THERAPIST SELF-DISCLOSURE AND CULTURAL EMPATHY FROM THE PERSPECTIVE OF RACIAL-ETHNIC MINORITY CLIENTS

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Thesis submitted to the University of Ottawa
in partial fulfillment of the requirements for the
Master of Arts Education (Counselling Psychology)

Faculty of Education
University of Ottawa

Acknowledgements

This study was co-created with four women who shared their stories vulnerably, openly, and honestly. I am endlessly grateful for their vested interest, ongoing curiosity, and incredibly rich stories of personal growth. Their voices are the heart of this study.

This study received funding from the Social Sciences and Humanities Research Council (SSHRC). However, the completion of this study would not have been possible without the people in my life that keep me afloat. This is directed to my mom and my dad who have always believed in me despite my self-doubt. This is also for Atirah and Akhir who have been patiently waiting to spend quality time with their big sister. To Omar, I am indebted to your discerning eye throughout the editing process and for your persistent encouragement.

Thank you to my thesis supervisor, Dr. Cristelle Audet. Your enthusiasm and excitement about this research are infectious. It has been a long road, and your unconditional support has meant the world. I am grateful for your expertise in therapist self-disclosure which inspired this research, and for your guidance throughout the entire process. I remain in awe of your commitment to this field as a compassionate researcher, educator, and psychotherapist.

Thank you to Dr. Pavna Sodhi and Dr. Nicola Gazzola for your time, expert feedback, and invaluable insights that have guided me immensely in the construction of this thesis. I have had the privilege of learning from both of you as I developed my micro skills to become a relational and person-centered psychotherapist.

The pursuit of this degree is in special thanks to my extended family that have always encouraged me to “tek yuh education” despite asking me when I will get married. To my cousins: While I get to be the first in our family to complete a graduate degree, I am not the last. I see you and I am proud of you. Whichever path you choose, or forge, is in honour of the people who crossed oceans for us.

Thank you to my friends who have been my cheerleaders and are eagerly awaiting a celebration of this milestone. I am immensely grateful to my clinical supervisor, Sabrina, and our team of therapists – your collective support has been a staple for self-care and continuous growth, professionally and personally.

Finally, I would like to acknowledge the girl who started this degree in 2020 during a global pandemic – When you do not believe in yourself, look at the people who believe in you.

You did it.

Dedication

To any individual out there who is unsure about the process of therapy, is unsure of where they belong, and needs someone who *gets them* – This is for you.

Abstract

The purpose of this study was to explore the experience of racial/ethnic minority (REM) clients during therapy when their therapist self-disclosed something personal to them. The literature suggests that therapist self-disclosure (TSD) with REM clients may play a role in cultural empathy, that is when a therapist responds to differences and similarities between them and the client in a way that can contribute beneficially to the quality of and dynamics within the therapeutic relationship. As little is known about the relationship between therapist disclosure and cultural empathy, the research question for this qualitative study was: "What are REM clients' experiences of cultural empathy during cross-cultural counselling when their therapist self-discloses to them?". To this end, I conducted a narrative inquiry to obtain rich stories of cultural empathy from REM clients who have experienced TSD during cross-cultural counselling. I audio-recorded interviews with four participants who were cis-gender women ranging from their early 20s to mid-to-late-30s. I analyzed the transcribed interviews using Braun and Clark's (2006) Thematic Analysis. I generated several themes that followed a narrative structure, including client cultural context, expectations about therapy, therapy process, experiences of TSD, definitions of cultural empathy, and reflections about therapy. I used the themes to organize and develop participant narratives as the output of the results. I offered my interpretations of participants' experiences using tenets of relational-cultural theory. The narratives garnered from this study contributed to the currently limited understanding of REM client perspectives, their experience of TSD in a cross-cultural context, and the potential role of TSD in therapists conveying cultural empathy. It is my hope that these narratives will deepen the understanding of culturally responsive therapy and improve the quality of care that racial/ethnic minority clients receive.

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Chapter 1: Introduction

As Canada becomes increasingly diverse, so too must its approach to psychotherapy. Racialized groups in Canada are 16.1% of the total Canadian population (Statistics Canada, 2023) wherein South Asians, Chinese, and Black Canadians comprise the majority of this demographic. Comparatively, there is a lack of structural diversity in the field of counselling and psychotherapy within Canada where most professionals are Canadian-born, cis-gender women of European descent (Bedi et al., 2016, 2018). The North American literature on racialized clients' experiences of therapy reports sentiments of inherent mistrust toward mental health professionals (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015) and a prevalence of racial microaggressions in therapy (Owen et al., 2014). Among the complex intersections within an individual's identity (Crenshaw, 1989), stigma toward help-seeking also influences whether racialized individuals perceive therapy as accessible (Cheng et al., 2013).

There is growing discourse in cross-cultural counselling acknowledging that therapist broaching of race and ethnicity with clients can be beneficial to therapy (Cardemil & Battle, 2003; Day-Vines et al., 2020). However, there is concern that therapists may lack cultural comfort (Davis et al., 2018) and subsequently avoid racial discourse in therapy (Cardemil & Battle, 2003; Chang & Yoon, 2011; DiAngelo, 2011; Drustrup, 2020). This may be due to numerous factors including a fear of offending the client, an uncertainty about how to initiate conversations about race and ethnicity and not knowing whether such topics are relevant (Cardemil & Battle, 2003).

Given a well-documented disparity in mental healthcare (Imel et al., 2011), it is critical to address and understand cross-cultural exchanges in counselling clients who self-identify as racial and ethnic minorities (REM). One promising phenomenon is cultural empathy, generally defined as "valuing the full range of differences and similarities or positive and negative features as contributing to the quality of that relationship in a dynamic balance" (Pedersen et al., 2008, p. 42). How can this be conveyed? One common therapeutic intervention is therapist-self-disclosure (TSD). Limited TSD research in cross-cultural settings suggests therapists may use TSD to explicitly acknowledge differences and/or similarities between them and the client in the therapeutic space (Burkard et al., 2006; Lee, 2014; Sunderani & Moodley, 2020). TSD has been shown to help increase trust and credibility in the therapist, promote a strong bond with clients,

and validate the role of racism/oppression in client lived experiences (Burkard et al., 2006; Cardemil & Battle, 2003; Day-Vines et al., 2020).

A critical review of the literature addressing cultural empathy and TSD suggests there is still a greater need to include and represent the voices of REM clients in therapy research (Hayes et al., 2015; Horrell, 2008), particularly in Canada. Therefore, the central research question for my study was: "What are REM clients' experiences of cultural empathy during cross-cultural counselling when their therapist self-discloses to them?" I conducted a narrative inquiry to obtain rich stories from REM clients who have experienced TSD during cross-cultural counselling, what that means to them, and how it might contribute to a sense of cultural empathy. Such a study could unveil when cultural empathy can be experienced, what is needed for it to be experienced, and how TSD could facilitate this process. Doing so could contribute to the currently limited understanding of TSD in a cross-cultural context and its potential role in therapists conveying cultural empathy.

Personal Prelude

As a racial and ethnic minority, I understand the concerns of my peers and members of my community who have felt discouraged from seeking or continuing therapy due to how the therapist managed cultural difference. I have seen firsthand that therapy is avoided due to its inherent perception as a Western value (Drustrup, 2020; Hwang, 2016) as well as the impact of stigma around seeking help (Sun et al., 2016). Alongside the matter of financial accessibility, I have also observed a lack of education and a lack of familiarity about therapy's benefits within REM families and communities.

I approached this study with my lived experiences of confusion over my cultural identity, uncertainty about where I belong, and questioning whether I could benefit from therapy myself. I understand what it can be like to grow up as a second-generation Muslim Canadian, who was born in Canada to first-generation immigrant parents. Within my family unit, my parents actively dedicate their lives to their children so that my siblings and I never have to survive, but truly live. I might hold certain responsibilities as the eldest daughter, but I have come to accept and cherish what I have been taught and have chosen for myself. Still, my experiences were very different from my parents. My dad supported his parents and siblings when they arrived in Canada. My mom navigated having to conceal parts of our identity because it felt as though white parents would not understand how we lived.

My parents' values and traditions derive from a small English-speaking country in South America known as Guyana, which happens to be its own melting pot. Due to a history of indentured labour, slavery, and colonization, the Guyanese identity holds roots in Indian, African, European, Indigenous, and Chinese cultures (Plaza 2004, 2006; Roopnarine, 2006). Guyana is divided not only by its cultures and religions—such as Islam, Hinduism, and Christianity—but also by its colonial history as an Anglo-Caribbean nation (Plaza, 2006). In my case, my family's ancestors predominantly arrived from India. However, despite some of our Guyanese values and traditions being rooted in South Asian culture, I experienced a sense of displacement since we are not solely Indian or Caribbean.

Within this Indo-Caribbean identity, I am Muslim which also separates me from other Caribbeans and fellow Guyanese who may not have the same values or traditions as me. Despite not being visibly Muslim, I know what it is like to be "othered" by the colour of my brown skin, having attended predominantly white schools and living in white neighbourhoods. I also know what it is like to grow up in a family ripe with intergenerational wounds, where mental health is heavily stigmatized against a backdrop of high rates of suicidality in my parents' home country. Despite this, a strong connection has grown amongst my parents, my siblings, and my close relatives.

What I can safely state is that I know what it is like to try and belong, to attempt to "fit in," to not feel Canadian or Guyanese enough, and to look Indian but not truly identify as such. While there is grief in never knowing most of my ancestral past, I have learned to cherish the Indo-Guyanese culture that my family has embodied. I know what it is like to eventually find ways in which my religious values can co-exist with Guyanese traditions, family values, and what I truly want. I also know what it is like to challenge traditional norms and stigma, navigate relational rupture, and seek therapy for myself. I cannot, however, claim to fully understand any other person's lived experiences, especially if it is based on a singular facet of their identity.

One key question I asked myself when approaching this study was: If culture is meant to include all aspects of our identity (including—but not limited to—age, race, ethnicity, gender, socioeconomic status, etc.) (Arthur & Collins, 2016), why am I focused on race and ethnicity? I say this with utmost confidence that race and ethnicity remain contextually important to a client's cultural identity and therefore experience within the therapy dynamic, which is deserving

of more care and understanding in a predominantly white society. Given this particular focus in my study, I sought to adopt a lens that could deconstruct the current norms (Randall, 2021).

While this study started with a focus on race and ethnicity within a white society, these identities arrive with a plethora of overlapping realities, such as immigrant status or biculturalism (those who have access to two sets of cultural norms, both mainstream society and from their parents' heritage) (Giguere et al., 2010). Kimberle Crenshaw (1989) coined this as intersectionality. It is with awe and humility that I include this term that encompasses an embodied experience that I previously did not know I was living and had a name that I could use. Intersectionality was born out of Black feminist theory, and it is how our social identities as well as lived experiences intersect within related systems of oppression, discrimination, and disadvantage (Crenshaw, 1989).

In recognition that we each carry unique cultural contexts within our social identities, I believe it is crucial for the client/participant to lead and tell their story, to frame their identity, and invite us into how their own racial/ethnic identity interacts with other facets of their *cultural* identity. Even as a therapist-in-training and while identifying as an REM, this does not mean that I know the best practices for conveying appropriate therapist self-disclosure nor cultural empathy. My aim was to approach this research with a beginner's mind, maintaining both curiosity and humility throughout the process. It is my belief that no therapist is fully immune from unintentionally harming their client, but that every therapist can work toward creating a culturally responsive and safer space for their client. The client is truly the expert of their story and, in this regard, the participants in this study were the expert.

Thesis Overview

In Chapter 2, I will cover themes from the literature to further contextualize the purpose of my study and the research question. Afterwards, in Chapter 3, I describe the research methodology in depth with emphasis on how applying a narrative approach serves to address the research question. Chapter 4 will describe the results as organized by themes and sub-themes. Finally, Chapter 5 will be the discussion where results are interpreted in a delicate balance between researcher and participants' voices. Implications of this study are interwoven within the discussion, followed by a revisiting of my pre-understandings and methodology. The final chapter will end with study limitations (and delimitations), future recommendations, and a brief conclusion.

Chapter 2: Literature Review

In this literature review, I begin with describing the social context in which psychotherapy takes place. I then define the term racial-ethnic minority (REM) in the context of therapy research and the current sociopolitical context. I will then summarize contextual considerations of REM individuals, including the relevance of intersectionality and prevalent barriers to help-seeking. Next, I address therapy considerations with REM clients, including ethical imperatives when working with REM clients, racial microaggressions in therapy, limitations to the current conceptualization of multicultural competence, consideration of the multicultural orientation framework, the advent of broaching race and ethnicity, and the relevance of addressing intersectionality with REM clients. I then define therapist self-disclosure (TSD), its types, its risks and benefits, its presence in the literature, its use cross-culturally, and its potential as an intervention in cross-cultural counselling. Finally, I define cultural empathy and demonstrate its potential connections to TSD as a foundation in cross-cultural counselling with REM clients and the importance of studying this from the client perspective.

Social Context in which Psychotherapy Takes Place

Psychotherapy takes place in a white and Western social context shaped by the same epistemological ideologies that drove European colonialism including capitalist care-for-profit structure, individual diagnosis, and evidence-based treatment (Smith, 2015). In the Western social context, "whiteness" is the norm (Randall, 2021; Smith, 2015). To ignore the presence of white supremacy, especially within Canadian society, is to maintain its power and reinforce dysconscious racism (King, 1991; Randall, 2021). Dysconscious racism is a "form of racism that tacitly accepts dominant white norms and privileges" and an "uncritical habit of mind—that justifies inequity and exploitation by accepting the existing order of things as given" (King, 1991, p. 135). Whiteness needs to be decentered so that those considered "other" who are not well-served by white supremacy can also benefit from counselling and psychotherapy (Randall, 2021; Smith, 2015).

When counsellors and psychotherapists subscribe solely to Euro-Western epistemology without question, this can create an expectation for how clients and the world itself are to be understood, conceptualized, and treated (Smith, 2015). Alongside the lack of structural diversity in the field of psychotherapy (Bedi et al., 2016, 2018), this Euro-Western framing can be harmful to clients who do not ascribe to Western values or whiteness as their norm, and are therefore

considered “other” (Randall, 2021). As early as the 1980s, models of alterity (the state of being different) began to surface and served to address and/or work with those considered “other” in Western society (Smith, 2015). Models of alterity range from political correctness (i.e., “people of colour”) (Deo, 2023) to colour blindness (i.e., ignoring ethnic and racial difference) (Smith, 2015) and structural diversity (increasing representation of “traditionally marginalized people”) (Smith, 2015). More directive approaches to alterity, such as social justice advocacy and decolonization, aim to view the individual within a larger system (i.e., society, family, etc.) and decenter the current Western epistemologies, respectively (Smith, 2015).

Whether consciously or unconsciously, therapists respond to both the client’s race and ethnicity during therapy and vice versa (Ertl et al., 2019; Owen et al., 2014). Therefore, therapists cannot ignore race and ethnicity within and outside the social context of therapy (Chesire & Noldy-MacLean, 2022; Houshmand et al., 2017; Owen et al., 2014). Acknowledging racial and ethnic identity within the social context of therapy may promote a more culturally responsive therapeutic alliance (Arthur & Collins, 2016; Burkard et al., 2006; Chesire & Noldy-MacLean, 2022; Day-Vines et al., 2020; Houshmand et al., 2017).

Terminology Chosen at Time of the Study

It is important to differentiate between culture, race, and ethnicity. Within cross-cultural counselling—which was the focus of my study—these terms are at times used interchangeably within the literature despite holding different meanings. “Culture” can be defined as a multidimensional construct that represents a plurality of positionalities (e.g., age, sex, birth location, religion, etc.), learned through the social context of interactions with individuals and groups (Arthur & Collins, 2016). While there are many definitions for race, it is generally defined by physical characteristics (e.g., skin colour) that are shared amongst a group (Owen et al., 2011a), as well as defined by historical and political oppression, and even certain norms or behaviours (Harley et al., 2002). Ethnicity generally refers to belonging to a group based on common cultural heritage, values, attitudes, and behaviours from specific regions of the world (Cardemil & Battle, 2003; Owen et al., 2014).

Throughout this study, I also referred to cultural and social identity. Cultural identity is an explicit sense of belonging that an individual feels toward a group of people that share the same traits, values, norms, experiences, and history (e.g., identifying as Indian Canadian) (Usborne & de la Sablonnière 2014). An individual’s cultural identity is constructed through

socialization, thereby teaching them a "way of being" that can include expectations of how to act and behave (Felt & Packer, 2023; Wan & Chew, 2013). A social identity is an aspect of the self that is developed through "interpersonal investment" in specific social groups such as being a member of a religious congregation (Felt & Packer, 2023).

For the purpose of my study, I emphasized a specific aspect of cultural identity—racial and ethnic identity. By relying on established literature at the time of the study, I observed the term "racial and/or ethnic minority" being used to describe clients who did not identify as white in their racial and ethnic backgrounds. I was primarily informed by the work of Owen and colleagues (2014) who use this hybrid term, integrating both race and ethnicity within the context of their study on racial microaggressions.

In Canada, "minority" is defined as individuals other than Indigenous peoples who are non-Caucasian or non-white in colour (Statistics Canada, 2021). However, Indigenous peoples who expressed interest in the study would be included. It is important to note that since the inception of my study, Statistics Canada now uses the term "racialized" groups (Statistics Canada, 2023, January 23), thereby signalling the evolving antiracism language within the "everchanging contexts of society, race, and racism" (Deo, 2023).

Although all counselling encounters can be considered cross-cultural (e.g., Paré, 2013), for the purpose of my study cross-cultural was intended to mean when there are ethno-racial differences between therapist and client. The visible differences in both individuals represent a microcosm of the broader society, wherein racism and discrimination do exist and cannot be overlooked (Day-Vines et al., 2018). Furthermore, in this thesis the term "white" was deliberately uncapitalized to decenter whiteness as the norm. The term "white" was derived from the socio-political context from which I chose to re-orient focus on the REM demographic.

Lastly, given the professional overlap and rapidly changing regulatory landscape in Canada, I used the terms psychotherapy/counselling and psychotherapist/counsellor interchangeably (Martin et al., 2013).

Contextual Considerations of REM Individuals

The following section addresses two important contextual considerations that have implications for therapy with REM individuals. Namely, the relevance of intersectionality and prevalent barriers to help-seeking.

Intersectionality

When contextualizing the experiences of REM individuals, decentering whiteness is crucial to understanding their multiple lived realities, history, and current story. Intersectionality accomplishes this by positing that all individuals possess multiple social identities where some aspects grant access to unearned privileges, while others lead to dis-privilege such as exploitation, oppression, and marginalization (Crenshaw, 1989; Smith, 2015). In the context of psychotherapy, individual and societal experiences are believed to be interconnected, wherein personal conflicts that individuals bring to therapy are connected to larger systems of power and privilege (Chesire & Noldy-MacLean, 2022). As intersectionality denotes, there exists different social identities that can intersect with one's race/ethnicity and that these intersecting identities generate unique lived experiences. Within these lived experiences, there can be several overlapping barriers to seeking mental health care. The following section serves to further contextualize these barriers for REM individuals.

Barriers to Help-Seeking

Within the intersections of race and ethnicity for REM clients, there exists help-seeking attitudes that may contribute to a low uptake in mental health services (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). However, a low uptake of mental health services is not necessarily due to REM clients being less likely to want professional help (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). The literature depicts barriers to help-seeking as arising from various factors, including perceived discrimination, mistrust in therapists' ability to fully understand their lived experiences, a lack of awareness of services, doubts about their effectiveness and appropriateness, perceived cultural and language barriers, and concerns about confidentiality not being preserved (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). Further factors include an inherent mistrust of the mental healthcare system, the therapist being perceived as an outgroup member, concerns of misdiagnosis (Hayes et al., 2015; Horrell, 2008), differences in cultural values, and unclear expectations about the therapy process (Chang & Yoon, 2011; Rogers-Sirin et al., 2015), all of which can influence therapeutic engagement and therapist credibility.

Within the help-seeking literature for REM individuals, the most prevalent barriers are inherent mistrust and racial microaggressions, complex stigma, as well as the level of acculturation/biculturalism. Inherent mistrust, covered in the following section, is of particular

importance, having been credited as a major reason for ending therapy alongside generally low expectations for a white counsellor's competency and credibility (Acton, 2001).

Inherent Mistrust. The insidious nature of racism can perpetuate implicitly into other facets of life, such as one's perceptions of mental health services. For many REM clients, a lack of cultural safety and inherent mistrust toward therapy derive from negative experiences related to prejudice, discrimination, and racial microaggressions that they experience in their daily lives (Burkard et al., 2006; Hayes et al., 2015; Sue et al., 2007; Williams, 2020). As a result, REM individuals may be hesitant in approaching therapists who appear to be culturally different from them.

Racial Microaggressions. Considered a less overt form of racism and cultural harm, racial microaggressions are defined as "direct or indirect (conscious and unconscious) insults, slights, and discriminatory messages" (Owen et al., 2014, p. 283). I next outline types of racial microaggressions and emphasize how this creates an inherent sense of mistrust, thereby a barrier toward help-seeking.

Sue and colleagues (2007) outline three types of racial microaggressions that can commonly occur. There are microinvalidations (i.e., denial of racism), microassaults (i.e., more direct racism experienced in private environments), and microinsults (i.e., treating cultural norms of a group as pathological). Racial microaggressions tend to be ambiguous and subtle in nature (Nadal et al., 2014). With respect to race and ethnicity, there can be biased comments that target nationality, values, cultural customs, language, or even physical appearance (Lee, 2014; Owen et al., 2014). Mazzula and Nadal (2015) suggest other common racial microaggressions which include: a) assumptions of white cultural values, b) colorblindness/unwillingness to discuss race, c) denial of individual racism, and d) assumptions of stereotypes.

No matter the type of microaggression, perceived discrimination can be associated with feelings of mistrust and discomfort among the REM demographic (Mazzula & Nadal, 2015). This is particularly concerning when the professional holds characteristics of those who have historically been the oppressor (Mazzula & Nadal 2015). As Chesire and Noldy-MacLean (2022) note, problems that appear to be intrapsychic are inextricably linked at the societal level, including past experiences of discrimination or oppression within a racist society (Atkinson et al., 1993). In effect, past experiences of racism as well as belonging to a particular racial/ethnic

group can create barriers for seeking help, with the increased potential for stigma (Cheng et al., 2013).

Stigma. Stigma—disapproval or shame—exists around help-seeking in REM communities which can diminish access to therapy (Cheng et al., 2013; Guo et al., 2015; Sun et al., 2016; Tiwari & Wang, 2008). The presence of stigma is complex, as it can be both external (i.e., from one's family, peers, society) and internal (i.e., from personal feelings). For example, family expectations and their influence can play a role in REM individuals' help-seeking behaviours (Guigere et al., 2010; Guo et al., 2015). If a person's family does not approve of help-seeking, they may be less likely to seek out mental health care (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). In addition, Cheng and colleagues (2013) found that as psychological distress increases, REM students perceive heightened stigma toward help-seeking. Individuals may also experience stigma if they identify as religious but experience a "religiosity gap" where their therapist identifies as non-religious (Magaldi & Trub, 2018). It is possible that within these dyads, clients may hesitate to disclose their religious beliefs if they fear that their therapist may not be accepting or understanding (Magaldi & Trub, 2018). This may lead them to avoid sharing that part of themselves, resulting in cultural concealment (Drinane et al., 2018; Magaldi & Trub, 2018), potentially stigmatizing part of their identity as well as their ability to continue seeking help. There are many intersections within a client's race and ethnicity that can contribute to whether they seek help or continue seeking help. Reasons can include inherent mistrust due to past negative and racist experiences (Acton, 2001) as well as external and internal stigma (Cheng et al., 2013). Another crucial factor to consider is the client's level of acculturation and/or bicultural identity.

Acculturation and Biculturalism. For some REM individuals, acculturation and/or their bicultural identity stemming from their immigrant lineage is part of their experience and can shape their beliefs about seeking help. Acculturation refers to the extent to which an individual adopts the values, customs, and institutions of the dominant culture (Atkinson et al., 1993). On the other hand, biculturalism, where individuals are caught between two (or more) cultures on a continuum, is thought to cause more psychological distress (Guigere et al., 2010). It is known that stress can arise from acculturation that is further accentuated by the presence of a white therapist (Acton, 2001). Generally, when a racial/ethnic minority group immigrates to North

America, their culture of heritage undergoes a major change within the mainstream culture (Atkinson et al., 1993).

In essence, both acculturation and biculturalism involve grappling with differences in cultural values within one's home, across generations, and within society. These challenges can bring about increased psychological distress (Loya et al., 2010) as well as shape help-seeking attitudes. Sun and colleagues (2016) report that "less acculturated" Asian Americans are least likely to recognize the personal need for professional mental health help. The authors suggest that low acculturation and low help-seeking attitudes are associated most strongly when one's values from their culture of heritage do not align with the Western values central to counselling and psychotherapy.

In sum, two main contextual considerations for REM clients include the relevance of intersectionality and possible barriers to help-seeking such as inherent mistrust and racial microaggressions, complex stigma, as well as the level of acculturation and biculturalism. In each case, one's cultural context might be integral to understanding whether they might seek help. None of these contextual considerations can be examined in isolation, but rather through a careful process of working to understand the REM individual as will be covered in the next section.

Therapy Considerations with REM Clients

According to the American Psychological Association (2002), mental health professionals are "cultural beings and may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically and racially different from themselves" (p. 382). Given a prevalent white therapist demographic (Bedi et al., 2016, 2018) serving a growing REM client population, it is important to address the need for cultural responsiveness in mental health services. The following section begins with an ethical imperative when working with REM clients, followed by racial microaggressions in therapy, limitations to the current construct of cultural competence, consideration of the multicultural orientation framework as an alternative, the advent of broaching race and ethnicity, and the relevance of addressing intersectionality with REM clients.

Ethical Imperative

There may be a risk of harming clients when therapists are unable to acknowledge cross-cultural dynamics in therapy (Cardemil & Battle, 2003). Indeed, the profession of counselling

and psychotherapy emphasized the importance of respecting inclusivity, diversity, difference, and intersectionality through "continued development and refinement of their awareness, sensitivity, and competence with respect for diversity (between groups) and difference (within groups)" (CCPA, 2020, B9, p. 11). The core values for continual enhancement of awareness, sensitivity, competence, and respect for diversity are reflected in the Canadian Counselling and Psychotherapy Association's Code of Ethics (CCPA, 2020, A12, p. 8). Counsellors/therapists have a duty to respect and collaborate with clients to create a plan consistent with the "needs, abilities, circumstances, values, cultural, or contextual background of clients" (CCPA, 2020, B1, p. 9). Unfortunately, literature has pointed to therapists showing better outcomes with white clients than with REM clients (Davis et al., 2018) as well as inadequate training around race and culture (Spalding et al., 2019). As such, there remains an ethical imperative to be culturally responsive—lest counsellors and therapists render the therapy ineffective or cause harm to the client (e.g., racial microaggressions).

Racial Microaggressions in Therapy

Failure to understand the client's cultural context has the potential to contribute to cultural harm in the form of racial microaggressions. This section summarizes existing knowledge on racial microaggressions in therapy as a form of cultural harm, its prevalence, and the potentially powerful effect of a strong therapeutic alliance.

Cultural Harm in Therapy. Racial microaggressions can reinforce previous cultural injustices, especially when not handled appropriately within the therapeutic process (Owen et al., 2014; Rogers-Sirin et al., 2015). As a form of cultural harm, racial microaggressions can be associated with psychological distress as well as shock, anger, fear, confusion, disappointment, anxiety, helplessness, and hopelessness (Owen et al., 2014; Houshmand et al., 2017). Some detrimental effects include potentially pathologizing the client's cultural way of relating to their elders and jeopardizing the therapeutic alliance (Owen et al., 2014) or assuming adequate knowledge of the client's culture that is not relevant to their experiences, thereby contributing to a sense of isolation (Rogers-Sirin et al., 2015). Receiving microinvalidations and microinsults from one's therapist can be interpreted as dismissive or even negating the client's cultural heritage and may lead to cultural harm (Acton, 2001; Owen et al., 2014). In all instances, there is potential to rupture the emotional bond with the therapist (Nadal et al., 2014; Owen et al., 2014).

Prevalence of Microaggressions and Potential for Repair. Two studies address the prevalence of racial microaggressions, the consequences, and the potential for repair. The authors respectively report that 53% (Owen et al., 2014) and 81.7% (Hook et al., 2016) of REM clients experienced at least one microaggression in counselling. Hook and colleagues (2016) found that racially matched therapist-client dyads were more impacted by the occurrence of a microaggression, suggesting a "stronger sense of betrayal" (p. 275). Perceptions of the therapist as having cultural humility were associated with a lower frequency and lower impact of racial microaggressions, suggesting an ability to repair the relationship more readily (Hook et al., 2016).

Owen and colleagues (2014) found that only 24% of the dyads discussed the microaggression experience and within those dyads, there was a higher quality alliance, similar to the dyads where no microaggressions occurred. The absence of discussing the microaggression was closely related to lower quality alliances, further corroborating previous studies. In sum, both studies highlight the potentially powerful effects of addressing missteps with the client as well as the effects of the therapist matching racially with the client and/or being perceived as having cultural humility (Hook et al., 2016; Owen et al., 2014).

Whether therapists are discussing potentially negative experiences with clients is not fully known. This is because therapists may be unaware of what clients perceived as a microaggression because they are typically indirect, unconscious, and unintentional (Houshmand et al., 2017; Nadal et al., 2014; Owen et al., 2014). It is clear, however, that a strong therapeutic alliance holds merit in overcoming potential ruptures caused by microaggressions. Therapist qualities and interventions that can contribute to a strong cross-cultural therapeutic alliance are examined next as alternatives to traditional understandings of cultural competence.

Cultural Competence

Multicultural competencies (MCC), generally consisting of awareness, knowledge, and skills, are critiqued for often reflecting a group approach to understanding culture that risks homogenizing individual experience (Vandiver et al., 2021). Moreover, evidence for these competencies remains sparse, largely due to reliance on therapist self-reports rather than client ratings (Davis et al., 2018). It is also believed that cultural competencies are not necessarily practiced (Arthur & Collins, 2016; Burkard et al., 2006; Owen et al., 2014). More specifically,

Vandiver and colleagues (2021) note a lack of emphasis within the MCC model on the sociopolitical contexts that can affect client mental health. Davis and colleagues (2018) advise that there are practical challenges to measuring MCC when identities are intersecting. Vera and Speight (2003) suggest that a grounded commitment to social justice is missing from MCC, with the therapist needing to engage in advocacy, prevention, and outreach. Cross (2012) emphasizes cultural competence as a developmental process which exists on a continuum, therefore there is always room for improvement when examining behaviours, attitudes, and policies which exist to work within cross-cultural environments.

Alternatives to MCC

New conceptualizations and approaches to MCC are emerging beyond a tripartite model of awareness, knowledge, and skills. A study from the perspective of immigrant clients described therapists' cultural competence as being open to learning about clients' cultures, using culture in an appropriate way, knowing when culture is not related to the presenting issue, demonstrating patience, and displaying empathy (Rogers-Sirin et al., 2015). In line with this, Owen and colleagues (2011b; 2013) proposed a multicultural orientation (MCO) to address the gaps with MCC. Unlike MCC, MCO supports the work of intersectionality, espousing that "all identities, as well as their affiliated privileges and oppressions, are interlocking, coexisting, and fluid" (Davis et al., 2018, p. 90).

Multicultural Orientation Framework. Within MCO, constructs such as *cultural humility, cultural comfort, and cultural opportunities* may hold answers for creating a culturally safe environment (Davis et al., 2018). In essence, MCO is a way for understanding and engaging with clients' intersecting cultural identities, with emphasis on a therapist's "way of being" rather than solely their cultural knowledge of a group (Davis et al., 2018). This particular focus necessitates enhanced awareness, knowledge, and skills that are focused on "attentiveness and responsiveness to the client's needs" (Davis et al., 2018, p. 91). Rather than focusing on "competence," MCO establishes an other-oriented approach to regulate ego involvement and subdue self-consciousness (Davis et al., 2018). This translates into the core value of cultural humility, a construct linked to fewer racial microaggressions in counselling (Hook et al., 2016).

The value of *cultural humility* is demonstrated by therapists who seize cultural opportunities and develop their own cultural comfort to work with different cultural identities (Davis et al., 2018). Regarding the self, cultural humility is about recognizing one's limitations

(Davis et al., 2018). Relating to others, cultural humility is about remaining other-oriented and suspending one's feelings of superiority (Davis et al., 2018). Altogether, it is "the ability to maintain an interpersonal stance that is other-oriented in relation to aspects of cultural identity that are most important to the client" (Hook et al., 2013, p. 354). *Cultural comfort* is the feeling of ease, of being open, calm, or relaxed before, during, and after culturally focused content (Davis et al., 2018). Such comfort comes from engaging in one's own identity development to better understand the identity of others (DiAngelo, 2011; Helms, 2017). As a behavioural extension of cultural humility, a *cultural opportunity* is a "marker that occurs in therapy in which the client's cultural beliefs, values, or other aspects of the client's cultural identity could be explored" (Owen et al., 2016, as cited in Davis et al., 2018, p. 92). While cultural opportunities can emerge when clients share their beliefs, values, or personal details, therapists can also initiate such opportunities when appropriate (Davis et al. 2018). When therapists initiate such cultural opportunities to discuss a client's cultural world, this is known as broaching (Lee et al., 2022).

Broaching Race and Ethnicity. The concepts of cultural humility, cultural comfort, and cultural opportunity may facilitate a safe environment for broaching race and ethnicity. Broaching entails "deliberate and intentional efforts to explicitly discuss and address various cultural aspects and systemic oppressions in the client's life-in-contexts, cross-cultural differences in the therapy dyad, and their impacts on the therapy relationship and process" (Lee et al., 2022, p. 311). The following sub-sections summarize the consequences of a failure to broach race/ethnicity, the support for broaching, and the micro-skills involved in broaching.

Failure to Broach. Research has already shown that when mental health services fail to acknowledge contextual racial-ethnic factors outside of the dominant culture, there is an underutilization of services, failed appointments, cultural mistrust, and high rates of premature therapy endings (Cardemil & Battle, 2003; Owen et al. 2012), and failure to show positive therapeutic outcomes (Acton, 2001; Hayes et al., 2015; Mazzula & Nadal, 2015).

It can be more challenging to see the harm that might be caused when the therapist is unaware of the significant role that racial and ethnic identity can hold for the client (Acton, 2001; Day-Vines et al., 2020). The lack of awareness itself may be interpreted as a lack of true empathy for the client (Acton, 2001; Comstock et al., 2008; Jordan, 2017). Discomfort within cross-racial interactions where therapists subsequently avoid racial discourse in therapy can

similarly diminish opportunity for conveying cultural empathy (Cardemil & Battle, 2003; Chang & Yoon, 2011; Drustrup, 2020).

Support for Broaching. Conversely, therapist broaching of race and ethnicity with clients can be beneficial to therapy (Cardemil & Battle, 2003; Day-Vines et al., 2020). Broaching has been shown to enhance therapist credibility and effectiveness, clients' depth of disclosure, satisfaction of therapy, and willingness to return to future therapy (Lee et al., 2022). Support for broaching is also clear in studies where therapists or "mock" therapists acknowledge perceived differences (i.e., seizing cultural opportunities). For example, Li and colleagues (2007) found that a counsellor, despite expressing values inconsistent with Asian culture, was more likely to be perceived as cross-culturally competent when they acknowledged racial differences with the client.

In support of broaching race and ethnicity, Chang and Yoon (2011) report that in cross-racial therapeutic dyads, 70% of participants perceived racial differences as less salient when therapists were described as "compassionate, unconditionally accepting, and comfortable discussing racial-ethnic relevant issues" (p. 579). Clients' ability to relate to the therapist through other aspects of cultural identity (e.g., gender, class, sexual orientation) and their mutual ability to navigate cultural misunderstandings further diminished the impact of race on the therapeutic relationship (Chang & Yoon, 2011). Evidently, an emphasis on similarities and strengthening of factors that support the therapeutic relationship can foster a sense of safety despite therapist-client differences (Audet & Everall, 2003; Chang & Yoon, 2011). This underscores the therapeutic alliance as a key focus for interventions in cross-racial therapy (Houshmand et al., 2017; Owen et al., 2012).

Micro-skills for Broaching. Lee and colleagues (2022) consider the micro skills that facilitate broaching, landing on cultural immediacy, reflective listening, and therapist self-disclosure. *Cultural immediacy* refers to the therapist's exploration of the here-and-now with regard to similarities and differences within the therapy dyad, seizing opportunities to address potential cultural misunderstanding and miscommunication (Lee et al., 2022). *Reflective listening* is considered the means by which empathy is conveyed, by either staying very close to what the client conveyed or moving beyond what the client expressed (Lee et al., 2022). The latter involves making inferences of greater meaning, reframing information, and reflecting feelings beyond the surface content (Lee et al., 2022). *Therapist self-disclosure* is generally

controversial due to concerns of boundary crossing, exploiting clients, and distracting from the therapy process meant to be client focused (Lee et al., 2022). However, it can have potential positive effects on therapy when intentionally used in favour of the client (Lee et al., 2022). These effects are considered further below. Before venturing into TSD, the relevance of addressing intersectionality with REM clients is next considered.

Slow Intersectionality. As cultural beings, mental health professionals possess their own social identities that lend privilege and dis-privilege while intersecting within systems of oppression, discrimination, and disadvantage (Crenshaw, 1989). Therefore, both therapist and client enter a space where unique contextual experiences are brought with them. Such difference (or potential similarity) necessitates a reflexive practice of slow intersectionality (Chesire & Noldy-MacLean, 2022) in an effort to prevent racial microaggressions in counselling sessions (Houshmand et al., 2017; Nadal et al., 2014; Owen et al., 2014).

Encouraging a more deliberate process, Chesire and Noldy-MacLean (2022) describe slow intersectionality as recognizing cognitive errors (i.e., faulty associations or judgments about a person's physical appearance, behaviour, or identity) and introducing slower, more effortful reflexivity to the therapy process. Using slow intersectionality means reflecting on and acknowledging intrapsychic experiences as being interconnected within experiences of privilege and oppression (Chesire & Noldy-MacLean, 2022; Smith, 2015). Within this dynamic, acknowledging privilege as well as a lack of knowledge or lived experience may open space for the client to share their experiences of discrimination without fear of judgment or invalidation (Chesire & Noldy-MacLean, 2022). Therapist disclosure in the form of acknowledging privilege, lack of knowledge, or lived experience to a client could potentially be a means to convey cultural empathy, which will be addressed next.

Therapist Self-Disclosure

In this section, therapist self-disclosure (TSD) is defined along with existing types of TSD, risks and benefits of TSD, and empirical attention TSD has received including in cross-cultural contexts and concluding with its potential as an intervention with REM clients.

Definition

The concept of "self-disclosure" was first introduced in the work of Sidney Jourard as a way of revealing one's inner self to another (Jourard, 1968). Hill and Knox (2002) broadly define TSD as "therapist statements that reveal something personal about the therapist" (p. 255).

It can take the form of either non-immediate self-disclosures or immediate self-involving disclosures (Audet, 2011; Hill & Knox, 2001; Lee, 2014). The former shares information about the therapist's life outside of sessions, while the latter conveys immediate feelings about the client, the therapeutic relationship, or the therapist's own experiences in relation to the client (Hill and Knox, 2002).

Lee (2014) suggests that the self is not something that can be decontextualized from its sociopolitical-cultural environment, calling into question the traditional definition of TSD. Rather than revealing aspects of the therapist's personal self, Lee (2014) asserts that TSD inevitably reveals different interconnected aspects of the therapist's self, including the personal, professional, and cultural self.

Types of TSD

Knox and Hill (2003) list seven subtypes of TSD as follows: disclosures of (a) facts (i.e., factual information about the therapist), (b) feelings (i.e., therapist revealing an emotion relevant to the client's story), (c) insights (i.e., moments of insight from the therapist's own experiences), (d) strategies (i.e., strategies the therapist has found useful in their own life), (e) reassurance (i.e., offering support, reinforcement, or validation based on personal experience), (f) challenge (i.e., confronting client's perspective, way of thinking, or behaviour), and (g) immediacy (i.e., revealing a personal reaction to the client).

As mentioned previously, there are also nonimmediate disclosures which are personal information therapists share about their past or personal beliefs (Hill & Knox, 2002). These disclosures have been critiqued for shifting focus away from the client and their therapy needs (Knox & Hill, 2003; Wachtel, 1993). However, research from the client perspective suggests nonimmediate disclosures can be beneficial to the therapy relationship and process (Audet & Everall, 2010; Audet, 2011).

Risks and Benefits of TSD

The risks of TSD outlined in the literature are clear and can include concern about deviating from the therapist's professionalism and lacking attentiveness to the process, disclosing frequently and burdening the client, altering expectations of therapy, generating role confusion, and violating boundaries (Audet, 2011; Audet, 2019). Audet (2011) also identified nuances where therapist credibility and competence were impacted either positively or negatively based on the context of the disclosure. Furthermore, striking a balance between the therapist's

professionalism and personal disclosure offers some benefit, depending on the context of the relationship (Audet, 2011).

Potential benefits of TSD also include equalizing a perceived power difference, humanizing and fostering the therapeutic relationship, communicating the therapist's empathy and presence, and deepening the client's meaning-making of experiences (Audet, 2011; Lee, 2014). TSD has been shown to facilitate trust and credibility in the therapist, promote a strong bond with clients, and validate the role of racism/oppression in client lived experiences (Burkard et al., 2006; Cardemil & Battle, 2003; Day-Vines et al., 2020).

Substantial support exists for TSD's role in promoting an authentic bond along with revealing the therapist's genuineness and positive regard to facilitate the client's growth and develop an effective therapeutic alliance (Hill & Knox, 2002; Ziv-Beiman, 2013). TSD has also been supported as a means for modelling openness, strength, vulnerability, and allows for perceived similarity, as well as empathic understanding (Henretty & Levitt, 2010; Sunderani & Moodley, 2020). While each form of TSD serves its own purpose, the use of immediate self-involving disclosures is more relationally oriented (Ziv-Beiman, 2013) with the potential to be an integrative therapeutic intervention on its own.

TSD Studies

Despite the mixed outcomes cited with TSD, this body of research is largely analog in nature, seeking observer input on "mock" sessions and studied overwhelmingly from the therapist perspective (Audet & Everall, 2010). Therapists' self-reports may be biased in reflecting the best possible therapeutic outcomes as they do not address instances where TSD may have interfered with the therapeutic process (Burkard et al., 2006; Sunderani & Moodley, 2020). Since most studies are based on the therapists' perspectives, they may have responded in ways that maintain a positive social impression (Burkard et al., 2006; Sunderani & Moodley, 2020). For example, Sunderani and Moodley (2020) found that therapists in their study reported only instances of TSD that produced a positive outcome for their clients. They elaborated that therapists may be susceptible to overestimating the effectiveness of TSD based on their own understanding about their intentions, as "opposed to accurately addressing the impact on the client" (p. 13).

TSD and Culture

A criticism of therapist self-disclosure research has been the lack of attention given to culture in the design of those studies. Constantine and Kwan (2003) suggest that TSD can be a useful tool to address cultural mistrust, demonstrate culturally competent skills, and set the foundation for clients to view therapist expertness. Sue and Sue (1999) also advise that disclosure might be necessary to prove trustworthiness toward clients who are culturally different. Moreover, in offering the idea of cultural immediacy for broaching, Lee and colleagues (2022) suggest that TSD can enhance broaching and bridging during cross-cultural encounters if used appropriately and being mindful of challenges therein. Indeed, TSD could be a therapeutic intervention well-suited to explicitly acknowledge cultural difference in the therapeutic space. While there have been few empirical studies focusing on TSD in cross-cultural counselling, what follows is a critical synthesis of that literature.

TSD with REM Clients. Thus far, recent studies have investigated the therapist's perspective in cross-cultural counselling using TSD. Burkard and colleagues (2006) interviewed eleven European American therapists for their use of TSD through consensual qualitative research. They identified several themes for using TSD, such as building rapport, acknowledging systemic oppression in clients' lives, and reflecting on their own biases. The authors found that therapists also shared their reactions to clients' experiences of discrimination, often reporting positive effects, such as clients feeling understood and becoming more willing to disclose other significant experiences. The authors do suggest that the therapists' self-reports may be biased in reflecting the best possible therapeutic outcomes and they do not address instances where TSD may have interfered with the therapeutic process.

In another study, Lee (2014) examined how therapists' culturally embedded values influence their assessment, assimilation, and engagement with culturally different clients. The author analyzed two case examples of recorded therapy sessions between European American therapists and REM clients, providing rich data on how therapists disclose aspects of their personal, professional, or cultural self while interacting with their clients and selecting relevant interventions. The case examples demonstrated that TSD may result in troubling and possibly culturally insensitive therapy interactions that are based on cultural assumptions held by the therapist. As a result, hindering effects included clients feeling discomfort and wanting to withdraw from the session (Lee, 2014).

Sunderani and Moodley (2020) interviewed nine therapists to investigate the ways in which they use or refrain from using TSD with REM clients. Regarding using TSD, the authors identified the subthemes of client curiosity, shared difficult or traumatic experiences, and cultural similarities. Reasons for refraining from TSD included boundary concerns, awareness of overidentification, and cultural differences. The authors note, however, that because their results were based on the therapists' perspectives, they may have tended to respond in ways that maintain a positive social impression. This study does contribute to the literature by considering the rationale behind why therapists may choose to use or not use TSD with culturally different clients.

In sum, this body of research on cross-cultural TSD suggests several important themes when utilizing TSD with REM clients, such as encouraging client curiosity, acknowledging cultural similarities and differences, and addressing cultural mistrust (Burkard et al., 2006; Sunderani & Moodley, 2020). As well, TSD can be useful in demonstrating a therapist's cultural sensitivity, thereby enhancing their credibility, and fostering trust with culturally different clients (Burkard et al., 2006; Henretty & Levitt, 2010). Conversely, TSD can demonstrate a therapist's cultural insensitivity, thereby creating uncomfortable interactions in therapy (Lee, 2014). Finally, TSD may serve as a model for REM clients, particularly those unfamiliar with the therapeutic process or whose cultural values stigmatize seeking help for mental health challenges (Burkard et al., 2006; Henretty & Levitt, 2010). For instance, when therapists share a difficult or traumatic experience, this could potentially promote healthy self-disclosures and mutually empathic exchanges with the client (Lenz, 2016; Sunderani & Moodley, 2020).

TSD From the Perspective of REM Clients. Generally, studies involving TSD and the perspective of REM clients are limited to studies conducted in the United States. Moreover, similar to TSD research that does not account for culture, these studies have been analog in nature (i.e., a simulated counsellor-client relationship), limited to undergraduate students, and focused on specific racial-ethnic identities (e.g., Mexican American, African American, East Asian American). The consensus among early studies that did address culture has been that participants' willingness to disclose may depend on the client-counsellor relationship (Borrego et al., 1982), as some clients end therapy prematurely due to finding TSD inappropriate (Cherbosque, 1987). This may suggest differences in expectations around TSD depending on the client's racial-ethnic identity. Overall, an important point to note about TSD literature is that

REM clients' perspectives of TSD remain less explored (Audet, 2011; Audet & Everall, 2010). A focus on REM clients' experiences of TSD becomes particularly important given TSD's potential to convey cultural information about the therapist and cultural empathy toward the client.

Cultural Empathy

Empathy is a fundamental condition for effective psychotherapy and a key factor in fostering positive therapeutic outcomes (Comstock et al., 2008; Rogers, 1992). It is generally described as the therapist's ability to "enter the client's world, to feel with the client, and to think with the client" (Chung & Bemak, 2002, p. 154). Further described as an interactive process, empathy depends on both affect and cognition through understanding of others' feelings and maintaining a clear perception between the self and other (Chung & Bemak, 2002; Dyche & Zayas, 2001).

Empathy has been further nuanced within a cultural context. A promising phenomenon to address and understand cross-cultural exchanges in counselling, cultural empathy is generally defined as "valuing the full range of differences and similarities or positive and negative features as contributing to the quality of that relationship in a dynamic balance" (Pedersen et al., 2008, p. 42). While the cultural empathy literature remains largely limited to a theoretical base (Levitt et al., 2022), it has been conceived to comprise the following: receptivity, knowledge, and collaborative skills (Dyche & Zayas, 2001). The therapist is meant to be open to the client's differing worldviews, continually learn about the client's culture, and work with the client to meet their needs with respect to their cultural values (Levitt et al., 2022; Ridley & Lingle, 1996). The importance of conveying this understanding effectively and with concern is crucial, as cultural empathy is a way of relating interpersonally and not solely about understanding or appreciating different cultures (Chung & Bemak, 2002).

Cultural Empathy and TSD

The intentions behind cultural empathy are primarily for the therapist to be attuned to cultural similarities and differences between them and the client to respond in ways that are helpful to the therapy process (Pedersen et al., 2008). One way among others to attend to difference and similarity is broaching, particularly through therapist self-disclosure (Lee et al, 2022). When done effectively, using TSD to broach similarity and difference can increase the therapist's credibility, strengthen the overall relationship, and prevent premature endings to

therapy (Acton, 2001; Cardemil & Battle, 2003; Chang & Yoon, 2011; Day-Vines et al., 2020; Magaldi & Trub, 2018). Building on the practice of broaching and utilizing TSD, cultural empathy is meant for the therapist to understand and appreciate cultural differences beyond the boundaries of traditional Rogerian empathy (Chung & Bemak, 2002).

Current Study

Cultural empathy necessitates acknowledging similarities and differences, and support exists for broaching cultural difference (Lee et al., 2022). In seizing cultural opportunities to broach (Davis et al., 2018), TSD might be a bridge to facilitating a sense of cultural empathy (Burkard et al., 2006; Lee, 2014; Sunderani & Moodley, 2020). For this study, I was interested in the experiences of TSD and cultural empathy from the perspective of REM clients in cross-cultural therapy. The social context from which psychotherapy takes place necessitates a shift toward REM perspectives (Randall, 2021; Smith, 2015). Intersecting realities that exist alongside race/ethnicity may bring complex understandings of how REM clients experience TSD as well as illuminate whether and how TSD might contribute to cultural empathy.

Prior studies on TSD in cross-cultural therapy have generally been with non-clients and have utilized quantitative designs (Audet & Everall, 2010). Burkard and colleagues (2006) specify that the use of qualitative methods may allow insight into inner experiences of real clients during past cross-cultural counselling processes. Audet and Everall (2003) also suggest that a qualitative approach provides a deeper understanding of the client's experience of TSD as well as its impact on the therapeutic process.

With this rationale in mind, the main research question for my study is: "What are REM clients' experiences of cultural empathy during cross-cultural counselling when their therapist self-discloses to them?" To address this question, I obtained and analyzed rich narratives from REM clients of the cross-counselling process they experienced. I provide a description of my methodology in the next chapter.

Chapter Three: Methodology

Theoretical/Conceptual Framing

The theoretical framing of this study was based on Relational-Cultural Theory (RCT) (Comstock, 2008; Jordan, 2017; Miller, 1976). RCT originated as an "adaptive alternative to individualistic and Western approaches to personal growth," developed in response to the experiences of women and later expanded to include individuals from racially marginalized populations (Lenz, 2016, p. 415). Nowadays, RCT is considered relevant to all individuals regardless of cultural identity. RCT proposes that a positive, growth-fostering relationship is characterized as involving perceived mutuality, relational authenticity, connection/disconnection, and relational empowerment (Lenz, 2016). These four tenets may be conducive for the experience of cultural empathy through TSD (Henretty & Levitt, 2010; Hill & Knox, 2002; Ziv-Beiman, 2013).

Perceived Mutuality. Mutuality is co-created in counselling relationships, by way of mutually empathic exchanges between therapist and client (Jordan, 2017). Through this mutuality, the therapeutic dyad has the potential to explore both similarities and differences between their respective worldviews. Such a dynamic process provides the therapist with the ability to understand the client's world and validate their personhood (Chung & Bemak, 2002; Comstock et al., 2008; Jordan 2017). Perceived mutuality requires maintaining a sense of self while remaining open to transformative experiences that arise through relationships with others (Lenz, 2016). This tenet is central to creating a therapeutic context rooted in respect and trust. It is through perceived mutuality that clients and therapists can articulate a degree of vulnerability, which can further instill a sense of mattering and empathy (Lenz, 2016). This idea is in contrast to the Western context of self-sufficiency and isolation, and instead new possibilities for growth and support are created (Lenz, 2016).

Relational Authenticity. Authenticity is described as the "capacity to bring one's real experience, feelings, and thoughts into relationship, with sensitivity and awareness to the possible impact on others of one's actions" (Jordan, 2010, p. 101). This occurs when the therapist and client acknowledge and express their true selves within the relationship, which can in turn promote growth and meaningful moments together (Lenz, 2016). Relational authenticity is closely tied to a quality of presence within a relationship wherein a sense of self-awareness, esteem, and healing can manifest (Lenz, 2016). Therapists, by way of self-disclosure, can model

this disposition of presence and thereby facilitate this ability with their clients (Audet & Everall, 2010).

Relational Connection/Disconnection. This tenet is characterized by mutuality, emotional accessibility, and the "five good things" that are needed to promote RCT (feelings of zest, clarity, worth, productivity, and desire for more connection) (Lenz, 2016). Disconnection can occur in several forms such as disappointment and a sense of being misunderstood, and can be contextually bound to issues of race, gender, and sexual orientation that can either marginalize or attribute power to others (Lenz, 2016). Jordan (2004) asserts that a core principle of RCT is learning to recognize and address moments of disconnection in ways that generate reconnection. By teaching and modelling strategies for repairing disconnection (e.g., normalizing vulnerability), therapists can help clients feel supported in making meaningful changes both personally and interpersonally; this is a benefit often shown with TSD (Henretty & Levitt, 2010; Jordan, 2004).

Relational Empowerment. Empowerment involves individuals embracing their uniqueness while understanding that conflict, when approached authentically and creatively, can foster growth (Jordan, 2004). Relational empowerment centers on affirming one's sense of self in relation to others and across different contexts (Lenz, 2016), promoting the values of cultural empathy (Pedersen et al., 2008). The process unfolds in therapy as clients engage in comforting activities while safely managing feelings of disconnection before applying these insights in similar situations (Lenz, 2016).

Linking to TSD and Cultural Empathy. Cultural empathy is an important relational component of therapy with REM clients (Chung & Bemak, 2002)**.** Moreover, it is known that TSD can facilitate the therapeutic relationship (Audet & Everall, 2010; Henretty & Levitt, 2010; Hill & Knox, 2002; Ziv-Beiman, 2013). The literature reviewed thus far shows that cultural empathy and TSD can have relational impacts aligned with the four tenets of RCT and this has the propensity to carry over into the cross-cultural context. Indeed, there is literature suggesting that TSD may be one way that therapists can broach differences (Lee et al., 2022) with REM clients (Burkard et al., 2006; Cardemil & Battle, 2003; Sunderani & Moodley, 2020). Applying RCT for the conceptualization of this study, the main idea was that TSD may create opportunity for or contribute to tenets of RCT in therapy, thereby facilitating cultural empathy. Conversely,

when TSD does not contribute to tenets of RCT in therapy, it could hinder the experience of cultural empathy.

RCT is informed by multicultural counselling, feminist theories, social justice, and antiracism. It is about bringing empowerment, connection, authenticity, and mutuality back into interpersonal interactions (Lenz, 2016). This is where health and growth can occur, both within and outside the therapeutic space. The four tenets of RCT served as guiding principles throughout this study.

Narrative Inquiry

This research study was an inquiry into REM clients' lived experiences of TSD and cultural empathy during past cross-cultural counselling. Their experiences were brought to the forefront using narrative inquiry. The aim was to collect narratives of each participant's experience, co-collaborating with them to give voice to their experiences, and provide a clearer picture of their perspectives as clients in therapy.

Narrative approaches were developed in response to the dissatisfaction of the positivist movement (Byrne, 2017). With the aim of unveiling lived experiences, narrative approaches developed as an interpretivist approach with the assumption that all knowledge is socially constructed (Byrne, 2017). Narrative inquiry follows assumptions of social constructivist theory that learning and development stem from collaborative interactions with others, society, and culture over time (Andrews, 2012; Wang & Geale, 2015). This approach is congruent to John Dewey's view of educational research: "to study life and education is to study experience" (Wang & Geale, 2015, p. 196).

Clandinin and Connelly's development of narrative inquiry is rooted in Dewey's philosophy (Wang & Geale, 2015), as Dewey used a three-dimensional space narrative structure based on interaction, continuity, and situation. *Continuity* runs along an experiential continuum where every experience builds up from previous experiences, which in turn modifies the quality of subsequent experiences (Kim, 2016). *Interaction* of experience is comprised of both objective and internal conditions that form a *situation* (Kim, 2016). Clandinin and Connelly expanded on Dewey's theory, developing personal and social elements (for interaction); past, present, and future (for continuity); and place (for situation) (Wang & Geale, 2015). Researchers can use this framework to analyze stories for both personal experiences of the participant and their

interactions with others within the context of their environment and thought processes (Wang & Geale, 2015).

Rationale for Choosing Narrative Inquiry

Narrative inquiry is considered well-suited to working with culturally different clients, especially clients who may be struggling with an unfamiliar culture (Dyche & Zayas, 2001). When therapists understand how an REM client interprets racial and ethnic similarity or dissimilarity within a therapy relationship, this understanding can help therapists respond in ways that strengthen the working alliance and support the client's development (Chang & Yoon, 2011). Although REM clients may hold certain perceptions of mental health services based on their therapist's racial identity, these perceptions may emerge differently for each client over time (Chang & Yoon, 2011). Racial identity development, acculturation, and historical trauma are other factors that may influence a client's cross-cultural experience in therapy (Chang & Yoon, 2011; Sun et al., 2016; Tummala-Narra, 2013). Therefore, REM clients' narratives about racial and ethnic similarity/dissimilarity in the therapeutic relationship may illuminate important individual differences and lived experiences (Chang & Yoon, 2011).

Currently, very little is known about how actual REM clients experience TSD, cultural empathy, and the plausible relationship between the two, and narrative inquiry may enable their voices to be heard on their terms. Narrative inquiry complements cultural empathy in that it supports a researcher stance of beginner's mind and not-knowing, and creates space for co-authoring with participants (Audet, 2019) to express their perspective on TSD and their experience of cultural empathy. Following the social constructivism epistemology of narrative inquiry, the researcher is not a knower or an expert, but a learner and a collaborator (Lee, 2014). Decentering practices in narrative approaches shift focus away from the researcher as the expert and source of knowledge, instead prioritizing participants' knowledge and lived experiences (White, 2007). This stance is particularly relevant, as previous studies on cross-racial/ethnic relationships have often prioritized the perspectives of therapists or researchers over thorough understanding of REM clients' experiences with mental health services (Chang & Yoon, 2011).

Participant Recruitment and Selection

As the perspective of REM clients within cross-cultural counselling was of focus for this study, an information-rich sampling method was needed (Creswell, 2013). Purposive sampling was used to recruit participants (Sandelowski, 1995), a method that involves intentionally

selecting individuals who have experienced the phenomenon of interest (Palinkas et al., 2015)—in this case individuals who had experienced TSD within cross-cultural counselling and were willing to reflect on its potential relationship with cultural empathy.

Inclusion Criteria

Participants met the following inclusion criteria: a) self-identify as a racial-ethnic minority; b) have received individual therapy from a counsellor or psychotherapist they deem racially/ethnically different from them; c) have experienced TSD during past therapy; d) therapy must be concluded prior to participating; and e) be 18 years of age or older (to provide their own consent). Therapy must have been concluded prior to participating in the study to prevent any interference study participation could have with concurrent therapy.

Sample Size

Narrative inquiry necessitates comprehensive contextual information; therefore, one participant is often sufficient (Creswell, 2013). However, for this study I aimed for a sample size of 2 to 4 participants to obtain a variety of rich in-depth descriptions that could be compared across narratives as participants shared the most meaningful aspects of their experiences (Subedi, 2021). This sample size also enabled respecting the time limits of a master's thesis. I aimed to recruit participants within Ottawa first, but in the event that there was insufficient recruitment, the scope would have extended provincially and/or nationally. Ultimately, four individuals agreed to participate in the study.

Recruitment

Ethics approval was first obtained from the University of Ottawa before the study could begin. Recruitment was done on a first come, first served basis through the University of Ottawa's counselling services, campus clubs and associations, through online ads (Appendix A), and through snowball sampling. Online ads were posted on social media websites such as Instagram, Facebook, Linked In, and Reddit. Requests (Appendix B) were emailed to relevant counselling/therapy services (e.g., Ottawa Community Immigrant Services Organization) to seek consent before emailing a recruitment poster (Appendix A). Snowball sampling was done by asking colleagues and friends if they knew of anyone who might be interested/eligible. Potential participants were asked to forward information about the study to anyone they might know to be interested.

Once contacted by prospective participants via email, I verified whether they met inclusion criteria (Appendix F). Participants who met the inclusion criteria were emailed a study description on the nature and purpose of the study (Appendix G). Participants who agreed to the study were emailed an informed written consent form (Appendix H).

Instruments Used

Demographic Questionnaire

A demographic questionnaire (Appendix C) was used to obtain contextual information on the participant's age (to confirm they were 18 or older), their racial-ethnic identity, their gender identity, and any other aspects of their cultural identity they deemed relevant. This was to assist with contextualizing the analysis of the data and in acknowledging the existing intersectionality within the participant's identity as an REM. It also asked about their counselling experience, length of counselling, counsellor/therapist characteristics (including their race/ethnicity), and reasons for seeking counselling. Such descriptions were useful to further obtain comprehensive contextual information (Creswell, 2013).

Interview Guide

I conducted a 60- to 90-minute individual, semi-structured, in-depth interview with each participant, where participants were invited to describe and reflect on their experiences of TSD and cultural empathy. I generated an interview guide (Appendix D) based on the dimensions of narrative inquiry—interaction, continuity, and situation—to obtain a more holistic narrative (Creswell, 2013; Wang & Geale, 2015). The interview guide followed a broad narrative arc, leaving space for the participant's story to guide the interview. Before interviewing participants, I piloted the interview guide with a volunteer to identify how questions flowed, were understood, and could be adjusted.

In terms of *continuity*, the interview guide built on the past, present, and future inquiry of the participant's experiences. Using prompts, I intended to broadly explore their initial impressions of therapy (e.g., "Tell me about your views and ideas on psychotherapy before you began seeking a therapist"), what led to seeking therapy (e.g., "Tell me what led to your decision to seek counselling/psychotherapy"), their experience of the therapy (e.g., "Tell me about your experience in therapy"), and future directions (e.g., "Tell me whether you would consider therapy/counselling again"). These broad segments served to build context for the main experiences of TSD and cultural empathy. *Interaction* could be seen within the main open-ended

questions posed for TSD and cultural empathy (e.g., “Tell me about a time when your therapist self-disclosed to you” and “Tell me about the therapist’s self-disclosure as it relates to cultural empathy”). As for *situation*, the interview guide contained suggested prompts that inquired about internal conditions (e.g., “How did it affect the therapeutic process?”) within the experience of the interactions.

Following the social constructivist lens of narrative inquiry, it was important to allow the participants’ own experiences of cultural empathy and therapist self-disclosure to emerge organically. I offered a broad definition for both terms prior to the interview to prime them, but the focus was on creating space for their stories to be shared and to understand what their experiences meant to them. Ultimately, my aim in this discovery-oriented approach was to explore potential connections between therapist self-disclosure and cultural empathy from REM clients’ perspectives. Thus, the interview guide (Appendix D) was a starting point and my approach with the guide evolved as I learned more from participants during the interviews. As such, the prompts contained within the guide were meant to serve as a checklist for the interviewer, but the conversation was guided primarily by what the participant shared (i.e., what was most meaningful for them as it emerged organically within a conversational flow).

Researcher as Instrument

Both the nature of qualitative research and my theoretical and conceptual framework, RCT, encouraged the researcher to engage in continual self-reflection and to explore how power and privilege may influence their life (Lenz, 2016). As the researcher, I was careful during interactions with the participant to prevent further oppressive experiences (Tummala-Nara, 2013). To facilitate this ongoing process, I aimed to heighten my self-awareness and to disclose my social location within my research. At the center of this theoretical and conceptual framework, the participant was the expert, and the researcher was there to help co-construct a narrative together. I aimed to practice my RCT values in order to promote mutuality, authenticity, connection, and empowerment with the participants, thereby equalizing power in the dyad (Hill & Knox, 2002; Lenz, 2016).

I also recognize that, as the researcher, I am not without assumptions. It is possible that I entered this research assuming that most REM clients/participants carry an experience of discrimination or racial microaggression based on my own personal experiences and review of the literature thus far. I was careful not to enter conversations specifically looking for instances

where TSD may have been conveyed negatively and to instead, be fully present and open-minded to the participants' stories. I expected to learn more from their experiences and to even come across narratives that may be in opposition to what knowledge I possessed. Knowing this might be the case, I wrote my pre-understandings which are available to the reader in Appendix E (Holloway & Freshwater, 2007; Mazzula & Nadal, 2015). I highlighted my social location and experiences related to my identity as a racial/ethnic minority, my intersecting identities, my position of privilege and dis-privilege, as well as my views regarding therapy with racial/ethnic minority clients, my view on therapist self-disclosure, and my understanding of cultural empathy (Appendix E).

Data Collection

Once a mutually agreed upon time and date were chosen, I met with each participant separately over Zoom. Each participant was asked demographic questions (Appendix C) at the start of the semi-structured in-depth interview and asked to choose a pseudonym for their anonymity. Interviews ranged from 70 to 110 minutes in duration, with average duration being approximately 90 minutes. Once the demographic information was obtained, participants were invited to share their experiences of therapy as it related to TSD and cultural empathy. The use of a semi-structured interview allowed for more flexibility while using broad questions and prompts that followed a narrative arc to encourage exploration of each participant's unique experiences (Sunderani & Moodley, 2020). The participants were provided with the interview protocol ahead of time so that they could review in advance. This may have provided opportunity to deepen reflection in the interview while also generating a sense of safety by having knowledge in advance about what would be asked. Interviews were audio-recorded via Zoom for later transcription and analysis. Security measures via Zoom were addressed with participants to further ensure safety and address any privacy concerns.

Data Analysis

Transcripts were analyzed using Braun and Clarke's (2006) thematic analysis (TA). TA is an appropriate and accessible approach for a multitude of data types, collection styles, and participant groups (Lainson et al., 2019). This method values the researcher's subjectivity as a resource while the researcher's accountability is established through the disclosure of their positionalities and research decisions (Lainson et al., 2019). Blending TA and narrative inquiry has been done before (Bradford et al., 2019; Patsiopoulos & Buchanan, 2011; Ross & Green,

2011; White & Hede, 2008), with empirical support for its usefulness in narrative studies mainly to discern patterns and establish themes across narratives (Riessman & Speedy, 2007; Salter & Rhodes, 2018).

Thematic analysis can be useful for analyzing the data set from narrative inquiry (e.g., story as data). While categories were produced from the thematic analysis of the data, the final output accounted for individual narratives of each participant's overall experiences (Lainson et al., 2019) following the elements of interaction, continuity, and situation. The narrative followed a *continuity* from the participant's decision to begin counselling/therapy, their experience of counselling/therapy, and their suggestions for an ideal therapist. The final narrative also included the participant's recount of specific *situations* with their counsellor/therapist, providing context of what led to these *interactions* and how it affected their experience of the counselling/therapeutic dynamic. For the purpose of the thesis, I organized and integrated the narratives by theme, but I first provided a narrative describing each participant's demographic and therapy history.

Thematic analysis complements narrative inquiry by valuing insider knowledge and subjective accounts while also encouraging researcher reflexivity and enhancing their awareness of how they influence the research process (Lainson et al., 2019). Instead of focusing on individual analysis, it emphasizes shared experience and themes across participants while remaining close to their accounts by integrating their own words (Lainson et al., 2019). Thematic analysis also requires close listening, and being attuned to the participant and implicit observations, allowing for a researcher's rich and complex descriptions of participant offerings (Lainson et al., 2019). Thematic analysis is comprised of six stages (Braun & Clarke, 2006), all of which were applied to each interview transcript before considering themes across transcripts:

1) **Familiarizing oneself with the data.** In this stage, I immersed myself in the data (i.e., interview transcripts), possessing prior knowledge given that I collected it through an interactive means. Transcribing the interviews was essential to this process of immersion. This involved multiple readings of each transcript in a purposeful way to search for emerging meanings and patterns. Braun and Clarke (2006) recommend reading through the entirety of each transcript at least once before coding. Taking notes or marking ideas for coding is similarly highly recommended and was done at this stage. I documented my notes within the margins of each transcript using Microsoft Word.

2) **Generating initial codes** (i.e., identifying meaningful excerpts of transcript text associated with TSD and cultural empathy). This stage began after familiarization and the generation of an initial list of ideas present in the data. For each transcript, I identified features of the data that were relevant to the aims of my study, paying particular attention to features that were unexpected but just as important to include. I was careful to code inclusively, to prevent excluding relevant content surrounding the target data. As Braun and Clarke (2006) highlight, "it is important to retain accounts which depart from the dominant story in the analysis, so do not ignore these in your coding" (p. 19). The initial coding step was in the form of paraphrasing the meaningful excerpts and then extrapolating the main idea to be represented as a code before moving on to the next step. These codes and their respective transcript excerpts were copied and pasted into Microsoft Excel sheets, with each Excel sheet representing each participant's transcript.
3) **Developing themes**. Once a comprehensive list of different codes was established for each transcript, I began to sort the codes into potential themes using Microsoft Excel. Each potential theme was given a specific colour that I used to highlight its corresponding code. For example, any codes that described the participants' experiences with TSD were coded as green. It was also possible that different codes were combined to form an overarching theme, such as participants describing how their experiences of TSD affected the overall therapy process. Given such overlaps, I parsed out the *Experiences of TSD* as a separate theme from the *Therapy Process*, while noting their similar code of origin. At this stage, I drew a thematic map for each transcript to identify the colour-coded themes present across transcripts and noted connections between themes (e.g., when an *Experience of TSD* directly related to a description of the *Therapy Process*). This helped to ensure that I was organized and could allow for flexibility as I sought to identify relationships between codes, themes, and levels of themes. There were some codes that did not fall into a particular theme, but I retained them in my Excel sheet for the next stage.
4) **Reviewing and refining the themes.** At this stage, I had a set of candidate themes, and this was the opportunity to decide which ones remained. Some themes were combined together while others did not have enough support to keep them. Level one of this stage involved reviewing the coded data extracts to assess whether they formed a coherent

pattern. If it was not coherent, I decided whether to rework the theme, create a new theme, find another suitable theme, or discard the coded data from the analysis. Level two involved a similar process but with the themes in order to determine whether they were an accurate representation of the data set. For example, many themes pertained to the process of therapy rather than to the experiences of TSD or cultural empathy. As such, the *Therapy Process* was a finalized theme in its own right.

5) **Defining and naming the themes.** This stage required that I revisit the collated data extracts for each theme. The goal was to organize them for coherence and internal consistency, followed by applying a narrative lens. As Braun and Clarke (2006) note, it was essential that I explained what was interesting about them and why. This involved situating each theme as following the narrative elements of *continuity, interaction,* and *situation.* Essentially, I was reconstructing a timeline that followed the interview guide (from before the participant began therapy, their decision to attend, their impressions, the TSD event and cultural empathy, closure of therapy, and future directions). Each individual theme required detailed analysis, in part identifying the narrative element that each theme held and how they each fit into the broader story I was telling about the data with respect to my research question. During this process, I did identify sub-themes within the main themes as well. Refinement of the themes was accomplished when I was able to concisely explain what they each represented in scope and content, following the narrative arc of a beginning, middle, and end. This marked the endpoint of individually analyzing each of the participant's transcripts.
6) **Producing the final analysis.** This final stage occurred when I had amalgamated fully worked-out themes within a narrative arc for each participant. In this phase, I was looking at themes across all transcripts to consider commonalities and differences. The analysis, including data extracts, were meant to be "concise, coherent, logical, non-repetitive, and an interesting account of the story" the overall data told (Braun & Clarke, 2006, p. 23). This step included choosing vivid examples or examples across transcripts that most clearly captured the essence of the themes I was demonstrating. In producing the final analysis of therapist disclosure as it related to cultural empathy, it was crucial to ensure I was providing an analytic narrative throughout the write-up; that is, to go beyond describing the data and to develop individual narrative outputs for each participant that

captured their respective experiences, followed by an overall discussion across the identified themes. These participant narratives were shared with the participants wherein they were given two weeks to provide feedback on the output. One of the four participants provided clarity to some of their quotations that were used. For example, they inserted additional words to further qualify their expectations of therapy, the therapy process, the impact of therapist self-disclosure, their definition of cultural empathy, and their post-therapy reflections. The additions did not change the overall output of the analysis but further corroborated the results. I included the participant's additional descriptions when applicable throughout the results section. Depending on the participants' narratives and their feedback, the discussion spoke to unique, context-dependent, and similar themes found. It was important to keep the participants' narratives apart to prevent homogenization of the data, but to bring them together as described in the results chapter to ensure there was a cohesive discussion of all included narratives (Connelly & Clandinin, 1990; Holloway & Freshwater, 2007).

Quality Control

In narrative inquiry, participants describe their world and their reality as they see it from their perspective (Holloway & Freshwater, 2007), within the confines of temporal and cultural contexts (Lainson et al., 2019). The researcher is then meant to re-present the voice of the participant, by remaining as faithful as possible to the meaning and experiences of the participants while transforming and interpreting them by way of *authenticity* and *trustworthiness* (Holloway & Freshwater, 2007).

Authenticity

Authenticity is comprised of fairness, ontological authenticity, educative authenticity, catalytic authenticity, and tactical authenticity (Holloway & Freshwater, 2007). An authentic study is when the research process is adequate, the ideas of participants are appropriately presented, and participants (and readers) gain better insight into the research problem, thereby moving toward improvement of their own problem or situation (Holloway & Freshwater, 2007).

Fairness pertains to the researcher being fair and just to participants, which may include taking their social context into account (Holloway & Freshwater, 2007). The researcher's social

context was outlined within the pre-understandings (Appendix E) and the participants provided their social context within the demographic questionnaire and interview. It was also important to obtain informed consent at the start and throughout the study (Holloway & Freshwater, 2007). Participants were given informed consent at every step of the study when screened, given a study description, signing the informed consent form, before participating in the interview, during the interview itself, and if they chose to participate in providing feedback for their narrative output.

Ontological authenticity means that the study serves to help both the participant and researcher understand their social worlds and human condition (Holloway & Freshwater, 2007). The entire research process was meant to be a collaborative process where the participant was invited to share their experiences through conversation with the researcher and provide their input after the interview to further give voice to their narrative. The researcher and participant were thereby involved in a process that allowed them to get to know each other and develop a rapport based on the shared understanding of the research problem.

Educative authenticity means that the study provides intersubjective understanding, wherein participants can improve the understanding of others (Holloway & Freshwater, 2007). This study will accomplish this form of authenticity once participants read the final report that will include the narratives of fellow anonymous participants who shared a similar (or different) experience with TSD. As well, the researcher has learned from and discussed the participants' insights and readers may greatly benefit from the participants' narratives of TSD and cultural empathy.

Catalytic authenticity refers to when participants' decision-making is enhanced by the research (Holloway & Freshwater, 2007). Throughout the research process, participants were invited to share their experiences at their own discretion and decision of what they choose to share. Their own self-disclosures were within their control, coupled with the continual process of informed consent.

Tactical authenticity is the final piece of authenticity where the research itself serves to empower the participants (Holloway & Freshwater, 2007). The very nature of the research topic was focused on how racial-ethnic minority clients perceive therapist self-disclosure as it relates to cultural empathy. This was an opportunity for REM clients to speak on their experiences and

identify whether there was a potential relationship between TSD and cultural empathy that could further benefit REM clients.

Trustworthiness

Trustworthiness can be achieved through the development of dependability, credibility, transferability, and confirmability. *Dependability* means that my narrative as the researcher is consistent and accurate, which can be ascertained by the reader through clarity of my decision-making process (Holloway & Freshwater, 2007; Moss, 2004). I described in detail my research design, data collection, and analysis to make clear how I arrived at my conclusions.

Credibility is the extent to which I can re-present the lived experiences and reality of the participants, as well as the meanings they give to their experiences (Holloway & Freshwater, 2007). To ensure this process remained true to the participants' experiences, I employed interviewing methods that stayed close to the participant's meaning. A beginner's mind, a sense of curiosity, relevant prompts (Appendix D), paraphrasing/summarizing, and checking in with participants about their meanings were all methods that I employed as a therapist-in-training as well as a researcher.

After the interview, I employed member-checking to ensure that participants were satisfied with the final narrative output. I invited participants to review the transcript to verify whether they wanted to change or add anything before I began the analysis. They were given a two-week period to respond via email. I also invited them to review the final individual narratives, and they were given a two-week period to respond. All participants provided approval at both instances, with one participant providing feedback in the form of clarifying descriptions for both their transcript and final narrative.

The findings from my research should be *transferable* to similar contexts with similar types of participants, thereby being applicable to other settings that have a related context to the initial investigation (Holloway & Freshwater, 2007). Given this was a study about the experiences of REM therapy clients, these findings might be applicable to similar settings where REM are recipients of mental health services. Furthermore, the extent to which transferability can be achieved is via the rich descriptions obtained of the participants' experiences and their

unique contexts. The themes/findings that emerged from these descriptions could enable the reader to assess how those themes/findings resonate for them.

With regard to *confirmability,* I ensured that my assumptions and preconceptions did not interfere with the findings and conclusions of the study (Holloway & Freshwater, 2007). To this end, my thesis supervisor completed an external audit to provide input on my interpretations that were integrated into my data analysis. I also kept a research journal to document my experience of the research process and to reflect on how I interpreted the participants' stories. This practice was done to support a more faithful representation of the participants' accounts by minimizing the influence of my own pre-understandings or expectations (Holloway & Freshwater, 2007).

Chapter Four: Results

This chapter is intended to carry the reader through participants' experiences of therapist self-disclosure and cultural empathy while in therapy. I applied a narrative format to organize the thematic analysis of relevant experiences into a temporal progression. The narrative begins by providing participants' demographics and therapy history, followed by their cultural context as clients and their expectations prior to starting therapy. The narrative progresses based on the themes that were generated using Braun and Clark's Thematic Analysis. The themes focus on therapy process, types of therapist disclosures that participants experienced, how participants defined cultural empathy, and how certain types of disclosures may have contributed to a sense of cultural empathy in the context of racial and ethnic differences. The narrative ends with the theme of participant reflections on their overall therapy experience and future therapy directions.

Participant Contexts

The four participants were Anna, Rosina, Rayan, and Afia. Their demographics, cultural identities, and therapy history are described below. Therapy history includes but was not limited to reasons and contexts for seeking therapy, therapist choice, number of therapists, duration of therapy, number of therapy sessions, and brief descriptions of their experiences with the therapists they chose to discuss in the interview.

Overall, participants were cis-women in their early 20's to mid 30's who identified as a racial-ethnic minority. Note that each participant's age, racial-ethnic identity, and profession were generalized to protect participants' identities. Most received therapy by more than one therapist between 2017 and 2022, some of which occurred during the pandemic. All had experience with a white therapist. Therapy took place in a province in Eastern Canada in a variety of settings, including university health services, private practice, and virtual therapy. Therapists' qualifications ranged from being a registered social worker to a registered psychotherapist. The following sections will delve into more detail for each participant's context.

Anna

Anna is a cis-gender woman in her early 20s and of Southeast Asian descent. A fourth-year university student born and raised in Canada; she identifies more with North American culture but stays connected to her roots through her culture's food. She started seeking therapy in

grade 9 at 14 years of age for anxiety at the recommendation of her guidance counsellor. By the time of our interview together, she had been in therapy since grade 9, on and off, up to her second year of university.

Anna had a total of three sessions with her first therapist, ending her therapy early due to a lack of connection. Anna's family doctor subsequently recommended a social worker who she saw for about a year and had introduced her to Cognitive Behavioural Therapy. She then saw an older male psychiatrist for 1-2 years for talk therapy. Afterward, she saw her fourth therapist for about half a year during her senior year of high school, where sessions were initially bi-weekly and then monthly. She had about 8-10 virtual sessions with her fifth therapist in her second year of university, through her school's mental health and wellness centre. She saw them on a bi-weekly basis during the pandemic. Overall, Anna's course of therapy lasted from the start of high school until her second year of university.

She mentioned that all five of her therapists were white and that she had chosen all her therapists herself. She stated that she did not notice a lot of Asian therapists when seeking therapy, but that it did not bother her as she just needed a therapist. Anna's most significant experience of therapist self-disclosure occurred at the end of her senior year of high school with her fourth therapist who taught her self-compassion.

Rosina

Rosina is a cis-gender Muslim woman in her early 20s. She identifies as East African and Black, both of which she named as important aspects to her cultural identity, alongside her religion. She emphasized that she is visibly Muslim as she wears a hijab. She is also a university student in the sciences. Rosina was around 15 years old when she first began therapy for anxiety.

She recalled starting therapy about one year after she first brought her concern to her parents. She mentioned struggling with anxiety ever since she was a child. Her first therapy experience was at a private practice when she was in grade 9, where she saw a registered psychotherapist for approximately 25-30 sessions. They met weekly in the beginning, less frequently while she was out of school, and then every 2-3 weeks near the end of therapy. She had found the therapist through her family doctor who had given her a list of therapists from which to choose. Rosina and her parents chose the therapist geographically closest to them. This

therapist was described as an older white woman. Rosina held the assumption that this therapist was in practice for a long time due to her listed graduation year, her mention of other clients having similar concerns to Rosina, and the visible age difference that Rosina perceived. The therapy relationship ended on a disagreeable note when Rosina experienced her therapist's increase in self-disclosures toward the end of therapy.

Rosina's second experience with therapy occurred in the summer after her previous therapy had ended. She saw this therapist, who was part of a group psychotherapy practice, for 5-6 sessions bi-weekly and virtually. Rosina described herself as having more choice in selecting this therapist and being more informed by reading about them and receiving a friend's recommendation. Therapy occurred virtually as the therapist was in another city in the same province. This therapist was described as having a Middle Eastern background, being a Muslim, and wearing a hijab just like Rosina. She described this therapist as "newer" to the profession and a younger woman, likely in her late twenties to early thirties. Therapy with this therapist ended when it was hard for Rosina to find time for sessions, and she felt she was in a better position and no longer required therapy.

Rayan

Rayan is a cis-gender woman in her early 20s. At the time of the interview, she was finishing up her second year of university in the sciences. She is a born South Asian who moved to Canada with her parents at a young age. Self-identifying as a first-generation Canadian, she described her childhood as growing up in a low-income household and having hard-working parents. Rayan spoke to having freedom to take her time to complete her education while also acknowledging the need to succeed, emphasizing the pressures of her parents' sacrifices and struggles as first-generation immigrants. These experiences shaped her needs within therapy where she believed it was important for her therapist to understand her past context.

Rayan sought therapy to help her process her feelings about growing up in poverty and living on social welfare as a first-generation Canadian, as well as feelings of resentment toward her parents. Her first encounter with therapy was facilitated by obtaining a list of mental health professionals through her parents' health insurance and finding a suitable therapist with a short waitlist. She initially saw a white male psychologist, but she felt they were not matching up well, describing a disconnect in experiences. She mentioned wanting a more empathic therapist after

that experience. Her mother subsequently contacted the Ontario Medical Association who helped them find a professional better suited to Rayan.

Rayan recalled that therapy with her second therapist started during the pandemic in her last few years of high school and lasted a little over a year toward the end of high school. Her therapist was white and held qualifications as both a social worker and psychotherapist. While Rayan saw her therapist regularly, every two to three weeks for a year, the therapy gradually "fizzled out." Rayan had been living with a chronic illness and enduring parental pressure to succeed academically, both of which she felt influenced her experiences with this therapist. After numerous instances of therapist self-disclosures in close succession, she delayed booking a subsequent appointment. By that point, she did not feel as though she needed therapy and felt somewhat disconnected from her therapist.

After this experience, Rayan pursued virtual therapy with a third therapist where she completed Cognitive Behavioural Therapy modules. Although she did not interact often with this therapist, she felt they connected on the basis of them both being minorities.

Afia

Afia is a cis-gender woman in her mid to late 30s who works in health research. She primarily identifies as African and Black, as well as a Christian, a mother, and a wife. She described her family background as not being far removed from colonial oppression.

In total, Afia saw four therapists over a span of three years during her early 30's. When asked about her past therapists' credentials, Afia felt it was disrespectful for her to ask for their credentials, trusted their experience, and acknowledged they were also in a position of power.

Prior to seeing her first therapist, Afia had been struggling with anxiety but did not know it at the time. She had been having panic attacks and experiencing deep feelings of worry and fear. A co-worker who took notice had recommended she make use of their Employee Assistance Program. She was assigned a counsellor and received two sessions over the phone during which the counsellor determined that Afia had moderate to severe anxiety and suggested she see her family doctor. Afia's next therapist, whose racial/ethnic identity was described as white, was also assigned since it was an urgent and direct referral within her doctor's family health team for

whoever was available first. She was able to have a limit of eight sessions with this psychotherapist, which took place bi-weekly for six months.

Afia then sought therapy for cultural differences in communication between herself and her partner. She described this therapist as being the same ethnicity as her partner. This course of therapy lasted one session, with the therapist's similar ethnicity to her partner inadvertently contributing to Afia's existing insecurities. Finally, she saw a therapist of her choice at a private practice through her personal insurance benefits. She described this therapist's racial/ethnic identity as mixed and Black. Afia had just become pregnant when she started seeing the therapist at the start of the pandemic. She noted that, at the time she was seeking a therapist, the sociopolitical climate was ripe with racial tensions that were especially high. She therefore wanted to see a Black woman specifically who also specialized in post-partum anxiety. This therapy experience lasted six or seven months with ten weekly to bi-weekly sessions until Afia ran out of benefits.

Themes

The unfolding narrative of therapist disclosure and cultural empathy in therapy is based on the thematic structure offered in Table 1 below. The thematic structure was generated from an in-depth analysis of each participant's interview transcript. The table depicts themes and subthemes generated from the analysis, as well as a sample verbatim excerpt from each of the transcripts to demonstrate substantiating the subtheme.

Table 1

Themes, Subthemes, and Sample Excerpts

Theme	Subtheme	Sample Excerpt
Client Cultural Context	Intergenerational trauma	I think every immigrant, every person of color needs therapy. Absolutely. I just feel like the way the things that as a collective, the things that we've gone through, in general… We have that shared trauma. We have the trauma of colonization. (Afia)
	Racial tension/stress	There was a time where it was like it felt like every week you were hearing about another

		Black man got shot… And then, you know, the residential school situations are coming up. Like it just felt like there was just so much hate, you know, everywhere all the time… (Afia)
	Making sense of religion and therapy	…coming from like a religious background, like for them it was also like we can overcome what you're going through, like Islamically, if that makes sense. So it's like they kind of had the mentality of like pray it away type of thing. (Rosina)
	Familial reactions to the idea of therapy	I definitely had the feeling that they might be like, 'Oh, you're making it up.' Which is a very common Asian stereotype. (Anna)
	Familial reactions to actual therapy	And when it's not like directly like – Like when there isn't like a direct effect of like one session, they almost wonder, like, is this even working out? Like, is it just better to do it the old way? (Rayan)
Expectations about Therapy	Accessibility	…it was like I knew it existed, but I didn't think it was an option for me. (Rosina)
	Stigma, mistrust, and skepticism	I was a bit more skeptical about it because obviously I've never done it. And there's always that stigma in South Asian families and a lot of like immigrant families in general about getting help. (Rayan)
	Vulnerabilities about starting therapy	I was very anxious that I wouldn't be understood or maybe my problems wouldn't be enough to justify going to therapy and taking up their time. (Anna)
Therapy Process	Humanizing elements	I didn't like dealing with my emotions, but she told me, like, don't hide it. Like, you can keep crying. But she obviously said this in a lot more gentle, warm, like, caring fashion. And like she would let me experience my ugly emotions that I didn't really want to. (Rayan)
	Therapist knowledgeability	…she was so knowledgeable, like, she was telling me like, how, like, you know, like

		thought patterns and how, like, you know, negative thoughts can lead to this and like this, that, like also she did also talk about, like, science, like how the brain works and everything. (Rosina)
	Broaching difference	… she never judged in a way that was like – Like for me the thing that I didn't like and I didn't want was like people to judge my parents. (Rosina)
	Shifts leading to change in therapist	It was when, like the relationship started, like, I don't know where it went, but it started like something changed about it, definitely. And I think it was that point where I was like, maybe, I don't know if it's the race playing the role or if it's something else, but something's affected here. (Rayan)
Types of Therapist Self-Disclosure	Disclosure of opinion	[Therapist said] “You need to go like, party and like, be drunk and like, pass out. And then the next day, like, you never know where you’re at.” (Rosina)
	Disclosure of challenge	[Therapist said] “You're saying so many mean things to yourself. You need to stop it because you wouldn't talk to someone else that way.” (Anna)
	Disclosure of partial similarity	[Therapist said] “And she told me about her university experience, how she went from like full time to part time working like numerous jobs just because she wasn't doing that great in school.” (Rayan)
	Disclosure of vulnerability	[Therapist said] “When I was your age, I attempted suicide as well when my mom died.” (Anna)
	Nonverbal disclosure	…she didn't have to share much just because of the just the fact that she's Black. You know what I mean? Like, you don't have to disclose nothing to me. (Afia)

Client Understandings of Cultural Empathy	"Matching" with therapist's culture	You're similar in culture. You might have like similar ways of life, right? So you might understand maybe the culture of Asian parents more. (Anna)
	Therapist's ability to connect	…understand the struggle or at least see that there's some sort of a struggle. And be like, yeah that sucks. You know what I mean? As opposed to being like ethnocentric… (Afia)
Experiences of Cultural Empathy through Therapist Self-Disclosure	Disclosures that facilitated cultural empathy	…regardless of who or where the person is from, the minute you both find out that you're mothers, like, you're automatically like you connect. (Afia)
	Disclosures that hindered cultural empathy	My parents weren't able to, quote, unquote, combust, especially when we lived in poverty. So her telling me, like, with all like the current, like financial stability I have now, like that I'm going to combust… (Rayan)
Reflections about Therapy	Empowerment	I think I know myself as a patient and what I need to help myself. So if they're, if they don't really fit into that criteria of what I need, then they're not going to be terribly useful or I'm not going to have great sessions with them. (Anna)
	Disconnection in therapy	And all of a sudden I'm being met with a lady that just reminds me of all the things that I lack. That's not going to be helpful. (Afia)
	"Matching" with therapist	And I'm not saying that like I need to be with a Muslim therapist specifically, but at least somebody who's, like, open to listening to what I'm saying. Instead of just saying like, 'Let's not talk about that. (Rosina)
	Preferred therapist traits	If I was working through like issues with my parents or issues about my upbringing as a child, I think it would be more important to talk to someone who would have a similar upbringing or understands a similar upbringing. (Anna)

1. Client Cultural Context

The following subthemes reflect cultural context of participants, which sets the stage for their respective experiences in therapy. The subthemes are as follows: *a) Intergenerational trauma, b) Racial tension/stress, c) Making sense of religion and therapy, d) Familial reactions to the idea of therapy,* and *e) Familial reactions to actual therapy.* The first three subthemes are most relevant to Afia, whereas the last two pertain to Anna, Rosina, and Rayan.

1a. Intergenerational trauma. Afia was the only participant to note intergenerational trauma as part of her cultural context and address it pointedly. She reflected that she believes "every immigrant" and "person of colour" needs therapy because of "the things that we've gone through." She spoke to the shared historical experiences of Sub-Saharan Africans due to "all slave trades, both Arab and trans-Atlantic" and the "trauma of colonization, civil war, and genocide." She described a "culture of silence" as an after-effect of colonial oppression where "stress and trauma is playing itself out…physically." Afia provided examples of the impact of intergenerational trauma on the physical health of African Americans, such as diabetes, high blood pressure, and hypertension. Afia is knowledgeable in health research and offered information from literature she had read to support her point, stating that, for Black women in the U.S., the "number one killer disease" linked to intergenerational trauma is chronic heart failure. She elaborated that the existing socioeconomic situations that affect this demographic also relate to slavery and colonization, which "over time are impacting our physical health."

1b. Racial tension/stress. In addition to intergenerational trauma, Afia identified racial tension and stress as part of her cultural context. She had just become a mother of three during the ongoing COVID pandemic and had concerns about job security, describing it as a "really stressful time because anxiety kicks in."

Afia described the heightened racial tension and stress by what she would witness in the news: "It felt like every week you were hearing about another Black man got shot" alongside "the residential school situations," referring to the discovery of unmarked graves of Indigenous children who had died due to maltreatment at residential schools. She described how "there was just so much hate…everywhere all the time." She noted it was "so distressing," that "if I mistrusted white people here during that time, I was like, I could go higher," referencing a heightened mistrust toward white people due to comments she would hear. She noted, "Yes, I

know it's not you. You didn't kill those babies in the 1940s. I know that. But like your ancestors did." She wanted the descendants of those who had oppressed to "at least [have] some sense of remorse for things," rather than to be "so dismissive," addressing the desire to hold dismissive white people to account.

Afia emphasized that a lack of remorse by white individuals "really hurts" as "they pass that on to their kids and then their kids come and act two ways towards my kids. So, I still struggle with that." She elaborated that she worries about "who's saying what to my child," and "how my child is interpreting things." Her daughter, for instance, talked about how she wanted "her hair to be straight and white." Afia responded by saying, "Your hair is beautiful. You have curly, big, beautiful hair." Afia observed that although her initial "race" was to "get out of financial trouble," racial tension and stress have changed that "race" as she raises her children in a time where "things are not as intense, but they are still quite tense," noting this period as "post George Floyd times."

Adding to the racial tension and stress, Afia described general mistrust toward medical professionals and the healthcare system: "Who's to say that, you know, these people that have done so much harm to my community can all of a sudden kind of help me." For Afia, this was an added layer on top of what she had heard from Black pastors, specifically African pastors, who said, "Don't spread your business to all these people. Talk to God, you know, because he knows everything." Afia mentioned that the Bible encourages people to "seek counsel" and "share your sins with one another so that you may be healed." She pointed out the confusion in being told not to share personal things but to trust the scripture that says otherwise, highlighting how a pastor was "talking from his own personal trauma of being betrayed by a white person, which is superseding what the Bible actually says about therapy itself."

1c. Making sense of religion and therapy. Afia and Rosina both spoke to the struggle between relying on their religious beliefs and the idea of seeking support through therapy. Afia spoke most pointedly to this dilemma. She explained that, prior to therapy, she was worrying about death and the safety of her loved ones, describing "feelings of fear and panic attacks." She recalled, "I kept guilting myself that I didn't have enough faith, which is why I was always so afraid." Both Rosina and Afia had grown up with the belief that one should rely on their faith to get through difficult times; Afia stated: "I felt like the response was just to pray it away… But it

wasn't working." She elaborated that she required the "natural stuff, like the slow process" such as "therapy or medication," while still believing that "God can miraculously set me free from the fear and all of that." She explained how placing these two beliefs together was a difficult process to comprehend:

> Because it's like if you really had faith, why wouldn't you just believe that God would heal you outside of all these other interventions? But then who's to say that God is not using those interventions to heal you?

Rosina echoed Afia's struggles with navigating religion and therapy, where her parents were "skeptical" and held a "pray it away mentality" that "didn't work." Rosina expanded on her religious background where she denoted from her parents' perspective, "We can overcome what you're going through, like Islamically." Her parents' techniques were to "read more Qur'an" and "pray more." Rosina spoke on how they would rely on methods of religious healing where they would "buy like Zamzam water... 'Just drink this. You'll be fine,'" and "it didn't work." Rosina explained that this religious healing created a year-long delay before finally seeing her first therapist. Similarly to Afia, Rosina spoke to viewing therapy as congruent to her faith, where "seeking help is also like an Islamic way."

1d. Familial reactions to the idea of therapy. Three of the participants mentioned their parents' reactions to the idea of therapy as it was being considered. Rosina and Rayan spoke to their family's lack of familiarity and skepticism, respectively, with therapy. Meanwhile, Anna spoke to her parents' support in contrast to cultural expectations about therapy.

Rosina described her parents' response to when she first considered therapy: "What do you mean? Like you're just paying somebody to talk to you? We can do that." She noted how they "want to be that person for me." She recalled that her parents disagreed with her needing a therapist, "It wasn't like a super hard no. It was just like, [they] don't really understand." Her parents viewed therapy as an "extreme" and not "normal." Rayan relayed a sense of skepticism from her parents as she considered therapy, saying: "I think I more or less expected it, given how they are. But I was like, this is fine. Like I'm still getting the therapy I need."

In contrast, Anna experienced her parents as "very supportive" in her decision to seek therapy. However, she was "normalized" to her cousins' experiences with their parents who were

“maybe not as nice.” This influenced her expectations of how her parents might react to her consideration of therapy. She recounted, “I was very, very afraid. I had really bad anxiety to start off with, so that made it even worse.” Before telling her parents, Anna explained, “I definitely had the feeling that they might be like, ‘Oh, you're making it up.’ Which is a very common Asian stereotype.”

1e. Familial reactions to actual therapy. Three of the participants, Anna, Rosina, and Rayan, spoke to their parents’ understandings of the therapy process as it unfolded. Their experiences were mainly marked by their parents questioning the effectiveness of therapy and looking for evidence of its progress.

While her parents were supportive of her starting therapy, Anna noticed their misunderstandings of the therapy process versus how therapy unfolded for her in actuality: “There were definitely times when I’d go to therapy and they're like, ‘Are you trying your hardest?’ You know? Because they don't understand what it's like to go through it… They're doing their best.” Her parents would ask, “So when are you going to get off these meds?” or they would “assume that it’s going to be a very linear path,” and become “disappointed a little when you step backwards.” She concluded, “But that's just the way of therapy.”

Rosina admitted to not understanding the full effect of therapy at the start and neither did her parents who were “still skeptical.” Similarly to Anna’s parents, they would inquire about her progress: “Okay so, what did you learn? Like, what is – Is this actually a thing?” Her parents spoke in hindsight, saying “Oh yeah, we could have told you that,” which Rosina found “funny.” In the beginning of therapy, Rosina described feeling “a little bit like an alien,” as she had been the first in her family to go to therapy. Her therapy attendance was kept a secret from her siblings: “That kind of shows, I guess, the relationship we had with therapy.” Rosina said that her parents eventually realized that going to therapy was “normal.”

Similarly to Anna, Rayan expressed a sense of trust in the process despite her parents’ skepticism: “And even though they can't see it right now, I know, like down the long run, it'll probably be for the better.” She described her parents as showing “conditional” and “wavering support,” with her mom asking, “Why are you acting the same? Like what, what are the benefits of this [therapy]?” Both of Rayan’s parents, being doctors, would ask to see her client file, though she would refuse. They said, “We want to see what you’re talking about.” She recalled

having “a relatively emotional conversation” with her therapist once, and her parents wanted to know why she was crying and couldn't talk to them. Similar to Anna and Rosina, Rayan’s parents questioned her progress in therapy: “When there isn't like a direct effect of like one session, they almost wonder, like, ‘Is this even working out? Like, is it just better to do it the old way?’” When asked about the old way, Rayan stated that she did not know what that could even look like.

2. Expectations about Therapy

The following sub-themes reflect participants’ expectations prior to starting therapy. The sub-themes are: *a) Accessibility, b) Stigma, mistrust, and skepticism,* and *c) Vulnerabilities about starting therapy.*

2a. Accessibility. In terms of accessibility, participants identified finances as well as lack of awareness about therapy as barriers to accessing therapy. Some of the participants shared that they initially did not see therapy as an option as it was seen as too expensive. For example, for Afia, therapy felt financially inaccessible, stating “I always knew that therapy was expensive… In fact, I was really broke for a long time, so it never even crossed my mind that that's something that I would do.” Therapy became more accessible for Afia once she went through her work’s Employee Assistance Program and her family health team. For Rayan, having insurance coverage primarily facilitated the process despite holding skepticism and stigma toward therapy: “My mom's like, ‘If we're paying for it, you might as well take advantage of it.’” A lack of awareness about the usefulness of therapy also seemed to render therapy less accessible. Rosina noted this reality in the following,

> I didn't at the beginning think therapy was an option because it was just, I never, it wasn't a thing that I thought was like accessible or I didn't – I was never taught that it was an option if you were struggling.

2b. Stigma, mistrust, and skepticism. Afia, Rosina, and Rayan shared stigma, mistrust, and skepticism they had about the therapy process. For Afia and Rosina, a sense of stigma was named when they shared that prior to starting therapy, they viewed it as something for people “that had really, really serious problems.” Afia mentioned, “So I never really thought, oh, maybe I should consider therapy.” For Rosina, accepting therapy was like accepting she was sick or that “I have something like, wrong with me.”

Rayan shared experiences of skepticism toward therapy, which she attributed to her lack of exposure to and experience with therapy. Her skepticism was also tied to stigma she had felt in South Asian culture as well as immigrant families in terms of seeking mental health help.

Afia also expressed initial mistrust toward the idea of therapy. She maintained that there is a history of racism from white people that created a deep level of mistrust. Observing that therapy is predominantly with white therapists, she found herself approaching therapy with a similar sense of mistrust. In Afia's experience, she had moved around a lot, having lived in Europe for a couple of years and leaving because of racism. She had also lived in Nigeria, working with white people, and still experienced racism, reflecting "So it's just been a constant theme in my life, this underlying theme of white people are not trustworthy because of X, Y, and Z." However, upon meeting her second therapist who was white, Afia noted, "there can be trustworthy white people." While Afia acknowledged that her second therapist must also have a "certain level of decorum as a professional," Afia has had experiences with "some shady white doctors." Therefore, meeting her second therapist was "an eye opener."

Finally, Rosina also experienced skepticism, as well as fear, after accepting that she was going through a difficult time in her life and may need to consider therapy. She acknowledged the possibility of media playing a role in her skepticism toward therapy. Her initial perception of therapy was that "not everybody can need therapy and still be normal." This skepticism motivated her to do her own research despite what she saw in the media or had heard from others. Her research included watching YouTube videos about others' first experiences in therapy and consulting with friends. This helped her to better understand what therapy could be like and weigh the pros and cons of starting therapy. Consequently, it allowed her to approach therapy with an open mind, where "the positive outweighed the negative. And I was like, you know what? I'll just try it because you know, what can I do?"

2c. Vulnerabilities about starting therapy. Rosina, Rayan, and Anna spoke to emotions that emerged related to the pending start of their therapy. Emotions surrounding starting therapy included fear, anxiety, shame, concerns of being misunderstood, and all seemed to reflect an experience of vulnerability. Rosina named what she referred to as a "fear" about starting therapy, stating: "It's like in the beginning, the therapist is a stranger." Anna also expressed feeling "very, very afraid" and "very anxious" of the process of therapy. Specifically, she was concerned about

whether she would be understood and whether her problems would be “enough to justify” going to therapy, stating: “I was very afraid that I would run out of things to talk about, or they didn’t have enough merit, and then I would just be wasting my time there.” In a similar vein, Rayan remembered feeling “the typical nervous” upon approaching therapy for the first time, like seeing “any new doctor,” where she wondered if she would be listened to. In addition to fear and anxiety about meeting a therapist for the first time, Rosina described feeling ashamed that seeing a therapist might mean “I'm not competent. I'm not like, you know, I'm not independent.”

Rayan expressed some concerns about being misunderstood related to what she would share about her upbringing. During therapy, she chose not to disclose aspects of her childhood, stating, “I think there was a lot about my childhood that I couldn't tell [the therapist], particularly just…like typical brown parents, they tend to, like, hit their kids when they're messing around.” More specifically, Rayan feared her therapist might judge her from a “Western perspective” and tell her, “That’s not okay.” Rayan consequently decided to “hold that back from her.”

3. Therapy Process

The following subthemes encompass participants’ observations of the therapy process, which included: *a) Humanizing elements, b) Therapist knowledgeability, c) Broaching difference, and d) Shifts leading to change in therapist.*

3a. Humanizing elements. Rosina, Rayan, and Afia spoke to humanizing aspects of the therapy process, reflecting their therapists’ capacity to make them feel seen and connected. Of the three participants, Rosina spoke highly of both her therapists, emphasizing their “gentle” and “soft-spoken” nature, as well as their “nonjudgmental” approach and their frequent check-ins to see how she was feeling. She recalled a sense of “safety” through their “body language,” “tone of voice,” and “eloquent” choice of words. Before therapy, Rosina had difficulties understanding and regulating her emotions while her family was unable to comprehend them. The start of her therapy experience marked the first time she felt “validated,” “heard,” and her struggles were “really seen.” Rosina described this as “amazing,” and was eagerly anticipating each session.

Rayan described therapy as “very warm and comforting, like having someone listen without having the automatic like judging of like, ‘Why wasn't it good enough for you?’ that I

would have had with my parents." Further contributing to the humanizing elements of therapy, she recounted a time when she tried to stop crying in session:

> I didn't like dealing with my emotions, but she told me, like, don't hide it. Like, you can keep crying. But she obviously said this in a lot more gentle, warm, like, caring fashion. And like she would let me experience my ugly emotions that I didn't really want to.

Despite initially disliking discussions about her childhood and emotions, Rayan believed the financial investment in therapy "kind of forced me to actually go through my childhood and everything that drives me and who I am as a person and how that played a role into it." Rayan valued the opportunity to take up space in sessions and found comfort in having a woman on the other end who was "warm and gentle." The fact that her therapist was a social worker who had worked with kids and teenagers added credibility for Rayan. As a teenager herself at the time, "it felt like more of like a connect in that sense."

At first, Afia imposed pressure on herself to appear as a "perfect client" with her last therapist who was Black. Despite lacking the "bandwidth to talk," her therapist reassured her that they did not have to discuss specific topics, offering Afia the freedom to share about her day or to choose moments of silence. Afia explained, "I was okay with her just being able to sit and just look and cry sometimes, not cry sometimes, you know?" Afia valued the permission in "just being able to show up and not feel performative," as well as the option to end sessions early if she needed: "I'm paying for this. I'm going to stay here quietly." These quiet moments, though not perceived as restful, served as "respite"—building momentum to face ongoing challenges. Afia also shared work-related experiences of racial microaggressions with her therapist, who offered support through silent understanding and suggestions for self-care, describing it as "talking to a friend," in the midst of racial challenges.

In contrast, Afia found her experience with her white therapist to be eye-opening. Her therapist's insights provided Afia with an in-depth understanding of her inner experiences and triggered states. Afia appreciated her therapist's use of examples, and ability to validate her experiences and foster understanding. Afia's connection with her therapist deepened when she learned about her therapist's breastfeeding journey as a working mom, breaking Afia's previous mistrust toward white therapists: "That's when I connected with her differently," indicating how such a similarity "humanized" her therapist. Afia described the following:

> I didn't feel like she's somehow out to get me, you know, or somehow, someway, she's going to slip and say something that's going to make me feel inferior, which always happened in the past. So that's – That was really surprising for me.

She indicated a sense of mutual respect throughout the relationship. Her therapist encouraged her to admit when she was not okay, while seeing through any of Afia's attempts to convince her of otherwise: "Wow, she's seeing through my soul pretty much."

3b. Therapist knowledgeability. Rosina and Afia spoke to their therapists' positioning in session as being educational and informative to their inner experiences. For example, Rosina felt that both of her therapists were "knowledgeable" and allowed her to better understand her experiences. Despite her first therapist's skepticism of the sciences, Rosina noticed that her therapist was able to explain anxiety to her while incorporating scientific facts about the brain. Rosina explained that it was very difficult to end therapy with her first therapist, as she was very skilled in Cognitive Behavioral Therapy. Her therapist had equipped her with tools and resources to reduce anxiety, which she still uses today. Despite the disconnect that she experienced with this therapist related to different views of science, she found the therapy experience to be "really helpful" overall when it came to understanding anxiety, hence Rosina's commitment to therapy.

Afia described her first therapist experience as enlightening, as the therapist had unveiled Afia's "incomplete perception" about how anxiety and depression can manifest into physical symptoms. Her first therapist helped her realize that she had been experiencing moderate to severe anxiety based on her presenting symptoms. Afia emphasized the therapist's psychoeducation as "enlightening" for her, despite her initial apprehension about working with a male therapist: "I just felt like he understood. So, I didn't really feel like there was like a—This is awkward, I'm on the phone with a random man." Afia also described her second therapist as educating her about her anxiety by using "really good examples" to explain its mechanisms and origins. She felt that her second therapist "listened to her a lot" and asked her "poignant questions about my faith." Together, they explored Afia's primary source of anxiety, namely the gap between her expectations as a Christian woman and her personal beliefs.

Anna was the only participant to describe a time when her therapist's knowledgeability was unhelpful and harmful. Anna explained being given a strategy: "If I'm feeling really anxious, to make a fist, like with my nails into my palm. And that should distract me from my anxious

thoughts." She reflected, "I think that's pretty damaging to tell a patient that they should be harming themselves." She continued, "Why would you want to hurt yourself? I think that's very different from, you know, this self-love that I later learned that was important for me." She noted how at the age of 14, "We're still vulnerable and impressionable." Anna emphasized the long-lasting impact that remained with her: "What you say definitely matters to a patient…because I'm never going to forget what she said."

3c. Broaching difference. Most participants had experiences regarding whether and how racial/ethnic and other cultural differences were broached in sessions, whether by themselves or by the therapist. Anna, for instance, mentioned that her ethnicity was never discussed in her sessions. However, she observed how what she considered significant age differences with her therapists often exposed differing worldviews that sometimes resulted in debates and challenges in their relationship:

> So if the age gap was too different, we'd have like pretty different world views. And then there was a lot of issues there. You know, we'd waste a lot of the therapy session debating a lot of irrelevant things because we just didn't agree.

Rosina found it challenging to broach certain topics with her white therapist due to their different backgrounds. She was met with dismissive responses, especially regarding religion, and felt she was "explaining things" to her therapist. A difference in worldviews became particularly evident when discussing her scientific pursuits, with Rosina noting her therapist's tendency to approach science with skepticism: "She was like 'Be careful.' I felt a little like, I had a little question mark in my head. I was like okay, I don't understand what that means."

In the beginning of therapy with her white therapist, Rosina felt it was important to bring up her religious identity. Her therapist responded by saying, "Let's not talk about religion." Rosina explained, "It made me feel like it was less important," and "It kind of made me question my own, I guess, struggle." She emphasized "being super young at the time" and noted the long-lasting impact: "for me, like okay, this is important. But then her shutting it down immediately was like okay never mind, it's not. And it didn't come back up, like years later." She described feeling "a little hurt and – But it was more a mix of, like, confusion and because I didn't know why she dismissed it." Consequently, Rosina explained, "And then just like I also dismissed my own thing."

Rosina also encountered the need to address cultural differences with her second therapist, who was Muslim and Middle Eastern. Rosina, being Muslim and East African, felt there were cultural similarities and differences between herself and her therapist. She provided an example of when she perceived differences between their cultures:

> I think she didn't know like when there was like a difference. It wasn't major. But like, if there were, like small differences… Like the way women are treated in different cultures, like it's kind of different. Or like different rules. Like something stupid, like my brother is allowed to go out late at night. I'm not allowed. Like that type of thing…Or I have to do this, but like my brother doesn't.

Despite these cultural differences, Rosina did not convey a necessity to broach them, and her therapist did not broach them either. Instead, she explained: "She never judged in a way that was like – Like for me the thing that I didn't like and I didn't want was like people to judge my parents." Rosina emphasized that her parents were "also unlearning the things of the culture that we don't want to keep." With this therapist, she did not have to overexplain herself in this regard. She reaffirmed feeling comfortable that she could tell her therapist things without fear of being judged.

Afia's white therapist was able to recognize and acknowledge Afia's inner struggle between her intersecting identities. Afia was experiencing a "cognitive dissonance" between her cultural identities as a Canadian, African, and Christian woman in relation to what she was taught in African church culture versus what she believed. Her therapist noted: "It feels like deep down you really don't believe it's true, but you're somehow really fighting to make it true for you." The recognition of Afia's suffering gave her "permission" to explore it in a safe space.

3d. Shifts leading to change in therapist. Three of the four participants experienced shifts in therapy that they deemed pivotal to their therapy process. Shifts over the course of their long-term therapy occurred when either feeling disconnected in their relationship with their therapist or discovering their therapeutic needs had changed. Such shifts were unaddressed by the therapist and led to ending therapy and/or seeking a new therapist. Afia was the only exception, where the shift she experienced occurred due to the changing social climate.

As previously mentioned, toward the end of her time with her first therapist, Rosina noticed her therapist's skepticism toward the sciences and dismissal of opportunities to discuss religion, alongside her therapist's imposition of differing values. These instances accumulated gradually over time. The therapist became increasingly forthcoming with her views where, for example, she disclosed that she outright rejected the notion of the COVID pandemic being real. Rosina reflected on the growing disconnect: "We didn't understand each other or the way we saw life." Recognizing how her religious identity was a "super big part" of her lived experiences, it became a growing need to discuss in therapy: "So I was in that moment looking specifically for someone who was like, closer to me in identity."

Rosina subsequently consulted a Muslim therapist who was an older man. Despite a match in religious beliefs, she viewed him as a "family member," not "super gentle," and "very firm." She recalled feeling like a "scared, 14, anxious, little girl" and not feeling "super confident." Moving forward from this experience, Rosina chose her next therapist based on research and a trusted friend's recommendation. Her new therapist was "younger," and Rosina inferred they would have "similar mentalities," alongside being Muslim and coming from a non-Western background.

Rayan found that her therapist's race, being white, meant that her therapist lacked similar lived experiences: "There's no way she's going to be able to relate to my perspective." Otherwise, Rayan did not perceive the racial difference as playing a role in the therapy process. She did however notice a shift in the therapeutic relationship. She noticed it had been "a lot more supportive" at the start and less so towards the end of therapy where she questioned "if it's the race playing the role or if it's something else, but something's affected here." The therapy process ended after 2-3 instances of her therapist disclosing "a lot of her life story," within "close succession." Although her therapist's disclosures held some similarity with Rayan, the disclosures lacked relevance to Rayan's cultural context of being a first-generation immigrant raised by South Asian parents. These experiences left Rayan feeling misunderstood. She also wondered whether the therapist's disclosures somehow breached client-therapist confidentiality or how much personal information a therapist was allowed to disclose. Regardless, she described herself as "pulling back a bit from that mainly." From this experience, Rayan reflected:

> I've heard that apparently, like a lot of people start therapy, they start up with, like, more of a white therapist. And then as they progress through therapy, they try to find one that's like, more aligned with their own values and perspectives and life experiences.

Afia similarly sought a different therapist as her therapy needs evolved. Her needs changed when noticing she wanted to discuss aspects of her cultural identity that had become more salient. For Afia, her journey with her white therapist started with her anxiety about motherhood and was limited by the number of sessions offered by her family health team. However, in 2020, she sought therapy once again, while pregnant and during a time of heightened racial tension and stress in society: "I just needed to talk to a Black therapist because I felt like I didn't think a white therapist could really understand the trauma of seeing another Black person being murdered," referencing the death of George Floyd. Speaking on whether she would instead have returned to her previous therapist who was white, Afia said: "There's no way in hell I would… It just would have felt like I'm torturing myself, really," explaining that there would have been more of a "disconnect." For Afia, she felt that her white therapist was not the "right person to talk to at that time" while "all this racist shit's happening down south" and "kind of happening in Canada."

4. Types of Therapist Self-Disclosure

This theme pertains to instances of therapist self-disclosure (TSD) participants identified. All four participants experienced some form of disclosure during therapy. Each subtheme is organized according to different types of TSD as well as how respective participants experienced it. The subthemes are: *4a) Disclosure of opinion, b) Disclosure of challenge, c) Disclosure of partial similarity, d) Disclosure of vulnerability,* and *e) Nonverbal disclosure.* Anna experienced helpful and unhelpful disclosures with multiple mental health professionals. Rosina experienced unhelpful disclosures with her first therapist toward the end of their relationship. She also experienced helpful nonverbal disclosures with her second therapist. Rayan experienced unhelpful disclosures toward the end of her relationship with her therapist within a short period of time. Afia encountered disclosures of vulnerability as well as nonverbal disclosures, both of which positively impacted the therapeutic relationship.

4a. Disclosure of opinion. Rosina, Rayan, and Anna all received disclosures from their mental health professionals that appeared to reflect an unsolicited opinion they had about the

participants' life circumstances, resulting in long-term impacts on the participant. Rosina experienced disclosures of opinion from her first therapist where, "She would push these ideas, other ideas where it was like what my life should be." Rosina explained how she was personally "all work and no play," whereas her therapist stated, "You need to live life." Rosina elaborated on her therapist's opinion, stating, "You need to go like, party and like, be drunk and like, pass out. And then the next day, like, you never know where you're at." These suggestions did not resonate with Rosina, describing her therapist's views as "very like Hollywood movie," and the "complete opposite" of Rosina's values as a Muslim.

For Rosina, another unhelpful disclosure of opinion consisted of her therapist sharing her political views. Rosina provided her familial context: "My grandmother was struggling with like COVID, and it got really bad." She explained that at first her therapist "validated my emotions," but "for her, she kind of put more emphasis on how like it was like, we're not supposed to be locked down and how the government is just putting us in a lockdown for no reason." Rosina made it clear that "I agree with the lockdown," and conveyed her background in the sciences. Her therapist stated, "Be careful, because they will teach you things that like it's not necessarily the truth," and mentioned later in therapy that, "No, I don't believe in the science, I don't believe in COVID." Rosina recalled "We kind of spent like a whole 25 minutes of just us going back and forth and just, like, disagreeing." She expressed, "I guess that really hurt me, and also annoyed me." She further explained:

> I'm like telling you something that's like super like, I don't know, it was a really difficult time and I'm opening up to you and you're taking this moment to push your political, I guess, like political view… I'm like, it just felt really insensitive.

Rosina noted, "I'm young and impressionable and it's just, I don't know why you are pushing your—And it wasn't even just, let's agree to disagree. We were just like, no, but like she was trying to convince me." Reflecting on the incident, Rosina recalled saying, "This is not the moment. I don't think it's appropriate for you to convince me of this, especially in this moment where I was vulnerable and telling you, I'm having a hard time. And you're telling me no." She emphasized on feeling hurt: "I felt like she wasn't really hearing me… It was like the fact that we could have focused on like the emotional part of it rather than like the whole like, COVID part of it," and "she kind of just took that opportunity to push her ideas." By this point, Rosina

described, “I was feeling a bit weird with that therapist because of a few things that she was saying in the last few sessions, but this time it was, this was a kind of like, my last straw.”

Rayan’s experience with a disclosure of opinion was when her therapist stated, “You're going to combust one day.” Rayan explained, “I did overwork myself in high school, and I still do to some degree.” She recalled her reaction to the opinion: “I’m not going to like, you’re overexaggerating. Like you’re making it really overdramatic.” Rayan told her therapist: “I’m not going to combust. I haven’t combusted in the past like, 17, 18 years. I made it through the majority of my life at this point, like all my formative years. Why would I combust later on?” She noted, alongside Rosina, the long-term impact of her therapist’s opinion: “I carry it with me, though, because nowadays I’m like, ‘Am I doing too much? Am I going to combust? When am I going to combust?’ Like it feels like a ticking time bomb,” reflecting Rayan’s self-doubt and questioning of herself.

For Anna, she referred to an experience with a mental health professional who had just diagnosed her with depression. They said, “You're never going to be normal. You're always going to have depression or anxiety in some form.” Anna felt it was “a terrible way to phrase it.” She experienced this opinion as “really damaging” to hear, stating: “I definitely still have depression, but that doesn't mean it's like inhibiting me from living a meaningful, happy life in any way.” She explained that they “should have clarified that living with depression can be completely manageable and fine.” Anna felt the long-term impact, noting she would often refer to this opinion in subsequent sessions with other therapists: “I would rant about like, why can't I be normal? And then they’d ask me, what is normal?” She described feeling “pissed off” because “They're kind of right. What is a normal person? What is a healthy person? They all have their flaws and quirks.”

Finally, Anna received an unhelpful disclosure of opinion from her first therapist: “I would tell her my issues, about being very socially anxious, you know, I'm too afraid to go out with my friends. She kind of like looks up from her paper and she's like, that's really weird, instead of helping me work through my issues.” For Anna, “that made me feel very hurt and made me feel like I didn't want to talk to her anymore.” She viewed it as “an example of, you know, not trying to connect and not trying to understand your patient.” Anna stated, “She accused me of not trying hard enough, which, kind of fair. But then I told her it's a little hard to

put in so much effort for something I didn't want. I was giving it all the limited energy I had at the time." She further explained, "I was very depressed, and I didn't want to be there. I didn't have the will to do anything. Of course that applied to therapy. And then I remember on the ride home, I was crying like I was sobbing my heart out in the car." This marked the end of the therapy relationship: "I was like I can't do that anymore. I don't want to see her. She doesn't understand me."

4b. Disclosure of challenge. Anna experienced a therapist disclosure of challenge from her fourth therapist. In such instances, the therapist presents a viewpoint that seems to dispute the validity of something the client shares in session (Hill & Knox, 2002). For Anna, this disclosure of challenge was deemed helpful.

Her therapist made it a point to challenge Anna's self-critical thinking in sessions. In their first session and onwards, her therapist consistently disclosed the following: "You just, you need to be kinder to yourself" and "That I [Anna] deserved to be kind to myself, that I shouldn't be saying these things about myself because I deserved love." Anna described these disclosures as "a game changer," where "I was sitting there, and I was dumbfounded that no one told me that before or that I never thought it myself." She described, "I was so shocked that none of my therapists told me that I should love myself a little more. Because I deserve love. Because I'm worthy of love. Most of my prior therapists focused on my flaws." Anna explained that prior to those disclosures:

> I really hated myself. Like it's never something I thought about in the slightest. You know, it wasn't in my brain at all. So, I think that's why it resonated so much with me, because it was something that I lacked so much that I really needed it. I also didn't know how to be kind to myself. She taught me what 'being kind to myself' consisted of. Things like recognizing negative self-talk and learning how to dismiss it.

Her therapist continually challenged Anna's ways of thinking critically about herself by indicating "You're saying so many mean things to yourself. You need to stop it because you wouldn't talk to someone else that way." Anna noted, "The compassion thing was her underlying message." Anna spoke of the impact that these disclosures continue to have on her: "Almost every day. Instead of lying in bed for hours, it's like, 'I love myself more than this. I'm not going

to do that to my body, you know?' And sometimes I still do. But it's definitely something I think about a lot."

4c. Disclosure of partial similarity. Rayan was the only participant to describe therapist disclosures that conveyed partial similarity between herself and her therapist. In both cases, she felt similarity with her therapist in terms of the issue she identified but her context was different from her therapist. This led to Rayan feeling misunderstood rather than connected.

In one instance, Rayan had been feeling "overwhelming pressure" to get into medical school. She said, "I felt like I was letting my parents down in that vein." Her therapist disclosed: "Not everybody gets in, and it roughly takes like three tries for somebody to get in." According to Rayan, her therapist disclosed, "how she tried repeatedly and how she failed. And she told me about her university experience, how she went from like full time to part time working like numerous jobs just because she wasn't doing that great in school." Hearing this, Rayan reflected, "That wouldn't work for me. Like, I wouldn't be—I'm not allowed to fail." While she understood where her therapist was coming from:

> I felt as though I wasn't afforded that ability to have that flexibility of like failing or going to part time or having bad grades sort of thing. So I felt like there was a disconnect in what she was trying to tell me versus what I was trying to tell her. And I felt as though she wasn't listening to the fact that I was trying to tell her that I don't have that. Like, technically, I could do that. Would my parents think great of me? To some degree, no.

In response to her therapist, Rayan recalled saying, "I don't think you're understanding me." For Rayan, "It was not comforting. Like it wasn't what I needed to hear at that time." She felt that her experiences of being the eldest daughter in a family living in poverty were not being understood, "I know what it was like. So, I was like, I don't feel like I'm afforded that sort of same ability to fail as—or not fail because she didn't fail—but that same ability to do less and to take on less."

In another instance, a disclosure of partial similarity occurred when she was processing the diagnosis of her chronic illness. Rayan described her shock, "Usually a lot of immigrants are in good health... But to be diagnosed with like a chronic illness at a young age isn't really like something you'll see commonly, and it's not really heard of." She explained, "I felt like there was

a disconnect there being like, this isn't what's supposed to happen. Like I'm supposed to be a normal, healthy teenager, not somebody who has a chronic illness." Her therapist's response was: "You have to deal with it. I have chronic illnesses, and I manage them all the time." She recalled how it was not the type of reassurance she wanted. She described how her therapist "went on like a little tirade of like, yeah, I take whatever, I take so many more medications, but we still have to get through it.'"

Rayan explained, "That's not how I wanted to deal with that… I know that I have to take the medications to help me feel better, but you don't need to tell me that this is going to be my forever. And like, especially at the very beginning." In sum, Rayan recalled, "instead of asking me…she started telling me about her own experience, which isn't what I wanted." Rayan noted, "I felt like she didn't really understand why I was so upset and emotional about it, because that's not what I was expecting and that's not what the plan was like for me." She emphasized feeling, "more or less, like shut down. Being like, this is now your new normal. Okay, give me some time to like process it."

4d. Disclosure of vulnerability. Anna and Afia both experienced instances where their therapists disclosed vulnerable information, both of which were received positively and helped build trust and credibility with their therapists as well as connection and solidarity. Anna reflected that her "best therapist was one that actually went through the same experiences as me." This therapist was a psychologist who was white and who had self-disclosed in their first session. This moment of TSD occurred as Anna had been transitioning from high school to university and had been recovering from a suicide attempt. Her therapist shared: "When I was your age, I attempted suicide as well when my mom died." For Anna, this disclosure of vulnerability "made me like really connect to her." She viewed her therapist as "someone who went through the same thing and knew how to navigate out." In that moment, Anna described feeling "very seen," and "less like a patient and more like a person that they were trying to help." She emphasized the importance of providing "vulnerable information" as a client so that "they can understand you as a patient and a person and how they can help you the best." Anna explained "I felt like, I could, like, trust her more," viewing her therapist as someone who had "been through it" and possessed knowledge of "what worked for them and what didn't work for them." She concluded, "So it feels, it's like asking a friend for advice. You trust their advice a little more."

Along the lines of building trust, Afia experienced similar effects with her second therapist who was also white. At this time, Afia had a one-year-old child and was attending therapy for anxiety "surrounding motherhood and family life." In their second session, Afia noticed a breast pump kit under her therapist's desk and said, "Oh. You're breastfeeding." From there, her therapist disclosed that she had a baby and briefly described the challenges of breastfeeding. Afia, having experienced similar challenges, reflected:

> I automatically knew that she can identify with, number one, the initial pain of breastfeeding, like how painful that is. Emotional roller coaster. And she experienced anxiety as well. Maybe she did, maybe she didn't. It doesn't matter. But the point is that she had her own journey in this motherhood thing.

Her therapist's embodied knowledge as a mother provided reassurance, as Afia stated "Okay, so you really do kind of see where I'm coming from," and "I can rest in that knowing that if she does share something, it's not all theory."

Similarly, Afia's last therapist, who was Black, disclosed being a mother by mentioning that her children might cause occasional disruptions that require her to "take a moment and step back and ground myself in order to, like, tackle that problem kind of thing." Afia, pregnant with her third child, immediately felt they shared solidarity: "Of course, you know what I mean? Of course she's a mom. And I understood that." Her therapist specialized in supporting new mothers, but her disclosure lent more credibility to her role, "I believe her because she's had kids. Like, this is not theory, you know what I mean? Like, she's actually probably done some of this stuff." Afia felt that disclosures of similar lived experience from both therapists "humanized them more." She emphasized that the therapeutic relationship is still a relationship that needs some level of reciprocity, "Probably not like 100%, 50/50, but some sort of give to sort of ground you guys. To know that, you know, we have some commonality here."

4e. Nonverbal disclosure. Both Rosina and Afia spoke to nonverbal disclosures with their therapists with whom they perceived to match along a particular social identity, such as race/ethnicity, religion, age, and gender. These nonverbal disclosures contributed to a sense of solidarity, understanding, and ease. Afia spoke most potently to this experience in terms of race with her last therapist, who was a Black woman:

> …she didn't have to share much just because of the…just the fact that she's Black. You know what I mean? Like, you don't have to disclose nothing to me. I just know just because we have the shared, very visible difference from the rest of the people, chances are the experiences that I've had, you've probably had some or maybe one of them.

Knowing that her therapist was also a mother, Afia inferred that they likely shared similar experiences as Black parents, "Even though she didn't outright tell me that she'd experienced it, but like, there was just an understanding that we understand." Afia further explained, "Because I don't know a single Black parent that hasn't experienced some form of aggression for their child because of their skin colour."

Afia also spoke on the experiences of racism and microaggressions at her previous workplace wherein she would have a session with her therapist during the workday: "Sometimes our sessions are just quiet. Because she'd be like, how was work? I'm like, I'll say, this is what happened. I just had a meeting. This is what came out of the meeting, and we would just be quiet." Afia explained that her therapist did not have to provide her with as much psychoeducation, "because it's like, how do you educate yourself out of racism? Like, what are you going to tell me that I don't already know? …What tips, what tools do I have to deal with racism?" Instead, she explained, "So the moments of silence, I guess you could say yeah, they were more like respite," and "It was kind of like building momentum to keep going." For Afia, her Black therapist provided her with a sense of solidarity and understanding without necessitating any discussion.

Rosina noted visible similarities between herself and her second therapist who was a Muslim and Middle Eastern woman, stating "I could visibly tell her background and also like she was hijabi." Rosina also perceived her therapist to be young. As such, Rosina inferred that they might share "similar mentalities" as opposed to her previous therapist who was older and with whom their differences in worldviews clashed.

5. Client Understandings of Cultural Empathy

This section addresses understandings of cultural empathy that participants provided. Their responses were based on their experiences with their therapists and their own lived

experiences. The following subthemes encompass their understandings of cultural empathy as: *5a) "Matching" with therapist's culture* and *b) Therapist's ability to connect.*

5a. "Matching" with therapist culture. Three of the four participants provided understandings of cultural empathy as having cultural similarity with their therapist. Rayan noted that she felt cultural empathy more at the beginning of therapy when her therapist was able to relate to salient aspects of her cultural context. For instance, her therapist disclosed having also lived through poverty as well as social welfare. Consequently, her therapist was able to provide Rayan a new understanding of her parents' absence during her childhood as they worked long days: "But you understand why they did it. They did it for you. And that's okay. And like, you're allowed to feel that way." However, this capacity to relate became limited toward the end of their time together when Rayan's therapist was not acknowledging her feeling pressured by her parents to succeed academically, an experience Rayan viewed as related to her cultural context.

Prior to being offered a definition of cultural empathy during the interview, Rosina thought that "you had to be with [a therapist] who's similar because otherwise you can't. You can't. There's just always going to be that disconnect." Upon receiving a definition of cultural empathy, Rosina noted a sense of cultural empathy with her second therapist who was visibly Muslim and Middle Eastern. Within the relationship, Rosina felt able to acknowledge both similarities and differences between them. Rosina clarified that any differences between herself and her second therapist were never "major," nor did they impact the therapeutic relationship. In contrast, her first therapist continually dismissed any opportunities to acknowledge cultural similarities or differences, especially within her religious exploration. From this experience, Rosina explained:

> I think it made me believe that you couldn't have two different like – I had to be with somebody who was similar to me. I could never be with another therapist again that's not like similar to me. Because I think there wasn't that that cultural empathy because, like, she didn't acknowledge the similarities or differences. It was just dismissed.

Further emphasizing cultural similarity, Anna construed cultural empathy as:

> You're similar in culture. You might have similar ways of life, right? So, you might understand maybe the culture of Asian parents more. Like the relationship between an

> Asian mother and an Asian daughter might be a little different [compared to] a white mom and a white daughter. They might be able to understand that a little more.

She elaborated that a therapist of colour might understand "faster than maybe people who are born here, their ways of life, traditions that Asian parents, you know, don't want to get rid of or don't want to break." She noted the difficulty to incorporate such traditions "into Northern American life," and the struggle to understand "that growing up in religion, maybe you want a break from that, maybe you want to stay in that, you know, it may be something they're not familiar with" referring to one's personal journey of taking a break from or staying in one's religion.

Anna explained how "a white therapist may not understand the amount of pressure that you're getting from your parents because, you know, it may or may not have been something that they went through." Anna provided an example of strict parenting observed in Asian culture: "Like if [a child] spoke out of line, they'd get, you know, slapped or you don't study what they want, you know, they'd get mad at you." She reflected on witnessing her Asian friends' experiences: "When they tell it to their white friends and they're like, 'Why can't you just do what you want?' You know, it's just a little different," emphasizing the lack of similarity and thereby decreased capacity for cultural empathy.

5b. Therapist's ability to connect. All participants spoke to cultural empathy as the therapist's ability to connect with a client. Therefore, cultural empathy was felt as a connection to their therapist in unique ways. Anna viewed it as being treated with compassion whereas Rosina viewed it as her therapist having humility and curiosity. Rayan attributed the importance of cultural knowledge as facilitating connection and Afia viewed connection as her therapist recognizing and respecting her cultural struggles.

When reflecting on cultural empathy, Anna nuanced it as an ability to connect as a human: "It's not a specific culture. It's just the culture of being human. And just caring about one another." For Anna, compassion is the crux of cultural empathy: "How can you be empathetic to someone if you're not willing to see the world through their view? I think that, you know, cultural empathy is a type of compassion for sure." Anna emphasized that therapists "don't have to be similar culturally, but they have to be willing to seek out a connection with you. You know? They, they need to not judge you for any differences you might have, cultural or otherwise."

In line with seeking out a connection, Rosina's understanding of cultural empathy evolved as she considered that a therapist "can be different. It's just you just need to listen and just, you know, be open to learn as well," beyond acknowledging the similarities and differences. Rosina emphasized that "it's okay to not know, like, you know, the answers," and to "just ask questions like if you don't understand." She reflected on her experiences of being dismissed by her first therapist, "I wasn't asking her like to have the answer, but honestly I just wanted to let it out." Tying back to the therapist's ability to connect, Rosina explained the value of empathy, "if she just nodded and just, 'Mm hmm.' You know, it would have been like – It would have been fine."

Rayan explained that having prerequisite knowledge is key to connection: "having knowledge on how the cultures work, what is important to the culture, what it's like living in X, Y, Z, what the expectations are, like the gendered expectations are of each person." Not only is prerequisite knowledge important, but also the application within therapy sessions. For Rayan, she reflected that her therapist might have lacked "that prerequisite initial knowledge, and then that made it a lot harder for her to do the whole like empathizing part because she didn't have the cultural part."

Finally, Afia perceived cultural empathy when her second therapist was able to "acknowledge" her struggle and "not disrespect it." Noting that her therapist was a "white woman" and "Canadian," Afia never once felt that her African culture and its men were critiqued. Afia explained, "I feel like if there was any hint of that, I would have automatically been put off because I'm like, there's this white woman coming to tell me how we should be living our lives, you know?" Afia explained that African church culture is its own subset of culture, but that a therapist does not have to be part of that culture to be empathetic. Rather, she stated, that they need to "understand the struggle or at least see that there's some sort of a struggle. And be like, yeah that sucks. You know what I mean? As opposed to being like ethnocentric."

Consequently, Afia stated that her therapist "really empathized" when recognizing Afia's conflict between her intersecting identities as a Canadian and African woman attending church. "I felt like she saw that I was struggling so much with just trying to merge the two of them together, but they just weren't." Her therapist recognized, "church is really a big part of your

identity. Being African is a really big part of your identity. But I don't think you really believe that some of these things are true." Afia recalled her therapist saying, "Like this is what I see and it looks really painful." Her therapist's recognition of her struggle gave Afia "permission to be able to say that I don't believe in it, you know, and then to walk in my truth."

6. Experiences of Cultural Empathy through Therapist Self-Disclosure

In this section, three of the four participants identified instances where they experienced therapist self-disclosure as either facilitating or hindering a sense of cultural empathy by their therapist. The subthemes are accordingly organized by facilitative and hindering experiences where Anna and Afia's experiences are facilitative in nature and Rosina and Rayan's experiences are hindering in nature.

6a. Disclosures that facilitated cultural empathy. Anna and Afia both experienced a disclosure of vulnerability that facilitated a sense of cultural empathy. In her experience with her therapist who had taught her compassion, Anna recalled:

> I think that she heard my story and realized, you know, 'This is something I resonate with. This is something I went through as well.' […] [My therapist] wanted to empathize with me and tell me that, you know, 'I've been there as well.' And I think that she just, she wanted to make sure that I knew I was seen in her.

Anna elaborated that, to her, cultural empathy is meant to help a therapist understand their client, "who they are and what they need," and identify "what you can say to them that will resonate with them."

Afia felt cultural empathy most potently with her second therapist who was white. Afia had inquired about a breast pump kit under her therapist's desk. Upon discovering her therapist was also a mother, Afia inferred that her therapist could relate to the "unique and divine experience" of motherhood. Afia stated, "regardless of who or where the person is from, the minute you both find out that you're mothers, like, you're automatically, like you connect." She described one such experience:

> Like when I talked about fear of my children dying…I remember when I talked to her about that, like I burst out crying. And like, I remember thinking that she looked like she was holding herself to not, number one, hug me and number two, not cry with me.

Not only did Afia see this experience as providing connection, but she also noticed a shift in being able to trust a white therapist. Reflecting on her background of mistrust toward white professionals, Afia stated, "I'm realizing now, regardless of—and it sounds contradictory, which is why it's so confusing for me—I feel like regardless of ethnic background or race, motherhood somehow connects people differently."

When reflecting on the "race dynamic" with her therapist, Afia noted that her white therapist "couldn't possibly understand that aspect of my life." She emphasized, however, that she met her white therapist at "the right time of my life because a lot of the anxiety I had was surrounding motherhood and family life."

6b. Disclosures that hindered cultural empathy. Rayan and Rosina were two participants who experienced disclosures that hindered a sense of cultural empathy from their therapist. They described the disclosures as not resonating with them and instead occurred in a way that dismissed their needs for connection and understanding, thereby leading to an end of the therapeutic relationship.

Rosina reflected on how her first therapist's disclosures of opinion impacted cultural empathy during the therapy. Having shared opinions on how Rosina should live her life regardless of her personal values, Rosina commented, "She knew my background, like my religion and everything and my culture…like [her opinion] it's not something I'm interested in. And I mentioned that to her." She clarified, "Even if I tried to explain, like she would dismiss a lot of things, especially I realized with the religion." Rosina believed that the therapist's difficulties in understanding stemmed from "the fact that we were from different, like completely different backgrounds," as well as not taking sufficient time to listen. Rosina surmised that, given she had to explain her religion to the therapist, "Maybe she didn't feel equipped for that [conversation]." She described ending the therapy with regret and difficulty, stating "I really liked her as a person." Rosina wished that that her first therapist had been honest about not knowing how to support her, or had shown curiosity about her values, rather than dismissing her when she broached religion.

Rayan identified two significant ways that therapist self-disclosure hindered cultural empathy. Her therapist's opinion that she would "combust" one day did not seem to acknowledge Rayan's cultural context as a first-generation Canadian. Rayan provided further context to substantiate her point,

> My parents weren't able to, quote, unquote, combust, especially when we lived in poverty. So, her telling me, like, with all like the current, like financial stability I have now, like that I'm going to combust. It was like my parents weren't afforded that ability to combust. Why would I be, okay? Like, why would I be able to combust now?

The other instance of disclosure that hindered cultural empathy was when her therapist shared having had difficulties succeeding academically and had experienced parental expectations too. However, this did not resonate with Rayan: "Like her parents' expectations of her versus my parents starting completely anew and fresh aren't going to match up. And I think that was a large part of like the differences." Consequently, "I felt like she wasn't applying the past to the present when they were very closely associated, or it was like my main motivating driving factor," indicating the importance of applying her past context to her present concerns at the time. Overall, Rayan felt that her therapist was missing adequate "overlap in culture and race" which Rayan felt prevented them from being able to relate toward "the later end," with their therapy relationship ending shortly thereafter.

7. Reflections about Therapy

This final theme depicts what participants thought about their therapy after it had ended, as well as their thoughts on future therapy. The following subthemes are: *7a) Empowerment, b) Experiences of disconnection, c) "Matching" with therapist,* and *d) Preferred therapist traits.*

7a. Empowerment. In their post-therapy reflections, all participants described sentiments that emerged relating to empowerment, such as personal growth, validation, confidence and a willingness to return to therapy. Rosina spoke most pointedly to empowerment within her collective experiences of therapy, describing it as "necessary and "really helpful." She continued, "I'm really, really grateful. I felt really lucky to have this access to therapy." She emphasized her growth: "I felt like with my first therapist and with my second therapist, like, I'm very lucky to have a lot of tools and like, I know a lot more and I think I'm at a place where I think I don't need

it as much." She reflected gratitude, "I feel happy, like thinking back, looking back at that time because it was like…wow, like, I don't know, it was like such—I guess, like an epiphany." She elaborated on this epiphany, where, after her first session:

> It was relief because it was like, okay, I'm not like crazy. Like, I'm not like, it's not my fault. It was also like the guilt, was like, the guilt was crushing me…And I think the validation and like, just somebody acknowledging like, this must be difficult for you.

Prior to therapy, she was feeling "guilt," as her family "could see the impact that it had on—like anxiety, like the mental health issues—the impact that it had on me." Her family felt that her reactions were "very big for something very small." In contrast, therapy provided her with validation: "Oh, wow…I'm not, like, super – It's not like, my fault type of thing. I'm not, like, super overdramatic for no reason." She described the growth felt with her parents: "Now we're super open. Like super open. Like the contrast is crazy…my parents do research. Like they research their own things sometimes." She spoke to her confidence and personal growth, stating, "I'm so equipped for a lot of things," noting "Had I not gone through that experience, I would have been a different person, I think for sure."

Similarly, Rayan stated that without therapy, "I more or less would have like combusted or like things would have gone downhill very fast." Rayan reflected on starting therapy early in life: "I think it mellowed out my personality a bit, especially in terms of like anger and resentment and driving forces in a good way." Rayan described her therapist as "somewhat like motherly, where it felt like she cared for me and like nurturing and wanted to hear about my experiences," which she acknowledged "did play a role into it, especially since a lot of my resentment was towards my mom, and so it kind of helped smoothen things out." In continual personal growth, she viewed her parents' expectations as coming from a "loving place" where "I think the pressure isn't as tense." She described finding a compromise between her goal and her parents' expectations: "I get to do the research I like and…my parents also get their slice of the pie."

Anna also echoed the empowerment of starting therapy when she was younger, stating "There's been a lot of pain and a lot of bad therapists," but that she received "a lot of good advice" and "things that I still think about now." She spoke to the importance of continuing therapy in the long term: "It's reprogramming how you think. And you can't just do a one and

done.” She acknowledged that “I just never liked it. And it was always a chore for me, you know? It was always something I dreaded. But I know it's good for me,” while noting it was not a “linear path.” Anna emphasized the importance of finding someone “willing to work” with her, demonstrating a sense of confidence:

> I think I know myself as a patient and what I need to help myself. So, if they're, if they don't really fit into that criteria of what I need, then they're not going to be terribly useful or I'm not going to have great sessions with them. I might as well find a new therapist that's going to do what I need.

Finally, Rosina and Afia notably considered themselves a “strong supporter” and an “advocate” for therapy, respectively, and both expressed feeling “open” to resuming with their last therapists.

7b. Disconnection in therapy. All participants spoke to experiences and/or a fear of disconnection when reflecting on their past therapy. For Afia, disconnection occurred in her second-last course of therapy with a Black therapist who was of the same ethnicity as her partner. Afia described, “I saw her once… She was West African. And I was like, ‘Oh, we're going to relate completely.’ But we related too much.” Afia stated, “And so when I was talking to her, when she was talking to me, I just kept getting mother-in-law slash aunty vibes, you know.” Afia’s presenting concern she wished to address in therapy related to cultural differences in communication between herself and her partner. She clarified:

> And if I, if I struggle to be like, I am having a hard time understanding my husband, like I want to get to understand his culture more and then feeling insecure that I'm not in his culture and I don't understand. And all of a sudden, I'm being met with a lady that just reminds me of all the things that I lack. That's not going to be helpful.

Afia sensed that this therapist was eager to work with her, stating: “I felt like she thought, oh, this is going to be great because we have the shared experience.” This contrasted with how Afia felt, where she expressed: “I’m like, that's the very thing that is pushing me in a way is the fact that we have this shared but weird experience.” Afia spoke to the cultural expectation of having to respect elders unconditionally, further reminding her of church culture: “I don't want to come to therapy and then be on my best behaviour… I want to be able to curse without you

being like, oh, you don't talk like that." Afia considered herself "not safe" with the therapist because "just her accent, her mannerisms, like, everything reminded me of my inadequacies."

Rosina spoke to an initial fear of judgement in sessions with her second therapist who was Muslim: "But I told her that I was like, I don't know, I feel I'm scared of your judgment." Although her second therapist was not judgmental, Rosina wondered if "It might have been like the religious aspect. Like, you know, like the fact we were similar, like, backgrounds." She reasoned that "if someone is, like, different, like I can say things without feeling judged."

For Anna, disconnection in therapy was described more generally, and at times stemmed from a therapeutic approach or the therapeutic environment. Anna reflected on the disconnection she felt with her therapist's approach of Cognitive Behavioural Therapy (CBT), where she had to "do a lot of homework" and "didn't like it." Anna felt that the process involved "putting numbers to emotions" and resulted in more anxiety and disengagement: "I end up not doing it at all." She left the experience with a "bad impression" of CBT, describing therapy as being urged to "vent" about things that caused her to feel "upset and depressed" with "a little bit of CBT." She felt sessions lacked productivity: "I want to come home with something to think about, you know, and to apply to my next situation. Instead, it left me dwelling on everything that made me depressed that week."

Anna's perceptions of the therapy environment also contributed to a feeling of disconnection, as she observed:

> I look at their fake plants or the sunlight coming in the window, it's really blinding me. But I'm too shy to ask them if I can move my chair. It's just it, it feels like a doctor's appointment every time, which it kind of is and you can really see when they're trying to make it not look like a doctor's office. The big plant is really, really dusty.

She spoke to feeling like "a patient, like some numbers on a clipboard." She clarified, "If you're not connecting at a therapy appointment, then it really feels like you're being questioned at the doctor's office…It's just an analysis." She stated, "It never occurred to me that I could speak up about the window because I was never comfortable enough to put my needs first."

In general, Anna stated: "There were definitely some [therapists] that I didn't really connect with, and that's why I would end things really quick." She stated that she did not

"connect well at all" with therapists who only disclosed "things about their personal life where we're making small talk." When it was time to end therapy, Anna related it to "ending a relationship," noting the feeling of awkwardness when paying for the last session of therapy: "because you're writing the check and they're like giving you the side-eye."

Rayan believed that her white therapist had "good intentions" when it came to addressing parental pressures, with the cultural context of achieving success in return for her parents' sacrifices as newcomers to Canada. However, she observed a shift in her therapist who applied a more "hard love" approach by the end of the therapy. Rayan recognized this approach as reminiscent of experiences with her parents, causing her to withdraw and decide not to share with her therapist anymore: "I'm going to pull everything away from you. Like, I don't need to tell you this anymore," in reference to her initial openness and vulnerability during therapy.

7c. "Matching" with therapist. All participants spoke with hindsight on matching with a therapist based on different social identities, including race/ethnicity. Afia spoke to racially matching with her last therapist when she reflected on how it had been a need for her during a time of heightened racial tension during and after George Floyd's murder. After having "overly" matched on race/ethnicity with her second-last therapist, Afia realized, "I guess it's not so much what the therapist looks like. Like, my therapist doesn't have to be Black per se…It was just like, I just need someone to talk to," suggesting a shift in importance toward having a safe space to talk rather than "matching" with race. She outlined, however, potential limitations to how similar a therapist can be to a client. Reflecting on the therapist who had overly matched with her partner's racial/ethnic identity, she noted "Because that culture thing is layers upon layers of trauma." Afia concluded from this experience that she remains open to therapists with cultural identities different from her.

After working with her second therapist, Rosina described an ease of resuming therapy with someone matching closely in culture where "I don't really have to explain that much." She particularly appreciated her therapist's approach of bringing Islamic knowledge into therapy. Rosina concluded: "And I'm not saying that like I need to be with a Muslim therapist specifically, but at least somebody who's, like, open to listening to what I'm saying. Instead of just saying like, 'Let's not talk about that.'"

Rosina attributed a sense of ease from her second therapist as her needs in therapy shifted to wanting to better understand her religious identity. In seeking her second therapist, she explained:

> …somebody else also that I knew went to that therapist and was like yeah, it's amazing. So, I was like, okay, you know, it should be good because like I trust the person and also the fact that she's like younger, it was like, okay, like I think we'll have like similar mentalities.

Anna reflected on the differences she experienced with past therapists and how this would impact her choice in a subsequent therapist: “If my last therapist was old, I would probably go, someone younger. Maybe I can connect with them better. Maybe if my last one was a man, I’ll try a woman next.” She reflected that she had never looked for a therapist based on race/ethnicity, stating, “Honestly? I think I want a therapist of colour.” She pondered whether they might have “something else to offer.” She stated that they might relate to her “more culturally” if they matched closely to her race/ethnicity or “even if they're not Asian, maybe something different.”

Rayan had also done therapy with a subsequent therapist, though it had been virtual CBT modules. Although she had limited communication with the therapist, she felt “there was a connect only on the basis of like, oh, you're also a minority. We were both minorities.”

7d. Preferred therapist traits. All participants spoke about preferred traits they would seek in a future therapist. Afia concluded that a therapist does not need to look like her but that it “boils down to just being empathetic.” She emphasized that the effort in trying to understand was the “most important thing.” For Afia, “They just need to be able to understand the struggle or at least see that there's some sort of a struggle. And be like, yeah that sucks. As opposed to being like ethnocentric about whatever it is that you're doing.”

Similarly, Anna noted the “importance of empathy” and not wanting “to be judged” for her problems, stating her refusal to tolerate a “mean therapist.” Anna elaborated on compassion, as she reflected on her therapist who had taught her this: “‘So why would you say that to yourself? Because you think you're lesser? Because you don't love yourself?’ You know, I never thought about the next layer.” For Anna, when a therapist comes from a different background:

> …there's going to be another layer of trying to make them understand where you're coming from. And I think it just wouldn't be as ideal. But as long as they're willing to make those connections, address your situation with care, and jump in headfirst, it would be alright. That's the most important part.

She clarified, "If I was working through like issues with my parents or issues about my upbringing as a child, I think it would be more important to talk to someone who would have a similar upbringing or understands a similar upbringing." She spoke to a sense of social awareness concerning the lack of racial diversity when it comes to therapists, describing how she read that individuals from the African Caribbean Black community may have a hard time reaching out for support for fear they are "not going to be understood or they might be faced with a lack of empathy if they discuss cultural issues with a therapist who doesn't share their background." Anna concluded: "So I think there is something important about, you know, trying your best to relate and empathize with your client in order to help them the best."

Echoing Anna's thought on "trying your best," Rosina expressed the following about her first therapist:

> She's human, she makes mistakes. And like, I think she's still an amazing therapist. But yeah, [if only she had said] "I don't know about this. And can you tell me more?" And like, being honest if I'm asking something that, like, it's beyond her knowledge. It's like [she could say] "I don't have the capacity to help you with this, but let's look for something or let's find where you could find an answer."

Rosina wished that her first therapist had been honest about not knowing how to support her, or had shown curiosity about her values, rather than dismissing an opportunity to broach difference.

Rayan believed it to be important for a therapist to offer some sense of solidarity where they "won't be able to empathize with everything I'm saying, but I know to some degree you're a minority. You have, you also have some experiences." She also spoke to the apprehension from immigrants who seek therapy, especially with the language barrier: "I think integrating those parts into more of their clinical and like literature, like theses and like stuff along those lines would really help minimize the disconnect." Alongside integrating the lived realities of

immigrants, Rayan felt it was important for therapists to offer services to low-income areas. She elaborated that “exposure is the biggest part,” when it comes to learning immigrants’ experiences, where “you're actually seeing the way things are.”

Chapter Five: Discussion

The previous chapter carried the reader through each participant's experiences of therapist self-disclosure and cultural empathy in a narrative format organized by a thematic structure. The beginning described their cultural context as clients and their expectations before starting therapy. The middle described the therapy process, what types of disclosures were experienced, and how they defined cultural empathy. The end described how certain types of disclosures may have contributed to a sense of cultural empathy in the context of racial and ethnic differences. The chapter concluded with participant reflections on the therapy experience and future therapy directions.

In this chapter, I interpret these results as related to the research question: "What are REM clients' experiences of cultural empathy during cross-cultural counselling when their therapist self-discloses to them?". I then revisit my pre-understandings related to the experience of therapy for REM clients, followed by methodological choices related to answering the research question. The chapter ends with study limitations and delimitations, recommendations for future research, as well as a short conclusion.

Interpretation of Results

Rather than address each theme or subtheme systematically, I organize the discussion by offering a narrative report. The report brings subthemes together to create an understanding of the relationship between therapist disclosure and cultural empathy through the perspective of REM clients. I begin with the relevance of the cultural context with which REM clients consider and enter therapy. This sets the stage for later discussion on experiences of therapist disclosure and its role in conveying cultural empathy. I then discuss the therapy process from the participants' perspectives which lends context to the space in which TSD took place. I continue by contrasting participants' unhelpful and helpful experiences of TSD based on whether they facilitated or hindered connection. Finally, I address participants' definitions of cultural empathy that will aid in understanding whether their experiences of TSD conveyed cultural empathy. I support my interpretations with relevant counselling literature and the four tenets of RCT where applicable and offer implications for therapy and counselling practice along the way.

Contextualizing Therapy: Intersections with Race and Ethnicity

Participants for this study were asked to delineate the parts of their cultural identities and their unique contexts that they felt played the most significant roles in their therapy. Cultural context was relevant to understanding their expectations of therapy, barriers to help-seeking, and how they engaged with therapy. The main interpretation I offer focuses on the need to consider intersectionality when working with REM clients. More specifically, I focus on how intergenerational trauma and racial tension, religiosity, stigma/skepticism toward therapy, as well as stage of life can intersect with race and ethnicity.

Intergenerational Trauma and Racial Tension. Intergenerational trauma and racial tension might intersect with race and ethnicity to create mistrust toward mental health professionals and influence therapist choice. In Afia's case, mistrust was both intergenerationally informed and exacerbated by the racial tension of the pandemic alongside present-day discrimination. This was seen when Afia shared her history of intergenerational trauma and experience of racial tension within her cultural context. She explained that the intergenerational trauma her family experienced—including colonial oppression and racism—underlies a sense of inherent mistrust toward white individuals. This mistrust affected her feelings toward medical professionals, including those in mental health. This finding is noted in the literature where a client's past experiences with discrimination can be accentuated when a professional closely resembles those who have historically been the oppressor (Mazzula & Nadal, 2015). She observed this mistrust when assigned to her white therapist through her family doctor's health team. Furthermore, her identity as a Black woman intersects with lived experiences and knowledge of colonization, slavery, civil war, and genocide that carry lasting impacts on physical and mental health. When entering a psychotherapy space that may perpetuate a white and Western social context (Smith, 2015), this may exacerbate mistrust (Hayes et al., 2015; Horrell, 2008). Further, ignoring the prevalence of whiteness in therapy might cause harm to clients with a history of intergenerational trauma closely tied to colonial oppression and racism (King, 1991; Randall, 2021). Indeed, as Afia considered whether she would have returned to her white therapist during the racial tension of the pandemic, she refuted this as a possibility. This may suggest an expectation that her white therapist might not fully understand her lived experiences as a Black woman (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015).

Racial tension during the pandemic accentuated mistrust toward white individuals alongside present-day discrimination. For this reason, Afia shifted to seeking a Black female therapist when returning to therapy during the pandemic and in the wake of George Floyd's murder. At that time, she experienced a heightened mistrust for white individuals and an observed lack of remorse from those around her. Further cementing the need for a Black therapist, Afia described the experience of an otherwise apathetic working environment ignorant of or else ignoring the impacts of racism. This experience alludes to the presence of "dysconscious racism," which is when white privilege and its norms are accepted without question (King, 1991). The presence of racism was further unveiled through Afia's anecdotes where she described herself as being in a constant "race" to protect her children from everyday racial microaggressions, further contributing to mistrust (Sue et al., 2007; Williams, 2020). She also noticed the mistrust toward white individuals emanating from her experiences with African church pastors.

Altogether, a history of intergenerational trauma, heightened racial tension, existing discrimination, and Afia's social identities as a mother and Christian woman intersect to influence a heightened mistrust toward white mental health professionals. These contributions to mistrust highlight a connection between personal conflicts and larger systems of oppression, power, and privilege (Atkinson et al., 1993; Chesire & Noldy-MacLean, 2022; Crenshaw, 1989) that may create barriers toward help-seeking (Cheng et al., 2013; Mazzula & Nadal, 2015). They may also influence therapist choice; such that racially matching with a therapist may feel safer and more comfortable especially when racial tensions are heightened. While racial trauma might interfere with help-seeking, help-seeking behaviour may be further conflicted by religiosity. This tension is considered next.

Religiosity. Religiosity intersected with race and ethnicity in a manner that influenced participants' approach to and engagement with therapy. Afia and Rosina presented tensions between their religiosity and therapy. In some instances, religiosity generated hesitations toward therapy and delays in accessing it, and in other instances tensions emerged during therapy depending on whether and how the therapist broached religiosity.

From Afia's perspective, inherent mistrust of African church pastors toward white individuals dissuades seeking help and espouses a reliance on religiosity. However, she described her religiosity as being in support of seeking counsel outside the church, highlighting conflicting rhetoric within her community. She also experienced tension between religiosity and therapy with expectations to "pray it away," referring to how her troubles could be resolved through prayer. Afia felt the "pray it away" approach was not enough for her and that she needed additional support such as therapy and medication. However, this led to feelings of guilt and fear about whether she had enough faith. Afia experienced a delay in help-seeking due to tension between religiosity and therapy as well as due to financial accessibility. As her anxiety worsened, Afia's co-worker recommended the mental health support available to her as an employee, bridging a gap between tension and help-seeking.

Rosina also struggled with tensions between religiosity and therapy. Although she later viewed therapy as "another Islamic way of healing," her family initially expected her to "pray it away." When circumstances were not changing for her, Rosina finally sought therapy to address her concerns. Tensions regarding whether to rely on familial methods of religious healing or on psychotherapy to overcome mental health struggles are complex and perhaps more common than currently understood (Guigere et al., 2010; Guo et al., 2015; Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). Although tensions between religiosity and therapy are not well addressed in the literature, religiosity would seem an important intersection for therapists to consider if it is part of an REM client's cultural context. This idea is further considered below as religiosity enters the therapy space.

The literature notes a "religiosity gap" where most therapists identify as non-religious while treating clients who identify as religious (Magaldi & Trub, 2018). Clients may sense that their therapist may not be receptive to or may not understand their religious beliefs, therefore they avoid sharing that part of themselves in the form of cultural concealment (Drinane et al., 2018; Magaldi & Trub, 2018). For Rosina, cultural concealment occurred after she first introduced the topic of religion in session and felt her therapist dismissed it. In addition to cultural concealment, such experiences can be interpreted as a racial microaggression that can potentially harm the client (Acton, 2001; Owen et al., 2014). Moreover, such instances of dismissal and concealment can shape how the client is understood (Randall, 2021; Smith, 2015).

Rosina continued to conceal this aspect of her cultural identity through the remainder of therapy, wishing that her therapist had been curious to broach religion. In contrast to Rosina's experience, Afia's therapist seemed to seize a cultural opportunity by recognizing how salient religiosity was to Afia's presenting concerns. In Afia's case, racial trauma as well as tensions between religiosity and therapy shaped her presenting concerns where her therapist's curiosity and subsequent broaching may have helped to deepen the exploration of her identity (Lee et al., 2022). Davis and colleagues (2018) use the term cultural opportunity in reference to therapists' curiosity when clients introduce topics of cultural relevance (e.g., religiosity). The authors state that seizing cultural opportunities requires having cultural comfort. Therefore, some therapists might hesitate or dismiss cultural conversations due to a lack of comfortability that may also arise when an REM client's presenting concern does not fully align with Western values (Davis et al., 2018; Randall, 2021; Smith, 2015). This idea may represent a pervasive concern within REM clients' existing stigma toward the idea of therapy and is addressed next.

Stigma/Skepticism toward Therapy. When REM individuals enter therapy with experiences of racial trauma, there may already exist an inherent mistrust toward white individuals and by extension, mental health professionals who may represent the broader microcosm of society (Cheng et al., 2013; Mazzula & Nadal, 2015). Furthermore, based on Rosina and Afia's stories, religiosity might be a pre-existing alternative to therapy, suggesting tension about help-seeking outside of one's religion. Within this intersection of racial trauma and religiosity, there may exist a prevalence of stigma around help-seeking within REM communities (Cheng et al., 2013; Guo et al., 2015; Sun et al., 2016; Tiwari & Wang, 2008). REM participants in this study shared how they viewed therapy as something for people with "serious problems" or that it implicated something being wrong with them, thereby stigmatizing their struggles (Cheng et al., 2013). After various methods of religious healing were not working, Rosina processed her stigma toward therapy upon accepting her struggles at the time. Rayan also acknowledged pre-existing stigma toward mental health issues and the idea of therapy within her intersecting social identities as a South Asian and a first-generation Canadian. Despite the stigma, financial accessibility was an added layer where access to employee benefits and/or insurance facilitated the process of help-seeking for Afia and Rayan. Although financial accessibility is not highlighted in the literature, it is an important consideration, alongside racial trauma and religiosity, before working with REM clients. Therapy might be considered something out of

reach financially, thereby impeding access or awareness of its potential usefulness, and further stigmatizing it (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015).

In this study, family influence also played a role in stigma and skepticism toward therapy (Guigere et al., 2010; Guo et al., 2015; Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). Rayan and Rosina approached the idea of therapy with skepticism, where Rayan noted her lack of exposure to therapy and Rosina did not view therapy as an option until she researched its pros and cons. Rosina recalled her family's lack of familiarity with therapy, labeling it as "extreme" and vouching for religious healing, whereas Rayan received skepticism from her parents and observations of stigma within South Asian and immigrant communities. While the level of acculturation for each participant was not clear, such skepticism suggests some participants' families were less likely to perceive the need for professional mental health help based on the values within their culture of heritage (Sun et al., 2016). Indeed, Anna expected to receive opposition from her parents based on observations of others' East Asian parents, describing such opposition as a "very common Asian stereotype." Anna's parents did question whether she was trying her hardest when she stopped her medication and expressed disappointment about her perceived lack of progress. Although her parents were generally supportive of her therapy, Anna's apprehensions toward starting therapy support claims in the literature that family influence can further stigmatize help-seeking (Guigere et al., 2010; Guo et al., 2015).

Lastly, Rosina was the first in her family to attend therapy and this was kept secret from the rest of her family. When asked what she learned in therapy, Rosina's parents commented that they could have helped her instead. Rayan described her parents as offering conditional support by questioning her behaviour and the benefits of therapy and asking her to share her therapy session notes. In these instances, the participants shared similar tensions in embarking on a very personal journey under a level of skepticism and potential scrutiny from their parents.

These findings are represented in the literature. When clients are not familiar or well-versed with therapy, the family system's existing skepticism may influence a client's process of seeking and engaging in therapy (Guigere et al., 2010; Guo et al., 2015; Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). An implication is that there may be benefits to therapists discussing with REM clients how they arrived at their decision to pursue therapy and what their

family involvement and reactions have looked like. Drawing from Anna, Rayan, and Rosina's experiences, this form of broaching might help discern whether there have been struggles to seek therapy and ensure that such concerns do not endure within therapy.

Wherewith less exposure to and awareness of therapy, REM communities might perceive less confidence in the appropriateness and effectiveness of therapy, further influencing clients and their families' trust in the therapy process (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). These concerns are not limited to REM client experiences but might overlap with one's level of acculturation, religiosity, and underlying mistrust toward more Westernized practices (Sun et al., 2016). Therapists seizing such a cultural opportunity might help normalize the therapy process for the client.

Stage of Life. An REM client's stage of life, such as age and relevant life role, is part of their culture that can intersect with race/ethnicity (Arthur & Collins, 2016). Anna, Rosina, and Rayan began therapy in their adolescence and while they were students. They began the process with skepticism from their parents who questioned the therapy process as they navigated it for the first time. When starting therapy, these participants described a collective vulnerability of fear, anxiety, shame, judgment, and apprehension about being misunderstood. These vulnerable sentiments potentially reflected concerns about mistrust in the therapist to fully understand their lived experiences (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015), amidst stigma from their social and familial environments (Cheng et al., 2013; Guigere et al., 2010; Guo et al., 2015; Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015). Indeed, Rayan described an instance of cultural concealment (Drinane et al., 2018) when she decided based on her therapist's white identity that the therapist might judge aspects of her childhood from a more "Westernized perspective," alluding to the social context of psychotherapy as a Western practice (Randall, 2021; Smith, 2015). Conversely, Afia entered therapy for the first time during her stage of life as a mother. Like the other participants, Afia was adjusting to the therapy experience for the first time, exploring her identity, and dealing with stigma in the form of inherent mistrust toward her white therapist. However, she experienced feeling seen and understood based on her white therapist's disclosure of also being a mother. Afia found that therapist disclosures about motherhood from both her white and Black therapists were impactful based on this shared identity. The stage of life is considered part of one's cultural identity (Arthur & Collins, 2016)

and participants' reports suggest that there may be value in therapists considering how race/ethnicity intersects with one's stage of life. Anna, Rosina, and Rayan described long-lasting impactful experiences in therapy during their adolescence. They each described themselves as young, impressionable, and vulnerable during moments of therapist self-disclosure that left them feeling misunderstood and disconnected. These instances suggest a need to examine intersectionality as a relevant tool during therapy with REM clients.

Slow Intersectionality as a Relevant Tool

Each participant carried unique cultural contexts that influenced their expectations of therapy, their engagement with therapy, and their experience of the overall process. As they engaged with therapists who were generally of a different race/ethnicity from them, such difference may benefit from what has been referred to as "slow intersectionality"—a tool that therapists can use to purposefully decenter white and Western values to prevent racial microaggressions (Chesire & Noldy-MacLean, 2022; Houshmand et al., 2017; Nadal et al., 2014; Owen et al., 2014; Smith, 2015). Slow intersectionality necessitates effortful reflexivity and a deliberate "slowing down" of the therapy process (Chesire & Noldy-MacLean, 2022). It is a chance to reflect on and acknowledge intrapsychic experiences as being interconnected within intersections of privilege and oppression (Chesire & Noldy-MacLean, 2022; Crenshaw, 1989). Participants' cultural contexts demonstrate how slow intersectionality can be a relevant tool to address the complexity of intersections with race/ethnicity that are also related to their presenting concerns (Cheshire & Noldy-MacLean, 2022; Crenshaw, 1989).

For example, Rosina started therapy for anxiety, but her presenting concerns transformed over the course of therapy where she wanted to address her identity as a Muslim woman in Canadian society. Rosina's therapist did not engage in slow intersectionality and instead dismissed the cultural opportunity. This experience necessitated a change of therapist to prevent cultural concealment. Afia's therapist appeared to practice slow intersectionality by acknowledging Afia's tensions between religiosity and therapy. This opened a space for Afia to talk about her Christian faith in the context of her gender as a woman and within two contrasting contexts of Canadian society and African church culture. When her struggles between these intersecting identities of gender and religion were acknowledged, Afia felt able to explore her

concerns in greater depth which included the complexities of biculturalism (Chesire & Noldy-MacLean, 2022; Crenshaw, 1989; Guigere et al., 2010).

In sum, the intersections with race and ethnicity that participants offered in contextualizing their therapy demonstrate the relevance of slow intersectionality. Moreover, cultural humility, cultural comfort, and seizing cultural opportunities via the practice of broaching (Davis et al., 2018; Lee et al., 2022) may be useful skills to practice slow intersectionality. The cultural contexts discussed thus far lay the foundation for understanding participants' perspectives of the therapy process. What follows is a look at the therapy process using the tenets of relational-cultural theory (RCT) which served as the theoretical framing for the study. The tenets of RCT will help describe how participants experienced their therapists, particularly with regard to addressing similarities or differences between them.

Contextualizing Therapy: The Process

Subthemes reflecting participants' perspectives of the therapy process include humanizing elements, therapist knowledgeability, broaching difference, disconnection leading to therapy closure, as well as shifts away from and toward "matching" with the therapist. I connect these findings to the tenets of RCT along with relevant concepts from the literature such as broaching, racial microaggressions, and the multicultural orientation framework.

Humanizing Elements. According to participants, humanizing elements referred to the qualities present that may have facilitated feeling seen by and connected with the therapist during their therapy process. These qualities included gentleness, nonjudgment, safety, validation, warmth, comfort, the permission to take up space and to be vulnerable, as well as silent understanding. For example, Afia described a deepened exploration of her faith when her white therapist was "listening to her a lot" and asked her "poignant questions," both of which seem to encompass what Lee and colleagues (2002) refer to as reflective listening in a cross-cultural context. Afia also described moments of shared silence with her Black therapist during the pandemic. This experience challenged her need to be the "perfect" client and permitted Afia to be herself in session. In both of Afia's experiences, her therapist's "way of being" seemed facilitative of *relational authenticity* and *connection*, where the client's true nature can be experienced in the session (Davis et al., 2018; Lee et al., 2022; Jordan, 2004; Lenz, 2016).

Altogether, these qualities associated with the RCT tenets of authenticity and connection may speak to an other-oriented "way of being" (Davis et al., 2018) that sets the stage for Rogers-Sirin et al.'s (2015) version of cultural competence—marked by openness to learning, respectful integration of culture, and empathetic engagement.

Therapist Knowledgeability. Therapist knowledgeability refers to therapists having the skills to address psychological concerns of anxiety in a decontextualized manner. Participants in this study perceived therapists as knowledgeable when they conveyed relevant psychoeducation, provided the appropriate tools, and facilitated the REM client's understanding of their anxiety. Therapist knowledgeability was especially important for two participants, Afia and Rosina, who previously mentioned being unable to consider therapy as an option for themselves and viewing it as something for people with extreme problems. While such apprehensions are found in the literature (Johnson & Nadirshaw, 1993; Mazzula & Nadal, 2015), Afia and Rosina both described feeling a sense of empowerment from their therapists' abilities to understand their anxiety. Such findings suggest that therapist knowledgeability conveyed via psychoeducation can help shift initial feelings of skepticism and stigma in the therapy process towards feelings of empowerment.

In addition to conveying knowledgeability through psychoeducation, therapists also conveyed certain knowledgeability through disclosures about their professional and personal experiences. Such knowledgeability facilitated client trust and credibility in the therapist. With respect to disclosure about professional experience, Rayan perceived her first therapist as trustworthy and credible based on her therapist having worked with other clients around her age. The literature on therapy with REM clients does not appear to address that knowledge of a therapist's professional experiences and training might influence trust and credibility. With respect to disclosure about personal experiences, Afia spoke of an increase in trust and credibility upon discovering that her white therapist was also a mother. Anna also described trusting her therapist who self-disclosed a vulnerable life experience. Anna viewed her therapist as someone who had been through the same thing and whose words held true meaning to generate a deepened understanding of herself.

Taken together, these experiences of therapists sharing knowledge that is relational in nature and relevant to the client seem to reflect the RCT construct of *relational empowerment.* That is, while the therapist and client are different from one another on salient aspects such as race and ethnicity, the therapist's sharing nevertheless instills trustworthiness and credibility for the client which, in turn, may facilitate a client's deeper understanding of themselves (Jordan, 2004). In addition to relational empowerment, sharing an experience that is similar to the client may facilitate the RCT construct of *perceived mutuality* – "the ability to maintain a sense of self, yet be open to the change experiences that emerge from relating to others" (Lenz, 2016, p. 416). Lenz (2016) elaborates that when therapists share something vulnerable with their client, it can promote a sense of mutuality within the dynamic. This is particularly relevant to Afia and Anna who learned of commonalities they shared with their therapists despite coming from different racial and ethnic backgrounds. Afia developed an increased sense of trust and credibility with her therapist based on their shared identities as mothers. Anna developed trust and credibility with her therapist after a relatable yet vulnerable disclosure against a backdrop of previous therapy experiences that ended with disconnection. This suggests that a therapist's knowledge based on their personal and professional experiences, when shared with relevance to the client, may deepen the therapeutic relationship and client self-understanding, as well as increase trust and credibility (Audet & Everall, 2003; Burkard et al., 2006; Chang & Yoon, 2011).

In contrast, a therapist's knowledgeability may not always translate to a positive outcome when the client receives it as unhelpful or harmful. Anna shared an experience of her first therapist's knowledgeability that resulted in a sense of disconnection. Anna's therapist had offered a strategy to distract from her anxiety by making a fist with her nails into her palm. Anna considered it an unhelpful strategy and questioned its harmful impact: "Why would you want to hurt yourself?" Contextually, this was Anna's first therapist at age 14, as she noted being "vulnerable and impressionable." She spoke of her first therapist's approach being different from the self-love she later discovered with her fourth therapist. There are implications for the sense of disconnection felt, as she received this strategy at a young age, stating: "I'm never going to forget what she said." Research from the perspective of younger clients in therapy has shown that the therapist's relationship with the client, frequent check-ins, and invitations to collaborate during the process are important factors for positive therapeutic experiences (Ferguson et al.,

2023). It is possible that Anna's experience of her therapist's strategy was seen as one-sided and lacking the necessary relational components to address the harm that she felt.

Broaching Difference. As a reminder, broaching is defined in the literature as a therapist's intentional invitation to discuss and address cultural aspects and systemic oppression in a client's life, differences in the dyad, and impacts on the therapy process (Lee et al., 2022). There is support in the literature for therapists broaching differences with clients as it can enhance therapist credibility and effectiveness, deepen clients' disclosures, and increase satisfaction with therapy and willingness to return to future therapy (Lee et al., 2022). Connection/disconnection is a core tenet of RCT that is directly implicated if the therapist failed to broach, if the client did not perceive a need to broach, or if the therapist chose to broach. Each of these possibilities are discussed next based on participant experiences.

Failure to Broach. Anna and Rosina experienced moments of disconnection when their therapists failed to broach differences in the therapy dyad. Both participants noticed differences in age with their therapists accompanied by differing worldviews. Anna described an inability to connect with the therapist, conflicts in the form of debates and challenges, and a consequent end to the course of therapy. Rosina experienced skepticism from her therapist when they approached topics related to science and the effects of the lockdown during the pandemic. The therapist's opinions took precedence over Rosina's perspective in session, conveying the therapist's failure to acknowledge factors outside of the dominant culture that were relevant to Rosina (Cardemil & Battle, 2003; Owen et al., 2012). Consequently, as was the case for Anna and Rosina, when there is no opportunity to address these missteps, it may contribute to a sense of disconnection such as a lower quality therapeutic alliance, cultural mistrust, and a premature end to therapy (Cardemil & Battle, 2003; Owen et al., 2012; Owen et al., 2014).

Rosina also identified disconnection when her white therapist dismissed a cultural opportunity to broach religion. Rosina's feelings of dismissal could be interpreted as a racial microaggression (Acton, 2001; Owen et al., 2014), particularly as it resulted in her concealing this part of her culture in future therapy conversations when the therapist ultimately conveyed her religious identity was "less important" (Drinane et al., 2018). This experience led to Rosina questioning her struggle and dismissing an aspect of herself for several years. Rosina expressed a

wish for her therapist to have shown curiosity. I suggest that either cultural awareness or cultural comfort might have been lacking in order to seize the cultural opportunity (Davis et al., 2018). When a therapist does not seize a cultural opportunity, clients may experience this as the therapist lacking true empathy for them (Acton, 2001; Comstock et al., 2008; Jordan, 2017).

In sum, clients might experience cultural difference, whether in the form of age or religiosity, as a disconnection when the therapist does not deliberately broach such difference with the client. Therapists may need to consider cultural humility which Hook et al. (2013) describe as an ability to maintain an other-oriented "way of being" when aspects of the REM client's identity are brought forward. It seems that the RCT tenet of connection might require a therapist to have an other-oriented stance. However, to be other-oriented in a culturally meaningful way seems to require certain cultural comfort to effectively engage cultural opportunities that surface in sessions. Doing so could serve to bridge perceived differences and facilitate client understanding.

No Need to Broach. While there might be disconnection when broaching does not occur, there can also be moments of connection without needing to broach difference. For example, Rosina felt a connection with her Muslim therapist based on salient similarities, which could exemplify inherent trust (Chang & Yoon, 2011). Rosina matched closely with her Muslim therapist on ethnicity, age, and religion. These factors were particularly important for Rosina who entered this therapy space after previous therapy where unaddressed differences over cultural values and worldviews led her to conceal her religious identity. While she did perceive some cultural differences with her Muslim therapist, she did not feel they needed to be discussed, instead valuing her therapist's nonjudgment and the comfort in not having to "overexplain" herself. Chang and Yoon (2011) note that racial differences recede in importance when participants perceive similarities in other characteristics with their therapist. An emphasis on similarities with the therapist might therefore contribute to a feeling of implicit connection for an REM client (Audet & Everall, 2003; Chang & Yoon, 2011).

When Broaching Occurred. Broaching occurred for two participants where their therapist acknowledged their struggles with either respect or with an attempt at relating to them, resulting in connection and disconnection respectively. Afia's white therapist was someone she

initially mistrusted, but this shifted once her therapist recognized the conflict between Afia's bicultural identity as a Christian woman within Canadian society versus her identity within the culture of the African church. In terms of connection, Afia described this experience as respectful of her personhood and giving her "permission" to explore her struggles. Indeed, Lee and colleagues (2022) suggest that broaching can enhance clients' depth of disclosures. Afia's example may also illustrate that when therapists demonstrate ease and openness in addressing racial-ethnic matters, the salience of racial differences can diminish (Chang & Yoon, 2011). Seizing this cultural opportunity by focusing on Afia's conflicted experiences within her intersecting identities also suggests the therapist possessed a sense of cultural comfort and an other-oriented way of being (Cheshire & Noldy-MacLean, 2022; Davis et al., 2018).

Conversely, Rayan experienced disconnection when her therapist attempted to relate to her struggles. Her therapist disclosed on different occasions that she had similarly grown up in poverty, applied for medical school, and lived with a chronic illness. While the issues were similar to Rayan's, Rayan felt the therapist did not understand the cultural context of being a first-generation immigrant raised by South Asian parents. Such an oversight may be considered a racial microaggression given that the therapist's experiences, while similar to a degree, did not align with Rayan's cultural understanding of the same experiences (Rogers-Sirin et al., 2015). In sum, the difference between whether broaching can create connection, or disconnection might lie in the extent to which a therapist embodies a sense of cultural comfort and an other-oriented "way of being" in response to cultural opportunities presented in session (Davis et al., 2018).

Disconnection Leading to Therapy Closure. Another observation worth noting about REM clients' experiences and the therapy process is that some experiences of disconnection can lead to ending therapy. Anna, Rosina, and Rayan ended their respective courses of therapy when they felt increasingly disconnected from their therapists. For example, Anna's experiences of her therapists challenging her based on age difference resulted in feeling disconnected which ultimately led to ending therapy. She offered further consideration for disconnection that can be caused by a disengaging therapeutic approach (Ferguson et al., 2023) as well as the environment in which therapy takes place (Jones, 2020). Rosina relayed that unhelpful therapist self-disclosures and differing worldviews were factors that caused disconnection and an eventual closure to therapy. Furthermore, her therapist engaged in assumptions of white and Western

cultural values that differed greatly from Rosina's cultural context, potentially resulting in racial microaggressions (Mazzula & Nadal, 2015). Rayan experienced feeling misunderstood largely due to instances of therapist self-disclosure that she felt lacked relevance to her cultural context and personal feelings. She theorized that as people start therapy, they may typically start with a white therapist and, as they progress, they may search for a therapist "more aligned with their own values and perspectives and life experiences."

Shifts Away from and toward "Matching" with the Therapist. The literature shows a preference for REM clients wanting to match racially/ethnically with their therapist, often perceiving them more positively (Cabral & Smith, 2011). Some REM clients, like Rosina, might resume therapy due to a personal evolution and seek someone who might better understand their religiosity. Other REM clients, like Afia, might seek therapy during a time when it only feels safe to speak with someone who looks more similar to them. Therefore, therapist choice for REM clients might be an important consideration based on their cultural context and the shift in their presenting concerns.

Conversely, Hook and colleagues (2016) report a "stronger sense of betrayal" felt when a racial microaggression occurs between a therapist and a client who match closely on race or ethnicity. Matching with a therapist based on salient characteristics of race/ethnicity may therefore carry an implicit sense of connection as well as an increased risk of cultural harm if the therapist does not meet the cultural expectations of the racially matched client (Hook et al., 2016). However, it is also possible that cultural harm can occur when the therapist *does* meet cultural expectations of their racially matched client. For example, Afia was reminded of her insecurities in her marriage because her therapist matched too closely to her partner's ethnic identity. She described the therapist as giving her "mother-in-law slash aunty vibes." This experience prevented Afia from being able to express her authentic self and contributed to an immediate end of the therapy.

How are Therapist Self-Disclosures Experienced?

In this section, I contrast participants' unhelpful and helpful experiences of therapist self-disclosure (TSD). The literature generally defines TSD as "therapist statements that reveal something personal about the therapist" (Hill & Knox, 2002, p. 255) and which can regard their

personal, professional, and cultural selves (Lee, 2014). Moreover, the literature distinguishes between non-immediate self-disclosures and immediate self-involving disclosures. Non-immediate self-disclosures reveal personal aspects of the therapist's life outside the therapy process whereas immediate self-involving disclosures reveal the therapist's immediate feelings related to the client or the therapeutic relationship (Audet, 2011; Hill & Knox, 2001; Lee, 2014). Within this, participants identified various forms of TSD that provided insights into the therapist's feelings, thoughts, and experiences. I categorize participants' TSD experiences based on types of therapist self-disclosure reflected in the literature. I also propose new types and tentative definitions when certain experiences of TSD are not reflected in the literature. I organize the discussion of disclosures based on whether participants found the disclosures helpful or unhelpful, as this distinction aligns well with the central tenet of Relational-Cultural Theory (RCT) of whether they facilitated or hindered connection.

Unhelpful Disclosures. Participants offered their unhelpful experiences of non-immediate disclosure (i.e., disclosures of opinion and partial similarity). They deemed these disclosures unhelpful because they contributed to disconnection from the therapeutic relationship. Below, I offer what is known in the literature for each TSD type to contextualize the unhelpful TSD experiences for each participant.

Disclosure of Opinion. It is important to note that disclosure of opinion is not formally defined in the counselling literature. However, a literal definition of "opinion" is "a view or judgment formed about something, not necessarily based on fact or knowledge" (Oxford University Press, n.d.). Anna and Rayan described their therapists as disclosing what they perceived to be an opinion about their life trajectories. For example, the therapists indicated that Anna and Rayan might "never be normal" due to a diagnosis, they might "combust" if they continue to "work too hard," or that their experience of social anxiety was "really weird." Rosina's therapist also disclosed opinions that COVID was not real, and that the lockdown was not necessary. Rosina perceived her therapist as revealing their political view. Therapist sharing political views is a disclosure topic which appears to be re-surging from earlier TSD literature (Edwards & Murdock, 1994; Hendrick, 1988) and reflected in more recent literature (Solomonov et al., 2018). This body of literature suggests therapists should tread carefully when sharing political views though political views that are shared implicitly and align with the client's views

may foster therapeutic alliance. In Rosina's case, the disclosures did not resonate with her as she worried about her grandmother's health during COVID. Although the therapist initially validated Rosina's worries, Rosina felt that her therapist placed more emphasis on their unsolicited political views at one point devoting up to 25 minutes of "back-and-forth disagreement." This aligns with a recent study suggesting that "increased TSD in teletherapy may be a potential marker for heightened distress in [...] therapists during a global crisis" (Luo et al., 2023, p. 1). Regardless of what informs therapist disclosure, a risk to clients may be a lack of attentiveness to the therapy process and the client's needs (Audet, 2011, 2019; Lee et al., 2022). Indeed, Rosina described the experience as feeling unheard, annoyed, and hurt, reflecting certain disconnection from the therapist.

In another example, Rosina described her therapist as "pushing" a viewpoint onto her as to how she should live her life (e.g., "You need to go like, party and like, be drunk and like, pass out"). She found this suggestion in opposition to her religious values and perceived it as her therapist espousing Western values. While her therapist may not have claimed this viewpoint as their own, it led to Rosina framing it as something unrelatable and culturally irrelevant to her, as she considered it more of a "Hollywood movie" view. Lee (2014) notes that cultural assumptions that therapists make may risk client discomfort and withdrawal from the therapy process. Rosina proceeded to end the therapy relationship shortly thereafter with mixed feelings. She deeply valued her therapist's knowledgeability and caring nature, but these disclosures of opinion occurring within close succession became the "last straw."

It should also be noted that the disclosures of opinion occurred at an early age for Anna and Rayan which created a lasting negative impression of "Why can't I be normal?". For example, Anna mentioned the difficulty to remain engaged with her therapist who judged her social anxiety. Instead, she felt hurt after being told that she was not trying hard enough: "I can't do that anymore. I don't want to see her. She doesn't understand me." Rosina also alluded to a risk of long-term harm when therapists share opinions when clients are "young and impressionable." These examples are consistent with Lee's (2014) report that the consequences of unhelpful TSD experiences often lead to withdrawal from the therapy process as well as with Cherbosque (1987) who notes that REM clients have been known to end therapy prematurely due to finding therapist self-disclosures inappropriate.

In sum, it is possible that participants perceived these interactions as opinion because they appeared to reflect a judgment rather than reflect a professional observation grounded in fact or knowledge. In other words, clients could interpret therapists' disclosures as revealing something about their personal beliefs—regardless of the therapists' intentions or even when the therapist does not overtly state it is as a personal belief. By definition, such disclosures of opinion might in fact reflect Hill and Knox's (2002) description of TSD as a "therapist's personal self-revelatory statement." At the same time, each disclosure of opinion was unsolicited and was not received positively. While such disclosures may have revealed the therapists' personal beliefs, they lacked consideration for how Anna, Rosina, and Rayan might experience them for their cultural relevance or their timing.

Disclosures of opinion are not clearly represented in the TSD literature. However, taken from the participants' perspectives, these examples seem to reveal an insidious form of TSD when experienced as unsolicited opinion. Regardless of whether these disclosures were intended as interventions, clients may covertly assess them for their relevance to their context. That said, disclosures of opinion appear to resemble non-immediate disclosures that can risk shifting meaningful focus away from the client, particularly if the opinion lacks cultural relevance, casts doubt, misunderstands, or neglects the client's experiences and values (Knox & Hill, 2003; Wachtel, 1993). Moreover, there may be unique implications that are not addressed in the literature about therapists disclosing opinions to younger clients. It is worth noting that participants in this study indicated long-term impacts in the form of self-doubt, frustration, and invalidation. Ultimately, disclosures of opinions risk creating disconnection of the client from themselves, between them and their therapist, and in some instances from therapy altogether.

Disclosure of Partial Similarity. Disclosure of partial similarity is a term I developed during the analysis process. I consider this type of disclosure as non-immediate as the therapist shared personal information about their past experiences (Hill & Knox, 2002). The word "partial" refers to the therapist sharing a similarity in terms of the client's issue but having an experience or understanding of the issue that is different from the client. Rayan offered two anecdotes that highlights this phenomenon, both of which she experienced as unhelpful and led to her to feel invalidated, misunderstood, and disconnected from the therapy process. Both

occurrences of disclosure were in close succession, which Rayan described as contributing to the ultimate disconnection of ending the therapy process.

In the first example, Rayan discussed the "overwhelming pressures" to succeed academically and get into medical school in return for her parents' hard work and how she felt she was letting her parents down. Her therapist disclosed a similarity of also having wanted to apply for medical school. However, the therapist's explanation that it was "normal to fail and to try again" did not resonate for Rayan. She felt discomforted by the disclosure as she believed "I'm not allowed to fail". This experience closely reflects Lee's (2014) finding that TSD can demonstrate a therapist's cultural insensitivity and contribute to discomfort in therapy. Furthermore, Rayan felt that her past context was not being heard or understood. Rogers-Sirin and colleagues (2015) note that an assumption of adequate knowledge of a client's culture that is irrelevant to a client's experiences may contribute to a client feeling isolated. Moreover, such feelings of isolation and feeling misunderstood when a client's cultural context is not considered may pose a risk of cultural harm in the form of a racial microaggression (Houshmand et al., 2017; Owen et al., 2014).

In the second example, Rayan was processing a diagnosis of chronic illness at a very young age. Her therapist disclosed having similarly been diagnosed with a chronic illness and told Rayan she just had to "get through it." The disclosure occurred early on in Rayan's processing of her diagnosis, and she experienced the comment as incongruent with her own understanding of the diagnosis. She emphasized feeling "shut down" and needing time to process her feelings. This example might lend to risks described in the literature where TSD can lack attentiveness to the therapy process (Audet, 2011; Audet, 2019).

In both cases, Rayan's therapist shared having a similar issue but conveyed an understanding that invalidated her context, whether culturally or emotionally. In other words, disclosures of partial similarity are not conducive to creating or deepening connection between client and therapist as they may contribute to feeling misunderstood, thereby creating a sense of isolation and disengagement from the therapy process.

Helpful Disclosures. Participants offered their helpful experiences of therapist self-disclosures (i.e., disclosure of challenge and of vulnerability). These disclosures are deemed

helpful because they contributed to a sense of connection and further engagement between the client and therapist. Once more, I offer what is known in the literature for each TSD type and suggest implications for helpful TSD.

Disclosure of Challenge. Disclosures of challenge occur when the therapist shares information about themselves in a manner that is immediate and self-involving because they confront the client's perspective, way of thinking, feeling, or behaviour (Hill & Knox, 2002). Immediate disclosures are generally more favoured for their potential as a relational intervention (Lee et al., 2022; Ziv-Beiman, 2013). Anna experienced a helpful disclosure of challenge from a therapist that embodied compassion and encouraged her growth. Anna's self-critical thinking was challenged from the start with this therapist, as she recalled them instilling their beliefs founded in compassion: "That I deserved to be kind to myself, and that I shouldn't be saying these things about myself because I deserved love." Anna spoke of her growth due to the consistent challenge to be more compassionate toward herself.

There is a possibility that this disclosure of challenge may not be perceived as a TSD, but rather a cognitive intervention to challenge Anna's self-critical thinking. However, Anna perceived her therapist as being directly involved in the dynamic with her, which she found to be a "game changer" and was "dumbfounded" upon realizing that previous therapists had never told her this before. Her therapist inserted themselves into the dynamic in a way that felt more personal to Anna, rather than asking her: "What would you say to a friend if they spoke about themselves so harshly?" From Anna's perspective, her therapist's response was a relational intervention that felt self-involving. She felt continually engaged with this therapist as she learned more about self-compassion: "She taught me what being kind to myself consisted of." This disclosure of challenge might demonstrate how an immediate self-involving TSD might be an effective relational intervention when used consistently in service of the client and while conveyed with compassion (Alfi-Yogev et al., 2023; Knox & Hill, 2003; Lee et al., 2022; Ziv-Beiman, 2013).

Disclosure of Vulnerability. Disclosure of vulnerability is another term I chose during the analysis process (Danzer, 2018). Participants spoke of such disclosures as times when their therapist disclosed something non-immediate but that conveyed a context that was relevant to the

client's context. It is unlike a disclosure of similarity between the therapist and client (Henretty & Levitt, 2010) because it goes beyond conveying a similarity to include conveying certain personal vulnerabilities, in this case a suicide attempt or the beginning of motherhood (Danzer, 2018). Participants experienced disclosures of vulnerability as helpful because they facilitated elements of connection such as empathy, trust, and credibility, all of which are benefits of TSD frequently shown in the literature (Audet, 2011; Burkard et al., 2006; Cardemil & Battle, 2003; Day-Vines et al., 2020).

Anna experienced a disclosure of vulnerability when her therapist revealed a similar experience of a suicide attempt. She described this disclosure as allowing her to truly connect to her therapist and view her therapist as credible because she "went through the same thing and knew how to navigate out." Anna felt "very seen" by her therapist and named an increase in trust. She described feeling "less like a patient and more like a person," and emphasized that her "best therapist" was "one that actually went through the same experiences as me." These sentiments might point to TSD as a connective intervention that can humanize the therapist (Audet, 2011; Lee, 2014) as well as promote an authentic bond and reveal the therapist's genuineness (Hill & Knox, 2002; Ziv-Beiman, 2013). This might also reflect how TSD can be a means for building connection by modeling openness and vulnerability (Henretty & Levitt, 2010). Sunderani and Moodley (2020) also report that therapists in their study used TSD to convey shared difficult or traumatic experiences. Sharing such experiences might model healthy self-disclosures for the client and may evoke mutually empathic exchanges (Lenz, 2016). I suggest that a vulnerable self-disclosure from her therapist might have especially fostered connection for Anna after unhelpful disclosures with previous therapists that hindered connection.

Afia also experienced a disclosure of vulnerability when her white therapist acknowledged the fact that she was breastfeeding. Despite the initial mistrust due to racial differences, Afia inferred that her white therapist could understand her experiences based on their shared identities as mothers. Without needing to hear her therapist's actual experiences as a mother, Afia trusted the embodied knowledge that contributed to her therapist's credibility: "I can rest in knowing that if she does share something, it's not all theory." Through this commonality, the impact of racial difference was significantly reduced for Afia when working

with her white therapist. Sue and Sue (1999) mention that TSD might be necessary to prove trustworthiness toward clients who are culturally different. Moreover, Chang and Yoon (2011) suggest that a client's ability to identify with their therapist through other dimensions of cultural identity might lessen the impact of racial differences within the therapeutic relationship.

Afia expressed a similar sentiment of connection with her Black therapist who was also a mother. She inferred that her Black therapist had similar lived experiences of the pervasive racial aggression experienced by Black parents and their children due to their skin colour. She noted that this shared vulnerability of motherhood with both therapists "humanized them more," facilitating a sense of safety and empathic understanding (Audet, 2011; Chang & Yoon, 2011; Henretty & Levitt, 2010; Lee, 2014; Lenz, 2016). The vulnerable experiences of motherhood might be an aspect to consider when working within cross-cultural dyads. There might be an underlying intimacy about motherhood that may facilitate a sense of connection irrespective of racial/ethnic differences or deepened by racial/ethnic similarities.

Nonverbal Disclosure. Nonverbal disclosure is a term that I chose from the literature during the analysis process when I observed that cultural information was being communicated to clients by their therapists without verbal confirmation (Gibson, 2012; Marais & McBeath, 2021). For example, cultural information can be inferred from the therapist's environment, disposition, or what they wear (Gibson, 2012). In this study, clients were able to make inferences about their therapists' identity based on salient characteristics (i.e., race/ethnicity, age, gender, religion). Afia and Rosina spoke most potently about this phenomenon, both of whom changed therapists to match more closely to their cultural identities. Afia's shift in her therapist choice occurred once she decided to resume therapy during the heightened racial tension of the pandemic, therefore prioritizing a Black therapist. Rosina sought a Muslim therapist upon reflection that she might want a safe and non-judgmental space to explore her religious identity. Both participants experienced nonverbal disclosures as helpful because they contributed to an implicit connection based on a perceived sense of ease, safety, and/or solidarity.

Rosina mentioned the ease of working with someone who matched closely with her cultural identity, as her therapist was visibly Muslim and a younger woman from a non-Western background. She found that she could infer having "similar mentalities" as opposed to her

previous therapist whose worldviews felt incongruent to Rosina's values. Afia explained a perceived sense of solidarity with her Black therapist: "...she didn't have to share much just because of the fact that she's Black." Afia attended these sessions virtually while she was processing racism and microaggressions in her workplace. She felt moments of silent understanding that contributed to "respite" and built "momentum to keep going," further alluding to a sense of solidarity. In both cases, Rosina and Afia demonstrate that nonverbal disclosures can be helpful when salient aspects of the therapists' identities bring a sense of ease, safety, and/or solidarity during a vulnerable time when they need to see someone with whom they can relate to more (Audet & Everall, 2003; Chang & Yoon, 2011).

Implications of TSD Experiences. Based on my interpretation above of REM participants' unhelpful and helpful experiences of therapist disclosure, I offer two observations for further consideration. One observation is that REM clients might assess disclosures as unhelpful when they perceive the TSD as lacking recognition of intersectionality relevant to the client. My other observation regards TSD's potential as a micro-skill to foster connection with REM clients.

TSD as Unhelpful When Intersectionality is Not Applied. During TSD, intersectionality (Cheshire & Noldy-MacLean, 2022; Crenshaw, 1989) becomes relevant when factors such as age, religiosity, and family involvement may have influenced whether the client feels the disclosure is congruent to their needs. Without the understanding of their clients' intersectionality, the therapists who offered unhelpful disclosures may have missed meaningful opportunities to connect with REM clients. Such was demonstrated with Rosina's therapist who disclosed unsolicited opinions that espoused Western values which contradicted her religious identity, and Rayan's therapist who lacked cultural context of Rayan's family involvement when disclosing a partial similarity. Some clients' unhelpful experiences of TSD brought long-lasting impacts of self-doubt, frustration, invalidation, and cultural harm in the form of racial microaggressions. Participants described themselves as young, vulnerable, and impressionable during these instances of unhelpful disclosures. Whether a disclosure of opinion or partial similarity, it may have interfered with the safety and nonjudgmental space they might have been searching for at that time.

TSD as a Micro-Skill for Connection. In this study, participants suggested the contextual relevance of a TSD might strengthen a sense of connection with their therapist. This phenomenon seemed to be evident in cases of helpful TSD when Afia and Anna's therapists shared vulnerable information about themselves that was relevant to their clients' contexts. A strengthened connection was especially evident when Anna felt more invested in therapy after her therapist challenged her self-critical thoughts by espousing beliefs that were conveyed with compassion. These moments translated to connection in the form of increased trust, credibility, and empathy (Audet, 2011; Burkard et al., 2006; Cardemil & Battle, 2003; Day-Vines et al., 2020). Therefore, disclosure relevance and the way in which it is conveyed may contribute to facilitating or hindering client-therapist connection. In effect, TSD might be a micro-skill for connection. Micro-skills are "soft skills" that therapists use to build rapport, foster understanding, and facilitate the therapeutic process—e.g., reflective listening and empathy (Lee et al., 2022). I revisit this observation in the next section in the context of cultural empathy.

How is Cultural Empathy Defined?

In this section, I discuss two different understandings of cultural empathy that participants seemed to offer. One understanding of cultural empathy regards the extent to which they perceived a "match" between themselves and an aspect of the therapist's cultural identity. A second understanding regards the therapist's ability to connect with them as a client in ways that do not directly appear to rely on aspects of cultural identity. As a reminder, the literature defines cultural empathy as therapist attunement to cultural similarities and differences between them and the client to respond in ways that are helpful to the therapy process (Pedersen et al., 2008).

"Matching". When participants offered their own definitions of cultural empathy, they initially defined it as them "matching" with an aspect of the therapist's cultural identity. They believed this to be necessary for the therapist to better understand their experiences as an REM client and to therefore "feel cultural empathy." However, participants subsequently nuanced this idea of matching, which is addressed below.

The relevance of matching for cultural empathy was highlighted through both positive experiences when there was matching and negative experiences when there was no matching. *Positive experiences* were observed when Afia sought a Black therapist during a racially tense

climate, and when Rosina sought a Muslim therapist so that she could be understood inclusive of her religious identity. Afia and Rosina chose their next therapists based on a shift in their personal needs—racial identity and religious identity. Consequently, they did not have to broach their respective identities, as they felt implicitly understood by their new therapists through nonverbal disclosure. Rayan also described feeling implicitly understood with a virtual therapist based on them being a racial-ethnic minority. This implicit understanding reflects a belief that a perceived similarity between the client and therapist can offer comfort, understanding, safety, trust, and credibility (Audet & Everall, 2003; Chang & Yoon, 2011; Ertl et al., 2019).

Negative experiences were observed when Rosina had unhelpful experiences with her white therapist who continually dismissed cultural opportunities (Davis et al., 2018) and during a consultation with an older male Muslim therapist with whom she described feeling like a "little girl." Anna and Rayan also experienced moments with therapists who were different from them that they felt discouraged their growth or invalidated their struggles. These positive and negative experiences suggest there are contexts when REM clients may prefer matching with a therapist of a similar race/ethnicity (Ertl et al., 2019), or perhaps they may prefer matching on other salient characteristics such as age and gender (Chang & Yoon, 2011).

That said, Afia identified a limitation of matching that hindered the possibility of cultural empathy. Although one of her therapists matched in ethnicity to her partner, such matching brought forth Afia's existing insecurities about being different from her partner. She pulled away from her therapist, noting that she could not express herself freely for fear of judgment. This experience suggests that cultural empathy may be difficult for clients to experience when the therapist overidentifies with a cultural aspect in the client's life. Ultimately, "matching" does not automatically engender cultural empathy (Ertl et al., 2019).

Furthermore, not all participants believed that matching was necessary for them to experience cultural empathy. Afia experienced cultural empathy when the initial mistrust toward her white therapist reduced upon realizing they were both mothers. Anna experienced cultural empathy after her therapist disclosed a vulnerable experience like hers related to suicide. Sunderani and Moodley (2020) note that therapists may choose to disclose difficult experiences to normalize their clients' lived experiences and foster connection. In both instances, these

disclosures of vulnerability humanized their therapists (Audet, 2011; Lee, 2014), validated Afia and Anna's lived experiences, and demonstrated the therapists' abilities to understand Afia and Anna (Comstock et al., 2008; Henretty & Levitt, 2010; Jordan 2017). Both participants also recounted a significant increase in trust and credibility (Burkard et al., 2006). In fact, the initial mistrust Afia felt toward her white therapist diminished upon perceiving her therapist as culturally comfortable with broaching her bicultural identity (Change & Yoon, 2011; Davis et al., 2018). These examples demonstrate that cultural empathy seems to hinge on the therapist's responsivity moment-to-moment and a sense of perceived mutuality rather than deliberate matching (Audet & Everall, 2003; Chang & Yoon, 2011; Davis et al., 2018; Lenz, 2016).

There remains a limitation to perceived mutuality and its ability to convey cultural empathy. In Rayan's case, she perceived a sense of mutuality with her therapist but described cultural empathy as fluctuating over the course of therapy. Perceived mutuality was observed when Rayan's therapist relayed similar experiences of living in poverty and being on social welfare. This disclosure provided Rayan a level of relatability which she likened to cultural empathy. However, she felt that her therapist's ability to demonstrate cultural empathy dissipated when it came to the therapist's disclosures in response to the pressure that Rayan felt to succeed academically and the processing of her chronic illness diagnosis. She no longer felt understood and instead became more disengaged from the therapy process, eventually leading to an end of the relationship. The client's experience of the therapist is considered in the second definition of cultural empathy that participants offered.

The Therapist's Ability to Connect. Another understanding participants offered about cultural empathy regards the therapist's ability to connect with them as a client in ways that did not always rely on aspects of cultural identity. Rayan suggested therapists should have prerequisite knowledge of immigrant experiences and South Asian culture to empathize. However, Rosina mentioned the importance of therapists simply listening rather than dismissing, and Afia identified the value of respect when her therapist broached her inner struggle with respect, resulting in a deepening of Afia's disclosures (Lee et al., 2022). These examples uphold what is known about cultural empathy thus far, as a practice that takes into consideration the client's differing worldviews, the therapist continually learning about the client's culture, and working with the client to meet their needs with respect to their cultural values (Levitt et al.,

2022; Ridley & Lingle, 1996). Anna further defined cultural empathy as "being human" and "having compassion" based on a deeply connective experience with her fourth therapist. In the literature, Ridley and Lingle (1996) emphasize cultural empathy as a means of connection, inclusive of understanding and appreciating the client's culture. The participants' perspectives corroborate the interpersonal quality of cultural empathy, where it is felt most when their therapist can connect with them in ways that are most meaningful to them based on what they need. Therefore, the therapist's "way of being" (Davis et al., 2018) is an element that can facilitate cultural empathy.

How Cultural Empathy is Experienced through TSD

In my study's theoretical framing, I initially proposed that RCT was at the core of meaningful therapist self-disclosures and a culturally empathetic therapeutic alliance. Below I make the case based on participant experiences that TSD can hinder, as well as contribute to, cultural empathy. I connect these relational experiences to the relevant concepts of RCT and end with thoughts on TSD as an intervention for cultural empathy.

TSD When Cultural Empathy is Not Experienced. There were two scenarios when participants spoke of TSD in the absence of cultural empathy. One scenario was when participants felt unhelpful TSDs conveyed the therapist's lack of cultural humility. Another scenario was when the TSD generated feelings of disconnection that remained unrecognized and therefore unaddressed by the therapist.

Cultural humility encompasses the therapist's "way of being" with the client (Davis et al., 2018). Davis and colleagues (2018) describe the importance of attentiveness, responsiveness, and being "other-oriented" as integral to cultural humility. According to participants in this study, they felt unhelpful disclosures conveyed that their therapist lacked attentiveness to them (Audet, 2011; Audet, 2019; Davis et al., 2018). They elaborated that those unhelpful disclosures of opinion and partial similarity shifted attention away from them, resulting in long-lasting negative effects and an eventual disengagement from therapy (Cherbosque, 1987; Owen et al., 2014; Wachtel, 1993).

With respect to *disconnection*, Rosina and Rayan's definitions of cultural empathy derived from unhelpful disclosures that conveyed what their therapists could not offer them (i.e., listening, holding prerequisite knowledge about their culture). Rosina and Rayan felt disconnected from their therapists, expressing sentiments of hurt and misunderstanding. In both cases, these instances of disconnection were not recognized by the therapist and led to disengagement from the therapy process.

Recognizing disconnection as a chance for repair is grounded in the process of reconnection within RCT (Lenz, 2016). The opportunity for repair was absent as Rosina and Rayan lacked a safe space for *relational authenticity*, a tenet of RCT which values one's real experiences, feelings, and thoughts within the relationship (Jordan, 2010; Lenz, 2016). Moreover, seizing the opportunity for repair after disconnection could demonstrate the RCT tenet of *relational empowerment*, which is the degree to which individuals can trust themselves to navigate difference and grow from conflict together (Jordan, 2004). For participants in this study, it appears that their therapists missed the opportunity for reconnection that may have had implications for their experience of cultural empathy. That such inattentiveness to the client may prevent the tenets of RCT and dissuade cultural empathy altogether is reflected in the literature (Levitt et al., 2022; Ridley & Lingle, 1996).

TSD When Cultural Empathy is Experienced. Participants also spoke of TSD in the presence of cultural empathy. Notably, these moments included nonverbal disclosures that generated a sense of perceived mutuality and relational authenticity as well as disclosures of vulnerability that contributed to perceived mutuality.

Perceived Mutuality and Relational Authenticity through Nonverbal TSD. Cultural empathy was present when participants matched with their therapists. Such matching was conveyed through nonverbal TSD which seemed to facilitate the RCT tenets of perceived mutuality and relational authenticity. This was most evident when Afia sought a Black therapist during a racially tense climate and when Rosina sought a Muslim therapist so that she could be understood inclusive of her religious identity. Consequently, they did not feel the need to openly discuss their respective identities, as they felt their new therapists implicitly understood them. Rayan also described feeling implicitly understood with a virtual therapist based on them being a

racial-ethnic minority. This implicit understanding reflects the RCT tenet of *perceived mutuality* as Rosina, Afia, and Rayan perceived their therapists as coming from similar backgrounds, experiences, and/or mentalities, thereby providing an inherent sense of connection rather than isolation (Lenz, 2016). Nonverbal disclosure can also lend to the RCT tenet of *relational authenticity*, whereby the therapist and client's actual selves are acknowledged, albeit implicitly, encouraging the client to further be themselves (Lenz, 2016). This is evidenced in Afia's description of "being able to show up and not feel performative" with her Black therapist as well as Rosina's sense of ease when she began working with her Muslim therapist. Therefore, the presence of cultural empathy seems to coincide with nonverbal disclosure that conveys perceived mutuality and relational authenticity by matching on known or salient characteristics.

Perceived Mutuality through TSD of Vulnerability. Cultural empathy was also present when therapists conveyed a shared vulnerability through their disclosure, which generated a sense of *perceived mutuality*. In terms of mutuality, Afia described how the initial mistrust toward her white therapist reduced upon realizing they were both mothers. Anna experienced mutuality when her therapist disclosed a vulnerable experience of a suicide attempt, the likes of which Anna was recovering from. Both participants described these disclosures of vulnerability as humanizing their therapists (Audet, 2011; Lee, 2014), validating their lived experiences (Sunderani & Moodley, 2020), and demonstrating their therapists' ability to understand them (Comstock et al., 2008; Henretty & Levitt, 2010; Jordan 2017).

TSD as an Intervention for Cultural Empathy. I initially approached this study with the idea that TSD might be a relational intervention well-suited to explicitly acknowledging cultural similarities and differences in the therapeutic space (Burkard et al., 2006; Cardemil & Battle, 2003; Lee, 2014; Lee et al., 2022; Sunderani & Moodley, 2020). In this study, participant perspectives highlighted TSD as a helpful relational intervention when the TSD conveyed similarity between the client and therapist, whether regarding a cultural aspect through nonverbal disclosure or a similar life experience through a disclosure of vulnerability. Conversely, participant perspectives also highlighted that TSD that lacks cultural humility and fails to address disconnection could pose relational interference within the therapy. While it is difficult to ascertain the direct impacts of TSD on cultural empathy, it would seem that TSD could have implications for cultural empathy given participants' reflections on these examples of helpful and

unhelpful TSD as they saw it relating to their understandings of cultural empathy. It is worth noting that participants initially defined cultural empathy as matching with their therapist, whether by cultural identity or similar life experiences. In all instances of unhelpful TSD, the participants did not match with their therapists, differing primarily on race, ethnicity, and age. Without matching through cultural aspects, their alternate definition of cultural empathy as the therapist's ability to connect becomes relevant. This is seen especially as Anna provides an alternate definition of cultural empathy as "being human" and "having compassion," emphasizing the quality of the connection.

Earlier on, I observed that TSD might be a micro-skill for connection and that it can result in harm when it does not consider the client's intersectionality. In the presence of cultural empathy, TSD seems to facilitate connection through similarity between the client and therapist. Still, there remain limitations to how closely a client and therapist can match before disconnection occurs (i.e., when Afia's therapist overly matched with her partner's racial/ethnic identity). In the absence of cultural empathy, TSD seems to hinder connection when it disregards a client's intersectionality, lacks attentiveness to the client, and misses opportunities to reconnect. In essence, TSD seems to shape the quality of the connection which, in turn, may have a bearing on whether they experience cultural empathy.

Revisiting Pre-understandings

As the discussion concludes, there remain some loose ends to acknowledge. Earlier, I included a personal prelude, and I also drafted my pre-understandings (Appendix E) prior to the data collection. What follows is a revisiting of my personal prelude and pre-understandings to identify what remained and what evolved over time in terms of my choice in terminology, my research interests, the purpose of the study, and my personal growth.

Evolution in Terminology. I started this research with the intention of focusing on the practice of TSD with REM clients. I would like to acknowledge a change in terminology, where I now wish to use the term BIPOC (Black, Indigenous, People of Colour) rather than racial-ethnic minority. Throughout my process, I struggled to find a term that well-encompassed the demographic I was seeking to better understand. As I further engaged with different communities, I deepened my understanding of racialized experiences from the eyes of Muslim

youth, women of colour, and those who identify as “African, Caribbean, and/or Black.” Outside of academia, I observed how the term “minority” was not being utilized as often as I have seen it used in past literature. In the real world, it is not about being a “minority,” but rather an individual who has been “racially minoritized” or “racialized” (Black et al., 2023). The shift in terminology signifies a more active process of understanding structural racism and the ever-evolving antiracism language (Black et al., 2023; Deo, 2023). Therefore, I recognize that once this study is published and as time goes on, terminology will continue evolving with continued academic discourse.

After recruiting the participants, analyzing the results, and approaching the discussion, I found myself no longer attached to the term REM—a term used more frequently in American counselling literature. Instead, I sought a term that did not perpetuate alterity or “otherness.” I considered the term BIPOC which represents solidarity among individuals who do not benefit from whiteness and do not self-identify as white (Deo, 2023). However, there are yet intersections within their identities as BIPOC that must be understood (Crenshaw, 1989). Deo (2023) recommends starting with any issue that involves BIPOC individuals before narrowing to specific identities or terminology under the BIPOC umbrella. Therefore, future studies should consider the terminology they use and note that BIPOC may be more inclusive as a starting point. In this study, however, I used the term REM with participants and only evolved my terminology after exposure to BIPOC communities and self-reflections post-analysis. Since participants self-identified as REM clients and solely engaged with this term upon recruitment and throughout the interview process, this term best represents the narratives that unfolded. If I had used the term BIPOC from the beginning when advertising for the study, it is possible that it would have yielded different results. Therefore, despite my change in terminology, this study represented the perspective of REM clients and signifies merely one beginning of seeking REM client perspectives within TSD and cultural empathy.

Deepening of Research Interests. My interest in TSD stemmed from a curiosity about connection in cross-cultural therapy dyads. How do REM clients feel understood in therapy? What can therapists do to demonstrate understanding? What if they shared something personal? These questions prompted me to research *what, how, why,* and *when* experiences of TSD could be helpful to the therapy relationship. However, the literature glaringly lacked the voices of REM

clients, often focusing on TSD from the perspective of the therapists (Burkard et al., 2006; Lee, 2014; Sunderani & Moodley, 2020). Instead, I found numerous articles describing the prevalence of racial microaggressions in therapy (Owen et al., 2014) and help-seeking attitudes of REM individuals that showed mistrust toward mental health professionals (Mazzula & Nadal, 2015).

Such observations prompted me to consider possible avenues for investigation. Was it a lack of cultural humility or cultural responsiveness? The former acknowledges when the practitioner is aware of their shortcomings and does not position themselves as the expert of the client—rather, the client is the expert (Danso, 2017; Tervalon & Murray-Garcia, 1998). The latter emphasizes intentional action that is made up of cultural humility, active knowledge seeking, and engaging at the institutional level to question existing policies and practices (Hopf et al., 2021). There was something else that I felt was missing to bridge the relationship between being aware of one's limitations to being an active change-maker. I noticed that participants' cultural contexts were necessary to understand the nuances of why TSD could be helpful and unhelpful. Their contexts were integral to the experiences of cultural empathy, where they felt most connected to therapists who understood their backgrounds or took the time to garner understanding.

Evolution of Purpose. At first, my lived experiences guided the purpose of the study. I was particularly interested in the experiences of REM clients who were Muslim, Indo-Caribbean, and/or first- and second-generation immigrants. However, I realized through my research that I needed to broaden my scope to consider intersectionality. If I focused narrowly on one intersection, I would miss the bigger picture that was occurring within the Western social context of a growing REM population with varying histories of trauma, displacement, and oppression (Deo, 2023).

Therefore, I reoriented my focus to center on REM client voices. Based on my experiences, I knew what it felt like to be racialized, to feel "othered", and to have identity confusion as well as uncertainty about where I belonged or came from. I knew the stigma toward discussing mental health in my family, as well as the skepticism about mental health services due to a lack of education and awareness. I knew that help-seeking was a value inherently tied to Western practices. I knew the fear of placing trust in someone who might not understand my

culture and the resulting hesitation to seek help. I also knew there were intergenerational wounds that would perpetuate if I did not seek help. Therefore, the purpose of the study drew inspiration from my lived experiences and developing knowledge of the world I lived in.

Personal Growth. From the perspective of being an REM client, I needed someone to understand my experiences and I wanted to be someone who could provide the same understanding to others. It means a world of difference when someone takes the time to understand an individual's story and how they have come to understand who they are. I have been humbled by the realization, too, that having cultural similarities with my therapist is not enough. While it enhanced my experience as a client, it did not become necessary to my growth, and I realized that I needed a different approach. I now seek mental health care that is more psychodynamic and relational in nature, qualities that are close to the work that I currently practice with clients. Intersectionality remains important to me, as it is necessary toward trauma-informed care, in understanding the nuances of a client's presenting concerns, and in developing an in-depth treatment plan (Isobel, 2021). I remain client-centered, but I prioritize the relationship that is alive in the therapy space, relying on an intuitive knowing, cultural humility, a capacity to empathize, a consistent sense of curiosity, and the freedom of creativity as I collaborate with the client.

The way that I conducted this study drew from my personal development and from how I practice psychotherapy. When designing the study, I focused especially on contextual considerations of working with REM clients based on what I knew from my experiences, ultimately guiding me to what was most salient in the literature. The themes of intersectionality and barriers to help-seeking were brought forward because they resonated with both my personal and professional experiences. I was freshly aware of the value of intersectionality and acutely aware of the inherent mistrust, racial microaggressions, stigma toward mental health, and the struggles of acculturation/biculturalism. Although I chose to forefront these themes in my research, I see now that participants arrived with other important aspects of their cultural context that resonated deeply.

I was reminded of the impacts of intergenerational trauma and racial tension that can bring mistrust toward therapy and influence therapist choice. I observed the tensions between

religiosity and help-seeking; this is a lived experience that I was also familiar with and had not included in my initial research. I was also surprised that I had overlooked the influence of family leading up to and during therapy engagement. I noticed how an individual's stage of life could determine whether a TSD would resonate or cause harm. From these observations alone, I see how vulnerable and honest participants were in sharing their experiences. Their stories have reminded me of the richness that lies within the intersections of one's cultural identity which can then paint the expectations and experiences of therapy. Hence, I found myself expanding upon the relevance of intersectionality when it comes to understanding the experiences of REM clients in therapy.

The Canadian Counselling and Psychotherapy Association's Code of Ethics mentions the valuing of the "contextual background of clients" (CCPA, 2020, B1, p. 9) and this became more evident as my interpretation of the results continuously returned to each participant's cultural context. It became clearer that racial microaggressions can easily occur when therapists are unaware of what intersections exist. However, the potential to work through such ruptures (Owen et al., 2014) gives me hope, but I wonder whether therapists understand just how valuable it can be to focus on the quality of the relationship. The multicultural orientation framework and its emphasis on the therapist's "way of being" (Davis et al., 2018) spoke to my vested interest in relational-cultural theory. The feeling of cultural comfort and the act of seizing cultural opportunities are relational in nature (Davis et al., 2018). The act of broaching similarities and/or differences presents a multitude of benefits to the therapy relationship.

Still, I recognize that my interpretations are limited by my bias as the researcher and by the experiences that are attached to me. I do not hold an expert stance on cultural empathy nor TSD, as I am still growing as a therapist. My goal was to facilitate an unfolding of participant narratives, but the complexity of experiences necessitated a thematic structure to organize what was shared. Thus, the common experiences that were shared became intertwined to create an overarching narrative to REM clients' experiences of TSD and cultural empathy.

Revisiting Methodology

Relational-Cultural Theory. Relational-cultural theory (RCT) was at the core of this study's theoretical framework. I initially theorized that TSD may have the potential to foster the

four tenets of TSD, thereby facilitating cultural empathy. Instead, the RCT tenets became a signifier for whether TSD was helpful or unhelpful and whether cultural empathy was felt. Therefore, connection/disconnection, perceived mutuality, relational authenticity, and relational empowerment remained central to the experience of TSD and cultural empathy (Comstock et al., 2008; Jordan, 2017; Lenz, 2016).

Narrative Approach. I chose to collect narratives of each participant through semi-structured interviews because I wanted to collaborate with them and provide a clearer picture of their perspectives as REM clients in therapy. Understanding how REM clients interpret racial and ethnic similarities or differences can provide therapists with valuable insights into developing a culturally empathetic therapeutic relationship (Chang & Yoon, 2011). REM clients may approach therapy with expectations shaped by their therapist's racial identity, but these expectations are deeply personal and can evolve over the course of therapy (Chang & Yoon, 2011).

In addition to race-based expectations, other factors may influence a client's cross-cultural experience in therapy, including their racial identity development, level of acculturation, and experiences of historical trauma (Chang & Yoon, 2011; Sun et al., 2016; Tummala-Narra, 2013). Therefore, it was important to facilitate meaning-making around racial and ethnic similarities/differences in the therapy relationship as narrated by REM clients during the interview process. I found that in doing so, I was able to gather important individual differences and lived experiences such as the age of participants when they experienced TSD, their status as a first-generation Canadian, and the importance of their religiosity.

Trauma-Informed. In my methodology, I stated that the researcher was an instrument throughout the qualitative research process. Therefore, my interactions with participants were founded on trauma-informed care, including ongoing consent-checking, providing the interview guide ahead of time, supporting participant choice (i.e., honouring the request for a break), building rapport, and using participants' language when reiterating their experiences (Isobel, 2021). The researcher's role was primarily to guide the conversation and to listen, with more emphasis on the interview dynamic than on the prepared questions (Isobel, 2021). At the end of the interviews, time was given for participants to share their experience of the interview process,

allowing for a return to the present moment (Isobel, 2021). The resounding feedback was an appreciation for being able to share their story and positive sentiments surrounding the importance of studying REM perspectives.

Participant Voice. The data were intended to alert the reader to how REM clients experience therapy within their cultural contexts and their experiences of the therapy relationship, including moments of TSD and the potential for cultural empathy. There remains limited insight into their lives as they chose to share what was most salient, but their words are captured to the best of my abilities as the researcher. The reader is given my interpretation as I stay as close as possible to the participants' verbatim and context, in service of platforming their voices. Participants were given an opportunity to review the interview transcripts to ensure accuracy of their stories. They were also given the opportunity to review a final narrative to determine whether their stories were captured the way they intended. Both rounds of member checks were received with valuable feedback and approval from each participant.

Process-Oriented. I implemented a process-oriented approach throughout the interviews, data analysis, and my integration of relevant literature to the participants' stories to deepen what they have shared. I followed a semi-structured interview that captured a "before, during, and after" of the therapy process as participants invited me into their most salient moments. The participants arrived either with a sense of preparedness (e.g., notes), they held a particular focus from which we discussed in depth (e.g., a history of racial trauma), or brought incidental moments of TSD. The development of themes not only stemmed from the structure of the interview but also from the way participants' stories overlapped or differed (e.g., disclosures of opinion were experienced as unhelpful).

My pre-understandings informed the entire research process, including my review of the transcripts, when drafting codes and themes, organizing the themes and subthemes, and editing the presentation of results. I aimed to notice my own biases and to instead revisit participants' testimonies. I utilized my interview guide (i.e., the main topics of cultural context, expectations, therapy process, TSD, and cultural empathy) to remain as close as possible to the phenomenon when analyzing and naming themes/subthemes. I found it especially difficult to condense the richness of what was shared that I was reading and rereading meticulously to discern my

interpretation of the theme or subtheme. I chose to begin generally and drew inspiration from themes echoed in my literature review (e.g., broaching race/ethnicity).

I am in awe of the participants' openness to the process, their vested interest in the topic of therapist self-disclosure, their curiosity about cultural empathy, and their vulnerability in sharing moments of connection as well as disconnection. It is my hope that I was able to communicate a sense of understanding, guided by my relational principles of connection, perceived mutuality, relational authenticity, and relational empowerment.

I learned how the therapists helped or failed to empathize and connect with clients, as well as whether they were treated with respect and dignity. It became evident that their contexts were crucial in understanding their needs during specific interactions with their therapists, as well as how and whether they experienced cultural empathy during instances of TSD. The prevalence of TSD was surprising both to me and to the participants. A commonality was evident across all experiences where participants remarked a sense of intrigue about knowing others had experienced TSD and they were not alone. Intersectionality itself became interwoven all throughout participants' expectations of therapy, experiences of the therapy process (including TSD and cultural empathy), and the recommendations they suggested for future therapy. Therefore, the data analysis, results, and interpretations that I described drew from the intersectionality of each participant's cultural context.

Limitations

This study was founded on the work of passionate, curious, and like-minded researchers, such as Audet and Everall (2003), Burkard and colleagues (2006), Lee (2014), as well as Sunderani and Moodley (2020). I recognize the "niche" of TSD research from which I designed this study and the bias from which I present the purpose of this research. I was driven by my curiosity toward therapist self-disclosure and its "taboo" reputation even as I practice psychotherapy now. I wanted to understand what it could mean to truly connect with clients despite perceived differences, from the perspective of racialized clients rather than therapists. The literature was saturated with the perspective of therapists and analog studies (simulated therapy), as well as lacked racialized client perspectives. The literature review was shaped by a need to capture their perspectives, an unfolding desire to decenter whiteness, a consistent gap in

current cultural competencies, and wanting to better understand cultural empathy beyond its theoretical existence. I fully recognize that my understanding of cultural empathy, while drawn from the literature, remains subjective and further informed by the subjective experiences of the participants. However, their definitions of cultural empathy are based on their personal experiences of therapy and must be treated with respect.

I am inclined to wonder how this study could be expanded upon by including further participants and longer interview times. This study was limited by the time constraints of a master's thesis, but it is a starting point in contributing to the perspective of racialized clients in the TSD literature. As a starting point, I observed that most client-therapy relationships in the study contained at least one white therapist, although this was not the intention during the study design. The intention was to examine cross-cultural therapy dyads in which the clients were racial/ethnic minorities, and the therapists were simply culturally different from them. I also recognize that the perspectives of the four participants, while all identifying as an REM at the time of participation, are not representative of every person who identifies as an REM (Black et al., 2023; Deo, 2023). For example, I am lacking perspective from individuals who identify as men, older individuals, and those who might come from an entirely different racial or ethnic background than the current participants. The possible intersections are endless which invites countless perspectives to the experience of TSD and cultural empathy.

For now, this study is specific to women of colour, ranging in age from their early 20s to mid-to-late-30s, some of whom are students or a working mother. Therefore, I recognize that I may lack a broader cultural context, but this study focused primarily on what felt most salient to each participant (i.e., discussing intergenerational trauma, racial tension, religiosity, family influence, life stage, and so forth). Similarly, the background and purpose of this study were developed based on what was most salient to the researcher's experiences. As Lee (2014) iterates, TSD inevitably reveals different interconnected aspects of the therapist's self, including the personal, professional, and cultural self. Therefore, this study reveals aspects of the researcher and the participants in a manner that fosters a sense of connection, understanding, and appreciation for what was shared.

Finally, I acknowledge that this study and its interpretations are subject to my researcher bias. As such, my pre-understandings before interviewing participants and the shifts in my bias after analyzing the data are available to the reader. Transparency is integral to the nature of this qualitative study, especially as I rely heavily on RCT as my theoretical framework and narrative inquiry as my methodology. Ultimately, I used RCT and narrative inquiry to co-create a story with the participants that could provide the necessary context to foreground the participants' rich experiences of TSD and cultural empathy.

Delimitations

This study is specific to the perspective of four women and their experiences of TSD as well as cultural empathy. They offered rich experiences of TSD that sometimes overlapped with one another and challenged the researcher to propose potentially nuanced types of TSD. They also offered unique recollections of the therapy process, TSD, and cultural empathy that stemmed from their needs in therapy and cultural context. A qualitative study founded on narrative inquiry offers a richness in exploration, building from the ground up as the researcher and participants co-create a story together. Meaning making occurred during the interview, during the analysis and the interpretation of themes/sub-themes, and was later confirmed or clarified by participants' approval, in turn strengthening the study's trustworthiness. These are clear advantages to using a smaller sample size which allowed for an in-depth narrative approach and the creativity of a semi-structured interview. The interview guide was a helpful resource, as reported by participants, which allowed for a sense of preparedness before the interview. There was strength in using a thematic approach to organize narrative data, where an emphasis on researcher's choice allowed for creativity in identifying and labelling themes/sub-themes (Braun & Clark, 2006).

The RCT framework served as a consistent foundation upon which guided my interactions with participants, analysis of their interviews (e.g., identifying moments of connection or disconnection), and structuring of a narrative that could best capture their voices. The inclusion of my pre-understandings before interviewing and its evolution post-analysis served to deliver transparency throughout the process. This study was a practice in vulnerability as a researcher as well as an opportunity to carry out inquiry driven by curiosity and an

incredibly humbling process of thinking, writing, editing, and doing it all over again both critically and creatively. My hope is that this study demonstrates the value of REM client perspectives where the researcher's interpretations are merely a method of transmitting their contextual knowledge to the reader. Ultimately, this study is open to the reader's interpretation and serves as one starting point for continued valuing of REM perspectives in therapy.

Recommendations

The themes identified in this study warrant in-depth explorations on their own, from the influence of intergenerational trauma and racial tension in therapy to the experience of tension between relying on faith and seeking therapy. Within a broader REM population, it might be useful to have certain intersections fore fronted as part of the demographic questionnaire during the interview and within the literature review (e.g., religiosity). I also recommend a reflexive exercise where the researcher and participant identify areas of both oppression and privilege in their lives, thereby co-creating a space that promotes relational authenticity, transparency, and equalizing the dynamic between both parties. I am also curious about what participants were seeking from therapy alongside their presenting concerns (e.g., Were they seeking a safe space? Were they hoping to feel connected with someone?). I believe it is important to inquire about their therapists' theoretical orientations, where some might be more relational than others. I would also like to know how it feels for them to experience the tenets of RCT, rather than interpreting them based on my theoretical understanding (e.g., What does it mean to connect? What does it mean to feel seen or understood? How do you know when you feel like yourself?).

Another topic that comes to mind is the experience of racial transference and countertransference (Holmes, 2006) (e.g., What assumptions are being made about the therapist before entering the therapy space? How are these assumptions playing out during therapy and how might they be evolving? Why are they evolving?). In this light, I would expand this line of inquiry toward therapist-client dyads that are not just centered on white therapists and racialized clients. I am interested in the experiences of TSD and cultural empathy from therapist-client dyads that are racialized, or dyads that contain a racialized therapist and a white client (Spalding et al., 2019).

The experience of the therapeutic relationship from the perspective of adolescents and younger clients is also an important consideration. How can the therapeutic relationship develop with adolescents in a manner that facilitates safety and comfort to broach a racial microaggression or feelings of misunderstanding or invalidation? From a cultural perspective, Davis and colleagues (2018) recommend markers of cultural humility such as cultural comfort and seizing cultural opportunities. Rogers-Sirin and colleagues (2015) suggest an openness to learning, using culture in an appropriate way, knowing when culture is related to an issue, having patience, and practicing empathy. From the perspective of participants, they presented the following that stems from their post-therapy reflections.

By the end of the interviews, participants described what would contribute to an authentic therapy experience. The following traits were stated: empathy, non-judgment, compassion, curiosity, humility, honesty, and a sense of solidarity. Anna considered the possibility of working with a therapist who is familiar with her family's culture if she were to explore her childhood. Once again, "matching" based on cultural context was expressed. This is significant for Anna, as she has only worked with white therapists and is now curious about working with therapists of different racial and ethnic backgrounds. Considering Anna's experiences with disconnection throughout her therapy journey, she emphasized the therapist's ability to relate to the client as most important. Rayan mentioned that exposure to immigrant experiences is crucial to understanding and suggested integrating such lived experiences into the therapy body of knowledge.

Potential avenues for disconnection during the therapy process may exist outside of TSD. Afia described her experience with a therapist who matched racially and ethnically to her partner, bringing up feelings of inadequacy. The therapist also reminded Afia of elders in her community, impeding her authenticity and creating an added level of power imbalance to the dynamic. Rayan also experienced similar transference when her therapist's "hard love" approach was reminiscent of her parents. When therapists "match" closely or begin to have traits that remind them of individuals in their lives, I suggest this might impede relational authenticity and connection. Rosina also named apprehension before starting with her Muslim therapist, alluding to a potential for judgment when "matching" with one's therapist based on religion. Afia considered how matching racially with her therapist during the pandemic made sense, but it was

less of a requirement when she just needed someone who could listen. When she saw a therapist who matched too closely to her partner, Afia realized that perhaps there were limitations to this requirement, expressing an openness to working with therapists of other social identities.

Overall, participants described positive sentiments within their post-therapy reflections. Rosina and Rayan were grateful for the early start to therapy despite the long-lasting impacts of unhelpful disclosures. Rosina emphasized growth, relief, validation, and feeling closer to her parents. Rayan noted a similar sentiment as she felt therapy helped her process parental resentment and reduced pressure on herself to succeed. These examples inspire hope from the clients' perspectives that despite disconnection, they still saw value in their experiences. Anna described the value of long-term therapy, acknowledging both the helpful and unhelpful experiences that helped her discover what works best now. Afia considered herself a supporter and advocate for therapy, stating she might return to her most recent therapist as would Rosina. Both therapists would have been the ones with whom they "matched" closely, with Rosina noting an ease in resuming with the same therapist.

Conclusion

Therapist self-disclosure, when used helpfully to facilitate tenets of RCT, might be a deeply relational intervention that can contribute to cultural empathy. When done without adequate consideration or knowledge of the client's needs and context, therapist self-disclosures might be received as unhelpful and harmful. Intersectionality is a reminder that clients and therapists enter the therapy space to work with intrapsychic experiences that are interwoven within larger societal issues that cannot be overlooked (Cheshire & Noldy-MacLean, 2022; Crenshaw, 1989). Within this reality, clients might have underlying needs related to the sociopolitical climate, their family circumstances, or other areas of their past and present context. It can be harmful for a therapist to assume similarity without curiosity or to present their opinion without humility. While we can consider the recommended competencies in the literature thus far, working with REM clients might go beyond those suggestions.

In this study, I discovered how participants define cultural empathy as a split between "matching" culturally and later prioritizing how the therapist can connect with them. The definitions are inherently personal to each participant but altogether paint a picture of something

deeply relational that considers their cultural and emotional context. Does a therapist truly have to match with their client? Is there merit in seeking a therapist who "looks like us" when we need that most? That sounds like a very personal choice. As a psychotherapist, I believe our responsibility lies in understanding how important this is to our client, inviting both parties to broach when there are similarities or differences, and to consider the purpose if we choose to disclose. After all, every moment that a therapist interacts with their client is an intervention, so what is the intention if not to foster connection and deepen understanding?

Truthfully, therapists might not ever truly know the "right" way to show cultural empathy or the "right" way to self-disclose. The beauty of working relationally is that any moments of disconnection are seen as opportunities to repair together. Is that not reflective of true human relationships and the capacity to heal? I find comfort in knowing the participants found this research validating and that there are researchers who care to know the clients' perspectives. To you, the reader, I am grateful for your discerning eye and patience in journeying with me through this thesis.

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Appendix A

Recruitment Poster

Do you self-identify as a Racial/Ethnic Minority?

Have you been in counselling or therapy with a counsellor/therapist of a race/ethnicity different from you…? AND… They self-disclosed to you?

If so, I would like to invite you to share your counselling experiences as a racial/ethnic minority client. This study seeks to gather stories from your experiences in counselling to inform and improve counselling services for racial/ethnic minority clients.

To participate in this study, you need to:

1. Self-identify as a Racial/Ethnic Minority. (Any person who does not identify as white).
2. Have had a counsellor/therapist who was from a different racial/ethnic background.
3. Have experienced instances where your therapist has self-disclosed to you in session. (E.g., They shared aspects of themselves like personal information, and feelings, among other things).
4. Have concluded counselling/therapy prior to participating.
5. Be at least 18 years old.

You will be invited for an interview of approximately 1 to 1.5 hours at a time that is mutually convenient over Zoom. Your participation is completely confidential and you will receive a $20 gift card as thanks.

Participants will be accepted into the study on a 1st-come 1st-served basis.

Please do not tag individuals to this post on social media.

The ethical aspects of this research have been approved by the University of Ottawa Research Ethics Board and this study is supervised by University of Ottawa faculty member Cristelle Audet, PhD.

Researcher: Ameena Ally,

Master of Arts candidate in counselling psychology at the University of Ottawa.

Appendix B

Letter to Professional Contact

Dear [Name],

I am a graduate student in Counselling Psychology at the University of Ottawa. Currently, I am completing my master's thesis research project, supervised by Cristelle Audet, PhD. For this study, I am seeking the perspectives of racial-ethnic minority (REM) clients who have experienced therapist self-disclosure (TSD). My hope is to gather the narratives of REM clients to better understand their experiences of therapy and to understand how TSD may relate to cultural empathy.

I am looking for individuals who (a) self-identify as a racial-ethnic minority, (b) have received individual therapy from a counsellor or psychotherapist they deem racially/ethnically different from them; c) have experienced TSD during past therapy; d) have concluded therapy prior to participating; and e) be 18 years of age or older (to provide their own consent). Participation would entail an online audio recorded interview via Zoom, lasting approximately 1 to 1.5 hours along with financial compensation.

I would highly appreciate your help in the recruitment process by providing information regarding this study to any interested individuals. Kindly find enclosed with this letter a recruitment poster to circulate within your network either via email or by posting in accessible areas at your organization. Please do **not** tag individuals to this poster if sharing via social media. If you would like any additional information or if you have any questions, please feel free to contact me via email. You may also contact Cristelle Audet, PhD, whose information will be provided below.

Thank you for your time and willingness to help.

Kindly,

Ameena Ally

Appendix C

Demographic Information Questionnaire

Pseudonym: _____ Date: _____

Cultural Identity

Our individual cultural identity encompasses several intersections such as race, ethnicity, gender, age, location of birth, socioeconomic status, etc.

1. What is your age? _____
2. What is your gender? _____
3. What is your racial/ethnic identity? _____
4. What are, if any, other important aspects of your cultural identity?

_____

_____

Experience with Therapy/Counselling

Consider the counselling/therapy experience that you wish to discuss:

1. What was your general purpose for seeking counselling/therapy?

_____

2. How long ago did you seek counselling/therapy? _____
    a. Month/Year of 1st session _____
    b. Month/Year of last session _____
3. How many sessions did you attend? _____
4. How regularly did you see your counsellor/therapist? _____
5. Where did you receive counselling?
    a. University counselling center
    b. Private office
    c. Hospital
    d. Community organization
    e. Other: _____

6. Was your counsellor/therapist from a different racial or ethnic background than you? How would you describe their racial/ethnic background?

   _____

   _____

7. What were the credentials of your counsellor/therapist? This can include their academic degree and professional licenses/certifications.

   _____

8. How many years of experience did your counsellor/therapist have?

   _____

9. Did you have a choice of counsellor/therapist?

   _____

Appendix D

Interview Guide

Before Embarking in Therapy/Counselling

Tell me about your views and ideas on psychotherapy before you began seeking a therapist.

[Prompts]:

- What were your initial thoughts before seeking therapy?
- How did you feel about therapy?

Process of Seeking Therapy/Counselling

Tell me what led to your decision to seek counselling/psychotherapy.

[Prompts]:

- What was it like for you to seek a therapist?
- What was going on for you at the time?

Experience of Psychotherapy/Counselling

Tell me about your experience in therapy.

[Prompts]:

- What was it like to begin therapy?
- How did your therapist make you feel?
- What was your experience of the therapeutic relationship?

Therapist Self-Disclosure

Therapist self-disclosure generally refers to moments when a therapist shares an aspect of themselves, whether it be personal information about their life outside of therapy or in-session feelings, among other things. Tell me about a time when your therapist self-disclosed to you.

[Prompts]:

- What was the context of the disclosure?
- How did it affect you?
- How did it affect the relationship?
- How did it affect the therapeutic process?

Cultural Empathy

Cultural empathy refers to times when a therapist acknowledges cultural similarities and differences between them and the client to respond in ways that are helpful to the therapy. Tell me about the therapist's self-disclosure as it relates to cultural empathy.

[Prompts]:

- How did your therapist show cultural empathy to you?
    - What was it like to experience cultural empathy?
    - How did it affect you?
    - How did it affect your relationship with your therapist?
    - How did it affect the therapeutic process?
- In what ways, if any, did the disclosure contribute to your experiencing cultural empathy in session?

Ending Therapy and Future Directions

Tell me how therapy/counselling ended for you.

[Prompts]:

- How did you experience the ending?
- Would you consider therapy/counselling again?
- What might you seek in a future therapist?

Reflective Question

- What might cultural empathy mean for you?

Lingering Thoughts

We are about to conclude the interview, and I would like to invite you to share any lingering thoughts that we may not have addressed together.

- What was it like for you to participate and share your experiences with me?
- Do you feel that your perspective was shared and represented adequately?
- Is there anything that I may have overlooked that you would have liked me to ask you?

Appendix E

My Pre-understandings

1. My cultural identity comprises of being a cis-gender woman and Muslim-born Canadian, raised by first-generation immigrant parents in a culturally Guyanese (West Indian) household in Ottawa, within a dominantly white Canadian society. I grew up feeling racialized by my skin colour, cultural heritage, and religiosity while attending primarily white schools, and living in white communities.
2. I grew up understanding that mental health was not a matter to be discussed in one's family. The topic of mental illness, much less mental health, was (and still can be) heavily taboo. Education around mental health and access to mental health services that were culturally relevant became integral to my pursual of a career as a psychotherapist.
3. Based on my lived experiences, most racial and ethnic minorities avoid therapy due to stigma and shame, alongside a lack of education or awareness of mental health services within families and communities. However, financial inaccessibility is also a significant setback, as mental health care is often considered a luxury more than a need, especially within the context of growing up in a Guyanese culture infused by South Asian practices. In other words, it is not seen as a need for "people like us." Our parents never needed or went to therapy, so why should we?
4. While my experience within and outside of the mental health field has been one drawn by cultural misunderstandings (from my own culture and towards my own culture), it is one that has involved a series of unlearning and re-learning ways to communicate effectively, thereby bridging the intersections of my own cultural identity and lived experiences.
5. I have been in individual therapy myself and I understand the arduous process of seeking support that is both financially accessible and culturally relevant to my needs. It is not an easy process, but I have noticed that sharing many cultural similarities with my therapist has greatly enhanced my experience as a client. I do indeed feel a sense of cultural empathy, one that I hope I can provide to future clients myself.
6. I recognize the importance of intersectionality, where one part of our cultural identity such as race/ethnicity is only one lens that interacts with other important aspects of our cultural identity (age, sex, religion, place of birth, etc.). Therefore, it is crucial to allow

the client/participant to lead and tell their story, frame their cultural identity, and observe how racial and ethnic identity interact with their other cultural identities.

7. I believe that no therapist or therapist-in-training is immune from unintentionally harming their client, even if the therapist is part of the same racial and/or ethnic group as the client. Therefore, I do not hold any expertise in what is deemed culturally relevant or empathetic, only that I have the perspective of having been a client in therapy for myself.
8. It is very important to hold a beginner's mind and to maintain both cultural curiosity as well as cultural humility when interviewing and interacting with my participants.
9. The participant (and client) is the expert here. My role as researcher is to facilitate the unfolding of their narrative with guiding questions and prompts to help co-create their story in the process.
10. Recently, I have learned that identifying as a racial/ethnic minority can still place one more at risk of maintaining certain biases. For example, I could have a false sense of security that I am culturally empathetic by virtue of my racial identity. There is no room to grow if I do not recognize areas where I can continue to learn and acknowledge possible missteps. Cultural empathy necessitates being a lifelong learner.
11. I recognize that I am a racial and ethnic minority who will be interviewing fellow REM clients while being a therapist-in-training as well as researcher. I am placed in positions of privilege by my parents' socioeconomic status, my career path, and my student status. I must remember and acknowledge those pieces as power in the dynamic with the participant/client, despite both of us identifying as REM. Once again, differing intersections create unique experiences that can affect the dynamic.
12. Since I am approaching this study with individuals who have been through therapy, I understand that I will be inquiring about sensitive information from their past. A trauma-informed perspective will be necessary all throughout my time with participants. This process begins before we interact, during our interactions, and at every step of the research process. I will include a section on my trauma-informed approach when I revisit my methodology in the discussion chapter.

Appendix F

Script for Verifying Inclusion Criteria are Met (for Internal Use)

Note: This script is useful for phone calls, but correspondence will be primarily via email, so this script is to provide guidance to the researcher when contacted by participants.

Hello, thank you kindly for your interest in my study. My name is Ameena Ally, and I am a master's student in Counselling Psychology at the University of Ottawa. The purpose of my study is to better understand the therapy experiences of racial/ethnic minority clients. I am seeking racial/ethnic minority individuals who have experienced therapist self-disclosure and who have completed counselling and/or psychotherapy to participate in my research. The results of this study will inform counsellors and therapists about racial/ethnic minority clients' needs and experiences, particularly as it relates to therapist self-disclosure and cultural empathy. Does this sound like something you might be interested in?

If not: Okay, thank you for your time and your interest. Goodbye.

If yes: Okay, that's great. The individuals who participate in this project need to meet specific criteria. Before I continue, do you mind if I ask you some questions about your age, racial/ethnic background, and counselling history to determine whether you are eligible to participate? Please know that you are free to say no, and to not answer any questions you don't want to answer.

If not: Okay, I understand. Would you like to hear more information about what your participation would involve before getting into these questions?

If not: Okay, thank you for your time. Goodbye.

If yes: Okay, thank you. My questions are the following:

1. Are you 18 years of age or older?
2. Do you self-identify as a racial/ethnic minority?
    - Any person who does not identify as white.
3. Have you recently received individual counselling/psychotherapy?
4. Was your counsellor/therapist racially/ethnically different from you?
5. Did your counsellor/therapist ever self-disclose to you? (E.g., Shared aspects of themselves like personal information, feelings, among other things).

6. Have you completed your sessions with this counsellor/therapist?

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

If inclusion criteria are met: Thank you. Based on your answers you meet the inclusion criteria for this study. May I tell you more about the project? If you have any questions, feel free to ask me at any time. Your participation would involve meeting with me virtually at a time that is convenient for both of us so that we can discuss the study and your participation more fully. If you give your consent, we will then complete a demographic questionnaire and an interview that can last from 1 to 1.5 hours. Your participation would be completely confidential, and you can also choose a made-up name for the study. With your permission, the interview would be audio recorded and transcribed for analysis. Do you have any questions for me so far?

If there are no further questions: I want to remind you that your participation in each step is completely voluntary. You have the right to decline to participate or to withdraw at any point during the project without any repercussions, however you will not be able to withdraw your interview responses once the study results are published. As compensation for your time, you will receive $20 at the end of the interview for your participation in the study. Once participation is agreed upon, you will still receive compensation even if you withdraw later. Does this sound like something you would like to participate in?

If not: Thank you for your time. I appreciate you taking the time to listen. Goodbye.

If yes: Thank you. I appreciate your help and support very much. Would it be alright if we schedule a time to meet to go over the study consent form and if you agree, conduct the interview? When would be a good day and time for you to meet? Do you have a preferred virtual platform that you use?

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

Thank you so much. I look forward to meeting you and learning from your experiences.

Appendix G

Study Description

Hello,

My name is Ameena Ally, and I am a master's student in Counselling Psychology at the University of Ottawa. I am currently recruiting participants for my master's thesis research project, supervised by Cristelle Audet, PhD. I am exploring the therapy experiences of racial/ethnic minority clients, particularly when their therapist self-disclosed to them (e.g., shared something personal) and how that might relate to cultural empathy. I consider participants to be co-researchers and experts of their experiences. I would be honored to learn from your experiences if you wish to participate in the study.

What is the purpose of this study?

The main reason for doing this project is because there is very little information available about the experiences of racial/ethnic minority therapy clients. There is even less information regarding therapist self-disclosure and whether/how it might relate to experiencing cultural empathy. My hope is that the stories gathered from this study will deepen the understanding of culturally responsive therapy and improve the quality of care that racial/ethnic minority clients receive.

Who am I asking to participate?

You are invited to participate if you:

1) Self-identify as a racial/ethnic minority.
2) Have received individual therapy from a counsellor or psychotherapist who was racially/ethnically different from you.
3) Have experienced moments when your therapist self-disclosed to you (E.g., shared aspects of themselves like personal information, feelings, among other things).
4) Have concluded counselling/therapy.
5) Are 18 years of age or older.

Note: Any individuals who are currently engaged in counselling will not be included in the study. Participation is on a first come, first served basis.

What will participation involve?

Should you choose to join the study, you will be invited to an online interview lasting approximately one to one and a half hours. During the interview, you will be asked questions about your demographics (i.e., what is your racial/ethnic identity?), and we would talk about your experiences related to therapy. For instance, I would like to learn your initial impressions of therapy, what led to seeking therapy, how you experienced the therapy relationship, future directions with therapy, and your experiences of therapist self-disclosure as it relates to cultural empathy. The interview guide will be sent to you ahead of time if you would like to review it before proceeding.

The interview would be via Zoom at a time that is mutually convenient for both of us. With your permission, I would need to audio-record the interview, which I would then personally transcribe for analysis. You would receive a $20 gift card for your time and participation.

You will also be given the option to review the audio transcription and the final write-up of your experiences to provide feedback. In both instances, you will be given two weeks to respond via email if you wish to participate in this process.

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

- Ask any questions about the study at any time
- Be given the interview guide to review in advance of the interview
- Decline to answer any particular question at any time
- Stop the interview or the audio-recording at any time
- Withdraw from the study without suffering any negative consequences
- Choose what information to disclose or not to disclose with the understanding that your name will not be used
- Be given the interview transcript and researcher's analysis for review

- Give feedback if you wish to add or delete anything

Are there any risks involved in participating?

Talking about your experiences in therapy, especially if they were negative ones, may give rise to feelings of discomfort or distress. Keep in mind that you can refuse to answer any questions, stop the interview at any time to take a break, or withdraw form the study without penalty. I will also be giving each participant a list of resources for community support services for their consideration.

Are there any benefits involved in participating?

You will have the opportunity to voice your experiences in therapy to contribute to the understanding of therapy experiences of racial/ethnic minority clients, with the intent of ultimately improving mental health services.

How will I maintain your privacy and confidentiality?

Your confidentiality will be safeguarded by allowing you to use a pseudonym (a made-up name) in the study to remain anonymous. Your identity will not be revealed at any time, and only your pseudonym and racial-ethnic identity will appear in interview transcripts, the thesis manuscript, and future publications. Anonymous quotes may be used in the report such that no identifying information will be included in those quotes. Confidential data collected during this study will be securely retained for the purpose of this research for five years and later destroyed.

Please contact me if you have any questions or are interested in being a part of this project.
My supervisor Cristelle Audet, PhD, can be reached by email or by phone.

Thank you very much for your consideration,

Warm regards,

Ameena Ally

Appendix H
Informed Consent Form

Université d'Ottawa | University of Ottawa
Faculté d'education | Faculty of Education

Title of study: Therapist Self-Disclosure and Cultural Empathy from the Perspective of Racial-Ethnic Minority Clients

Name of researcher: Ameena Ally, MA [Ed], Counselling Psychology Candidate

Name of supervisor: Cristelle Audet, PhD, Faculty of Education, University of Ottawa

Invitation to Participate: I am invited to participate in the above-mentioned research study conducted by Ameena Ally, in the context of a master's thesis, under the supervision of Cristelle Audet, PhD.

Purpose of the Study: The purpose of this study is to better understand the experiences of racial/ethnic minority clients who have experienced therapist self-disclosure (TSD) and how that might relate to cultural empathy, from their perspectives. The knowledge created in this study will inform and improve therapists' work so that they may provide culturally responsive services to racial/ethnic minority clients.

Participation: If I agree to participate in this study, the following will occur:

1. I will take part in an audio and video recorded interview session at a mutually chosen time and date over Zoom that best ensures my comfort, safety and confidentiality. I have the option of reviewing the interview guide ahead of time to prepare me. The interview will last approximately 1 to 1.5 hours.

2. In the first part of the interview, I will be asked basic demographic information including questions about my age, gender, race/ethnicity, counsellor/therapist's race/ethnicity, and therapy history.

3. I will then be asked about my therapy experiences, particularly as they relate to therapist self-disclosure and cultural empathy. There is no pressure to share any details about the therapy sessions themselves (e.g., I do not need to talk about the issues I was experiencing). I am free to share as much or as little as I want, and to refuse to answer any question.

4. Some interview topics may revolve around the context of the therapist self-disclosure, how they experienced the self-disclosure as it relates to cultural empathy, and their overall experiences of the therapeutic relationship with respect to cultural empathy and TSD.

5. I will be asked to choose a pseudonym for the study. Ameena will transcribe the audio recording of my interview. She will immediately delete the video recording of the interview, with my understanding that it is automatically generated along with the audio recording.

6. I will be given the opportunity to review the transcript of the interview, with the option of providing feedback by email within two weeks of receiving the transcript from Ameena. I will also be given another opportunity to review and provide feedback by email on the narrative that Ameena will generate based on my transcript within two weeks of receiving it. I do not have to agree to give feedback in either case in order to participate in the study.

7. I will be given a $20 honorarium for my time, even if I withdraw from the study. Ameena will also provide me with a list of free community resources at the end of the interview. She will be available via email if I need to follow up with any questions or concerns after our interview.

Assessment of risks: My participation in this study will involve sharing my perspectives as well as prior experience of psychotherapy. This may cause me to experience some emotional or psychological discomfort. I have received assurance from the researcher that every effort will be made to minimize these risks, such as stopping the interview should I wish to take a break, skipping any questions I do not wish to answer, withdrawing from the study altogether, and providing feedback on the transcript and narrative should I wish to add, change, or remove any content. I can inform Ameena of my discomfort at which time she will provide me with a list of resources for support services in my community for my consideration. The list of resources will be offered at the end of each interview regardless of expressed distress. She will be available via email if I would like to follow up with any questions or concerns after the interview to provide additional resources if needed.

Benefits: By participating, I will have the opportunity to voice my experiences in therapy to contribute to the understanding of therapy experiences of racial/ethnic minority clients who have experienced therapist self-disclosure and cultural empathy, with the intent of ultimately improving mental health services.

Confidentiality, anonymity, and security: I have received assurance from the researcher that the information I share will remain strictly confidential. My identity, or that of any person that I mention, will be known only to the researcher and her thesis supervisor, and will not be revealed at any time. I understand that my story will only be used for the purpose of the current study and subsequent publications and dissemination, and that my confidentiality will be protected through safe, secure, and password-protective measures of the information gathered.

As a participant, I can choose a pseudonym for the study that will be used in the interview transcripts, thesis manuscript and future publications. Any details in the interview recordings that can identify me will also be changed during transcribing, while my racial-ethnic identity will be maintained. Quotes may be used by the researcher, but no information that can identify me will appear in them. Lastly, only the researcher and her thesis supervisor will have access to the interview recordings and transcripts.

I acknowledge that the security of videoconferencing through the Zoom platform cannot be fully assured. Although Zoom is widely accessible, it lacks end-to-end encryption, which means communication between me and the researcher is not guaranteed to be completely secure. Appropriate steps will be taken to reduce any risks to security, as well as to ensure the protection of my confidentiality and anonymity, such as utilizing a personalized meeting link.

Conservation of data: I understand that consent forms and the collected data (including demographics, audio recordings, transcriptions, transcript and narrative feedback sent via email, and a participant identifier tracking sheet with pseudonyms) will be securely stored in password-protected folders on password-protected devices. These devices will be kept in a locked cabinet within the supervisor's locked office. It is important to note that video recordings are automatically generated when the recording feature is enabled on the Zoom platform. However, since the researcher will not use video recordings in this study, they will be deleted immediately after saving both the audio and video files to a password-protected folder on the researcher's password-protected device. Access to this information will be restricted to the researcher and the thesis supervisor. The data will be securely maintained for five years following the completion of interview data collection, after which all electronic files and any physical documents will be permanently destroyed.

Compensation: I will receive a $20 gift card as an honorarium for my participation. This compensation is guaranteed even if I decide to withdraw from the study.

Voluntary Participation: My participation in this study is completely voluntary. I have the freedom to withdraw at any time or to refuse to answer specific questions without any negative consequences. If I decide to withdraw, any data collected up to that point will be deleted. However, once the data is published, it can no longer be removed.

I am aware that this research has been supported by funding from the Social Sciences and Humanities Research Council (SSHRC).

Acceptance: I, _____, accept to participate in the outlined research study conducted by Ameena Ally of the Faculty of Education at the University of Ottawa

under the supervision of Cristelle Audet, PhD. Should I have any questions about the study, I may contact the researcher or her thesis supervisor.

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

There will be two copies of the consent form, one of which I can keep.

Participant's name	Signature:	Date:
Researcher's name	Signature:	Date:

Appendix I
Resource List

Ottawa Resource List
Black Youth Helpline Website: blackyouth.ca Email: info@blackyouth.ca Helpline. Culturally relevant assessment.
Chimo Services http://www.chimoservices.com/ Crisis and suicide intervention counselling for adults. Multilingual services offered (Mandarin, Cantonese, Punjabi, Hindi, Urdu, Tagalog, Japanese and Korean).
Crisis Help Across Canada – Association for Suicide Prevention https://www.crisisservicescanada.ca/ Call 1.833.456.4566 Text 'Start' to 45645
E-Mental Health www.ementalhealth.ca List of resources in Ottawa.
Mental Health Crisis Line 613-722-6914 24-hour crisis line.
Naseeha 1-866-627-3342 (Phone) 1 (866) 627 3342 (Text) Muslim youth helpline.
Ottawa Distress Center 613-238-3311 24-hour crisis intervention.
South Asian Mental Health Alliance https://www.facebook.com/pg/southasianmentalhealth/about/?ref=page_internal

A supportive environment to discuss mental health concerns that can also be accessed through Reddit.com for individuals from the South Asian community.
Subtle Asian Mental Health https://www.facebook.com/groups/354874495069490/?ref=br_rs Private online community for individuals of Asian descent to share their experiences in an open and safe space.
SUCCESS Chinese Helpline https://www.successbc.ca/eng/services/family-youth/counselling-service/ Culturally sensitive support for Chinese Canadians who are navigating language and cultural barriers. Cantonese Helpline 604-270-8233 Mandarin Helpline 604-270-8222
Talk 4 Healing 1-855-554-HEAL (4325) Text and call https://www.talk4healing.com Support and resources for Indigenous women, by Indigenous women, 24/7.
The Colour Project https://www.thecolourproject.ca/ One-on-one peer support. Anonymous and text-based, free of stigma, for individuals of colour struggling with mental illness.
Additional resources can be found at the following: Cold Tea Collective. (2020, January 29). *Mental health support for the Asian Canadian community and beyond*. Cold Tea Collective. Retrieved January 26, 2023, from https://coldteacollective.com/mental-health-support-for-the-asian-canadian-community-and-beyond/ Ottawa Public Health. (2023, March). *Mental health and wellness resources for African, Caribbean and Black communities*. Ottawa Public Health. Retrieved March 27, 2023, from https://www.ottawapublichealth.ca/en/public-health-topics/resources/Documents/ACB-MHA-Resource-List-EN.pdf

Appendix J

Certificate of Ethics Approval

28/02/2023

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-02-23-8928
Titre du projet / Project Title	Therapist Self-Disclosure and Cultural Empathy from the Perspective of Racial-Ethnic Minority Clients
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)	28/02/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	27/02/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Ameena ALLY	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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28/02/2023

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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 completedfour 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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