adequately support their relational skill-building. Meena

described this issue occurring in conversations regarding difficulties she experienced with her parents-in-law. Specifically, she expressed that her therapist focused largely on her personal reactions or feelings to familial issues rather than focusing on helping to resolve the issues themselves. For instance, Meena expressed that a therapist would suggest that she try to "(…) come to terms with how someone has reacted" or prompt her to try to give her in-law "some grace." For Meena, this approach failed to consider culturally-embedded norms occurring within her issues with her in-laws. When describing what would have been useful to her in psychotherapy, Meena reported desiring relational skill-building that was culturally informed: "(…) how do I stand my ground when I am talking to these people without necessarily coming across as rude or disrespectful?"

In describing her first encounter with psychotherapy, Nasima echoed Meena's experience of a more "individual focused" approach. She spoke about how the tools her therapist proposed centered on navigating her own response or feelings as opposed to being interpersonal- or community-focused. Nasima communicated the following when discussing her issues with this individual-focused approach:

> (…) it is one of the reasons why I kind of didn't continue, because my biggest challenge that I was facing at the time is that although I would change my attitude or my response to different things, it wasn't gonna change my community, right? And the members of my community that are actually the source of my stress.

Similar to Meena and Nasima, Lena spoke about having a need to navigate issues within her family through culturally-informed means. When discussing issues related to boundaries within the family, Lena emphasized how differences in cultural norms required more "creativity in figuring out how to assert boundaries." This need for creative boundary-setting strongly intersected with her identity as a South Asian woman "(…) especially not just as somebody who's South Asian, but like a South Asian woman because growing up, I had to be the good Indian girl, right? I had to be perfect and people may not like, understand that nuance." Lena further noted that her need for relational skills extended beyond issues within her family, and related to her desire to also build a stronger social support network. She expressed lacking the tools needed to make friends and build a support system outside of therapy, and described wishing that there was "more encouragement and emphasis on building coping skills and tools" that were "holistic" and not just therapeutic in nature.

4. Helpful Elements

The following theme captures elements from participants' psychotherapy experiences that they found to be helpful or supportive in their overall journey. The following subthemes are presented: *a) psychoeducation*, *b) feeling heard*, *c) shared identity, d) practical solutions,* and *e) non-traditional modalities.*

4a. Psychoeducation. For Oshani, Nasima, and Lena, a valuable component of their psychotherapeutic experiences involved receiving psychoeducation—that is, times when their therapist provided them information that helped them understand and/or cope with mental illness. In Lena's second experience with psychotherapy, her therapist provided her with "a lot of psychoeducation" and resources related to mental health (e.g., podcasts, books). Lena spoke about how having psychoeducation was instrumental in her psychotherapy due to requiring a sense of understanding "what was happening to [her] and what was going on." Through receipt of psychoeducation, Lena reported shifting from a place of emotional disconnection to emotional regulation:

> I went from somebody who had like the concern of...there's like a disconnect between my brain and my body in the sense that I'm just like crying or I'm having these symptoms, but I don't feel anything. I don't know what's wrong with me to a point where I was intensely feeling all my emotions and underwent like severe like mental health crises, and now to a point where I am slightly better at regulating them. So, I think over time I have learned a lot and understood a lot and it's just been so helpful.

Like Lena, Oshani and Nasima initially struggled with understanding their own mental health experiences. For Oshani, psychoeducation related to "basic psychological concepts," such as information related to cognitive distortions, gave her the "language to understand [herself]." This new language also allowed her to communicate what she was experiencing to others with greater ease. In Nasima's case, psychoeducation about "dysfunctional family systems" played a critical role in helping her understand the dynamics at play within her family. She credited psychoeducation with helping her to "rationalize" her experiences as opposed to "placing the whole blame onto [herself]." In turn, she found herself able to "make sense" of her experiences and comprehend that the "cause and effect [of her family situation] was much larger" than the scope of her own actions.

In addition to providing information to make sense of their experiences, Nasima and Lena both credited psychoeducation with helping dispel stigma around mental health or psychotherapy. Lena spoke about how her sessions with her psychiatrist involved psychoeducation that helped her rethink "(…) stigmas around medication and mental health." For Nasima, psychoeducation allowed her to re-conceptualize and better understand the nature of psychotherapy as a treatment. She expressed how one of her "biggest stereotypes" coming into psychotherapy was that "(…) you have to be in therapy forever and there's no end to it." Through psychoeducation, Nasima came to view psychotherapy as "any other treatment" that allowed her to come in with an issue, receive tools or support, and continue or discontinue at her own will.

4b. Feeling Heard. Several participants spoke about how having a safe space to vocalize their emotions and feel seen contributed positively to their psychotherapy experience. Meena talked about seeking therapy to find "validation for the grief [she] was experiencing." By simply having a space to share her experiences and have her emotions validated, she was able to feel that a "weight lifted off [her] chest." Similarly, Oshani appreciated having the opportunity to share her experiences in a space that was "confidential" and not connected to her family.

For Nasima, entering into psychotherapy for the first time was a kind of "surrender," whereby she allowed herself to be vulnerable with, and supported by, her psychotherapist. She spoke about how this experience was "freeing," particularly due to feeling validated by her therapist. Nasima also described how her therapist's validation felt unusual for her given her own experiences with invalidation from her community: "Like in my community, it's as a woman, if I speak or if I give opinions or if I make certain observations, I'm going to be constantly questioned, right?" Through therapeutic validation, Nasima reported being able to begin to establish trust with her therapist—a major step given her initial skepticism. She highlighted that her therapist's "genuine empathy" and lack of judgement ultimately made a significant difference by increasing her own feelings of safety and comfortability in the therapeutic space. Moreover, Nasima emphasized that experiencing validation from her therapist led her to recognize her own needs:

> I felt like one of the biggest realizations that I had was that I feel like in our community there's a lack of empathy, a huge lack of empathy for the sake of like being practical, you

> know, working. Like there's a cultural element to it. And so, I realized there was a need for softness that I experienced in either of these sessions.

Here, Nasima sheds light on what she perceives as a lack of empathy or emotional validation her community. When juxtaposed to validation from her therapist, she was able to clearly identify her own need for "softness" or empathy.

4c. Shared Identity. For Thurga, Lena, and Nasima, having a therapist with a shared cultural or ethnic identity was beneficial to their psychotherapeutic experiences. Thurga described how having a South Asian clinician present during her equine group therapy experience helped to increase her feelings of safety within the space. She noted this was particularly helpful given her geographic location in Alberta where, up until that point, she had experienced therapeutic spaces that were predominantly White:

> (…) it helped having [the South Asian clinician] there 'cause I felt more safe 'cause I typically—I don't feel safe in like White spaces just because I'm a person who is very vocal and if um, I'm going to call it for what it is. I don't... like Alberta is a very much like "nice" racism. It's not blunt, like calling you the N-word type of thing. It's like little microaggressions, like things like that, that people don't want to admit that they're being racist because it means being considered like the bad person.

Thurga further highlighted how being located in Alberta directly connected to her feeling unsafe in White therapeutic spaces. She expressed that having a South Asian therapist was particularly valuable due to her experiences of racism in Alberta, as well as the dearth of South Asian representation within the province itself. She noted that her preference for a South Asian therapist would not be present "if [she] lived in Toronto" due to the "natural support" emerging from having a "(…) a massive South Asian demographic, where you have accessibility to different South Asian services, food, culture." Thus, Thurga's preference for a South Asian therapist was contextually related to her geographic location.

In Lena's experience, having a South Asian woman as a therapist was an "empowering" experience that helped to increase her feelings of connection with both her therapist and her own identity. In describing the process of connecting with a South Asian therapist, Lena spoke about how, after her first few rounds of psychotherapy, she intentionally sought a therapist who was a person of colour and queer-friendly. She expressed that she made this decision in order to help her unpack and grow past "a lot of internalized racism." Lena eventually was paired with a

therapist that was a South Asian woman through a community grant program for low-income individuals. She described how her therapist was also an immigrant like herself, which she found to be valuable given the therapist's greater understanding of the immigrant experience. Specifically, Lena highlighted how her therapist understood that the mental health concerns of immigrants are often "(…) linked with quote unquote, practical or real-life concerns." Lena further expressed that having shared identities with her therapist, such as being a South Asian woman and an immigrant, was "freeing" and allowed her to feel "seen" by her therapist. In particular, the experience enabled her to access "locked away parts of [her] identity" that she had initially wanted to move away from. Through this, Lena described being "able to integrate my South Asian identity and understand that I can decide who I want to be and how I—like I make the rules." Consequently, having a therapist with a similar background helped to promote both an ease in therapeutic understanding and an integration of Lena's own identity.

Like Lena, Nasima spoke about how working with a therapist with a shared background allowed her to feel seen in the therapeutic space, and further provided her with tools and solutions that were culturally-relevant. She specifically highlighted her experience with her second therapist who, like her, was a young Bengali Muslim woman. Nasima was paired with this therapist through her Employee Assistance Program, and noted that she did not seek a therapist with a specific background when reaching out. However, Nasima ultimately found being paired with consideration to her identity to be highly useful to the therapeutic process. She spoke about how having shared identities (i.e., ethnicity, gender, religion) with her therapist allowed her to feel "(…) seen by a person through [her] multiple layers" which included "South Asian, Bengali, third culture, different experiences." Through this, Nasima found relief and validation in not having to explain the cultural or religious "subtext" of her experiences during psychotherapy. In addition, given their shared background, Nasima spoke about how her therapist was able to provide her with "solutions that were more community focused, community driven, a little bit more spiritual as well." Taken together, Nasima expressed that these solutions enabled her to help not only herself, but also her community.

4d. Practical Solutions. Two participants, Nasima and Meena, highlighted the usefulness of practical solutions or tools their therapists offered. For Nasima, these practical solutions directly tied to her cultural and religious background. Specifically, Nasima's therapist helped her navigate familial and community-related issues by connecting Nasima's values with a religious

text. Nasima reported that bringing religious texts into therapy was not originally her therapist's intention, but became a tool that her therapist introduced after recognizing that it may be relevant for her. Employing religious texts within the sessions was a practical tool made possible particularly given the therapist's shared cultural and religious identity with Nasima. Nasima described the following to convey how her therapist led her to develop practical, community-oriented solutions to her issues:

> (…) she did it [bringing in religious texts] in a way that it brought my kind of values, which is like, you know, taking care of the community and all that. She said, you can't take care of the community, you can't serve, you know, God and all these things, if you are now accepting, right, the indulgence of your mom who is probably in error in her way, right? And so, she kind of put it together in a narrative that's like helpful for me, but also a narrative that I could use to explain to my community. Here is the issue. Here is the real issue here. So, she helped me put those things in perspective and kind of offered me different religious texts and different things that we would touch base on, but she would always tie it back to different religious things that we would talk about at the end.

In Meena's experience, solution-focused therapy was particularly valuable. Her therapist employed this approach to help her navigate PTSD symptoms (e.g., replaying experiences, persistent panic) by developing practical, everyday solutions. Specifically, her therapist provided her with tools for grounding and pathways to reduce the risk of re-traumatization. For Meena, these solutions permitted her to get outside of a more cognitive, "philosophical" space and instead find tools to "take back control."

4e. Non-Traditional Modalities. Oshani and Thurga both spoke about the value of experiencing non-traditional (or non-Western) therapeutic modalities. Both participants specifically defined these approaches as not aligning with "talk therapy," of which they had each previously experienced. Oshani expressed feeling that, while talk therapy and cognitive-behavioural therapy (CBT) had been helpful, many of these changes were "hard to maintain" due to "ingrained" automatic thoughts. Her subsequent therapist introduced somatic work where the therapy focused on the connections between the body and the mind. Oshani described that, while it had initially felt "silly," after beginning to implement the somatic exercises, she found that they "resonated" with her more than CBT techniques. She highlighted that these techniques allowed her to "connect" with her body and its sensations—a novel change given how she was

"(…) someone who's in [her] head a lot." Oshani further expressed that she continues to utilize these somatic techniques several years after the end of her work with this therapist due to the tools' alignment with her needs.

Similar to Oshani, Thurga described previous experiences with "traditional therapy" as ineffective for her. She spoke instead about resonating deeply with equine-assisted therapy—a therapeutic modality that involves the use of horses to help facilitate emotional processing and behavioural change. Thurga described how her work with equine-assisted therapy felt more "profound" in nature, and allowed her to generate personal insights about herself that she was not experiencing in traditional therapy:

> So initially when I would enter [the horse] enclosure, I was hovering behind people, hiding behind people. And I noticed that like they represented the emotions that I didn't want to deal with... basically, I was just like, nope, not dealing with it. I'm going to put it in a box or like, I'm not really going to address this unless I'm at home alone crying in a corner or something like that. But so, that was very insightful, I guess, because as I continued to work with the horses, I felt more open and welcoming, which now I notice like when I start feeling those rough feelings, I just allow it versus like fighting it or just being like, nope, not going to deal with this. Like just being avoidant with it. So, that's kind of given me some concrete steps versus like [with] traditional therapy.

Thurga also spoke about how she found a sense of comfort in not feeling "judgement" from the horses—a feature which she highlighted as being a "negative thing" present in her experiences with traditional therapy. Expanding on this, Thurga emphasized the value in working with a horse that "(…) doesn't really care what color you are or like what you bring or how you look or, you know, and they're not verbally saying, 'Yeah, that's a pretty stupid thought,' like they're just there, they just exist." Thus, equine-assisted therapy was beneficial for Thurga given its disconnection from the social world and potential forms of prejudice or judgement. With equine-assisted therapy, Thurga found solace in the inherent neutrality of horses.

5. Psychotherapy in the Future

The subsequent theme conveys how participants described seeing psychotherapy fitting into their future. Subthemes capture elements that participants either desire in their future therapy experiences, or they see as potentially impeding them from accessing psychotherapy in the

future. This includes the following subthemes: *a) need for intersectionality, b) seeking shared identity*, and *c) financial barriers*.

5a. Need for Intersectionality. Several participants spoke about having a need for their future psychotherapist to take an intersectional approach in therapy. In other words, participants described wanting their future therapists to recognize how other facets of their identity, in addition to being South Asian, impacted their experiences in life. Oshani emphasized the value of a more "individual" approach, such that therapists engage in a process of "(…) humility to learn about different variations [of South Asian women's identities] and not make assumptions around like, us being like, quiet, shy." Meena and Nasima both spoke about this need for intersectionality through the lens of migration. For instance, Meena described hoping that therapists would work to understand the "unique struggle" of trying to reconcile "multiple cultural identities" as a South Asian immigrant woman. Nasima shared a similar sentiment, expressing that migration (either personally experienced or through familial history) played a major role in understanding the mental health of South Asians. She spoke about how therapists should prioritize understanding such intersections by potentially "forefronting" these topics in the first few sessions.

Nasima and Lena further described a need for their future therapists to account for the specificities of being a South Asian woman. As a South Asian woman, Nasima expressed having "multiple roles and responsibilities" within her community. She highlighted the necessity of having a therapist be "mindful and sensitive to these challenges [of having multiple roles]." On a similar note, Lena emphasized the importance of therapists making space to understand potential gendered community expectations. She provided an example of growing up in a "conservative community" whereby it was expected that her "purpose in life" was to be a "good wife." Lena noted that these expectations ultimately "impacted [her] self-esteem and self-worth."

In addition to highlighting gender as an intersectional feature, Lena spoke about the need for therapists to understand other intersecting features that shape her and other South Asian women's experiences. Although not directly applicable to herself, she mentioned how the realities of "entrenched casteism" may tangibly impact the mental health of South Asians belonging to lower castes. Moreover, she described the importance of having future therapists understand social climates and their impact on South Asian clients' experiences. Here, she specifically pointed out the presence of racism in Canada: "I do think it would be so important

for [therapists] to understand the intricacies of what it looks like to exist as South Asian in Canada right now given the racism and increased hate against South Asians, especially online."

5b. Seeking Shared Identity. When asked to describe potential qualities they would seek in a future therapist, three of six participants expressed wanting a therapist with a similar or shared identity. All three participants emphasized seeking shared identity due to wanting their therapist to have greater familiarity with their own culturally-specific experiences. Meena, when reflecting on the issues that had initially brought her to psychotherapy, described how it would be helpful to have a therapist who "(…) gets South Asian culture and just how much—you know, how challenging your in-laws can be." Meena spoke about the "huge mental responsibility" involved in previously disclosing her struggles, and the frustrations involved with having to repeat her narrative due to therapists not being able to fully understand or help her:

> Like you're saying stuff, divulging all these things, and it's a lot of mental effort to pull stuff that you don't really want to be thinking about out to the front and to talk about it and think about it because it causes panic. It causes more depression or negative feelings and, you know, you're avoiding that and when you're not getting anywhere with the person you're talking to, um, it's disheartening.

Consequently, Meena's preference for a therapist with a shared cultural background was rooted in her own past experiences of feeling misunderstood or unsupported. She noted that—while she was not particularly fixated on her future therapist being South Asian—she ultimately struggled to find non-South Asian therapists who could understand South Asian culture.

Similarly, Kirat's desire to have a therapist who had "familiarity with [her] culture" was connected to her negative past experience with psychotherapy. She described how she felt that she had previously attempted to "justify" and "explain" herself to her past therapist—an experience that she was not interested in repeating. Like Meena, Kirat also expressed not requiring her future therapist to be South Asian. Instead, she spoke about a preference for a therapist that had a "(…) lived experience of growing up in a culture that their parents aren't part of the majority."

Thurga expressed wanting her future therapists to be "people of colour." She emphasized how her geographic location in a "primarily White community" oriented this preference. As previously mentioned, Thurga highlighted how living in Alberta and lacking local South Asian representation resulted in her feeling more "sensitive" toward issues of "relatability." These

sensitivities toward relatability were further exacerbated by her own negative experiences with White therapists and racism in Alberta. Consequently, Thurga reported wanting to ensure that she accessed providers who were "(…) somewhat similar in ethnic background or socioeconomic status" given "(…) how much harm it can be when you find the wrong practitioner and the damage inadvertently that they do just by not saying or doing the right things in a therapeutic environment." Nonetheless, Thurga emphasized the difficulties associated with finding a therapist meeting her desired characteristics, pointing out that it is "(…) very rare to find proficient therapists of colour who could relate."

5c. Financial Barriers. For Meena and Lena—despite wanting to continue therapy—financial issues posed a barrier to accessing psychotherapy again in the future. In Lena's experience, all of her therapy experiences had ended due to either limited sessions (imposed by her university and a community grant) or insurance-related issues. She emphasized her desire to continue with therapy, expressing she felt it was "(…) very important for me to still be in [therapy] because each time I've quote unquote graduated from therapy, it wasn't necessarily because I wanted to." Lena further noted that publicly-accessible services often had "really long" waiting lists, and that many therapists' sliding scale fees were also unaffordable for her current financial situation.

Similar to Lena, Meena described how she struggled finding affordable therapists after completing EAP therapy that had a session limit, expressing that finances were the "only barrier" and a "deterrent" for her to get back into psychotherapy. Meena spoke about how she had initially accessed EAP due to its affordability. However, she ultimately found it to be dissatisfying due to either a lack of connection with the therapists or being unable to continue with a therapist after completing the limited number of sessions offered. She reported that she was actively looking at different options for psychotherapy, including mental health platforms such as BetterHelp—an online counselling platform aiming to provide reduced cost, virtual therapy with licensed therapists. However, Meena expressed that all options that she had looked into were "very expensive for [her] salary." Meena also noted worrying about committing to a therapist that was not the right fit and, as a result, paying out of pocket or using up her insurance:

> We are talking here [about] doing two or three sessions, where, what if I don't find the person, right? So, I've just out of pocket—or let's assume I haven't used my insurance for this year. I'm gonna use the entire capped amount of whatever my private insurance

covers, and then I'll be out of it. And then I'm like, OK, the next one I find, the next therapist I find, I have to pay out of pocket. And what if she's not a good fit again?

Consequently, Meena's previous experiences of lacking fit with psychotherapists also contributed to her concerns about potentially misapplying her limited funds to the 'wrong' therapist.

6. Community Context

This theme describes elements from participants' experience that they identified as linked to contextual influences from their community. Participants described elements they considered to be potentially meaningful or present throughout their psychotherapeutic journey (i.e., before, during, and after psychotherapy). Subthemes include *a) generational differences* and *b) traditional healing*.

6a. Generational Differences. Several participants briefly described observing differences in perceptions of mental health and psychotherapy between older and younger generations in their community. For instance, Kirat spoke about how, while her parents' generation, viewed psychotherapy as a "Western way of doing things," perceptions were "completely different" within her own generation. Lena, Thurga, and Nasima described how older generations' negative perceptions toward psychotherapy and mental health were also changing due to influence from youth. Nasima expressed how she herself played an integral role in initiating this change within her community. She spoke about how, in order to help others experiencing mental health challenges during the COVID lockdown, the "(…) older generation has had to change their focus, try to understand it [mental health] more." To support increasing her community's understanding, Nasima described bringing information to her community—particularly by sharing her own experiences of psychotherapy. She emphasized that generational differences in understanding were likely due to a "(…) lack of knowledge, readily available knowledge that existed out there for the older generation, what it [mental health] is, different services, different things." Consequently, while many participants described having experienced stigma toward mental health and/or psychotherapy within their communities, they highlighted how younger generations were experiencing shifts in understandings of mental health.

In Thurga's perspective, social media played a major role in helping to facilitate a greater degree of mental health understanding amongst younger generations. However, she spoke about how portrayals of mental health on social media felt "glamorized" by influencers sharing their

struggles with mental health. Specifically, she questioned whether or not social media portrayals helped to lessen stigma toward mental health in the community. She provided an example, stating there were still "(…) certain topics you can't talk about [in the community], like suicidality." Thurga further spoke about how she felt that, in spite of the younger generations' greater understanding of mental health, they were ultimately susceptible to stigma previous generations held. She expressed, "I think culturally there's still obviously a taboo and I think this generation is also unfortunately taking in how their family feels about mental health." Thus, while younger individuals in her community were more likely to be exposed to mental health information, Thurga doubted the notion that youth would not carry forward stigmatizing beliefs held by their community or family members.

6b. Traditional Healing. When describing interventions for mental health, Meena, Lena, and Thurga shared ways in which their communities practiced traditional healing. All three noted how prayer and attending religious services were considered an option that could help to rectify one's struggles with mental health. As Lena described, "(…) when it comes to anxiety, it was like, 'Oh, pray to God' or like, you know, 'Chant this mantra and that will bring you peace and comfort'." Meena spoke about she felt that recommendations to pray were dismissive of the degree to which individuals struggled with mental health, stating that "(…) there was no focus on getting the help needed and it's almost like you just put it as an afterthought that this person doesn't need help. They just need attention. They need to pray."

Thurga described how she felt that South Asian understandings of mental health were deeply rooted in spiritual or more traditional conceptualizations of health. She expressed the following: "I guess South Asian people, their understanding of mental health is like, 'Oh, send them to the *koyal*[3]' or like, you know, 'We're going to send them to the 'woo woo' [traditional healing] doctor'." Thurga emphasized how traditional practices such as Ayurveda were commonplace in the community stating that, in her family, "(…) you don't go to the doctor, you just figure it out at home." She expressed feeling that her exposure to traditional health practices increased her own receptivity to non-traditional modalities of psychotherapy. Her experience with equine therapy described in a previous theme demonstrated this: "I'm open to [equine therapy], I think because of the type of Ayurvedic stuff that my family would do." She specifically highlighted resonating with the more "holistic health" components embedded within

[3] Koyal [Tamil] = "Temple"

her equine-assisted therapy, including acupuncture, mindful meditation, aromatherapy, and somatic work. As such, Thurga's upbringing with traditional healing practices positively influenced her own ability to resonate with a less traditional or 'alternative' therapeutic modality such as equine-assisted therapy.

7. (Not) Talking Psychotherapy.

The following subthemes reflect participants' decisions to disclose, or not to disclose, their experiences in psychotherapy with others in their life. Subthemes include *a) secrec*y, *b) lacking support*, and *c) sharing information with community*.

7a. Secrecy. Most participants reported that they had not discussed their psychotherapy experiences with their family or had intentionally provided very few details. As such, participants' psychotherapy experiences were often shrouded by some degree of secrecy when it came to family discussions. Kirat expressed that she had told her parents that she was attending psychotherapy "(…) for science, to learn what I'm going to do." She emphasized that she connected her education and future career in psychology to this explanation as she felt that it would be "understandable to [her parents]." Likewise, Thurga stated that, in place of telling her parents that she was attending equine therapy, informed them that she was "(…) seeing horses every Sunday." Thurga noted that she felt that her decision to not tell her parents about therapy was a result of her own upbringing whereby discussions of mental health were "hush hush" or simply not discussed.

Both Lena and Oshani spoke about finding ways to prevent their family members from finding out that they were attending psychotherapy. Lena stated the following when expressing how she feared her "very controlling parents" would know that she was in psychotherapy: "(…) at some point I was paying for therapy in cash because I did not want them to see that on my bank transactions." Similarly, Oshani noted that they had intentionally not submitted insurance claims for their psychotherapy due to having been under their parents' insurance at the time. Thus, like Lena, Oshani also feared her parents finding out that they were attending psychotherapy. When describing her fears, Oshani spoke about experiencing "internal pressure to not share [her experiences]" due to her worrying that her parents would believe she was not doing well. She noted that, at the time of her attendance, she had been "doing fine" and had chosen to go to psychotherapy to ensure she would not "(…) fall back into a bad place again." Consequently, Oshani's secrecy regarding her psychotherapy experiences was preventative in

nature, such that it helped to ensure that her parents would not become concerned for her well-being.

7b. Lacking Support. For several participants, feeling a lack of support from their family members was linked to their decision to not disclose their psychotherapy experiences. Both Lena and Thurga described lacking a feeling of safety in divulging their experiences. Lena's decision to not disclose information extended beyond psychotherapy: "Nobody in my family knows that I've been on medication or been to therapy or been hospitalized or even struggled with mental health issues at all, just because they [her family] did not feel like a safe space to do that." Thurga emphasized that her choice was connected to her "(…) cultural upbringing of not talking about your feelings" whereby "you hide your feelings, you cry in silence (…) that's just what I experienced growing up. So, I knew that it wasn't safe for me to express those types of things." She highlighted that choosing to discuss mental health had the potential to result in her being "labeled *pythium*[4]" by her family or, alternatively, to be met with unhelpful responses such as "*uthan vidhi*[5]." Consequently, perceived dismissiveness and a lack of support from her family contributed to Thurga's feelings of unsafety. Thurga further spoke about how her upbringing impacted her other relationships in her life, including with her in-laws. She noted that she struggled to talk about her mental health experiences despite her White in-laws having encouraged her to do so:

> It was always a resistance because you're not used to that. You're not used to this type of family dynamic, which may or may not be healthy. But to me, it felt like I was under attack. I was like, "I'm not going to tell you about my mental health." So maybe even that was a form of unconsciously something coming from my family upbringing where I was very defensive, like "What? I'm not going to talk to you about my mental health. Like who the hell are you?" And that is coming from like my upbringing of like you don't talk about mental health.

Thurga highlighted what she perceived to be differing cultural dynamics occurring within her interactions with her in-laws, expressing that she felt that "(…) mental health is more accepted within White families versus brown families." As such, for Thurga, a lack of support

[4] Pythium [Tamil] = "Crazy"
[5] Uthan vidhi [Tamil] = "That's your fate"

and acceptance for mental health within her own family led to a generalized "resistance" to discussing her experience with others.

Meena also expressed opting to avoid discussions of mental health with her family due to a lack of support. She highlighted that—through previous conversations with family members—she had "(…) learned not to talk about specific things or just not, you know, that you talk about certain things with certain people, depending on what the reaction is." Specifically, she noted two factors as contributing to her decision to not disclose, including feeling disinterest from her parents when discussing mental health, as well as perceiving "negative associations" around mental health from others in her extended family. Meena spoke about how she felt that it "takes a person who's empathetic and responds a certain way to be able to divulge [mental health experiences]" and that it was not necessary to "poke the bear" by discussing mental health in environments where such conversations were stigmatized or dismissed. While she had not personally been able to discuss her psychotherapy experiences with many of her family members, she emphasized the potential benefits of doing so in other contexts: "I feel like there's a lot of healing that comes through with being able to talk that openly with someone about therapy and I haven't been able to do that with any of my family."

Thurga and Nasima both spoke about how being a South Asian woman intersected with potentially lacking support from the community. Nasima described how South Asian women have "multiple roles and responsibilities" including family caretaking which, part and parcel, generally involved lacking a "supportive figure" for oneself. In Thurga's perspective, South Asian women "do (…) and don't have a lot of support." She expressed that, while South Asian women could find support through their friends, they were often "disenfranchised" by their families who were "(…) causing them some of the distress or [were] the reason that they're seeking out counselling." Thus, seeking out support from one's family could be perceived as out of the question for women whose families were one of their primary concerns.

7c. Sharing Information with Community. Three of six participants described sharing information about psychotherapy with others in their community. Information shared was largely educational in nature (e.g., related to seeking or engaging with psychotherapy), and not typically descriptive of participants' personal experiences. For instance, Thurga provided information related to her equine therapy experience, primarily "(…) because [she] wanted them to experience it for themselves." She expressed that her decision to discuss her experience was

shared “more so as a resource.” For Lena, this involved talking with friends who were considering therapy or had questions about therapy processes. She reported providing information in order to help “normalize going to therapy” and described instances where she had shared her experiences to help friends identify issues such as a lack of therapeutic fit or therapy “resistance.” Similarly, Nasima talked about how she helped out friends to “demystify [her] experience” with an employee assistance plan (EAP)—a conversation which ultimately resulted in one of her friends reaching to their own EAP for a consultation.

Nasima also described how she pursued psychotherapy in order to share her first-hand understanding with members of her community. She expressed engaging in this task due to a “lack of knowledge” available to the older generation. When speaking about therapy to community members, Nasima emphasized how engaging with psychotherapy did not necessitate taking medication which was “(…) really appealing because not necessarily everyone wants to go through that route [taking medication].” Consequently, by directly partaking in psychotherapy herself, Nasima was able to share information with members of her community that showcased potential treatment options.

Chapter Five: Discussion

In the previous chapter, participants' experiences were described linearly along their therapeutic journey—in other words, experiences as occurring before, during, and after psychotherapy. Descriptions of participants' experiences 'before' psychotherapy focused on their perceptions of mental health and psychotherapy, as well as their decision-making related to seeking out help. The 'during' psychotherapy stage focused on illuminating participants' experiences within therapy itself, including the nature of their therapeutic relationship and the overall process of their therapy. Finally, the 'after' psychotherapy stage elaborated on participants' outcomes following psychotherapy, and whether or not they were interested in seeking psychotherapy in the future.

The following discussion chapter will provide an interpretation of results as oriented around the before, during, and after of participants' psychotherapy experiences. This interpretative approach will be utilized in order to help shed light on the study's research question: "What are the lived experiences of South Asian women who engage in psychotherapy?" I will then re-examine my pre-understandings related to the research question and explore implications for counselling practice. Finally, I will review study limitations, propose recommendations for future research, and provide a conclusion.

Interpretation of Results

To interpret results, I provide a narrative approach focused on understanding psychotherapy accessibility and use. With regard to structure, the interpretation of results will be organized around the before, during, and after of participants' psychotherapy experiences. In order to build a more cohesive narrative understanding, results will nonetheless be pulled from across all timepoints to create a richer, more inclusive appreciation of participants' experiences as they unfolded. As such, themes and subthemes will not be interpreted independently, but holistically and in relation to other themes. I will specifically focus on key elements that initially propelled the study's research question, including perceptions and beliefs regarding mental health and psychotherapy, overall service accessibility (including barriers and supports to service use), and community conversations about mental health and psychotherapy.

I will begin by discussing how participants conceptualized mental health and psychotherapy use prior to beginning psychotherapy themselves. I will then describe how participants initially sought psychotherapy, and then analyze therapeutic needs as they occurred

during their psychotherapy experience(s). In addition to therapeutic needs, I will examine how participants navigated the primarily Western therapeutic context of their psychotherapy experiences with particular attention paid to therapist positionality and culturally-responsive care. Finally, I will discuss participants' desires for greater understanding in their future psychotherapy experiences as well as anticipated barriers to future therapy. Throughout this discussion, I will embed counselling literature that guides and supports my interpretations of participants' experiences. Using participants' demographic information, I will incorporate an intersectional analysis within my interpretation of the results. Implications for therapy and counselling will also be woven throughout the discussion. Importantly, all results are considered to be delimited to the experiences of South Asian Canadian women.

Before Psychotherapy: Conceptualizing Mental Health

In this section, I address different ways participants perceived and understood mental health and psychotherapy prior to having their own psychotherapy experiences, with a focus on stigma, lacking information, shame, generational differences, and the resilience myth. Contextual elements, such as community influences, are also emphasized, ending with implications for receptivity to psychotherapy and service use.

Stigma Reinforcing a Lack of Information. Mental health stigmatization in South Asian communities may be a major obstacle toward seeking psychotherapy (Islam et al., 2017; Karasz et al., 2019; Prajapati & Liebling, 2022; Rastogi et al., 2014). The presence of stigma was a reality highlighted by several participants in the study—a result which typically occurred in conjunction with participants feeling their communities lacked information related to mental health or psychotherapy. For instance, two participants, Lena and Meena, spoke about how relatives in their family struggled with mental illness. In describing their relatives' realities, Lena and Meena both noted that medication was used as the treatment of choice, with Meena expressing that the medication was "poorly managed." They both emphasized that their families did not view psychotherapy as an option due to a lack of knowledge about different treatment options or, alternatively, an unwillingness to know more about other options. Given the reality of mental health stigmatization, an unwillingness to learn more about different treatment options may be unsurprising. As Lena described, simply discussing mental health had the power to reflect negatively on an individual's character, implying that there was something inherently "wrong" with the individual. Likewise, Thurga noted that—aside from fantastical and often

degrading depictions of mental illness—mental health was a subject that was not to be discussed within the family. Consequently, existing stigma and general dismissiveness toward mental illness may potentially reinforce a lack of readily available information (regarding mental health or psychotherapy) within the community. In other words, stigma may help to promote an unwillingness toward increasing mental health knowledge which, as a result, contributes to a greater lack of information in the community. This cycle of reinforcement is demonstrated via Lena and Meena's descriptions of their family members' experiences with mental health, whereby discussing their family members' mental health or seeking out other treatment options was both simultaneously unheard of and likely to be shunned. Research demonstrates that, indeed, self-stigma and negative attitudes toward mental illness may decrease the likelihood of seeking mental health information (Lannin et al., 2016). As such, the presence of stigma towards mental illness may perpetuate and reinforce the reduced availability and knowledge of mental health information within South Asian communities.

Growing Awareness. Although participants emphasized the presence of stigma and the lack of information in their communities, several reported having a greater degree of knowledge relative to their community members. This difference in relative knowledge may be attributed in part to what participants highlighted as generational differences. In Thurga's perspective, younger generations of South Asians in Canada were more likely to have been exposed to mental health information via sources such as social media. On a similar note, Kirat noted that while her parents' generation viewed therapy as inherently 'Western,' this was a perspective that was unlikely to be held by her own generation. Indeed, younger generations of South Asians may be more likely to independently seek out psychotherapy than older generations who, instead, are more likely to receive treatment via primary care referrals (Rastogi et al., 2014). Given that this study's sample consisted entirely of participants between the age range of 20 to 40, participants in this study may have been more likely to be knowledgeable of and receptive towards psychotherapy due to their relative age.

Another critical detail that may inform a client's knowledge of and receptivity toward psychotherapy may be their degree of acculturation (Miller, 2007; Shapoval & Jeglic, 2016; Sun et al., 2016). To restate, acculturation is a process through which individuals or groups experience changes in culture and experience following continuous, direct contact with another cultural group (Ryder et al., 2013; Shapoval & Jeglic, 2016). Research based in the United States

suggests that individuals who report greater acculturation are more likely to view psychotherapy as a viable mental health treatment option (Miller, 2007; Shapoval & Jeglic, 2016; Sun et al., 2016). Acculturation levels may increase over generations, with acculturation "gaps" potentially occurring between second-generation children and their first-generation parents (Harris & Chen, 2023). Half of this study's sample consisted of second-generation Canadians and, as such, receptivity to engaging with psychotherapy may have been higher amongst these participants. Consequently, participants' awareness of mental health information and/or receptivity toward psychotherapy may be the result of key demographic features including age and migratory background. Thus, it may be relevant for therapists working with South Asian clients to be attentive to age and migratory background as they may potentially intersect with clients' knowledge of and receptivity toward psychotherapy.

Intertwining Shame and the Resilience Myth. Although not originally anticipated as a barrier to service use in this study, participants frequently described shame to be commonplace within their communities. Research suggests that shame may be a critical barrier to help-seeking for mental health struggles (Rüsch et al., 2014), particularly for South Asian women (Goel et al., 2023; Mustafa et al., 2017; Sangar & Howe, 2021). Literature also suggests a link between shame and courtesy stigma—a form of 'stigma by association' whereby family members experience discrimination or disapproval due to association with a mentally ill relative (Prajapati & Liebling, 2022; Sangar & Howe, 2021). As a result, shame may serve a functional, regulatory purpose (Pask & Rouf, 2018) in order to protect a family's honour from courtesy stigma (Sangar & Howe, 2021). While participants in this study expressed an increased understanding of and receptivity toward psychotherapy, several described how discussions of mental health were still shrouded in shame within the community. For instance, Nasima and Thurga spoke about how mental health struggles within their communities were either hidden or outright denied by families and individuals due to shame. In this regard, experiences of suffering were intentionally obscured to prevent potential social stigma. Unsurprisingly, participants in the study also reported their own secrecy about their mental health and psychotherapy journeys as they seldom discussed their experiences with others in their families. Decisions to remain private about mental health experiences may have been partially influenced by the presence of stigma or shame within communities and, consequently, the lack of support from community members.

Further amplifying the notion of shame for participants was the presence of a 'resilience myth' within their communities. As previously described, the resilience myth is a belief that individuals should single-handedly display strength over their struggles, such that they are able to conquer or withstand any form of suffering. As described by Kirat, attending therapy had the potential to convey an individual as "weak" or as lacking the skills to cope alone. Similarly, for Thurga, the resilience myth manifested as a form of suffering in silence, such that "[y]ou hide your feelings, you cry in silence." Alternatively, individuals could also turn to normative and acceptable forms of traditional healing such as prayer. By attending religious services or engaging in prayer, it was expected that individuals could alleviate their suffering without seeking external support. An additional manifestation of the resilience myth was presented in processes of "othering." In Lena's case, seeking out psychotherapy or experiencing mental health struggles happened to "other people." Her adherence to the resilience myth would thus result in her struggling to cope with her own mental health. For Oshani, this inability to adhere to the resilience myth concluded with her experiencing strong guilt and feelings of failure upon attending psychotherapy. Here, the resilience myth likely collides with the notion of shame in South Asian communities. By failing to be resilient, individuals face increased susceptibility to shame—thus resulting in feelings of guilt, failure, and potential identity dissonance. In this fashion, the resilience myth may also serve as a regulatory function that aims to reduce or extinguish experiences of shame.

The intertwining of the resilience myth and shame may be a critical barrier to help-seeking. First, adhering to the resilience myth may result in South Asian women seeking to be self-reliant when coping with mental health struggles. This self-reliance may reduce engagement with external supports such as psychotherapy. A subsequent failure to be self-reliant may induce experiences of shame which, as previously mentioned, may work to reduce courtesy stigma and hamper help-seeking (Pask & Rouf, 2018; Sangar & Howe, 2021). In other words, increased shame following the failure of the resilience myth may doubly lend itself to decreased help-seeking behaviours in South Asian women. As such, South Asian women experiencing shame and the resilience myth may find themselves having to reconcile these two factors before and during engagement with psychotherapy. Given the relationships between shame, self-harm (Sheehy et al., 2019), and suicidality (Kealy et al., 2021; Sadath et al., 2024), it may be critical for clinicians to identify shame and subscriptions to the resilience myth as potential risk factors

for some South Asian clients. The need to reconcile shame and the resilience myth is discussed in the following section.

Before Psychotherapy: Seeking Help

In this section, I examine processes and experiences occurring as participants made the decision to seek psychotherapy. Facilitators to service use are explored, including subthemes such as experiencing a crisis and service accessibility.

Reconciling Tensions: Hitting a Limit. Nearly all participants in this study first attended psychotherapy after experiencing some form of a crisis or, alternatively, 'hitting a limit.' This result was largely unsurprising given previous research with South Asian participants demonstrating similar findings, whereby South Asian clients attended therapy only after experiencing a crisis event (Kinha, 2023; Tummala-Narra et al., 2012; Yasmin-Qureshi & Ledwith, 2021). For several participants, adhering to the resilience myth by resolving their struggles alone was a normative reality. Indeed, seeking out support through their families or communities was unheard of or inconceivable due to the presence of stigma for these participants. For instance, Thurga expressed how community expectations dictated that individuals suffer in silence. She further spoke about how she viewed psychotherapy as an "emergency" option taken only when she felt that her life was "falling apart." On another note, for Nasima, family expectations as the eldest daughter necessitated that she not only resolve her own struggles alone, but also those of her brother. An inability for participants to successfully adhere to the resilience myth (i.e., by resolving their own struggles or those of others) thus resulted in crisis events. Participants' experiences of crisis were often reported by them feeling 'out of control' in some form, with several describing physical manifestations of their pain (e.g., vomiting, spontaneous crying). These manifestations thus alerted participants to the need to seek formal treatment and support.

Given the commonly reported presence of stigma in regard to mental illness, it is expectable that participants sought external support via psychotherapy only after exhausting their own capacities to cope alone. Of particular importance to this study was participants' need to reconcile tensions—including stigma, shame, and the resilience myth—before and after choosing to engage with psychotherapy. Participants reported how mental health struggles were often seldom discussed in their communities or were intentionally hidden away (possibly to prevent courtesy stigma within the family). In addition, the overarching narrative of the resilience myth

necessitated that individuals find ways to alleviate their own suffering—not ask for help. Thus, considering psychotherapy as a viable option required participants to experience challenges that felt insurmountable in nature which, consequently, entailed reconciling tensions between stigma, shame, and the resilience myth. After finding themselves in psychotherapy, tensions inevitably materialized early in psychotherapy. For some participants, materialization of tensions was demonstrated by their difficulty expressing their emotions. As described by both Kirat and Oshani, inexperience with discussing mental health—a key contextual element of their realities—led to difficulties being able to vocalize emotions in therapy. Likewise, Nasima struggled with reconciling shame related to her experiences while in psychotherapy. She spoke about how she grew over time to recognize her own avoidance with sharing shame-bound topics in psychotherapy. Ultimately, for participants in this study, tensions (i.e., shame, stigma, the resilience myth) related to attending psychotherapy initially presented themselves as barriers to psychotherapy. After experiencing some form of a crisis that facilitated their engagement with psychotherapy, tensions experienced prior to psychotherapy at times manifested again within the therapy room.

Ease of Accessibility. Financial barriers have been cited as a potential barrier to service accessibility for South Asian clients (Islam et al., 2017; Rastogi et al., 2014). Given that this study sought to interview participants who had engaged with psychotherapy, it is unsurprising that all participants had some form of means to attend psychotherapy. All six participants in this study accessed or had previously accessed psychotherapy through reduced cost means (e.g., insurance, free services, sliding scale options). None of the participants in this study reported having paid out of pocket for the entire duration of their psychotherapy experience(s). The availability of reduced cost or free services was a facilitating factor to engage with psychotherapy for some participants. As described by Kirat, sliding scale services that her university offered were a “big reason” for her to begin therapy given the cost associated with full-price psychotherapy. Likewise, another student, Lena, spoke about initially worrying about fees but was ultimately able to access reduced-cost services through her university. Thus, while finances were not initially cited as a barrier to service use for participants in this study, it is clear that costs associated with therapy was a concern for some participants. Interestingly, concerns regarding finances were particularly emphasized *after* engagement with psychotherapy, and are described further along in the discussion.

As previously described, participants may have had to reconcile several tensions, including stigma and shame, prior to engaging with psychotherapy. Although not explicitly described by participants in this study, such tensions may have previously coincided with financial barriers to therapy. For instance, in a study by Rastogi et al. (2014), clinicians working with South Asian clients described how stigma associated with mental illness intersected with an unwillingness to pay for services. Consequently, given the presence of barriers such as stigma and shame, reduced cost therapy options may also be an appealing option to clients contending with pre-existing tensions. In other words, in contexts where finances and tensions (i.e., stigma and shame) represent dual burdens to psychotherapy engagement, relieving one burden (i.e., finances via reduced cost or free services) may help to encourage individuals to 'test the waters.' Thus, for some South Asian clients struggling with stigma or shame related to mental health, reduced cost options may be a facilitator to first-time engagement with psychotherapy and ease overall accessibility.

During Psychotherapy: Therapeutic Needs

In this section, I examine participants' therapeutic needs as they occurred during their psychotherapy experiences. Needs are defined as elements of psychotherapy that participants highlighted as being particularly critical or essential to their experience in psychotherapy. Several subthemes are explored within this section, including feeling heard, shared identity, lacking cultural understanding, and psychoeducation. Intersecting subthemes are also drawn into the interpretation of participants' needs, including secrecy and lacking support.

The Value of Safety. In describing essential, helpful elements of their experience, participants reported strongly valuing therapeutic safety. The conceptualization of therapeutic 'safety' may vary (Podolan & Gelo, 2023); thus, within the context of these results, I define therapeutic safety as aligning with the notion of *emotional* safety, such that clients are 'feeling safe' as opposed to 'being safe' (Lyndon et al., 2023). Experiencing emotional safety in the therapeutic alliance may enable clients to readily share their experiences and emotions without fear of judgement (Mair, 2021; Rappoport, 1997). Some psychotherapists therefore view safety as an integral component for therapeutic change (Mair, 2021; Rappoport, 1997).

In this study, participants described two qualities of their therapy experiences as contributing to a core need of therapeutic safety: feeling heard and having a shared identity with therapist. As previously discussed, participants spoke about how they felt heard in psychotherapy

through their therapists' provision of emotional validation and empathy. Meena expressed that validation from her therapist allowed her to feel a "weight lifted off [her] chest," and Nasima felt that her own experience was "freeing." Nasima further described how experiencing emotional validation was a welcome change from experiences of invalidation within her community. She noted how feeling heard by her therapist helped to decrease her feelings of skepticism toward psychotherapy and increase her own comfortability. This contrast between emotional invalidation within the community and emotional validation within the psychotherapy space aligns with some participants' sentiments of lacking support from their communities. When discussing whether or not they chose to discuss their psychotherapy experiences with their families, participants overwhelming reported avoiding doing so. Common reasons cited for a lack of disclosure included stigma and cultural dynamics (e.g., not normative to discuss emotions). As expressed by both Lena and Thurga, it was not "safe" to discuss their struggles with mental health issues or experiences in psychotherapy with family members. Given the pertinence of lacking support within the community, feeling heard in psychotherapy may be especially valuable for some South Asian women. The experience of emotional validation and empathy within psychotherapy ('feeling heard') may serve to increase safety, particularly when—in past experiences of emotional vulnerability—emotional safety was not offered.

Having a shared identity with their therapist was another commonly mentioned quality that increased participants' feelings of safety within the therapeutic space. In contrast to literature signaling some distrust toward South Asian clinicians (Moller et al., 2016; Prajapati & Liebling, 2022), several participants in this study reported a desire for therapists with shared identities as well as positive experiences with therapists with shared identities. For Thurga, this need was particularly stressed due to contextual elements of her experience. As previously reported, Thurga noted how living in a predominantly White area contributed to feelings of unsafety with White therapists. She described being sensitive to therapists' nonverbal cues demonstrating dismissiveness or a lack of understanding—behaviours that align with research examining clients' evaluations of therapist's safety (Mair, 2021). Upon working with a South Asian clinician, Thurga expressed feeling "more safe" within the context of her largely White group therapy space. Indeed, a clinician's understanding of the contextual reality of a client may be a highly critical element of therapeutic safety (Lyndon et al., 2023). As Lyndon et al. (2023) highlight, patient or client safety integrates an acknowledgement towards and respect of clients'

historical sociocultural contexts. By sharing similar identities with their therapists, participants described feeling that they were able to be more fully understood by and connected to their therapist. As Nasima expressed, a shared cultural and religious background with her therapist allowed her to not have to explain the "subtext" of her experiences due to the implicit, shared understandings present in the therapeutic relationship. All in all, the ease of understanding involved in sharing identities with their therapist allowed some participants to feel safe within the therapeutic space—to be seen as they are without judgement or additional explanation.

Familial Distress and Cultural Understanding. Previous research suggests that, when compared to South Asian men, South Asian women may experience increased psychological distress when experiencing family-related conflict (Masood et al., 2009; Noor, 2018). As anticipated, two participants in this study, Meena and Nasima, cited family-related distress as a major point of concern bringing them to psychotherapy. Both participants described a need to learn relational skills in psychotherapy to better communicate with their family members; however, they ultimately experienced difficulties finding practical solutions or skills that were culturally responsive. Specifically, both participants expressed finding that the solutions or skills their therapists offered were individualistic in nature. Meena spoke about how, in trying to navigate issues with her in-laws, her therapist suggested that she try to "(…) come to terms with how someone has reacted." She emphasized that the disconnection felt with her therapist's approach was likely related to a lack of cultural understanding on the part of her therapist. As previously mentioned, Meena felt that her therapists were unable to fully grasp the nature of a "strong hierarchy in South Asian culture"—a critical element that was woven into her familial conflict. Consequently, her therapist's approach ultimately was unable to align with her contextual reality.

Likewise, Nasima found that her therapist focused on trying to change her own "(…) attitude or response to different things" which ultimately "(…) wasn't gonna change [her] community." However, Nasima's subsequent therapist was able to culturally adapt the tools and skills offered in psychotherapy. Specifically, her therapist provided her with relational tools attuned with her own values and religious identity (e.g., using scripture from religious texts to help facilitate communication with her mother). This provision of culturally-responsive care was supported by Nasima's shared identities (ethnic and religious) with her therapist at the time.

An additional factor of importance underscoring some participants' experience of familial conflict was the presence of cultural gender norms. As evidenced by previous research, gender expectations related to upholding traditional family norms may be related to increased psychological distress for South Asian women (Masood et al., 2009), particularly when experiencing difficult familial relationships (Noor, 2018). Nasima expressed sentiments that aligned with research suggesting stressors related to gender role constructs, describing that—in her experience—South Asian women took on "multiple roles and responsibilities" within the family (e.g., family caretaking). She further spoke about how such expectations contributed to South Asian women lacking a "supportive figure" for themselves. Lena also spoke about gender norms in her community, expressing that she grew up with the notion that she was expected to be a "good wife" and the "good Indian girl." Such expectations may be particularly pertinent to consider with South Asian women who are experiencing familial conflict, as failure to meet these expectations may potentially lend itself to greater friction within the family (Noor, 2018).

Ultimately, the experiences of participants in this study demonstrate a critical need for culturally-responsive care for South Asian women experiencing family distress. Indeed, prior research demonstrates the importance of cultural and religious sensitivity when working with South Asian clients (Islam et al., 2023; Naeem et al., 2024; Rastogi et al., 2014). Moreover, as previously discussed, approaches emphasizing individualism or personal autonomy may not resonate for some South Asian clients (i.e., the recovery model approach; Naeem et al., 2020), particularly when a client's source of distress is their family. Techniques that aim to divert clients away from core cultural beliefs and values may therefore be ineffective (Naeem et al., 2024) and may potentially deter further engagement with care. In addition, gender dynamics further influence the degree of psychological distress felt by South Asian women experiencing family conflict (Masood et al., 2009; Noor, 2018). Clinicians working with South Asian women experiencing familial distress may therefore aim to 1) explore and examine the potential role of gender expectations, and 2) work with the client to navigate issues through a culturally-responsive approach. Techniques to broach topics of race, culture, and ethnicity (REC; Day-Vines et al., 2020) may be particularly useful.

Putting Words to Feelings. For Kirat, Oshani, and Nasima, initial psychotherapy experiences involved some difficulty vocalizing their emotions. Given the aforementioned presence of mental health stigma within South Asian communities (e.g., Islam et al., 2017;

Prajapati & Liebling, 2022; Rastogi et al., 2014), this feature of participants' experiences is unsurprising. Participants spoke about how their lack of experience discussing mental health within their families and communities—potentially due to the presence of stigma—subsequently led to difficulties doing so in psychotherapy. For instance, Kirat spoke about how she struggled to "name emotions" in psychotherapy, and that this was likely connected to being from a culture where you "(…) don't talk about your problems." Similarly, Oshani expressed lacking an "(…) understanding of how to talk about [her] mental health." Kirat further offered two recommendations that she felt would have improved her therapy experience, including slowing down with increased patience from her therapist, as well as tools such as a feelings wheel to help guide her to identifying her emotions.

In psychotherapy, tools such as a feelings wheel may be used as a form of psychoeducation. As previously defined, psychoeducation is an intervention that involves providing clients with evidence-based information on mental health to increase levels of understanding and coping skills. Interestingly, psychoeducation was commonly cited as an element that was beneficial to some participants' psychotherapy experiences. Lena, Nasima, and Oshani all spoke about how psychoeducation their therapists provided aided with increasing their level of understanding in regard to mental health. As Oshani stated, psychoeducation provided her with "language to understand [herself]." Given the presence of mental health stigma in South Asian communities (e.g., Islam et al., 2017; Prajapati & Liebling, 2022; Rastogi et al., 2014), psychoeducation may be a critical need for some South Asian women in early psychotherapy experiences. As evidenced by some participants' experiences in this study, this need for psychoeducation may be particularly salient for clients with inexperience discussing their mental health. Literature suggests that psychoeducation may also help to dispel stigma or misconceptions related to mental health for clients arriving with internalized stigma (Alonso et al., 2019). Indeed, both Nasima and Lena spoke about how psychoeducation helped to reduce internalized stigma and increase their levels of understanding about mental health and psychotherapy. Findings from this study thus suggest value in psychoeducation as an intervention with South Asian clients. Psychoeducation with South Asian women in psychotherapy may help with putting 'words to feelings' for clients struggling to vocalize their emotions and may also aid with dissipating internalized stigma.

During Psychotherapy: Navigating the Western Therapeutic Context

The ensuing section describes how participants experienced psychotherapy situated within a Western, North American context. In particular, aspects such as the receipt of culturally-informed care, therapist positionality, power dynamics, and client context will be examined. Subthemes brought to the fore include difficulty vocalizing emotions, non-traditional modalities, and lacking cultural understanding.

Assumption of Trust. As previously described, several participants in this study reported having difficulties vocalizing their emotions early on in their psychotherapy experience. Difficulties vocalizing emotions were generally related to inexperience discussing feelings given cultural non-normativity. For Kirat, difficulties discussing her feelings clashed with expectations she perceived from her therapist. Specifically, Kirat felt that there was an "assumption of trust" from her therapist, such that she felt obligated to immediately disclose her feelings without a gradual development of trust over time.

An 'assumption of trust' aligns with the concept of the fiduciary relationship in psychotherapy. As defined by the Canadian Counselling and Psychotherapy Association, the fiduciary relationship between therapist and client implies that the therapist is in a position of fidelity and trust to the client (CCPA, 2021). In other words, the client may entrust the therapist to act with integrity to uphold responsibilities (e.g., confidentiality, ethical care) in the therapeutic relationship. While the assumption of trust may have been a normative element of psychotherapy to Kirat's therapist, it ultimately conflicted with Kirat's own capacity to discuss emotions. Given Kirat and other participants' inexperience with discussing their emotions, this may be unsurprising. It is possible that, for some South Asian clients with inexperience discussing feelings, the assumption of trust present within some therapists' conceptualization of the fiduciary relationship may be problematic. For instance, both Oshani and Kirat reported requiring time to open up to and develop a relationship with their therapist. As such, the act of entrusting a therapist (i.e., embracing the fiduciary relationship) may not feel immediately accessible to some South Asian clients given the novelty of vocalizing of emotions. Thus, approaches embodying an 'assumption of trust' may not be culturally responsive in nature. Clinicians therefore may benefit from attuning to South Asian clients' readiness (or lack thereof) to discuss emotions or feelings without deferring to an assumption of trust.

An additional element that may have interfered with participants' trust in and vulnerability with their therapist was their therapist's positionality. Thurga spoke about how she hesitated to "fully reveal [her] inner, darkest feelings" due to feelings of guardedness with White clinicians. Kirat echoed similar sentiments, stating that her therapist—a White man—reminded her of White male authority figures she had "(…) negative interactions with." Thurga and Kirat's experiences align with some research suggesting that some South Asian clients experience difficulties opening up to White providers due to beliefs that they may not be knowledgeable or culturally-informed (Moller et al., 2016). Skepticism toward providers may have critical implications for the nature of a therapeutic relationship. Due to clients' pre-existing ambivalence or skepticism, it is likely (as evidenced by Thurga and Kirat's experiences) that therapists assuming trust may be met with some resistance or distrust. An assumption of trust may consequently lead to difficulties establishing a strong therapeutic relationship. As such, it may be useful for clinicians working with South Asian women to recognize how their own positionality may influence clients' readiness to open up in psychotherapy. The implications of therapist positionality are discussed further in the following section.

Therapeutic Microcosm. For Thurga and Kirat, elements from their sociocultural contexts were reflected within their therapeutic relationship. Put differently, their social realities were captured within the therapy room which, consequently, acted as a kind of 'therapeutic microcosm' (Day-Vines et al., 2018). As previously described, both Thurga and Kirat highlighted their therapists' race as interfering to some degree with their psychotherapy experience(s). Thurga reported feeling guarded around White providers, and Kirat expressed feeling that her White therapist was "very cold." In both of these examples, participants' social contexts provide essential insight into their perceptions and experiences. In Thurga's experience, her geographic location in Alberta contextualized her feelings of guardedness. She spoke about how her experiences of racism in Alberta, alongside a lack of South Asian representation, led to her feeling unsafe in White therapeutic spaces. Consequently, she found reprieve in equine-assisted therapy while working with horses that were free of judgement and removed from the therapeutic microcosm. For Kirat, her perception of her White therapist was shaped by a reminder of previous authority figures she had difficult interactions with. In turn, she struggled to feel comfortable with her therapist and felt herself revert to a more "(…) insecure version" of

herself. Thus, both participants' past experiences and contexts shaped their interpretations of their providers.

To some degree, Thurga and Kirat's experiences align with the psychological concept of transference, such that clients' perceptions of their therapist are unconsciously shaped by projections and experiences with other individuals (Levy & Scala, 2012). Indeed, more recent psychodynamic theorization supports that historical sociocultural contexts arise within the therapy room and therapeutic dyad (Altman, 2004; Yalof, 2016). However, what may be essential to understanding dynamics of transference is what Yalof (2016) describes as the reality of a "oppressed-oppressor paradigm." In other words, there existed a real, tangible power dynamic present in Thurga and Kirat's therapeutic relationships. In this paradigm, Thurga and Kirat historically and socially occupied the roles of the oppressed (as racialized women) and their therapists (White clinicians) occupied the role of the oppressor. Yalof (2016) highlights that the therapists' recognition of these historical factors is fundamental when evaluating potential transference-related dynamics. The consideration of these factors further maps onto cultivating therapeutic safety through understandings of clients' contextual realities (Lyndon et al., 2023).

Unfortunately, both Thurga and Kirat emphasized feeling that their therapists failed to meaningfully consider their contextual realities or, alternatively, express cultural humility (i.e., curiosity, openness, and respect toward clients' cultural backgrounds while attuning to one's own beliefs and values; Hook et al., 2025). As previously reported, Thurga spoke about sensing dismissiveness when communicating her experiences of racism with therapists. On a different note, Kirat expressed feeling that her therapist made assumptions about her familial relationships and lacked adequate cultural understanding. In this regard, Thurga and Kirat's therapists may have demonstrated cultural *counter*transference (Reinhart & Audet, 2025), such that they may have projected prior cultural assumptions or microaggressions into the therapeutic space. Experiences of microaggressions within the therapeutic space are negatively related to therapist cultural humility and are linked to poorer therapy outcomes (DeBlaere et al., 2023; Hook et al., 2016). Furthermore, beyond dynamics of transference or countertransference, Kirat and Thurga's therapists also seemingly failed to broach topics of race, ethnicity, or culture (REC; Day-Vines et al., 2020). As opposed to inviting their clients to discuss how they personally process REC factors (intraindividual), experience REC in the external world (inter-REC), or experience REC within the therapeutic room (intracounselling), Thurga and Kirat's therapists recreated the

realities of their social worlds by reinforcing power dynamics (i.e., through a failure to broach; Day-Vines et al., 2018). By doing so, their therapists may have further failed to uphold client safety (Lyndon et al., 2023), and contributed to premature termination (Day-Vines et al., 2007) as evidenced in Kirat's experience.

Holistic Approaches. As previously discussed, holistic or mind-body psychotherapeutic approaches (e.g., somatic therapies, mindfulness, transpersonal psychology) integrate components of counselling that address not only cognitive elements of the self, but bodily sensation and awareness as well (Mullan, 2014; Sue et al., 2019). Holistic approaches often integrate elements from non-Western and Eastern Indigenous healing practices, including yoga, meditation, and breathwork (Mullan, 2014). Two participants in this study, Oshani and Thurga, resonated strongly with holistic or integrative approaches to psychotherapy. For instance, Thurga described her time in equine-assisted therapy as "profound," particularly when compared to her past experiences with talk therapy. Thurga highlighted that her appreciation of equine-assisted therapy was linked to its inclusion of non-Western healing practices (e.g., acupuncture, meditation, somatic work). Thurga spoke about how she grew up with her Ayurvedic and traditional healing practices in her home which, consequently, increased her openness to a non-traditional approach such as equine-assisted therapy. These findings align with suggestions indicating that holistic approaches incorporating Eastern healing elements may resonate with some racialized or South Asian clients (Naeem et al., 2024; Sodhi, 2024).

Thurga also emphasized that her appreciation of equine therapy was partially rooted in not feeling judgement from horses. As mentioned earlier, Thurga reported experiencing dismissiveness when discussing experiences of racism with therapists during talk therapy. When working with horses during equine-assisted therapy, Thurga highlighted how the horses did not and could not "(…) care what colour you are (…) or how you look." Thus, Thurga's appreciation of equine-assisted therapy was rooted in 1) its disconnection from the 'therapeutic microcosm,' and 2) its integration of culturally-responsive traditional healing practices. Clinicians working with South Asian women may benefit from considering more holistic approaches that incorporate traditional healing practices or mind-body elements.

After Psychotherapy: Avoiding Sunk Cost

In this final section, I discuss how participants envisioned potentially engaging with psychotherapy in the future. Specifically emphasized are participants' desires to improve their

psychotherapy experiences such that they may avoid 'sunk cost' with dissatisfying experiences. Subthemes interpreted include financial barriers and participants' needs for intersectionality and shared identity with their therapist.

Need for Greater Understanding. Several participants in this study described having experienced difficulties with providers lacking cultural or contextual understanding. Despite past negative experiences, participants were steadfast in their desire to engage with psychotherapy again—however, with certain caveats and conditions. Unsurprisingly, three of these participants reported desiring to work with a clinician with a shared cultural identity. Research with South Asian participants indeed suggests that an identity-based match between therapists and clients may be beneficial (Islam et al., 2017). As Kirat expressed, she hoped that—by sharing a similar identity with her future therapist—she would not have to "justify" or "explain" herself as she had done in her previous psychotherapy experience. Similarly, Thurga desired for her future therapist to be able to "relate" to her experiences. Interestingly, both Kirat and Meena did not necessitate that their future therapist identified as South Asian. However, given dissatisfying past experiences, they ultimately hoped to find a therapist with similar lived experiences.

For clients seeking cultural understanding, sharing an identity with their therapist may indeed be highly valuable. As evidenced by the experiences of some participants in this study (e.g., Nasima and Lena), sharing identities with a therapist may aid in the provision of culturally-responsive care. In instances of a culturally-dissimilar therapist-client dyad, a failure to broach on topics of race, ethnicity, and culture (REC; Day-Vines et al., 2020) was perceived as a frustration and contributed to unfulfilling psychotherapeutic experiences (e.g., Thurga and Kirat). In this essence, cultural understanding and a shared identity overlapped or were congruent for participants. Given the aforementioned value of safety, sharing an identity with a therapist may be a key element to a satisfying psychotherapy experience for some South Asian clients. As such, participants in this study aimed to avoid experiences where issues of culture would be poorly handled, and instead were motivated to find future psychotherapists whom they felt would be able to cultivate a culturally-safe space. The motivation to seek greater understanding through shared cultural identity points toward the importance and value of South Asian representation in mental health spaces.

Limited Sessions and Financial Barriers. As previously described, although financial issues may be a major barrier to psychotherapy accessibility for some South Asian clients (Islam

et al., 2017; Rastogi et al., 2014), all participants in this study were able to engage with psychotherapy through some means. However, in considering attending psychotherapy in the future, Meena and Lena highlighted financial barriers as a roadblock to future attendance. For all participants, insurance, sliding scales, and free services offered accessible entry pathways into psychotherapy. However, many of these services only offered limited sessions. In Lena's experience, all her psychotherapy experiences had ended due to circumstances beyond her control, including running out of limited sessions. Consequently, despite wanting to continue attending psychotherapy, Lena expressed being unable to do so due to limited financial means. Similarly, Meena spoke about how her experiences with her employee assistance plan were frustrating due to both limited sessions and a lack of connection with therapists. She noted that she had looked into options outside of her employee assistance plan but expressed fears about paying out-of-pocket for a therapist who she may not end up connecting with. As such, Meena was careful to avoid 'sunk cost' by paying for psychotherapy sessions that may not be a worthwhile long-term investment. Ultimately, although limited sessions initially enabled participants to easily access psychotherapy, it was not always a viable and satisfying long-term option.

Limited sessions may have critical implications for psychotherapeutic outcomes. When speaking about her difficulty opening up in psychotherapy, Oshani described struggling to "develop a relationship" with her therapist when knowing that her sessions were limited. Indeed, research suggest that clients may find short-term psychotherapy dissatisfying (De Geest & Meganck, 2019), with limited sessions potentially impairing the formation of the therapeutic alliance (Stiles et al., 1998)—an element strongly associated with positive psychotherapy outcomes (Ardito & Rabellino, 2011). Thus, although participants in this study were able to initially access psychotherapy, it may be important to recognize the disadvantages of short-term therapy options (e.g., potential poorer outcomes), particularly for clients for whom limited sessions are the only option. For instance, although participants in this study were able to access psychotherapy, limited sessions led to difficulties establishing therapeutic relationships (e.g., Meena and Oshani) or completing psychotherapy to fruition (e.g., Lena). Thus, clinicians working with South Asian women may aim to be cognizant of their clients' financial situations and tailor their approaches as needed. Sliding scale options and more structured approaches may be potential options for clients with limited sessions.

Implications for Psychotherapy Practice

At the end of interviews, I invited participants to discuss what they hoped clinicians working with South Asian women would know about South Asian women. Participants' answers to these questions are woven throughout the results and are embedded in recommendations listed for psychotherapy practice in some passages. I personally noted and described additional recommendations throughout the interpretation process as well. I compile and simplify these recommendations below.

1. Invite clients to discuss their process of choosing to attend psychotherapy early on as opposed to focusing exclusively on their presenting problem. This may involve discussions of perceptions of mental health and psychotherapy within their community. By doing so, clinicians may be able to identify issues such as stigma or shame that underscore South Asian women's narratives.
2. Attune to clients' readiness to discuss certain topics. For South Asian women struggling to talk about their emotions, walk alongside the client and move at their pace. If a client is interested, the provision of tools or psychoeducation may be valuable in these circumstances. It may be beneficial to explore if this is new territory (e.g., discussing emotions) for the client.
3. Invite clients to discuss topics of race, ethnicity, and culture (REC; Day-Vines et al., 2020) and intersections of their identity. To prime discussions of REC, it may be useful to begin by exploring salient identities that arise (e.g., gender, migration, religion) during therapy. If clients are not interested, then these topics may not be relevant to their experience; regardless, relevant clinical information is still gathered in the process.
4. If a South Asian woman's presenting problems appear to be culturally embedded, work with the client with curiosity and cultural humility (Hook et al., 2025) to understand how to approach their concerns in a culturally-responsive fashion.
5. Consider the therapeutic microcosm by recognizing your positionality within the therapeutic space and reflecting on how clients may perceive and experience it. Approach issues of race, culture, and ethnicity with curiosity, not assumption.
6. Explore traditional healing practices (if any; Sodhi, 2024) of clients. If clients discuss traditional healing practices, work with them to see if they feel it may be useful to embed

in your work together. This may involve the integration of somatic or body-centric approaches and modalities.

7. Assess whether clients are experiencing limited financial means and work with them on potential options. This assessment may also involve determining whether offering limited sessions may potentially impair therapeutic outcomes. Alternative pathways may involve sliding scale options or referrals to accessible services.

Revisiting Pre-Understandings

As per the Gadamerian principle of the fusion of horizons, my interpretations of participants' experiences were inevitably wrapped up in my own lived experiences as a South Asian woman. Prior to collecting data, my pre-understandings (Appendix A) of the phenomenon studied were detailed in order to account for the influence of my positionality and potential prejudices. These pre-understandings were embedded throughout the research process, including within the interview guide, the development of the thematic structure, coding, and the overall editing process. I tracked my pre-understandings throughout this experience and endeavoured to ensure that participants' testimonies were conveyed with precision and accuracy in the results (Alsaigh & Coyne, 2021), while recognizing the inevitability of a fusion of horizons within my interpretations. I revisit my pre-understandings with respect to the results found in the following passages.

I was initially guided to conduct this research by questions I had concerning South Asian women's utilization of mental health services. Within my pre-understandings, I documented how intersectional feminist thought (Crenshaw, 1989) oriented my expectations of how participants accessed psychotherapy. Specifically, I anticipated that participants may have experienced different barriers and trajectories to service use dependent on their socioeconomic status, and that those with an ease of access would be over-represented in the participant sample. Indeed, participants within this study expressed accessing services with relative ease. However, this was largely related to the availability of cost-reducing services such as insurance, freely-available services, and sliding scales. Three of six participants in this study were students who had accessed psychotherapy through insurance or university programs, and no participant in this study had paid for psychotherapy entirely out-of-pocket. Rather, participants who were of lower socioeconomic status experienced financial barriers to *re*-access psychotherapy after completing the limited amount of sessions offered through insurance or accessibility programs.

In addition to socioeconomic status, I anticipated that participants' generation of migration may influence service use and trajectories of help-seeking. In particular, I hypothesized that second-generation South Asian Canadian women would be over-represented in the study sample. Interestingly, the study consisted equally of first- and second-generation participants. Both groups of participants did not demonstrate strong contrasts in experiences of service accessibility or trajectories of service use. It is possible that help-seeking attitudes are more likely to be influenced by participants' age than migration status. All participants in this study were between the ages of 20 to 40, and some evidence suggests that younger generations of South Asian Canadians may indeed be more receptive to psychotherapy than older generations (Rastogi et al., 2014).

As I anticipated, nearly all participants underwent some form of crisis prior to engaging with psychotherapy. These results are in line with previous research demonstrating that South Asian clients typically experience a significant precipitating event that leads them to engage with psychotherapy (Kinha, 2023; Tummala-Narra et al., 2012). While considering the research question posed in this study, I contemplated how stigmatization of mental health in South Asian communities impacted service (under)utilization. Although research demonstrates that South Asian Canadians underutilized mental health services, it was inevitable that there were individuals who *did* end up accessing and engaging with psychotherapy (Gadalla, 2010; Grace et al., 2016). I was curious about how these women navigated narratives of stigma in order to access services and strongly resonated with evidence suggesting that South Asian clients engage with psychotherapy as a last resort option (Kinha, 2023; Tummala-Narra et al., 2012). Consequently, I anticipated that participants would indeed access psychotherapy only after experiencing a significant precipitating event, largely due to stigma hindering earlier engagement. While it is not presently possible to interpret the extent to which stigma influenced participants' trajectories of access (i.e., accessing psychotherapy after experiencing a crisis), I noted participants' descriptions of having to reconcile both stigma and shame before and during psychotherapy. Therefore, experiencing a crisis may have been a facilitator to psychotherapy engagement for some participants.

I further anticipated that participants would be likely to describe issues of familial support and distress. In my pre-understandings, I specified that experiencing a lack of familial support may lend itself to participants seeking out psychotherapy. Within this study, participants

did not explicitly specify a lack of familial support as contributing to their decision to engage with psychotherapy. However, I observed how several participants reported discussing familial distress as a presenting concern during psychotherapy. Issues of familial distress were further interconnected with gender roles and dynamics. Therefore, while the degree to which a lack of familial support is connected to help-seeking is unclear, familial distress appeared to be a common presenting concern.

Finally, I detailed my anticipation of issues of transference and countertransference potentially arising in participants' psychotherapy experiences. Participants did not report experiencing any transference in regard to South Asian clinicians (e.g., difficulties trusting South Asian providers; Sharma et al., 2020), but did report hesitancies about working with non-South Asian or White clinicians. These hesitancies were corroborated through some participants' experiences of countertransference and microaggressions in the therapeutic space. Some participants' experiences of countertransference were, as expected, negatively influential on their psychotherapy and contributed to early termination. Nonetheless, these negative experiences did not appear to impact participants' interest in future psychotherapy. Rather, participants described how they were interested in continuing therapy at a future timepoint but would be selecting their next therapist with greater intentionality (e.g., necessitating a shared cultural identity with their therapist). I found that participants' interest in continuing psychotherapy, despite disappointing or dissatisfying experiences, spoke to their resilience and hardiness.

Limitations

There were several limitations to this study. First, consistent with the hermeneutic phenomenological methodology employed, the findings from this study reflect the lived experiences of the six women interviewed and are therefore situated within a specific social and cultural context. As such, the findings are not intended to be generalizable to all South Asian Canadian women who have engaged with psychotherapy. Relatedly, my own pre-understandings of participants' experiences are considered to be bound up within the interpretations of the results. Although I was reflective of the potential influence of my biases or prejudices throughout the research process, Gadamerian hermeneutics acknowledges that a fusion of horizons is inevitable during interpretation.

Next, all participants in this study were between the ages of 20 to 40 years old. Consequently, the experiences of older South Asian women were not captured within this study.

As highlighted earlier, it may be the case that younger generations of South Asian women are more likely to engage with psychotherapy—hence, the overrepresentation of younger women in this sample (Rastogi et al., 2014). The younger age of the sample obtained may also be partially due to the nature of recruitment. Although recruitment advertisements were distributed to community organizations, most or all participants in this study discovered this study through social media advertising. In addition, unless potential participants were physically located in Montréal, interviews were conducted virtually via Microsoft Teams. It is likely that younger people were more likely to view the study's advertisement on social media as well as engage with a virtual, Microsoft Teams interview.

In addition, participants sampled were highly educated and reported completing, at minimum, a bachelor's-level degree. Several of these women also expressed having taken or were in the process of taking psychology-related courses. Although the majority of South Asian women in Canada report holding a bachelor's degree (approximately 70 percent; Statistics Canada, 2022b), there is potential that participants' education informed their engagement with psychotherapy. As such, this study may not necessarily capture the experiences of South Asian Canadian women with lower educational attainment or those without prior psychology knowledge.

Moreover, all participants in this study accessed psychotherapy by choice. In other words, this study did not convey experiences of South Asian women who were required to attend psychotherapy through pathways such as mandated treatment or hospitalization. Women who first accessed psychotherapy through these non-voluntary pathways may have trajectories and experiences that contrast those described in this study.

Furthermore, individuals currently in therapy were intentionally excluded in this study in order to avoid any influence on their therapeutic process. However, by excluding participants currently engaged with psychotherapy, there is potential that this study failed to capture the experiences of clients with positive, ongoing therapeutic relationships. This study may further have an overrepresentation of participants who terminated psychotherapy after dissatisfying experiences.

Finally, this study incorporated eligibility criteria that delimit the findings of these results. Specifically, the findings from this study may represent key considerations for South Asian Canadian women who speak and understand English. Results from the study are therefore

delimited to women with fluency in English. Although it was beyond the scope of the study to recruit participants who did not speak English, it is possible that South Asian women without fluency in English may have differing experiences of psychotherapy that contrast those showcased in this study.

Recommendations

Expanding on the aforementioned limitations and the results found in this study, there are several recommendations for future research. To my knowledge, this is the first study directly examining the psychotherapy experiences of South Asian women in Canada. Further research may aim to focus their recruitment on demographic subsets of South Asian Canadian women that this study did not capture. Specifically, it may be beneficial to examine the psychotherapy experiences of older South Asian Canadian women (e.g., 40 years and older). Although this study aimed to recruit South Asian Canadian adult women across all age ranges, it is likely that younger generations of South Asian women are more likely to access psychotherapy (Rastogi et al., 2014) and engage with a primarily virtual study. By sampling older South Asian Canadian women, we may be able to grasp different factors underscoring service underutilization and engagement.

Relatedly, it may be useful to home in on the psychotherapy experiences of first-generation South Asian Canadian women. This line of research may be particularly benefitted by the availability of translators for participants that may not be fluent in English. As previously discussed, language barriers may be a pertinent issue for some first-generation women, and trajectories of service access may therefore differ when compared to participants in this study.

An additional demographic group that warrants further investigation are LGBTQ+ South Asian Canadian women. Within this study, half of participants reported identifying as bisexual. This representation of bisexual women aligns with research demonstrating that bisexual (and LGBTQ+ individuals broadly) experience poorer mental health outcomes (e.g., Hajo et al., 2024; Plöderl & Tremblay, 2015). While participants' sexuality was not a primary focus of this study, it may be beneficial to narrow in on the psychotherapy experiences of LGBTQ+ South Asian women given the implications of their intersecting identities. For instance, are there differences in trajectories to access or presenting concerns that arise? How do LGBTQ+ South Asian Canadian women navigate their intersecting identities in psychotherapy? By exploring these

questions, future research may better understand the counselling needs and service utilization of a particularly marginalized demographic group.

As described in the limitations, the present study was unable to capture the experiences of South Asian Canadian women who did not initially access psychotherapy voluntarily. Consequently, future research may aim to explore the psychotherapy experiences of South Asian Canadian women who accessed services through pathways such as mandated therapy or hospitalization. It may be useful to examine how issues such as stigma or shame are navigated and/or reconciled within contexts of non-voluntary psychotherapy. Furthermore, it may be valuable to explore perceptions of psychotherapy before, during, and after engagement with involuntary psychotherapy. Exploring the aforementioned questions may potentially garner results that contrast or differ to those found in this study given participants' voluntary engagement with psychotherapy in this study.

Moreover, as mentioned previously, participants within this study reported high educational attainment and some past or current psychology-related education. It may therefore be beneficial to examine the psychotherapy and help-seeking experiences of South Asian Canadian women with lower educational attainment. It is possible that, for women without higher education or previous psychology-related knowledge, pathways to and engagement with psychotherapy may be qualitatively different than women with higher educational attainment. Likewise, a quantitative examination of help-seeking rates based on educational attainment may also provide further insight into service utilization.

In this study, I emphasized the examination of familial support and dynamics. As previously noted, although it was unclear how familial support interplayed (or did not) with accessing psychotherapy, familial distress was a prominent presenting concern for some participants. In light of participants' family distress, it may be valuable to examine the experience of family therapy for South Asian Canadian women. For example, how do South Asian Canadian women choose to engage with family therapy, particularly given the presence of stigma within communities? What are the perceptions and attitudes toward family therapy versus individual therapy? In addition, what were clients' overall experiences with family therapy like? Through this line of examination, we may be able to gather some insight into the potential use of family therapy for South Asian clients presenting with familial distress.

Throughout this study, clients' testimonies demonstrated the critical importance of cultural humility and responsiveness in therapeutic settings. To better meet the clinical needs of South Asian Canadian women, future research examining culturally-responsive care may be useful. For instance, in previous experiences of psychotherapy, what aspects of their experience did women find culturally responsive or unresponsive? Moreover, what were clients' interpretations of their therapist's degree of cultural humility? Alternatively, in what ways did their therapists engage with—or neglect—topics of race, culture, or ethnicity? Examining the aforementioned lines of questioning may lead to a better understanding of culturally-responsive care for South Asian women.

Finally, this study did not distinguish between professional designations practicing psychotherapy. In other words, participants working with any professional (e.g., psychotherapist, social worker, psychologist) practicing psychotherapy were sampled. Future research may aim to examine potential differences in access and engagement with psychotherapy based on the professional designation of South Asian women's therapists.

Conclusion

The present study was conducted to explore the experiences of South Asian Canadian women who have engaged with psychotherapy, with a particular focus on better understanding service accessibility and (under)utilization. Oriented by an intersectional lens, philosophical hermeneutic phenomenology was used to explore the unique lived experiences of South Asian Canadian women who have accessed psychotherapy. Overall, participants within this study shared several commonalities in their experiences with psychotherapy. Psychotherapy was first accessed by nearly all participants after experiencing some form of a crisis and was generally facilitated by the availability of accessible services (e.g., university programs, insurance plans). Psychoeducation and integrative, holistic approaches stood out as valuable aspects of psychotherapy for several participants. Therapists' lacking cultural understanding or failing to attune to clients' readiness were commonly cited as frustrating elements of participants' experiences. Participants' experiences in psychotherapy were seldom discussed within their families or communities due to the presence of stigma. Despite some potentially dissatisfying psychotherapy experiences, all participants in this study reported an interest in pursuing psychotherapy again in the future. This study contributes to the literature by directly examining the experiences of South Asian Canadian women who have engaged with psychotherapy, and the

interrelation of their experiences before, during, and after psychotherapy. Despite service underutilization (Gadalla, 2010; Grace et al., 2016), no previous studies to my knowledge have explored the experiences of South Asian Canadian women who have accessed psychotherapy. Results from this study may provide clinicians with essential insight into precipitating events prior to psychotherapy engagement, the value of culturally-responsive care, and some of the clinical needs of South Asian Canadian women.

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Appendix A: Pre-Understandings

My understandings of the experiences of South Asian women in therapy have largely been informed by my positionality, intersectional feminist thought, and the anecdotal experiences of others. As such, I anticipate that the results from this study will largely be shaped by the overlapping demographic features of participants. Given that I will be assessing processes and perspectives before accessing psychotherapy, I anticipate that there will be significant differences to barriers to service use depending on socioeconomic status. For instance, I expect that participants who are lower-income or working class will have more difficulties accessing psychotherapy, and may have ultimately accessed services through insurance or freely available services provided to them by institutions (e.g., universities). Indeed, class may also play out in the psychotherapeutic relationship itself given the inevitable impact of class on various facets of individuals' lives (Thompson et al., 2012). In contrast, I believe that participants who have the means to pay out-of-pocket for services will not express similar barriers to use. This may also play out in the overall representation of the sample itself, as it is likely that participants who have ease of access to services will be over-represented.

Moreover, it is likely there will also be differences in experience due to other demographic features such as gender (e.g., transgender or non-binary women), sexuality, and immigration status (e.g., first- or second-generation, residents, etc.). Such features may lead to differences in precipitating presenting problems (i.e., what prompted individuals to seek out psychotherapy) as well as existing social support in the participants' lives due to the presence of prejudice or discrimination. For example, one study by Jaspal et al. (2021), found that Black, Asian, and minority ethnic (BAME) queer individuals in Britain were more likely to have experienced rejection, discrimination, and stressors in comparison to queer White men. As such, queer South Asian women's lived experiences of psychotherapy may differ to those of heterosexual, cisgender South Asian women due to additional stressors. Moreover, previous research has indicated that second-generation South Asians are more likely to seek or engage with psychotherapy than first-generation South Asian immigrants—thus, pointing to a potential change in perceptions and attitudes toward mental health help-seeking over generations (Satrang & South Asian Network, 2006). This may result in a sample that is over-represented by second-generation South Asian women or, alternatively, contrasting perspectives of first- and second-

generation participants. Consequently, differing demographic features of participants may result in varying experiences prior to, during, and after psychotherapy.

As previously mentioned, it is likely that participants' presenting problems will vary. However, in accordance with previous research conducted with South Asian participants (Kinha, 2023; Tummala-Narra et al., 2012), I anticipate that participants' interest and engagement in psychotherapy will occur due to some form of a significant precipitating event. Prior research with South Asian participants suggests that individuals typically access services after they have exhausted self-help attempts or after their presenting problems have catalyzed or compounded (Kinha, 2023; Tummala-Narra et al., 2012). This is unsurprising given the common presence of mental health stigmatization in the South Asian community, which may lead to a greater reluctance to access services (Islam et al., 2017; Karasz et al., 2019; Prajapati & Liebling, 2022; Rastogi et al., 2014). Similarly, given that South Asian women may experience greater psychological distress when faced with a lack of familial support (Masood et al., 2009), I believe that a significant number of participants in this study may have experienced reduced familial support that subsequently led them to seek out therapeutic services. All in all, I anticipate that a lack of available support (i.e., due to stigma in the community) in conjunction with a significant, precipitating event will contribute to participants' engagement with psychotherapy.

Furthermore, I anticipate that transference and countertransference will be an additional factor influencing participants' experience of psychotherapy. Transference involves clients projecting assumptions based on past experiences onto their therapist, and countertransference involves projections onto the client by the therapist. A study by Tummala-Narra (2013) with South Asian women examines these processes of transference: for instance, South Asian clients may intentionally choose non-South Asian therapists due to beliefs that South Asians providers may judge them negatively or gossip within the South Asian community. Indeed, prior research suggests that South Asian clients may intentionally seek out non-South Asian providers due to difficulties trusting South Asian providers (Sharma et al., 2020). On the other hand, countertransference may involve therapists perceiving South Asian female clients through pre-existing assumptions about women or the South Asian community (Tummala-Nara, 2013). One example of this would be microaggressions experienced in session by South Asian women. This is critical to note given that racialized clients who experience microaggressions in session may have poorer psychotherapeutic outcomes (Hook et al., 2016). Consequently, such transference

and countertransference occurrences in psychotherapy may significantly impact both participants' psychotherapeutic experiences and overall perspectives on psychotherapy post-intervention.

Appendix B: Ethics Approval

16/10/2025

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-09-25-11834
Titre du projet / Project Title	South Asian Women and Psychotherapy: A Phenomenological Analysis
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	16/10/2025
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	15/10/2026

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Aranee SENTHILMURUGAN	Faculté d'éducation / Faculty of Education	Chercheur Principal / Principal Investigator
Cristelle AUDET	Faculté d'éducation / Faculty of Education	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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16/10/2025

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

Le Comité d'éthique de la recherche (CÉR) de l'Université d'Ottawa, opérant conformément à l' *Énoncé de politique des Trois conseils* (2014) et toutes autres lois et tous règlements applicables, a examiné et approuvé la demande d'éthique du projet de recherche ci-nommé.

L'approbation est valide pour la durée indiquée plus haut et est sujette aux conditions énumérées dans la section intitulée "Conditions Spéciales ou Commentaires". Le formulaire « Renouvellement ou Fermeture de Projet » doit être complété quatre semaines avant la date d'échéance indiquée ci-haut afin de demander un renouvellement de cette approbation éthique ou afin de fermer le dossier.

Toutes modifications apportées au projet doivent être approuvées par le CÉR avant leur mise en place, sauf si le participant doit être retiré en raison d'un danger immédiat ou s'il s'agit d'un changement ayant trait à des éléments administratifs ou logistiques du projet. Les chercheurs doivent aviser le CÉR dans les plus brefs délais de tout changement pouvant augmenter le niveau de risque aux participants ou pouvant affecter considérablement le déroulement du projet, rapporter tout évènement imprévu ou indésirable et soumettre toute nouvelle information pouvant nuire à la conduite du projet ou à la sécurité des participants.

The University of Ottawa Research Ethics Board, which operates in accordance with the *Tri-Council Policy Statement* (2014) and other applicable laws and regulations, has examined and approved the ethics application for the above-named research project.

Ethics approval is valid for the period indicated above and is subject to the conditions listed in the section entitled "Special Conditions or Comments". The "Renewal/Project Closure" form must be completed four weeks before the above-referenced expiry date to request a renewal of this ethics approval or closure of the file.

Any changes made to the project must be approved by the REB before being implemented, except when necessary to remove participants from immediate endangerment or when the modification(s) only pertain to administrative or logistical components of the project. Investigators must also promptly alert the REB of any changes that increase the risk to participant(s), any changes that considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project or the safety of the participant(s).

Riana MARCOTTE
Responsable d'éthique en recherche / Protocol Officer
Pour/For **Barbara GRAVES** Président(e) du/ Chair of the **Comité d'éthique de la recherche en sciences sociales et humanités / Social Sciences and Humanities Research Ethics Board**

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Appendix C: Letter of Information

Hello,

My name is Aranee Senthilmurugan and I am a Master's candidate in the Counselling Psychology program at the University of Ottawa. I am currently completing my thesis under the supervision of Dr. Cristelle Audet. The study I am completing will be exploring the psychotherapeutic experiences of South Asian women in Canada. If you are interested in participating, I would greatly appreciate the opportunity to listen to your narrative and perspectives.

Study Purpose
The objective of this study is to examine the experiences and perspectives of South Asian women in Canada who have engaged with psychotherapy. Despite representing the largest racialized group in Canada, data suggests that South Asians significantly underutilise mental health services. Furthermore, South Asian women in particular are at higher risk for mood disorders when compared to men. Nonetheless, there is a lack of research that explores the narratives of South Asian women who have accessed psychotherapy. Given that psychotherapy is considered a gold-standard treatment approach to addressing mental health issues, I hope to explore the ways in which South Asian women perceive, engage with, and respond to psychotherapy. Through this study, I aim to contribute to a greater understanding of South Asian Canadian women's mental health and service needs.

Participation Criteria
To participate in this study, you must a) be 18 years of age or older, b) identify as a South Asian woman, c) be a current resident of Canada, d) have previously completed at least one psychotherapy session, and e) not currently be in psychotherapy or counselling.

Study Process
If you decide to participate in this study, you will be invited to complete a demographic questionnaire and an interview lasting approximately 1 to 1.5 hours. Your interview may be conducted virtually or in-person (if you are in the Montréal, Quebec area) at your preference. Interview questions will revolve around your experiences and perspectives before, during, and after you accessed psychotherapy. More specifically, I will ask about why and how you accessed psychotherapy, your experiences with psychotherapy, and your perceptions of psychotherapy itself. If you are interested, you may request to view the interview guide before your interview if you feel this may be helpful.

For the interview, we will arrange to meet at a mutually agreed upon date and time. Virtual interviews will be conducted using Microsoft Teams, a secure online video platform. You are not required to register an account with Microsoft to participate in a virtual meeting using Microsoft Teams. If you choose to meet in-person (Montréal area), we will arrange a location convenient for us both that ensures confidentiality and privacy. After you have provided your consent, I will audio-record and transcribe your interview. Virtual interviews will also be video-recorded, but video files will be used solely to extract audio-recordings. Video-recordings will not be retained for any further study purposes.

As a participant, you have the right to confidentiality and anonymity. This includes being able to:

- Ask questions about the study at anytime
- Decline to answer a question
- Stop or take a break from the interview
- Withdraw from the study without any negative consequences
- Select a pseudonym to anonymize your interview transcript
- Withhold or retract any identifying information from your interview transcript
- Request to view your transcript, and to add or detract from it

Once you have completed your interview, I will send you your interview transcript to review and you will have two weeks to provide any feedback via e-mail. You will receive a $25 digital gift card for your time and participation.

Potential Risks of Participation

Discussing your experiences with psychotherapy may potentially lead to some discomfort or distress. Your participation in this study is voluntary, and you may decline to answer any questions or withdraw from the interview at any time. If you are experiencing any distress, you are welcome to alert me such that we may re-orient the interview to your comfort. I will provide a list of support resources at the end of the interview (or at any other time if requested) for all participants.

Potential Benefits of Participation

Participating in this study may help shed light on experiences that are not frequently discussed, which may be a rewarding and positive experience. In addition, your participation will help fill in critical gaps in research and inform a broader understanding of the mental health and service needs of South Asian Canadian women.

Privacy and Confidentiality

Any information you provide will remain strictly anonymous and confidential. All written research data, including any data appearing in the interview transcripts, thesis manuscript, or subsequent publications, will be de-identified to protect your anonymity. I will confidentially and safely store study data on an encrypted USB drive that will be located in a locked cabinet at my home for five years. Any paper documentation of study data, if produced, will also be stored in a locked cabinet in my home for five years. Data will be destroyed following the five-year period.

If you have any questions or would like to participate in this study, please feel free to contact me by email at [removed]. You may also reach out to my supervisor, Dr. Cristelle Audet (she/her), at [removed].

Thank you for your time and consideration.

Sincerely,
Aranee Senthilmurugan (she/her)

Appendix D: Recruitment Poster

SEEKING PARTICIPANTS!

Are you a South Asian Canadian woman who has been in psychotherapy?

uOttawa

We are seeking participants for a research study exploring the psychotherapeutic experiences of South Asian Canadian women.

You may be eligible to participate if you:

- Identify as a South Asian woman ages 18+
- Currently reside in Canada
- Have previously completed at least one psychotherapy session
- Are not currently in psychotherapy

Participation involves a **1 to 1.5 hour virtual *or* in-person interview** (Montréal area) and is completely voluntary and confidential. We are seeking 4 to 7 participants (selected on a first-come, first-serve basis).

Interested? Contact Aranee Senthilmurugan (MA candidate in Counselling Psychology at University of Ottawa)
at

Participants receive a $25 e-gift card for their time!

The ethical aspects of this research have been approved by the University of Ottawa (S-09-25-11834). This study is supervised by Dr. Cristelle Audet

*This study is funded by the **Social Sciences and Humanities Research Council***

Appendix E: Letter to Professional Contact

Hello [contact name],

My name is Aranee Senthilmurugan and I am a Master's candidate in the Counselling Psychology program at the University of Ottawa. I am currently completing my thesis under the supervision of Dr. Cristelle Audet. My work will be exploring the psychotherapeutic experiences of South Asian women in Canada in effort to better understand service utilization within the community. Through this, I hope to provide insight into the mental health and services needs of South Asian Canadian women.

To participate, individuals must a) be 18 years of age or older, b) identify as a South Asian woman, c) be a current resident of Canada, d) have previously completed at least one psychotherapy session, and e) not currently be in psychotherapy or counselling. Participation in this study involves taking part in a 1 to 1.5-hour long interview. Interviews may take place virtually or in-person if participants are located in the Montréal area. Participants receive a $25 digital gift card as compensation for their time.

I would greatly appreciate your assistance in sharing the attached study recruitment poster with any women that may be interested. I have also attached a detailed study description letter and the ethics certificate obtained for this study. If you require any further information or have any questions or concerns, please do not hesitate to reach out to me via e-mail at [removed]. You may also reach my supervisor, Dr. Cristelle Audet, at [removed] if you have any questions or concerns.

Thank you for your time and consideration.

Best,
Aranee Senthilmurugan

Appendix F: Informed Consent Form

uOttawa

University of Ottawa
Informed Consent Form

Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

Project Title: South Asian Women in Psychotherapy: A Phenomenological Analysis

Names of Researchers and Contact Information

Aranee Senthilmurugan (she/her)
Master's Candidate
Faculty of Education
University of Ottawa
Email: [removed]

Dr. Cristelle Audet (she/her)
Thesis Supervisor
Faculty of Education
University of Ottawa
Email: [removed]

Invitation to Participate: I have been invited to participate in a research project conducted by Aranee Senthilmurugan, under the supervision of Dr. Cristelle Audet, as part of her Master's thesis in Counselling Psychology at the University of Ottawa.

Purpose of the Study: The purpose of the study is to explore the psychotherapeutic experiences of South Asian women in Canada.

Participation: My participation will consist of an audio- and video-recorded (if I participate virtually) interview about my perspectives of and experiences with psychotherapy. The time needed for this interview is approximately 1 to 1.5 hour(s). The interview will take place at a mutually-agreed upon time, date, and place (virtually on Microsoft Teams or in-person in the Montréal area). I will be offered the opportunity to review the interview transcript and to provide feedback and/or add or retract any content from it. I may do so within two weeks of receiving the transcript.

Assessment of Risks: My participation in this study involves a discussion of my mental health and psychotherapeutic experiences which may potentially entail some psychological distress or discomfort. I have received assurance from Aranee that every effort

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will be made to minimise risk, including being provided with opportunities to stop the interview for a break, skip or decline a question, or withdraw from the study altogether. Participants will further be provided with a list of support resources.

Benefits: By participating, I will have the opportunity to share my perspectives and experiences of past psychotherapy. My participation may contribute to a more informed understanding of the mental health and service needs of South Asian women in Canada.

Confidentiality, Anonymity, and Security: I have received assurance from Aranee that the information I share will remain strictly confidential. I understand that my interview and transcript will be viewed only by the researcher and her thesis supervisor, Dr. Cristelle Audet. I understand that my interview transcript will be used only for the purpose of the study and any subsequent publications or dissemination. My confidentiality will be protected through safe, secure, and password-protected measures.

My identity will be protected. I will be given the opportunity to select a pseudonym that will replace my name in the interview transcript, thesis manuscript, and any future dissemination of the study.

Reasonable measures will be undertaken to minimise any security compromise as well as my confidentiality and anonymity (e.g., meeting room limit of two individuals and the use of a personalised meeting link). If the interview takes place in person, I understand that the selected meeting place will be a mutually agreed upon place that I deem as safe and confidential.

Conservation of Data: If I participate virtually, the video-recording of my interview will be securely destroyed following audio-file extraction. Video-recordings will not be retained for any further study purposes. I understand that all data used for the purpose of this study, including interview audio recordings and electronic transcripts, will be stored securely in an encrypted USB drive stored in a locked cabinet at the principal investigator's home. Any paper documentation of study data, if produced, will also be stored in a locked cabinet in the principal investigator's home. The data will be used for the purpose of the researcher's thesis and will be stored for five years following the interview date. Following this five year period, all electronic and paper documentation of data will be securely destroyed.

Compensation: For my participation, I will receive a $25 honorarium in the form of a digital gift card. I am entitled to this compensation even if I withdraw my participation at any point.

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, unless already published or disseminated.

Acceptance: I, _____[*Name of participant*], agree to participate in the above research study conducted by Aranee Senthilmurugan as part of her Master's thesis in Counselling Psychology at the University of Ottawa under the supervision of Dr. Cristelle Audet. My consent will be audio recorded by the researcher. I will receive a copy of the consent form for my records.

If I have any questions about the study, I may contact Aranee Senthilmurugan or Dr. Cristelle Audet.

If I have any ethical concerns regarding my participation in this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, 550 Cumberland Street, Room 154, (613) 562-5800 ext. 5387 or ethics@uottawa.ca.

_____

Participant's Name Date:

Aranee Senthilmurugan

Researcher's Name Date:

Appendix G: Demographic Questionnaire

The following demographic questionnaire seeks to better understand how your social identities (e.g., ethnicity, sexual orientation, etc.) intersect with your experiences in psychotherapy. Answers from this questionnaire will be used to explore any commonalities in experience that occur between participants. You are welcome to skip any questions that you prefer not to answer.

The questionnaire should take approximately 10 minutes to complete. Once completed, please return the form to me be by email at: [removed]

Name: _____ **Date:** _____

1. How old are you?

2. What city or town do you currently live in?

3. What is your ethnic background (e.g., Bengali, Sri Lankan Tamil, Gujarati)?

4. What is your religious identity (if applicable)?

5. Place of birth:

    a. Where were you born?

    b. Your parents?

    c. Your grandparents?

6. What is your gender identity?

    - ☐ Cisgender woman
    - ☐ Nonbinary woman
    - ☐ Transgender woman
    - ☐ Other: _____
    - ☐ Prefer not to answer

7. What is your sexual orientation?

- Bisexual
- Heterosexual
- Lesbian
- Asexual
- Other: _____
- Prefer not to answer

8. Do you identify as a person with a disability that was present at birth, caused by an accident, or developed over time?

   - Yes
   - No
   - Other: _____
   - Prefer not to answer

9. What is your current employment status (e.g., part-time, full-time, retired, student)?

   - Employed part-time
   - Employed full-time
   - Not employed
   - Retired
   - Student
   - Other: _____
   - Prefer not to answer

10. What was your total household income range before taxes last year?

    - Less than $25,000
    - $25,000 to $51,999
    - $52,000 to $83,999
    - $84,000 to $129,999
    - $130,000 to $220,999

- $221,000 or more
- Do not know
- Prefer not to answer

11. How many people does the above household income support, including you?
    _____ person(s)

- Do not know
- Prefer not to answer

Engagement with Psychotherapy:

1. How long ago did you last attend psychotherapy?
2. Approximately how many sessions of psychotherapy have you attended?
3. How long did you attend psychotherapy in total (e.g., a few weeks, months, years)?
4. When you were attending psychotherapy, how often did you see your counsellor (e.g., weekly, biweekly, monthly)?
5. What was your counsellor's professional background (e.g., psychotherapist, psychologist, social worker)?
6. How did you locate or find your therapist (e.g., by referral, Psychology Today)?
7. What was the ethnic/cultural background of your counsellor?
8. How did you access psychotherapy (e.g., paid out-of-pocket, insurance)?

Appendix H: Interview Guide

Introduction

Interviewer Introduction and Context:

- Thank you for taking time to speak with me
- My name and background
- Role in conversation: Asking questions to understand your experience of psychotherapy as a South Asian woman in Canada
- Brief review of demographic questionnaire
    - Is there anything that you would like to correct or clarify?
- Do you have any questions about the consent form or any of the information I shared earlier?

Reminders:

- I will audio record and transcribe our conversation, but will remove any details that could identify you
- There are no right or wrong answers; I am only interested in hearing your opinions
- Please feel free to be open and honest
- You are free to end the interview at any time

This interview will be composed of three sections, consisting of your experiences and perceptions before, during, and after psychotherapy. We will then conclude the interview with a short debrief.

Before we begin, do you have any other questions?
Start recording and inform participant

Before Psychotherapy

The following questions will be divided into two parts. I will first ask you about your understandings of psychotherapy and mental health before you sought out psychotherapy. After this, I will ask you a few questions about your process of seeking out psychotherapy.

Perception of Psychotherapy:

1. Prior to accessing services, what was your initial perception of psychotherapy?
2. Did you know of anyone who had personally experienced psychotherapy?
    - Probe: If yes, what was their experience?
3. How would you describe your overall understand of mental health?

Process of Seeking Psychotherapy:

1. Tell me about your decision to see a therapist.

- Probe: What influenced your decision to engage in psychotherapy (e.g., other individuals in your life, current life circumstances)?
- Probe: What informed your decision to seek out a therapist (e.g., specific therapist qualities)?
- Probe: What feelings did you experience during the process of seeking out psychotherapy?
- Probe: Did you discuss this experience with anyone in your life? If yes, how did this go?
- Probe: How long did it take to see a psychotherapist?
- Probe: Did you experience any barriers to seeking out psychotherapy? Any facilitators?

During Psychotherapy
The following set of questions will ask you about your experiences in psychotherapy.

Attending Psychotherapy:

1. Tell me about your experience in psychotherapy.
    - Probe: What were your feelings before your first session? What about your feelings during your first session?
    - Probe: What was your impression of your psychotherapist? Can you describe the quality of your therapeutic relationship?
    - Probe: What approach did your psychotherapist use? How did this resonate with you?
2. Did you share your experiences with anyone in your life?
    - Probe: Why or why not?
3. What were some helpful aspects of therapy, if any?
4. What were some hindering aspects of therapy, if any?
5. What was your overall impression of your psychotherapeutic experience?

Closure of Psychotherapy

1. Tell me about how your therapy experience ended.
    - Probe: Was this planned or unplanned?

After Psychotherapy
I will now ask you about your perceptions of psychotherapy after your experience came to an end.

Perceptions of Psychotherapy

1. How did you feel after you ended psychotherapy? What thoughts did you have?

2. Do you feel that your experience in therapy addressed what you initially sought out therapy for?
    - Probe: Why or why not?
3. What did you like or not like about your experience in psychotherapy?
4. Did you experience any change in your perceptions of psychotherapy?
    - Probe: If so, what were they?

Future Psychotherapy

1. Do you see yourself seeking out psychotherapy again?
    - Probe: Why or why not?
    - Probe: If yes, who would you seek out?
    - Probe: If no, what do you see as a potential alternative to psychotherapy in your life?
2. What would you have changed, if at all, about your experience in psychotherapy?

Debrief

We are now at the end of the interview. I would like to use this time to discuss your interviewing experience before we conclude.

1. Is there anything else that you would like to discuss that we have not covered?
2. Did you feel that this interview accurately conveyed your experiences and perceptions of psychotherapy?
3. How did this interview process feel?
4. Do you think you will continue to reflect on this conversation? Why or why not?

Appendix I: Resource Guide

all resources are available 24/7

Ottawa

Ottawa Distress Centre: 613-238-3311

Mental Health Crisis Line: 613-722-6914

Mental Health Mobile Crisis Unit, Ottawa Hospital: 613-722-6914

Montréal

Suicide Prevention Centre of Montréal: 1-866-APPELLE (1-866-277-3553)

Le Transit: 514-282-7753

Tracom: 514-483-3033

Toronto

Toronto Distress Centres: 416-408-4357 or 408-HELP

Toronto Community Crisis Service: 2-1-1

Gerstein Centre: 416-929-5200

Canada-Wide

Crisis Services Canada: 1-833-456-4566

Suicide Crisis Helpline: 9-8-8

Mental Health Crisis Line: 1-866-996-0991

If you are experiencing an emergency, please call 911 or go to your nearest hospital emergency department.