Intersectional sameness and difference in psychotherapy: Women of colour's experiences of the therapeutic alliance.

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ABSTRACT

The therapeutic alliance is crucial for positive therapeutic outcomes, as it sets the foundation for the therapeutic process. In South Africa, a diverse and multilingual country with high levels of inequality, access to healthcare services, poor quality of healthcare, and discrimination in healthcare settings are persistent issues. Women of colour are often disproportionately affected by these health inequities. However, little is known about how sameness and difference are experienced in the therapeutic alliance in South Africa, which makes it essential to explore experiences of women of colour in this context.

Using an exploratory qualitative research design, this study recruited and interviewed 11 self-identified women of colour using purposive sampling. Data collected were analysed using a reflexive thematic analysis to identify themes and analyse the findings. Two primary themes emerged: feeling understood and agency. The study suggests that sameness and difference are palpably experienced in the therapeutic encounter. Various factors shaped the role that sameness and difference played in the therapeutic experience, including feeling understood, having agency, therapist disclosure, validation, cultural competence, collaboration/engagement, socioeconomic status, and setting up the frame.

Previous research highlights the importance of exploring the therapeutic alliance in diverse contexts, where clients' diversity may influence their therapeutic experiences. The findings of this study contribute to the literature on the therapeutic alliance in diverse contexts and emphasise the importance of acknowledging and engaging with sameness and difference in the therapeutic process. The results have implications for mental health practitioners working with women of colour in South Africa and highlight the need for cultural competence training in the field of psychology. Further research is required to explore the experiences of women of colour in the therapeutic alliance in other diverse contexts.

Keywords: therapeutic alliance; sameness and difference; South Africa; psychotherapy; intersectionality

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CHAPTER 1: INTRODUCTION

The relationship between a healthcare provider and their patient is an important point of consideration because it could facilitate the degree of quality care received, which is further impacted by historical or current health inequities. As mental healthcare providers, psychologists promote mental health and contribute to the third sustainable development goal (SDG). The third SDG focuses on ensuring healthy lives and promoting well-being for all ages; a specific target under this goal is reducing premature mortality from non-communicable diseases and promoting mental health and well-being (United Nations, 2022). As healthcare professionals, psychologists know that the relationship between themselves and their patients is the foundation of good quality care. Therefore, it stands to reason that the therapeutic alliance is one of the most studied concepts in psychotherapy research. It is one of the factors most central to positive therapeutic outcomes (Flückiger et al., 2018; Horvath et al., 2011). While variously conceptualised by different therapeutic modalities, it broadly refers to the mutual collaboration and engagement between a therapist and client (Horvath et al., 2011).

This therapeutic alliance might be affected by various factors, including sex, race, ethnicity, age, social class, and factors that might signify social positionality (Balmforth, 2009; Cheng & Lo, 2018; Flückiger et al., 2013; Ryan et al., 2021; Schmalbach et al., 2022). However, research on these factors' role in shaping the alliance has been inconsistent, highlighting a need for it to be better understood in various contexts within diverse populations (Meissner, 2006; Ryan et al., 2021). South Africa is one such context in which race, culture, religion, ethnicity and language intersect to produce various experiences between healthcare providers and the populations they serve. These experiences are shaped by the country's colonial history and Apartheid, as seen in African-American populations, which could result in mistrust between healthcare providers and patients (Read et al., 2021).

South Africa has a culturally and racially diverse and multilingual population with eleven official languages. The 2011 census indicated that the country comprises 79.2% Black African, with the Coloured and White population at 8.9% each. Indians and Asians make up 2.5% of the general population. Even though people of colour[1] Make up the numerical majority of the population. It is important to note that when referring to a minority in the context of this paper, it relates to any person who identifies as not white (Krog, as cited in Esprey, 2013). As a legacy of the racially based policies of Apartheid, South Africa has high levels of inequality, which influences access to health care, discrimination in health settings, poor quality health care, and high maternal and infant mortalities (Chinwe, 2015). More than two decades after democracy was established, healthcare in South Africa is still gendered and racialised (Mbali & Mthembu, 2012; Mhlanga & Garidzirai, 2020). Women of colour are more likely to be affected by health inequity and compromised treatment quality (Chinwe, 2015). South Africa has a high prevalence of mental health disorders; less than 16 per cent of people with a mental illness have access to care (Petersen et al., 2016). These inequities extend to psychotherapy treatments where women of colour receiving care or seeking care for their mental health might compound these inequities based on their various identities (Mhlanga & Garidzirai, 2020; Siyothula & Pillay, 2008). The multiple identities of patients and historical contexts could impact the therapeutic relationship as it could illicit feelings of mistrust and misunderstanding (Read et al., 2020). Given the intersectional nature of the health inequities in this country, questions about the factors that might affect the therapeutic alliance and its influence on therapeutic outcomes seem warranted.

Contextualising Psychology and Psychotherapy in South Africa

[1] People of colour refers to people who identify in the South African context as Black, Coloured or Indian based on the legal racial classifications. For this study, participants were asked to self-identify as a woman of colour since the term encompasses all the categories besides White. This decision was made to promote inclusivity and to provide people the agency to self-identify.

The history of psychology in South Africa is firmly rooted in colonialism and the apartheid laws and policies aimed at segregating racial groups to create an unequal society. This history resulted in the disparities in access to healthcare encountered by people of colour, which persist (Mhlanga & Garidzai, 2020). Although a few pioneering psychologists took notice of race and its effect on psychology during the early 1920s, this research was primarily inspired by political upheavals during the 1960s and 1970s, when freedom fighters pushed against stratified race-based systems (Cooper, 2014). The majority of the South African population identifies as black, but race remains a deeply divisive issue within this historically fraught society. Psychological research has shown that race undeniably impacts people's experiences and life outcomes (Harrell, 2000), so it stands to reason that racial inequality would also have severe psychological consequences for South Africans.

South Africa is known for its diversity culturally, linguistically and ethnically, with the legacy of Apartheid still impacting how we perceive and react to each other (Esprey, 2013; Johnston, 2015). As Esprey (2013) explains, "It is a country where self- and other identification of race happen automatically, almost unconsciously" (p.33). Practising or receiving psychotherapy in South Africa is complex because of the country's history, diversity, and pervasive inequality. This inequality reaches beyond socioeconomic status to encompass access to health care, education and infrastructure. Furthermore, in 2017, the HPCSA surveyed registered psychology professionals and found that the majority were middle-class white women (HPCSA, 2017). This survey indicates that accessing culturally or linguistically relevant or diverse mental healthcare is limited, raising the question of whether psychology is relevant in South Africa (Long & Foster, 2013). Compounding this issue is the lack of freedom patients must make their own therapeutic choices if accessed through medical aid, non-governmental organisations or a company wellness plan. For example, Johnston (2019) conducted a study with clinical psychologists in South Africa to explore the impact of the

country’s cultural diversity on their therapeutic alliances. They found that the patient's language, religion, race and socioeconomic status were challenges psychologists face in the therapeutic space.

Biko (2009) noted that white people had begun to believe in the inferiority of blacks and despised black people because they believed them to be bad or inferior. The belief in white superiority and black inferiority infiltrated the university and training spaces. It resulted in the racial skewing of the psychology profession to white middle-class people (Pillay & Siyothula, 2008). This racial skewing is still evident today; more than 20 years after democracy, primarily white women still practise the profession (HPCSA, 2017; Pillay & Siyothula, 2008). Given the country’s demographic composition, Siyothula and Pillay (2008) highlighted the inequity of clinical psychology training where most students training as clinical psychologists are white and middle class. They emphasise the potential consequences this could have for South Africans who seek mental health services from someone who is culturally, ethnically or linguistically similar. The potential consequences contribute to the question of psychology's relevance for most South Africans (Long, 2013; Macleod, 2004).

Initially, white Afrikaans language and culture theorists dominated the profession, which had a different take on race and colonialism than their English-speaking counterparts (Cooper, 2014). This resulted from the creation of psychology departments across various universities in South Africa; certain universities used Afrikaans as a medium to position themselves as "African", legitimising their claim to South Africa (Cooper, 2014). During this period, psychotherapy was viewed mainly within the context of race-based thinking and practices such as Apartheid, the English language group opposed some of the racist views and ideas of their Afrikaaner counterparts (Cooper & Nichols, 2012). However, both groups excluded black people. Later, with increasing awareness of race issues within South African

culture and academic exclusions, new perspectives emerged, leading to more nuanced ways of examining race and its societal implications.

Psychology was utilised as a political tool to justify other races' inferiority and serve the political agenda of segregation (Painter & Terre Blanche, 2004). This was achieved by using psychological tests in a biased and unfair way to provide a scientific basis for the belief that black people were subhuman (Cooper et al., 1990). Various studies have shown an increase in black psychologists and registered counsellors (Ahmed & Pillay, 2004; Cooper, 2014); however, considering the demographics of South Africa, it is still not enough to fully remediate the effects of Apartheid in training and producing psychology graduates. Initially, universities relied heavily on Western theories and texts, emphasising colonial thought processes. However, more diversity and South African culture are presented by academics writing textbooks that speak to the multicultural needs of psychology students (Cooper & Nicholas, 2012). This, in turn, led to a greater public acceptance of psychological therapies that addressed race as an essential component.

Psychology in South Africa is relatively young but has made tremendous progress in recent decades. Racial diversity has helped shape how psychologists practice and contribute to the body of knowledge on mental health in the region. Prominent psychological studies on race, identity, culture and values continue to come out of South African universities (Cooper, 2014). Practically speaking, there has been an increased focus on improved access to quality mental health services within South Africa's diverse communities. However, the current state of psychology in South Africa is concerning, as disparities among citizens create physical and mental health disparities that are difficult to overcome. For example, disparities in access to psychological services often exist along racial and economic lines, with some privileged groups accessing better resources than others. Moreover, disparities are observed when assessing the training and qualifications of psychologists operating within the country, with certain regions

needing more service infrastructure to adequately equip all practitioners with the tools needed for effective practice (Ahmed & Pillay, 2004; Pillay & Siyothula, 2008) While there has been national and global development to increase resources for mental healthcare and make psychology more accessible, disparities persist (Mental Health Care Act, 2002). These are not just structural disparities manifest in transport difficulties or affordability but disparities within sameness and difference in the therapeutic spaces that are not attended to.

Rationale

The relationship between healthcare providers and their patients determines patients' quality of care. As healthcare professionals, psychologists specifically focus on the relationship between them and their patients because it is the foundation of their treatment. Consequently, the therapeutic alliance is central to the beneficial outcomes of psychotherapy. Most of the research concerning the therapeutic alliance has been from the therapist's perspective. However, research has shown that the client's experience differs from that of the therapist, and the client's experience is a stronger predictor of therapeutic outcomes (Ardito & Rabellino, 2011), underscoring the importance of exploring clients' experiences of the therapeutic alliance.

Furthermore, psychology in South Africa is primarily a middle-class profession overrepresented by white women (HPCSA, 2017). However, South Africa has a culturally and racially diverse population and a traumatic history of systematised white supremacy that persists in various ways. It stands to reason that sameness and difference in South African psychotherapeutic settings may be especially fraught. Exploring the experiences of South African women of colour and their perceptions of how the experience of sameness and difference affects the therapeutic alliance seems especially important to developing psychotherapeutic services that are more equitable, reducing disparities and ensuring the promotion of mental health and overall well-being.

Aims and Objectives

The proposed study explores clients' perceptions of how sameness and difference shape their experience of the therapeutic alliance. The objectives of the proposed study are to explore:

1. participants' perceptions and experiences of the therapeutic alliance,
2. the aspects of sameness and difference that participants identify between themselves and their therapists.
3. Participants' understanding and experience of sameness and difference might have shaped their experience of the therapeutic alliance.

Thesis Structure

There are five core areas covered in the chapters of this thesis:

1. **Introduction**: This chapter includes a brief background, rationale, and the aims and objectives of the study.
2. **Literature review**: In this chapter, an abbreviated review of the literature aims to provide enough of an academic rationale for the study.
3. **Methods**: This chapter includes the research design of the study, the sample, data collection, procedure, data analysis, ethics, data management and reflexivity and trustworthiness.
4. **Results and discussion**: This chapter provides an overview of the emerging themes and an integrated discussion of the findings about existing literature and methodological decisions. The findings are also discussed in relation to the theoretical framework. In this way, a theoretical formulation of the findings is presented.
5. **Conclusion**: The final chapter provides a summary of the thesis and draws appropriate conclusions that are supported by the findings. This section will also include recommendations, limitations and discuss the significance of the study.

CHAPTER 2: LITERATURE REVIEW

The therapeutic alliance is one of the most researched psychotherapy factors (Flückiger et al., 2018) due to it being a strong predictor of successful therapeutic outcomes (Ardito & Rabellino, 2011). Broadly, it refers to the collaboration between therapist and client that results in a mutual understanding of the goals and activities of treatment (Dryden & Reeves, 2008; Horvath et al., 2011). However, this alliance might be affected by therapist and client differences in age, gender, social class, ethnicity, culture and race (Johnson & Caldwell, 2011). Given South Africa's legacy of Apartheid that emphasises differences along racial, cultural and class lines, understanding how these experiences of difference and sameness might play out in the therapeutic process is essential. This chapter will explore various approaches to psychotherapy regarding the therapeutic relationship. It begins with the common factors approach, in which the factors common to all approaches are explored. The various therapeutic outcomes follow this concerning the therapeutic alliance and then an exploration of sameness and difference as it relates to the South African context. Matching sameness and difference are briefly discussed concerning its effect on therapeutic outcomes. Finally, power in the therapeutic relationship is unpacked to understand the intersectionality of sameness and difference.

Common Factors Approach to Psychotherapy

Common factors in therapy have been shown to predict successful therapeutic outcomes more than specific therapeutic factors (Fife et al., 2013). In 1936, Saul Rosenzweig first proposed the concept of ‘common factors’ in therapeutic processes (Grencavage & Norcross, 1990). He asserted that successful therapeutic outcomes were not a result of the various psychotherapy approaches, but because of the common factors shared across all approaches. In other words, it was not the specific techniques that made individual therapies effective, but rather the non-specific or common factors that underlie these techniques.

Research since then has identified the common factors to include the therapeutic alliance, the therapist qualities, for example, warmth, empathy and cultural adaptation, client characteristics, and expectations and hope as related to treatment structure (Grencavage & Norcross, 1990; Norcross & Lambert, 2018; Thomas, 2006; Wampold, 2015). Research has focussed increasingly on discovering and defining common factors, resulting in a varied and increasingly long list. However, most therapists endorse factors common to building the alliance (Cook et al., 2010; Stamoulos et al., 2016). Stamoulos et al. (2016) found that while all common factors were considered necessary by clinicians, certain factors, such as empathy and alliance, were crucial.

Tschacher et al. (2014) investigated the constructs of common factors to find a standard definition. It became evident that certain common factors carried more weight than others. These were patient engagement (patient participates actively in the therapeutic process), affective experience (patient experiences emotions and affect related to their problems) and therapeutic alliance (Tschacher et al., 2014). However, studies have shown that clients have varying beliefs about what contributed the most to change (Thomas, 2006). Therapists placed the therapeutic relationship as the most important factor for change, but clients emphasised their hope and expectations (Thomas, 2006). Hope is necessary in the therapeutic alliance because the therapist should support and encourage hope and positive expectations (Ward et al., 2007). This aligns with Sprenkle and Bow (2007), who posited that a client must find the therapeutic tasks credible, and the expectations of therapy should fit with the approach.

Therapeutic Alliance and Outcomes

Therapeutic alliance and therapeutic relationship are often used interchangeably (Cuijpers et al., 2019). However, for this section, only therapeutic alliances will be used. Various therapeutic approaches differ in their view of the alliance. Freud (1936) first introduced the alliance concept in relation to the transference and countertransference between

therapist and client (Ardito & Rabellino, 2011). Horvath and Luborsky (1993) specifically moved away from this definition in psychodynamic therapy and distinguished between the working alliance and transference. Rogers (1951), in his person-centred approach, focussed on empathy, congruence and unconditional positive regard as necessary to the therapeutic alliance. Studies have shown that cognitive behavioural therapy, psychodynamic therapy and the person-centred approach had no specific impact on successful therapeutic outcomes, but the therapeutic alliance consistently showed beneficial outcomes (Doran, 2014; Horvath, 2001; Schmalbach et al., 2022). Therefore, the emphasis is on the therapeutic alliance rather than the treatment approach.

The therapeutic alliance is a collaborative engagement effort between the client and therapist (Flückiger et al., 2018). Therefore, the client and the therapist must contribute to the alliance. Bordin (1979) proposed a theory for working alliance that is still primarily used today, considering the working alliance between the client and therapist to be the critical change agent. Consistent with Bordin's (1979) thesis, Wampold (2015) identifies three components to the therapeutic alliance: (1) the bond between therapist and client, (2) agreement about the goals and expectations of therapy, and (3) agreement about the tasks in therapy. The bond refers to establishing trust in all therapy tasks, whether homework or feedback. This bond might be affected by the duration of the treatment or the role of the therapist. Further to this, collaborating on goals, expectations and tasks in therapy as it links to the difficulties the client experiences (Bordin, 1979; Wampold, 2015).

The alliance's strength in therapy is thought to be independent of other variables such as theoretical orientation, therapist experience and training (Horvath, 2001). This might be because the relationship between therapist and client underpins all therapeutic schools of thought (Bordin, 1979). There is substantial evidence for the importance of the therapeutic relationship independent of specific therapeutic factors resulting in successful therapeutic

outcomes (Horvath, 2001; Norcross, 2019). This is not always the case, though, as Beutler et al. (2012) found that therapeutic alliance only sometimes significantly predicted therapeutic outcomes and stated that it was imperative for treatment to fit with the client. However, the strength of the therapeutic alliance has implications for the early termination of therapy, the client's engagement in the therapeutic process, and the beneficial outcomes derived from therapy (Fife et al., 2013). The therapist influences the client towards a strong alliance (Horwitz, 1974).

Sameness and Difference in Psychotherapy

The idea of sameness and difference in identity has been discussed at length among philosophers for centuries, from the ancient Greeks like Aristotle and Plato to modern philosophers such as Hegel and Heidegger (White, 1980). This concept has been explored in psychology regarding gender (Schmalbach et al., 2022), culture (Hook et al., 2016), race (Morales et al., 2018), and the therapeutic relationship (Johnson & Caldwell, 2011). Experiences of sameness and difference are intersubjective in that they inform the relationships between people. The therapeutic space is created by two subjectivities in which race, gender, age, socioeconomic status and sexual orientation shape the therapeutic relationship (Esprey, 2013). Differences could originate from many seen and unseen variables (Swartz, 2007). Bordin (1979) noted that social class, working styles and personality differences could influence the therapeutic relationship. Swartz (2007) posits that race and the colour of one's skin are immediate signifiers of sameness and difference that signify how we relate to others.

Furthermore, it carries assumptions about education, language and history (Esprey, 2013). Fort (2018) asserts that ideas around gender roles shaped the mental health-seeking experiences of women of colour in unexpected ways compared to their white counterparts because of cultural experiences. Research should focus on examining how those differences shape the experience of the therapeutic alliance. The differences one sees in others allow one

to hold prejudices and assumptions, which could affect interaction; in this way, the person is othered. Othering will affect the therapeutic alliance and have implications for the success of the therapeutic alliance (Esprey, 2013; Johnston, 2015). Studies have shown that white therapists lack awareness of systemic racism, stereotyping and white privilege, which leads to adverse cross-cultural effects on the therapeutic alliance (Case, 2015). This unconscious unawareness results in not acknowledging race and positions of privilege, threatening the safe therapeutic space and trust in the relationship.

In a qualitative study on social class, Balmforth (2009) found that clients felt the therapist needed more understanding concerning access to resources, finances and life experiences. South Africa's history has entrenched racialised lines between people, communities and the therapeutic space (Swartz, 2007). Coetzee et al. (2019) described a case from the therapist's perspective in which a South African therapist and client could find common ground through shared experiences despite their difference (Coetzee et al., 2019). They were able to do this by negotiating differences together in order to find a mutual understanding. Coetzee et al. (2019) emphasised the need to engage with sameness and difference in a country where differences are often felt. This resulted in a solid therapeutic relationship and bond of trust. It suggests that understanding sameness and difference and their impact on the therapeutic relationship is complex. Acknowledging the difference is necessary when entering the therapeutic space. As Swartz (2007) puts it, "No amount of dissociation, however, prevents messages arriving from the unconscious" (p.180).

A meta-analysis of studies on therapeutic alliance with racial and ethnic minority groups found that socioeconomic status, race and ethnicity played an essential moderating role in the therapeutic alliance and therapeutic outcomes (Flückiger et al., 2013). Hook et al. (2016) examined racial microaggressions in therapy and found that participants experienced them even if matched to someone of the same race. Further, research has consistently shown that

successful therapeutic outcomes on racial and ethnic minorities were considerably lower if the therapist was white (Hayes et al., 2016; Morales et al., 2018). Similarly, Ryan et al. (2021) found that matching therapists to clients according to ethnicity had positive outcomes. This indicates that sameness and differences between therapist and client on factors such as race and ethnicity could impact successful therapeutic outcomes.

Matching

Matching refers to matching therapists and clients based on visible external factors. However, studies on matching a therapist to a client via external factors (age, sex, race, culture, etc.) have shown mixed results. Johnson and Caldwell (2011) found significant positive outcomes when clients were matched with the same gender. Cheng and Lo (2018) confirmed their hypothesis that therapeutic alliances are significantly correlated with the matching of gender between client and therapist. Similarly, in a qualitative study, clients noted that the gender of their counsellor was an essential factor that shaped their therapeutic experience (Kastrani et al., 2014). However, Schmalbach et al. (2022) found that matching clients and therapists by gender showed no significant advantage in symptom reduction or quality of life among clients. Most of the studies in this area are from North America, highlighting a need to explore how culture, race, gender and socioeconomic status are perceived and experienced in the therapeutic alliance in other countries, like South Africa (Flückiger et al., 2018). Meissner (2006) noted that while many studies stress the importance of the alliance in determining therapeutic change, this will need to be explored in various contexts across a broad range of treatments. The sameness and difference between therapist and patient may significantly dictate the power differentials in the therapeutic space (Berzoff, 2022).

Power in the Therapeutic Relationship

The therapeutic relationship is assumed to be one in which there are inherent power differentials between therapist and patient. Fors (2021) discusses the various forms of power

in the therapeutic relationship. These are related to diagnosing patients even if they reject the labels, the imbalance of knowledge of the therapist possessing more knowledge about the patient than the patient has, and the therapist's training which provides them with greater authority and external social power brought into the therapeutic space. The therapist knows as a professional, and the knowledge shared by the patient with the therapist creates a power imbalance favouring the therapist (Fors, 2021; Williams & O'Connor, 2019; Zur, 2009). However, a patient might have a power advantage by purposefully not participating in the therapeutic process to undermine the therapist's competencies (Williams & O'Connor, 2019).

Further, how power is enacted in the therapeutic space could make the therapist feel helpless and victimised (Berzoff, 2011). Therapists might not be cognisant of the power differential. However, there are many ways in which power is enhanced through office arrangement, professional jargon, tone of voice, communications, payment and note-taking (Williams & O'Connor, 2019). Exploring the various power differentials in the therapeutic space becomes necessary because it creates the potential for a rupture in the relationship or an abuse of power by the therapist (Arora et al., 2022).

The therapeutic relationship is shaped by sameness and differences between therapist and patient; these differences affect the power dynamics in the therapeutic space (Kirmayer, 2012). Particularly salient are differences in culture, language, religion, sexuality, age, class, disability and gender (Fors, 2021; Kirmayer, 2012). These social constructions of identity could result in certain cultural or racialised groups being disadvantaged when seeking healthcare through affordability, choice or understanding of mental health issues (Kirmayer, 2012). It is universally believed that mental health services and promotion should include culture to produce positive mental health outcomes (Anderson et al.Akt, 2003). However, Zur (2009) critiques this by stating that a power differential between female patients and male psychologists should not exist as it dictates that women are powerless. He applies this thinking

to other groups where a power differential could exist, noting that it incorrectly assumes certain groups are more vulnerable than others. Various authors have highlighted that the therapeutic space is one in which we unconsciously re-enact power dynamics concerning race, gender, sexuality, culture, socioeconomic status or trauma (Altman, 2000; Berzoff, 2022; Layton, 2006). Therapists and clients could be aware of these differences but still hold internal contradictory feelings that are triggered and enacted in therapy (Fors, 2018). More importantly, this dynamic is fluid and constantly changing, meaning it must often be renegotiated for the therapeutic alliance to thrive (Fors, 2018).

A way to reduce these power dynamics is by ensuring cultural competence. Cultural competence refers to: "the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patient's social, cultural and linguistic needs" (Betancourt, 2003, p.5). This is meant to maintain clinical and professional competence. Instead, it posits that cultural competence should be viewed as important as the other two competencies (Kirmayer, 2012). However, all clinicians should be aware of their role in the therapeutic space and consistently reflect on challenging their biases and beliefs (Berzoff, 2011). A body of literature exists on power issues in therapy. However, these power issues are explored mainly from the therapist's perspective or focussed on specific groups, thus highlighting a need to study power from an intersectional viewpoint (Fors, 2018). Little is known about sameness and difference in the South African context and clients' experiences of it in the therapeutic space. Expressly, these differences could be visible or assumed how these can be understood concerning power. However, they might have a role to play in the therapeutic relationship and therapy outcomes. This is especially important in South Africa, a diverse and multicultural society where the psychology profession is still racially skewed. It is, therefore, vital to explore the experiences of women of colour and their perceptions of how the experience

of sameness and difference affects the therapeutic alliance in South Africa. Exploring these experiences could provide insight into training programs around cultural competence.

THEORETICAL FRAMEWORK

Intersectionality is a theory that emerged in the 1980s to explain that every individual has multidimensional identities that produce multiple oppression areas (Berzoff, 2022; Crenshaw, 1991). Intersectionality is rooted in black feminism and critical race theory; critical race theory refers to the racial bias inherent in various systems of society to exploit and oppress people of colour (Carbado et al., 2013). Therefore, intersectionality was born out of the critique of these systemic issues and the feminist movement in which the patriarchy is seen as the only enemy, consequently failing to consider women of colour, transgender women, and women of low socioeconomic status (Fors, 2018). Intersectionality can engage on various issues within various disciplines across multiple countries and continue to move to other social contexts and structures of power (Carbado et al., 2013). It is the study of social systems and their interaction to critique power, oppression and inequality (Grzanka et al., 2017). Intersectionality theory argues for the acknowledgement of multiple factors that shape personal identity and the links that allow these factors to intersect and influence each other (Crenshaw, 1991; Fort, 2018). These factors include gender, race, socioeconomic status, education level, religion, culture etc. No person is unidimensional, and no person's lived experience can be understood by focusing on one identity. Young-Bruehl (1996) emphasised that how women experience sexism differs between races, and the experience of racism differs according to race.

Grzanka (2020) provides multiple ways in which to understand intersectionality: as a critical framework for conceptualising the human experience of power and inequality, an approach for understanding multiple social identities which function in complex social systems, a metaphor that exposes social life, oppression and privilege; and as a way of linking scholarship and activism. The intersectionality lens allows for engagement not just on

differences but also on similarities, not just of privilege but of victimhood and highlights these shared experiences of marginalisation and discrimination (Carbado et al., 2013). The aim of intersectionality is to engage and explore these dynamics in order to drive social change (Crenshaw, 1991).

This model has significant implications for psychotherapy research and practice because psychotherapy is contextualised by a relationship, which is a social system (Fort, 2018). Fors (2018) wrote, "How can we work as therapists if societal power dimensions increase the natural power asymmetry of therapy?" (p.25). This relationship is affected by the various social factors which intersect in ways that consciously or unconsciously highlight the differences between therapist and patient. Furthermore, given the nature of the work, power differentials between the therapist and the client are inherent to the process. Consequently, the positionality of both the therapist and client is essential to understanding the experience of the therapeutic relationship (Grzanka, 2020). Intersectionality examines the interlocking mechanisms of oppression and can be used to create a safe space in therapy to discuss power and privilege (Arora et al., 2022). Grzanka (2020) argues that exploration is needed on why differences matter, not on what those differences are.

Intersectionality theory is relevant to the proposed study as it allows for understanding how sameness and difference intersect to shape the therapeutic space. It provides the researcher with the tools to explore how sameness and difference intersect as experienced by women of colour who have been in therapy. It further allows for an understanding of the power dynamics inherent in the therapeutic space but also of the power dynamics that are external and brought into the therapeutic space. These external power dynamics resulting from race, culture, age, ethnicity, socioeconomic status and gender are influenced by the various social systems in which individuals find themselves. These differences can be seen in the body as an indication

of an individual's power or powerlessness (Berzoff, 2022). This framework would allow for a nuanced understanding and critique of the inherent power in the therapeutic alliance.

Research Questions

This study answers two main research questions as detailed below:

1. How do women of colour, as clients, perceive sameness and difference within the therapeutic relationship and
2. How does this shape their experience of the therapeutic alliance?

Sub-questions

The study answered three sub-questions listed below:

1. What are the participants' perceptions and experiences of the therapeutic alliance?
2. What are the aspects of sameness and difference that participants identify between themselves and their therapists?
3. What are participants' understanding and experiences of how sameness and difference might have shaped their experience of the therapeutic alliance?

CHAPTER 3: METHOD

Research Design

This study adopted an exploratory qualitative research design to explore the experience of the therapeutic alliance from the perspective of women of colour who have been in psychotherapy. Qualitative research provides an in-depth understanding or exploration of a person's subjective perspectives and histories (Creswell & Poth, 2016). It attempts to understand phenomena from those who have lived through it (Spencer et al., 2003). Qualitative research allows the exploration of the nuances evident in human experience (Silverman, 2013). For this reason, the exploratory qualitative research design was considered appropriate for understanding participants' experiences of sameness and differences in the therapeutic relationship.

Sampling and Recruitment

Using purposive sampling, 11 participants were recruited to participate in the study. This non-probability sampling method allows participants to be selected based on specific inclusion criteria (Babbie, 2016). Each participant had to self-identify as a woman of colour. Women of colour are chosen as the sample due to the evident health inequities in South Africa. To participate in the study, participants had to be in South Africa, over the age of 18, currently in therapy or have terminated therapy within the last year, and able to identify at least one way in which their therapist was different to them. Participants were not asked to identify any specific difference, only that a difference between them was evident.

Furthermore, participants would have to have been in therapy for at least five sessions since research has pointed to this as the peak of the development of the therapeutic alliance (Ardito & Rabellino, 2011). Purposive sampling did not generate the required sample size; therefore, a snowball sampling strategy was utilised (Babbie, 2016). Due to this specific requirement of the participants, snowball sampling was used to recruit participants from

participants who have responded to the study. These participants located others who fit the criteria. Participants were recruited by posting a flyer on various social media sites for two weeks. The flyer outlined the aim of the study, the requirements to participate and contact details if they were interested. Twelve participants enquired via email and WhatsApp. However, only eleven filled out the consent forms to participate. The first few participants were asked to share the flyer with those who might meet the criteria. Participants were not asked where they saw the flyer or who sent it.

Data Collection

This research aimed to provide a voice to women of colour and their experience in therapy. Intersectional research prefers data collection methods that focus on participants and their experiences. An interview allows for understanding a person's shared experiences and how that has shaped their beliefs (Esposito & Evans-Winters, 2021). In intersectional research, it is essential to explore the participants' experiences that have been shaped by race, gender, class, etc.; therefore, utilising a semi-structured interview would allow for open-ended questions and flexibility (Esposito & Evans-Winters, 2001). Semi-structured interviews were considered appropriate for this study because they use predetermined questions as guidance while allowing for the interview to unfold conversationally. This provides the opportunity for the researcher and participants to explore issues they feel are essential and allows participants to elaborate on their views and experiences (Longhurst, 2016).

Interviews were conducted in person or via a video platform. Participants could choose depending on their location or comfortability to meet during the COVID-19 pandemic. Only one participant indicated wanting to be interviewed in person. There was an option of a telephonic interview for participants who could not afford the cost of data, but no participants chose this type of data collection. Interviews were 45-60 minutes long, and an interview guide was used (Appendix A). The questions were informed by the literature, theory and the probing

of statements made by participants. Final questions were determined in consultation with my supervisor. Participants were not asked their reasons for attending therapy, their therapist's name or content related to their therapy. Any research involving human participants has power dynamics (Esposito & Evans-Winter, 2021). The research relationship could result in exploitation or an attempt to ignore power regardless of whether the researcher aims to keep it equitable. To mitigate this, participants could choose their mode of data collection, and no questions were asked that I would not consider answering.

Procedure

Once ethics approval was received from the Ethics Review Committee in the Department of Psychology, University of Cape Town (Appendix B), the recruitment of participants began. The study was advertised via "Rushtush", a fitness and health entrepreneur and social media influencer who agreed to disseminate the recruitment advert (Appendix C) on her social media platform. She was chosen because her focus is on women's health, and in one month, her one social media account reached 70012 individual social media accounts. Over half (57.2%) of her audience for that month was based in Cape Town. However, the statistics show various other parts of South Africa. Her audience is between the ages of 18 and 54, with 81.7% being women. She was provided with the recruitment advert posted on Twitter, Facebook, Instagram and WhatsApp. Participants were also asked to send the advert to people who might be interested. The advertisement provided a contact number and email for interested people to contact me for more information about the study.

Participants who contacted me were sent an information sheet and consent form outlining the aim of the study, the risks and benefits, the storage of information and confidentiality (Appendix D). A suitable time and online platform/venue for the interview were arranged. Interviews took place from 06 May 2022 to 20 May 2022. One participant requested an in-person interview and was invited to the Child Guidance Clinic, where the interview was

conducted in my office. The remaining participants preferred online interviews, and Zoom was deemed the most suitable application due to its end-to-end encryption. All interviews on Zoom were recorded directly to a cloud drive and transcribed. The face-to-face interviews were stored in the Apple cloud and then transcribed.

Data Analysis

Bogdan and Biklen (2007) distinguish between analysis and interpretation; in their view, interpretation is the development of ideas and relating those findings to the literature. This is a process that could take place throughout the study. As data were collected from participants, it was understood with the available literature and theoretical framework. Furthermore, after the first four interviews, I met with my supervisor to discuss the emergent ideas and what had been observed.

Once the data had been transcribed, it was analysed using Braun and Clarke's (2019) method for reflexive thematic analysis with the most recent version of NVivo software. Reflexive thematic analysis is widely used within qualitative research (Braun & Clarke, 2006). It involves identifying, analysing and reporting patterns or themes within data and organises and describing data in rich detail (Braun & Clarke, 2006). This thematic approach considers the reflexivity and subjectivity of the researcher as imperative to the process (Braun & Clarke, 2019; Charmaz, 2001). The researcher actively creates meaning from the data at the point where data, analytic process and subjectivity intersect (Braun & Clarke, 2019). This process allowed for a more nuanced data analysis, which provided a rich, thick description of participants' experiences with the therapeutic alliance. Braun and Clarke (2006) proposed six phases of data analysis:

Phase 1: Familiarisation with the data

I was familiarising myself with the data, which involved listening to the recordings and reading the transcripts multiple times. This allowed me to make connections within the

interviews and between the interviews. In addition, I constantly discussed this with my peers to flesh out my ideas and any biases I might have in my initial ideas. Considering my theoretical framework of intersectionality, I needed to know that my understanding of the data is not the absolute truth.

Phase 2: Generate initial codes

Charmaz (2001) noted that coding is the link between data collection and data analysis. Codes are broken into manageable pieces to generate ideas and questions. Initial codes were generated by moving through the transcripts line by line. A code was provided based on understanding and engaging with the literature on therapeutic alliance, sameness and difference, and intersectionality. Any code generated was clearly defined and described. A rough memo was kept noting any concerns, thoughts or feelings I might have towards the data. This allowed for reflection and comparison of the data with the data. Any uncertainty regarding codes was discussed with my peers and my supervisor. A codebook was generated and sent to my supervisor, and 303 codes were listed and described. These codes were refined and merged further.

Phase 3: Search for themes

Themes were searched for from the codebook and Nvivo's software tools, which could chart and compare various codes to highlight their importance. Initially, themes were considered based on the sameness and differences mentioned by participants. However, after consultation with my supervisor, I removed myself from the analysis. I gained an understanding of the literature, my study aims, and my memoing to bring myself back to make meaning of my data through the lens of intersectionality.

Phase 4: Review themes

Literature was consulted to determine if themes could be merged or separated and to understand how the themes interacted to provide a clear picture of the participants' voices. The

preliminary themes were discussed with trusted peers and my supervisor. Two overarching themes were decided on with various sub-themes. My memoing was considered throughout the process, and the coded data was utilised.

Phase 5: Define themes

Themes were defined based on the theoretical framework of intersectionality concerning various therapeutic alliance concepts.

Phase 6: Write up themes

Themes were written up through the lens of intersectionality and the variations of power experienced in the therapeutic relationship based on sameness and difference. A detailed description can be found in the findings section.

Ethics

Before the interview, all participants were required to complete and sign the information and consent form sheet, which details the study's aims and the security and use of their information.

Informed consent

Participants were required to be over the age of 18 to provide consent to participate in the study. They were informed of the study's aim and purpose and advised of what would be required of them should they agree to participate: 45-60 minutes of their time, access to the internet or a telephone, or access to transport to the Child Guidance Clinic. Participants were advised that their participation is voluntary, and they have the right to withdraw at any time without consequence or to refuse to answer any questions they do not feel comfortable answering. Ten participants completed and signed the informed consent form and emailed it to me before the interview began. The remaining participant was a face-to-face participant, and the information sheet was explained to them and signed before the interview was initiated.

Risks and benefits

Participants knew there were no direct benefits except to contribute to understanding therapeutic relationships in South Africa. However, each participant was offered R100 for transport or data costs incurred. Only two participants accepted the R100 for data costs and transport. This study is of medium risk as specific questions could elicit uncomfortable feelings around their therapeutic process. Participants were not asked questions on the content, process or reason for therapy. They were also not asked to reveal the identity of their therapist. The questions asked allowed them to reflect on their experience of sameness and difference within the therapeutic alliance. Each participant had multiple therapeutic experiences and spoke about their past experiences. If participants were in therapy, they were encouraged to share their experiences with their therapist.

Confidentiality

The identity of all participants was kept confidential; only the researcher was aware of the participant's identity. Pseudonyms were utilised to ensure anonymity when transcribing, analysing and writing the thesis. The interview was recorded to allow for transcription to take place. All the identifying data was removed from the transcription.

Participants were informed that the data would be used for a Master's thesis and might be published in an academic journal. However, all identifying information, including participants' names, place of work, or any other information that makes them identifiable to someone else, will not appear in this research report or any publications.

Data management

All data collected was stored on a password-protected computer, and only my supervisor and I had access to the transcripts. Once the interview recordings were transcribed, the interview recording was destroyed and removed from the Zoom cloud. The transcriptions were then imported into NVivo to code and identify themes. Only the researcher had access to the Nvivo project, and the project was saved on a password-protected laptop. Further, all

identifying data was removed, and participants were provided pseudonyms for the analysis; in this way, anonymity was maintained.

Reflexivity

Reflexivity is a central concept to qualitative research in which the researcher is aware of their role and influence on the research process (Dowling, 2006). Chenail (2011) states that the researcher is the primary data collection instrument. Reflexivity is not a method to employ; it is a way of thinking and a continuous process that aids in interpretation and meaning-making (May & Perry, 2013). I needed to retain awareness of my biases and worldviews that might affect how I collected, analysed and made meaning of the data. As a researcher, I questioned my role and social position to deepen my self-reflection and awareness. This reflection and awareness would support the trustworthiness of the research (May & Perry, 2013). As a woman of colour who identifies as coloured, a research psychologist and a clinical psychologist in training to practice in South Africa, this topic was of personal interest to me.

Furthermore, I was born in the Apartheid era and grew up on the Cape Flats, speaking a mix of two languages, Afrikaans and English. However, I am aware of how other parts of my identity intersected in ways that provided me with privileges around socioeconomic status or social class. I could access healthcare, including good mental healthcare, when necessary. These multiple identities shaped me and provided me with experiences my participants might not have had in their therapeutic experiences. I was aware of my biases around the therapeutic relationship and the freedom to find a psychologist who matched me in certain ways. I have been in therapy on and off for 18 years and have consequently built up my own assumptions on sameness and difference in therapy. I needed to understand that not everyone had the same experiences in therapy as I had.

Using the framework of intersectionality allowed me to reflect on my position as a researcher in the process of interviewing, data collection and data analysis. The power dynamic

between myself and the participants might have been heightened because I identify as a coloured woman and research psychologist. The participants and I experienced sameness and difference throughout the interview process. Visibly being a woman of colour assisted my participants in identifying with me and expecting to be understood because we were the same. The difference in education level was evident with some participants, who seemed nervous and looked to me for guidance because I was a clinical psychologist in training. It is feasible that this had an impact on what was shared. However, I continuously strived to reflect on my position within this research and kept a journal of my thoughts and feelings. This journal was used throughout the stages of the research to inform the data analysis process.

At the beginning of this study, I was unaware of how researching this topic would profoundly affect me. I felt utterly undone at some points because they were me, and I was them, but our experiences were not the same. I asked everyone from my supervisor to my friends to colleagues why I always found myself in therapy with a white person when it was clear from most of my participants that they would avoid this. Until recently, I never had an answer, but reading Black Feminist Thought by Patricia Hill-Collins sent me into a tailspin. Exploring why this took place in therapy, I realised that my thesis topic is profoundly personal and shakes the foundations of my identity. It is possible that through my environment, I internalised messages that white is best and White knows best, but since I am a woman of colour, this thought process goes against everything I am.

Power became evident when recruiting participants made me aware that while I understood from an academic perspective what is meant by a woman of colour. There is implicit power in using words and concepts to recruit people not in academia or the social sciences because the concept meant little to them. In this way, I was aware that I probably excluded participants. A few questions I received while recruiting focussed on changing women of colour to stating various racial categories. Another question I received during the

recruitment process was about wanting to discuss a previous therapist or previous therapy experiences, but they were in therapy with someone else. Considering my experience with multiple therapists, I had not considered this, but it was resolved in consultation with my supervisor. All but two participants refused to accept the R100 for data costs or transport. This made me reflect on whether my participants were from a majority well-off socioeconomic background and whether the amount was inconsequential or whether the power dynamics between us dictated whether they accepted it or not based on their financial need.

After each interview, I had to take stock of what I heard and where I fit in relation to my participants as a researcher. I consulted trusted peers and shared my thoughts, feelings and the emotions it evoked me. When participants struggled to speak about race and used terms such as "White" or "Coloured" or "Black", I self-disclosed and told them the topic of race made me uncomfortable too, that I understood why they could not say it or why they struggled to find the correct words to whisper. Various intersectional researchers highlight self-disclosure as a form of participant engagement to reduce power imbalances (Esposito & Evans-Winter, 2021).

As a woman of colour in South Africa, my participants and I had shared identities. This was further compounded by participants who were similar in religion, language, or culture. Researchers have posited that sharing identities with your research participants could threaten the research process. Participants might have been afraid to discuss topics contrary to cultural, religious, age and race norms (Esposito & Evans-Winters, 2021). However, I found that participants were comfortable sharing their therapy experiences because I disclosed that I had been to multiple therapists and struggled to connect with most of them. My sameness made them feel that I understood them through their language, such as Cape Town slang or religious terms. Participants would make comments while speaking, stating that I would understand what they mean or that I "got it". I was aware that while we might have shared identities that made

them feel comfortable and understood, any generalisations made by them and me could be risky in the context of intersectional research.

Parts of me questioned how and why my experiences in therapy differed from theirs. Glaringly evident was my privilege in accessing mental health care when I needed it and not relying on an allocation of a therapist for a certain period because of a wellness scheme, NGO or medical aid. Further, I was in a position of power as the researcher, a professional research psychologist and a student in training as a clinical psychologist. Participants enthusiastically spoke about how I was filling a need as a woman of colour psychologist in South Africa and bringing my understanding to clinical practice by reducing the judgement they felt. However, this was merely based on assumptions of me and how I looked than anything I might have said. I questioned the visibility of sameness and difference, even over a Zoom call. What did this mean for me as a clinical psychologist in training? What did it mean for my identity that I was viewed as the same but unsure if we were the same? What did it mean that their words and their painful experiences spoke to the core of who I am? I realised that even though I denied the racial and cultural differences I felt while moving through the world, they still existed and affected me in ways I have yet to comprehend fully. I also noted that the inherent nature of the researcher-research participant relationship could be why participants felt the need to tell me I would be different from therapists they had seen to avoid offending me.

At each point in this research process, I engaged with the literature from Kimberly Crenshaw to Patricia Hill-Collins to Angela Davis to Bell Hooks. I found myself in a world I never considered as part of me. This shaped the way I understood and made sense of my data. Power is inherent to all relationships, even if we do not acknowledge it; our multiple identities shape how we experience the world and relationships like the therapeutic alliance, even if we fail to address it.

Trustworthiness

Lincoln and Guba (1985) proposed establishing trustworthiness in qualitative research. Trustworthiness refers to credibility, dependability, transferability and confirmability. In order to ensure credibility, I engaged frequently with my supervisor. To achieve dependability, I kept detailed records of the process and notes in my reflexive journal and as memos in NVivo as the data was coded. The data collection took place over two weeks; detailed notes were taken after two to three interviews. The detailed notes provided a rich, thick description of my process from data collection to analysis and write-up, which could allow for the transferability of the study. However, the nature of qualitative research is rooted in the context of participants. NVivo allowed me to keep an audit trail of the data analysis process. Engaging reflexively in the process with my supervisor, my trusted peers, my journal and in therapy assisted in removing personal values and bias as much as possible from the process. However, bias and personal values cannot be excluded significantly because my multiple identities impacted the conclusions drawn from the study. To counteract this, I discussed the meanings I derived from the data with peers, especially if the meaning was unexpected. However, I am also aware that the meanings derived and my experiences and positions in the world inform interpretations made.

CHAPTER 4: RESULTS AND DISCUSSION

This section explores participants' experiences of sameness and difference within the therapeutic relationship and how these shaped the therapeutic alliance. Eleven women shared their experiences via in-depth interviewing. Participants were from Cape Town (n=8), Johannesburg (n=2) and Durban (n=1). Nine participants spoke about having been to more than one therapist over several years. Five participants were currently in therapy with their second or third therapist. Using Braun and Clarke's (2006, 2019) approach to reflexive thematic analysis, I organised the data into two overarching themes, each comprising three subthemes, as summarised in Table 1. Each theme and its corresponding subthemes are discussed concerning the relevant literature.

Table 1: Themes and Subthemes

Feeling Understood	**Client Agency in Therapy**
Validation	Setting the Frame
Therapist's Self-Disclosure	Socioeconomic Status & Freedom to Choose
Cultural Competence	Collaboration/Engagement

These themes and subthemes are discussed below, supported by relevant data from participant interviews.

Feeling Understood

Understanding can be conceived of as a collaborative process in the therapeutic relationship, in which meaning is made together (Pocock, 2002). Feeling understood in the therapeutic relationship contributes to the therapeutic alliance and is the foundation for perceptions of warmth, empathy, trust and non-judgment in the relationship with the therapist (Pocock, 2002; Stamoulos et al., 2016). The data in this study showed that feeling understood played a significant role in the therapeutic relationship for participants. Ward et al. (2007) found that participants' knowing that their therapist would listen is essential for the therapeutic

relationship. The feeling of being understood was more likely if there was a perception of sameness evident between the therapist and the client. This sameness could be related to race, culture, education, career, social class, geography or shared stories.

Further, three subthemes emerged from feeling understood, validation, therapist's self-disclosure and cultural competence. Each theme highlighted how sameness and difference shaped the feeling of being understood. Participants who felt that they experienced certain similarities to their therapist expressed how easy it was for the therapist to validate their experience, allowing them to feel understood. The therapist's self-disclosure to relate to the participants on an aspect of sameness made participants feel understood. However, if there were visible differences, participants expressed the need for the therapist to be culturally competent, especially considering the South African context, to feel understood and to reduce lengthy explanations of the client's context. The experience of feeling understood was influenced by the client's perception of sameness and the difference between the therapist and the patient.

> Zara explained, *I do not think if I were if we went to any other like lady, I don't think she would've picked that up, and I think because she understood that yes, I definitely didn't have to go into so much detail, into making sure that she really understood my background and who I am.*[2]

Zara emphasises not having to explain every detail of her context to feel understood because they shared similarities in culture and race in which the unspoken was automatically acknowledged. She indicated that her therapist disclosed experiencing similar challenges with mental health, which made her feel heard and understood.

[2] In the interest of authenticity, participant quotes are presented verbatim, and no changes were made to language and grammar.

Zara highlighted the importance of feeling understood during the therapeutic process, *she just really understands and like I say she really just explains what you're going through so well and I feel like that's really important, with someone that's got like mental, uhm, I wouldn't say mental issues but like someone who's yeah, got mental health.*

This experience of being understood has facilitated a normalising of her troubles. Carmen indicated the importance of her therapist understanding and relating to what she felt without explaining it to her because there were aspects of sameness in race, culture and community. How her feelings were validated was a crucial therapeutic experience she had not felt with previous therapists.

Carmen shared, *when I feel sad or angry, there is a lot of shame attached to it. Nevertheless, with her, she does not… she tries to take away that shame for me. Um, so she allows me to cry and to be angry and to swear and to be upset about certain stuff without me feeling more ashamed than I already do.*

Carmen's awareness of their sameness helped shape a safe therapeutic relationship for her, one in which she felt understood and validated. Other participants felt that the differences between them and their therapists left them feeling poorly understood or even misunderstood, especially when discussing religion.

Amina indicated feeling a need to speak about spirituality, *I felt like the missing element was even though I speak about, like, you know, like, religious and spiritual things, I just think that it would have been better towards the end if I had a Muslim person.*

Amina, a Muslim, noted the experience of something "missing" in her interactions with her non-Muslim therapist, a gap that may have been closed with a Muslim therapist. Understanding the complex and nuanced feelings associated with a relationship to religion may be difficult for a non-religious person to understand.

Nadia points out, *so, I think when you are outside of the religion, maybe it is harder to hold the ambivalence because you can be both very pissed off and then realise that at the end you are going to feel good with the choice that, you have made after you have been through the bit of frustration. And I think for her it was but be free you know, be spontaneous, be free, why is religion punitive, do you really think things are going to go wrong if you do not follow a particular set of rules?*

The difference in religion was visible to participants, with most participants describing how they perceived their religious dilemmas to be viewed by the therapist as not being critical, indicating their lack of understanding.

Ghayat expressed, *she would have understood the severity and impact that it would have on me because it is something that you grew up with. It is something that has been ingrained in you from a young age. It is not just something that is cultural or whatever.*

Amina, Nadia and Ghayat attended therapy with middle-class white women. While the therapeutic experience was fruitful, there were instances of feeling misunderstood or longing for someone with a shared religious identity. This aspect of sameness and difference sometimes produced ruptures in the therapeutic relationship as participants struggled to feel understood or safe in the therapeutic space. In multicultural contexts, therapists must take clients' religion seriously (Whitley, 2012). Religion and mental health have a long, complicated history. Religion provides people with a sense of coherence, plays a vital role in shaping human experience through community, and is considered an invaluable resource in times of suffering (Kleinman, 2007; Whitley, 2012). However, religious competence is often viewed as different to cultural competence and has yet to be recognised as central to patient care. It is important to acknowledge and understand the context and community in which a therapist might work because it has implications for feeling understood.

Race is an aspect of sameness and difference immediately visible to the participants, especially in South Africa, where race has been used to divide (Esprey, 2013). Participants remarked on the race of their therapists, and, for some, racial differences shaped the relationship in other positive ways. However, some participants immediately felt they would not be understood by their therapist and indicated that it shaped how much they shared in therapy and that frustrations in explaining those racial or cultural differences resulted in wanting to give up on therapy. Carmen noted, *"Like as a white woman, you will not be able to understand what a woman of colour is going through, and your upbringing, you know, is very different to a person of colour's upbringing."* Race differences in the therapeutic relationship have been identified as a factor that could strengthen or weaken the alliance. In particular, the issue of race in treatment could potentially affect the safe space that mental health is meant to be (Hook et al., 2016).

> Nancy describes how she knew she would not have a good therapeutic experience because it was likely a middle-class white woman, *and this is how Cape Town is spatially segregated, still by race, and so we got to see a white counsellor again. And then, um, the first thing … ja, well, she was like: Oh, you people get married very young. And I was like: Which people? And then I was being a little facetious and going like: Well, what do you mean? Explain yourself, and … And she just was digging her grave further and further and I was trying to give her the opportunity maybe to just be like: Okay, I didn't mean to say it like that, like you know.*

Nancy mentions Cape Town being spatially segregated by race to indicate that she knew what race her allocated therapist would be. Therefore, assumptions are made based on the location of the therapist's office. Nancy also felt misunderstood and angry at the stereotypes the therapist was unconsciously showing. She indicated that the therapist used "microaggressions" during the session without realising it.

> Fadwa reflected on the disconnect she felt with the therapist based on their race, *I think like it's that disconnect man. That yes, we wanna go into those environments, and yes, They have experience. They've been doing it for years. But they've been doing it for years, only focussing on a certain element, you know, or certain type of people. Or certain type of experiences of people from a certain type of environment, right?*

She emphasised that they might have years of experience. However, it might only be relevant for certain people, experiences and environments in which the psychologist is familiar based on their race.

All participants indicated being aware of the race of their therapist and how it might have played a role in feeling understood in the therapeutic relationship. Often, participants expressed not wanting to "sound racist" or were unable to say the word "White" out loud. However, it is evident that it played a role in all interactions and whether they felt understood as individuals in their multiple identities. Fadwa explained that she finally found a therapist of colour, and their lived experiences cannot be denied for their importance in understanding her. Carmen mentioned that women of colour have similar upbringings that a white therapist would struggle to relate to and, therefore, struggle to understand.

Gender emerged as an aspect of sameness and difference, with the majority indicating that they would not be comfortable working with a male therapist even though they might not have been in therapy with a male therapist. Ghayat shared her expectation of a male therapist not being able to understand her, "*and I just felt like they would not… no matter how hard they would try, they would not understand how it is to be a female."* Carmen saw a male therapist but terminated after one session because they could not relate to each other, stating, "*I have had male therapists before I went to one session, and I realised this is not for me.*"

Power hierarchies are enacted when race, class, gender and culture come into play in the therapeutic space, which always warrants a discussion (Davies, 2011). Participants were

consciously aware of various visible differences that put them at a disadvantage and disrupted their therapeutic relationship. However, gender differences between therapists and patients have shown mixed results in studies about therapeutic outcomes, showing that it only affects certain situations with specific subpopulations. This could indicate that there is an assumption from the participants that male therapists would not be able to understand the lived experience of women. It is essential to consider the rates of violence against women in South Africa (Mbali & Mthembu, 2012); this could indicate that not being open to a male therapist might be related to a feeling of safety.

Interestingly, the age of the therapist played a role in feeling understood. Multiple participants mentioned not having someone "too old" who would remind them of their mother. Furthermore, they spoke about not having someone too young because that person would lack experience. Fadwa said, "*She was quite mature in age, so, she was probably like in her late fifties already. Um, so that was also another big thing that I think also had like a disconnect in what we could relate to".* In this respect, significant age differences appeared to evoke various responses in participants. From the above, it seems clear that participants' experience of sameness and differences in race, culture, gender, and religion played an important role in feeling understood by their therapists. Within the broader theme of 'Feeling understood', three subthemes were identified that addressed some of the nuances of participants' experiences of therapeutic understanding that were moderated by perceptions of sameness and difference. These included validation experiences, therapists' self-disclosure, and therapists' cultural competence.

Validation

Participants mentioned validation as an essential aspect of the therapeutic relationship. This validation allowed them to feel understood. Perceptions of sameness and difference lead to assumptions of how the therapist would understand them; validating their experiences is

essential to a good therapeutic alliance and is predicated on sameness and difference. Validation in the therapeutic relationship encompasses listening, understanding and accepting what the client has to say. It involves acknowledging what the patient is going through and affirming it (Linehan, 1997). It is the process of actively listening to the client, recognising what they say and reflecting on the validity of her feelings around the event or experience (Linehan, 1997).

> Nancy shared her experience of being validated on a shared experience of motherhood, *Ja, I know what this is like. Like exam pressure, and pressure as a mother, and all kinds of stuff. It was very much like, you know, I just felt that feeling when she when she was like: Yo, this is, this is really difficult. This must be difficult for you, and validating my experiences. That was also missing with the first two.*

Nancy mentioned seeing her third therapist, whom she felt she could relate to because of a shared culture and education. In this case, Nancy felt validated when the therapist told her how difficult it must be. This was something lacking in her previous therapy experiences, where she was left to feel misunderstood. Zaib was seeing a white male therapist and felt that even though there were differences between them, the validation she experienced strengthened the therapeutic alliance, the *"validation I get from that therapist where it's somebody that's actually telling me, you know, like, I'm not crazy to think this way. Like, this is completely valid and, you know, um, that just, like, strengthened my foundation."*

All participants mentioned experiences with therapists in which they felt seen, heard, acknowledged and validated. Carmen shared that her white therapist validated her feelings on death, which she appreciated even though she perceived their connection as poor, *"my white therapist was able to validate my feelings on death."* She felt that because death was universal, it was the one area where they had common ground. It stands to reason that regardless of differences between participants and the therapist, validating their experiences positively

affected their therapeutic relationships. It normalised participants' feelings and experiences, removing the self-doubt they might have had about being "crazy". Linehan (1997) wrote, "When validating the individual, one validates everything that is" (p.357). The concept of validation is closely related to Rogers' (1961) notion of unconditional positive regard, in which the client is accepted regardless of who the person is and what the person says or does. This could indicate that through feeling validated, participants experienced the therapeutic relationship as strengthened because they felt accepted regardless of any perceived sameness and difference. Experiencing validation could result in increased levels of feeling understood.

In the therapeutic relationship, unconditional positive regard represents a complete acceptance of the person, including acceptance of any sameness and difference. When there are apparent differences, validating the client's experience through unconditional positive regard may mitigate any shame experienced when having to repeatedly explain oneself and one's context.

> Amina shared how religious differences raised the need for a therapist from a similar context*, so, Islam teaches you, like, you know, have love and respect and everything for your parents. Whereas with her, it was, like, no, but you can draw the line. So I think when, um, when, like, in that context, I think that's when I thought, okay, maybe I should go to someone that reminds me of, like, the Sunnah way, if that makes sense.*

Her explaining her religion to convince the white therapist that she could not follow her advice would have had less of an effect if the therapist had validated her experience of her mother instead of trying to fix it. She also felt that the therapist's assumptions of class and money resulted in her feeling judged,

> Amina explained that when she felt judged, *to her for example one thing that would always happen is I would have to explain to her how with my sister it is basically like I*

felt like I was raising this child, you know. But why isn't there like a nanny? or whatever, but it doesn't like, it doesn't work like that, you know?

She indicated that the therapist was unaware that nannies were not given in her world and struggled to understand that.

Validation could be explicit in words, body language, and actions (Linehan, 1997). Participants picked up on the therapist's body language. Ghayat shared, "*She kind of just stares at me for a while before she answers me. She is hard to read. I think it is awkward."*

Similarly, Nadia highlighted that body language had an impact on her therapeutic relationship, *"body language does play a big, big impact for me because it is like… you know when you… it is almost like when you are in a conversation, you can sort of pick up like the social cues from it."*

Iman expected to be judged when there was sameness related to cultural context and religious beliefs. She said, *"I felt like I'd probably be judged for certain things, uhm because yeah, I felt like if you have the same upbringing obviously there's certain things that you can and can't do and certain things that are like taboo."* In this way, Iman assumed that if she were to see a therapist similar to her, they would not be able to validate her experiences as they might see it as taboo or against the religion. Zara added that her therapist did not need to be from the same religion as her. However, they had to be a person of colour in order to understand her because, in South Africa, people of colour are generally religiously and culturally aware of others, *"even though my therapist isn't a Muslim, she still knows what entails or how it's so like engrained in you from a young age uhm, which I don't think yeah a white therapist would be able to understand to be honest."* Based on their shared women of colour identity, they navigated the religious differences by feeling validated and understood. This echoes Coetzee et al. (2019), who treated a client with visible differences; they noted that engaging in this sameness and difference would strengthen the therapeutic alliance. Similarly, even if there

were visible differences between the therapist and client, participants felt that the therapist's self-disclosure about aspects of sameness they might share resulted in building up the therapeutic relationship.

Therapists' self-disclosure

Participants indicated that therapist self-disclosure as a tool to show sameness or difference strengthened the therapeutic alliance. It gave them a feeling of being able to relate to the therapist and feel understood. Therapist self-disclosure has been a contentious topic even though research has made a case for it strengthening the therapeutic alliance (Audet, 2011). There are various forms of self-disclosure: immediate self-disclosure, which reflects on the client in the present, and non-immediate disclosure, which focuses on personal information about the therapist and their experiences, values and beliefs (Audet, 2010; Knox & Hill, 2003).

> Carmen describes how her therapist showed an element of sameness with her by disclosing her experience, *one of the issues that I was seeing my therapist for was my relationship with my mother. I think that is so cliché because everyone is of their parents. So, um, my… I was seeking advice about my relationship with my mother, and she was able to relate back to her relationship with her mother.*

The therapist could relate to Carmen, the client, by disclosing their relationship with their mother. Practitioners who practice from a critical/feminist theory perspective advocate for disclosure as sharing knowledge reduces the power imbalance between patient and therapist (Brabeck, 2000). Participants shared that disclosure from the therapist helped them to feel understood regardless of whether sameness or difference existed. Despite the differences with their therapists in gender, age, race and culture identified among the participants whose data is presented below, some sense of being understood and connected was achieved through the therapist's self-disclosure.

> Iman captures it well; *I was like, okay, now I know that you know exactly what I'm feeling and exactly what I'm going through because, of course, you can sympathise with someone, and you can do your best to understand, but if you haven't experienced it yourself, it's a little bit different.*

Here, Iman shows a greater confidence in her therapist's capacity to understand her feelings as a direct result of her therapist sharing something personal about herself. For Zara, the opportunity to talk about "other stuff" has made her feel closer to her therapist, "*I know this might sound weird but I feel like she's one of my friends, like we just get along so well. Sometimes like we don't even end up speaking about work, we just like talk about other stuff."* Participants noticed differences between them and their therapists and felt that disclosing their own experiences or personal information assisted in reducing those differences by strengthening the therapeutic relationship. The participant shared that after the therapist's disclosure, she was more comfortable sharing because it provided a sense of normality to what she experienced and how she experienced it. Another participant expressed how their relationship felt more like friends as they shared information. However, all participants knew this professional relationship's various boundaries and expectations. Most participants who spoke about disclosure brought up the issue of boundaries and indicated they were aware of it and that the therapeutic relationship is professional. The client-therapist boundary framework exists to maintain acceptable behaviours and roles in therapy (Audet, 2011; Bordin, 1979). Boundaries can guide the client's expectations. All participants expressed some ideas about professionalism, disclosure and boundaries. Zara relayed, *"I think I suppose that's also the other good thing is that we kind of understand where the boundary is, and we respect it."* Participants knew that the therapist was not a friend or a family member, that there were specific rules of engagement, and that there were explicit boundaries. Therapist self-disclosure

is a form of a blurred boundary because whether a disclosure is therapeutic or not depends on various factors such as timing, relevance, depth of the disclosure and a particular client's needs.

Carmen shared that the disclosure made the relationship stronger by allowing her to relate to the therapist, but she would prefer it if the therapist kept "personal stuff" private*, "I do not like to know personal stuff of the person that I am seeing. She shared stuff with me that has just been relevant to what I was going through, and that has been very helpful for me."* Carmen is ambivalent about therapist disclosure; she needs the disclosure to be relevant to the therapeutic space. This is consistent with previous literature on disclosure, which found that patients were more comfortable with a therapist's disclosure if it was relevant (Audet, 2010). A therapist should consider the context of the patient and their own skill level before disclosing (Myers & Hayes, 2006).

Additionally, Myers and Hayes (2006) found that clients were left feeling powerless if the disclosure was not negotiated well with the client. In this way, disclosure can impact the power imbalance in the therapeutic relationship. However, the therapeutic relationship is predicated on the client disclosing everything to the therapist and the therapist providing minimal personal information. Therefore, therapist disclosure might balance the scales between therapist and client. Disclosure by the therapist addresses the power imbalance by "demystifying the person of the therapist and allowing the client to experience therapy as an interchange between two humans" (Brown & Walker, 2013, p. 146). It empowers the client by alluding to a collaboration between therapist and patient.

Therapist disclosure, when done correctly, could provide the client insight into whether the therapist can relate to them regardless of any sameness or difference, as Zara notes, "*and she said she's got Muslim family as well so I think that also kind of gave her a lot of insight into how we are and how we're brought up and how we think."* The therapist disclosing that she has family who share religious beliefs with Zara meant that the therapist was able to

understand Zara's context, which in turn strengthened the therapeutic relationship. Similarly, Iman's therapist revealed a similar experience of difference in beliefs with his parents, helping her to feel more connected to him, *"he was like kind of related on that as well, so he said sometimes he also has, you know, certain liberal beliefs that maybe his parents don't approve of."*

Most participants indicated that they initially lost faith in therapy and psychology as a profession. The two quotes above are an indication of the need for the client to feel understood by the therapist in relation to various social factors that indicate the difference. Participants emphasise therapists' self-disclosure to increase the feeling of being understood by sharing relevant information. Therapist self-disclosure is a way to close the gap on aspects of sameness and difference, reducing the feeling of alienation. Further, if there is a sign of the therapist being culturally competent, it is also possible to reduce the impact of differences.

Therapists' cultural competence

Participants assumed therapists in South Africa would be culturally competent to understand the diverse population. Cultural competence aims to make health care more accessible and effective for individuals from diverse backgrounds (Kirmayer, 2012). It refers to the training or understanding of therapists on the various cultures existing in their context and being able to tailor health care delivery to fit patients' cultural, linguistic and social needs (Betancourt et al., 2003). Various participants were frustrated at not being understood and having to explain their cultural context during each session. Possessing or not possessing cultural competence came up often for participants in how the therapeutic alliance was experienced.

> Nancy shared that there was no room for difference in the therapeutic approach because it appeared that the therapist was working from a script, *that was … was difficult. Um, especially in talking about roles between a husband and a wife. And then you have*

different … in the context of South Africa and in Cape Town certainly, like everybody's going to have different kind of roles, or ways of doing things, depending on their different cultural, um, you know, upbringing or socialisation.

Nancy expressed frustration at not being understood culturally and having ideas that were against her values imposed on her. She also mentioned that considering our country, one would assume therapists would be culturally competent. This indicates an assumption of what could be understood based on the participants' perceptions of sameness and difference. Sameness implies that there is an expectation of being culturally understood without needing to educate the therapist.

South African psychologists face unique difficulties in providing services to the diverse post-Apartheid country (Johnston, 2019). Health disparities exist, and multicultural work is held back by social tensions even though culture in South Africa is central to working, practising or training in the country (Eagle, 2005; Johnston, 2019). Various studies propose that therapists should actively reflect on their roles in a diverse context and what it means to engage with sameness and difference in the therapeutic process (Ngcobo & Edwards, 2008; Watts-Jones, 2010). Actively reflecting on diversity helps create a safe space where the clients feel comfortable and understood by the therapist. Kauthar discussed her expectation of going to a therapist of the same culture, *"I would definitely go for someone of colour because I believed that they would understand some of the cultural norms and some of the cultural crimes that people like myself come from."* Here, Kauthar, who previously had white middle-class women psychologists, indicates that a person of colour would better understand her culture and, by default, her life experiences, strengthening the therapeutic alliance.

Participants noted feeling ashamed of having to justify and explain their cultural or religious beliefs that indirectly affect their lives. Fadwa described how she felt, "*Ashamed. Literally ashamed, like I there's … I needed to over-explain and try and like vouch for the*

importance as to why, why I'm okay with it." In this instance, it seems clear that the therapist's lack of cultural competence left the participant feeling profound shame and an urgent need to justify her beliefs in ways that likely left her unable to explore her ambivalence and complex feelings.

> Similarly, Kauthar proposed that her reason for not feeling understood in therapy is related to the differences in cultural norms. [3]Kauthar described, *I think, with the lady in Cape Town, she didn't have a cultural understanding of Indians don't believe that you need to go for psychology. Indians believe that if someone dies, you just need to pick yourself up. Women are grown to be strong and pick themselves up. I don't think she came from that background.*

This is consistent with the literature which proposed that cultural competence is about consistently recognising and respecting the multiple identities of individuals (Kirmayer, 2012). In this case, the participant not only identifies by her race as Indian but also by being a woman. There is an awareness that these two identities intersect to produce her lived experience. Kauthar discussed how she perceived the impact of her disability status on how she was understood, "*maybe I just need to find a psychologist who can actually understand a person with a disability better and ritualising that kind of behavioural perception more because I don't know*." Her multiple identities of being a woman, being Indian and having a disability shaped her therapeutic encounters and caused frustration at being misunderstood.

The lack of cultural competence affected the participants' therapeutic relationships, making them feel frustrated, misunderstood, and shameful. Anderson et al. (2019) found that if the patients perceive the therapist to have low multicultural competence, it increases the risk of early termination because the therapeutic alliance is weak. Therefore, it becomes crucial to

[3]Culture is a complex issue and challenging to unpack in South Africa. Culture and race are sometimes used synonymously, but culture is also seen as more than someone's race.

understand and locate the individual through their various networks and communities to understand power, otherness, and identity. This understanding would reduce power dynamics in the therapeutic relationship concerning sameness and difference because patients want to be understood. However, the differences patients observe may be immediately noticeable and a barrier to an open, trusting therapeutic relationship. Amy mentions how her therapeutic process was hindered by race, "*with that, um, I must just say sometimes I use their whiteness as an excuse not to open up to them."* While Nancy was frustrated at needing to explain, the context and culture of her lived experiences in a country as diverse as South Africa. She was acutely aware that educating her therapist was not her job and was not the reason she was in therapy*, "It took so long for me to explain to her what Coloured is, and that also was not what I thought the place … it was not the place."*

Various therapist characteristics could mediate the effect of differences not understood in therapy. Nadia expressed various struggles around her therapist's age, religion, and race in the therapeutic space. However, she felt like they had a solid therapeutic relationship and could resolve it, "*I definitely appreciated my therapist as a person. Um, she was someone that was very confident, um, just in her therapist self, and in that way, I think I felt more comfortable to bring myself, bring my struggles*." In the quote, she refers to feeling comfortable enough to bring those struggles into the therapeutic space because the therapist was secure in herself. Due to the therapist's competence and acknowledgement of her ignorance, they could find space to work through it. Watts-Jones (2010) explained that even if the clinician is unaware of the culture, it is essential for them to acknowledge their ignorance about it. It is evident from the participants that they would have appreciated the effort from therapists to be culturally competent. However, it is clear why practitioners might avoid this topic in the therapeutic space. It is not always easy to engage with these sameness and difference issues in depth

because there is the chance that it could rupture the therapeutic relationship beyond repair (Watts-Jones, 2010).

There is an unspoken assumption that sharing aspects of sameness with the therapist would result in being understood. However, this was only sometimes the case because participants felt better understood going to a therapist of a different race or culture as they felt this would reduce judgements for not behaving within their cultural or religious norms. Further, participants have indicated that even if the religion is shared, they still struggle to be understood since they followed a more "liberal" version. Feeling understood in therapy forms the basis for the relationship, and many factors could impact it, affecting the security of the relationship or causing ruptures. Feeling validated, having the therapist disclose similarities and having the therapist show cultural competence all shape the experiences of the therapeutic relationship. During their interviews, there was a hint of surprise from participants. This reflects the expectation that they had to be misunderstood based on the visible differences. The impact of differences in the therapeutic relationship could be mitigated by the therapist being culturally competent, acknowledging ignorance or providing a space to discuss it openly. This would ensure that their patients feel understood regardless of sameness and difference.

Client Agency in Therapy

A central theme that emerged from the data was client-agency in the therapeutic space. It relates to the participants' sense of control during the therapeutic process. Client agency in therapy is a prominent theme and consists of the following subthemes: setting the frame, socioeconomic status, and freedom to choose, and collaborative engagement. Agency refers to an individual's autonomy, which strives towards self-assertion and the ability to influence the course of their own life (Huber et al., 2021). Clients are active agents of change in their process and perceive a sense of control in the therapeutic space. It is a subjective experience of an individual's capacity to act autonomously. Huber et al. (2019) found that a higher agency

resulted in a more potent therapeutic alliance. A solid therapeutic alliance is associated with more beneficial therapeutic outcomes (Flückiger et al., 2018). The agency is viewed as a mechanism for change by using therapy to make changes in their daily life (Huber et al., 2019). Participants described the agency as the reason they believed they had a good relationship with their therapist. Furthermore, participants who were provided with clear guidelines on the relationship and what to expect during the therapeutic process felt as if the therapeutic process was being demystified and they had the agency to make therapeutic decisions.

Possessing the agency to choose a psychologist emerged as a sub-theme. Socioeconomic status dictated their ability to choose a professional or the length of their therapy; participants entered the therapeutic space feeling unsure or nervous about the person chosen for them. Collaborative engagement is the final sub-theme; participants who felt part of the process and were provided concrete tools to practice when leaving therapy were likelier to indicate that they had a good relationship with the therapist. Zaib noted that she felt the therapeutic relationship was intense, "*I felt the reason why it worked so well is because she allowed me to establish what our relationship is. And, allowed me to establish the rules of engagement, basically."* Zaib was given the agency to establish the rules of engagement in the therapeutic space, and this provided her with a sense of control over the process.

> Nancy discussed how it felt to leave a therapy session with a plan or a goal in mind, *this is all you're going to have to do. And then I walked out there feeling like: Okay, I got this. It was a plan for me, of what I would do when I leave there. And it was very practical. And I think she picked that up from me, that was needed.*

Participants who had a sense of agency felt optimistic about the therapeutic process. Nancy explained that having a plan for what she would do after therapy gave her a sense of agency and empowered her. Agency in the therapeutic space refers to the perception that the

patient has control over their therapeutic process and self-awareness of their ability and feelings (von Below, 2020).

It plays a role in the strength of the therapeutic relationship; as provided by Nadia, *she is much older, which I think creates another dynamic you know, culturally what does that mean for respect and arguing. So that was good for my growth also, which I think where her defensiveness is useful because had she just given me the space, um, you know, it would have been easy. But because I had to then actually bring my agency a bit more, it was therapeutic.*

Nadia describes the growth that she had to bring her agency to therapy to engage with her therapist adequately. She mentions the age of the therapist and the difficulties she encountered in challenging the therapist because cultural respect for elders is essential. She described having to bring more agency to therapy to counteract those challenges. Though her therapist was different culturally, racially, and age-wise, she provided the space for Nadia to challenge her and the therapeutic process; this, in turn, strengthened their therapeutic alliance into one which she described as being excellent. However, participants also indicated that knowing what to expect during the initial contact with the therapist set the tone of the therapeutic relationship regardless of any perceived sameness and difference.

Setting the frame

Setting the frame is an essential step in navigating the therapeutic relationship. Most participants indicated that information about the therapeutic approach, how the sessions would work, the cost, and the rules of engagement gave them a sense of agency and trust in the therapist.

Carmen stated, *she set out from the start, um, you know, she feels that this is what we will be working to, this is how long it will take. It is not something where I just go from day to day, and we have no end in sight.*

Carmen valued the expectations and goals set from the outset; this reduced the uncertainty around the therapeutic process for her. Studies have shown two essential phases in the therapeutic alliance: the initial contact phase (Ardito & Rabellino, 2011). The initial contact phase consists of three to five sessions in which collaboration is fostered, goals are agreed on and confidence in the therapeutic approach and therapist's ability. Participants who felt a therapeutic relationship worked for them regardless of any differences noted that at the beginning, a contract was signed, and expectations were clear; Ghayat mentions the document she signed, "*which spoke about the process and confidentiality, like the circumstances in which she would tell someone about like suicide."* In this instance, the setting of the frame provided Ghayat with all the information she needed to address the uncertainty she felt with her previous therapist.

> Zara described feeling comforted after the process was explained to her in a way that provided her with the agency, *I know that I'm just going to feel so much better, and I think that was that was nice, that she wasn't trying to like babysit me or baby me, she was like, this is what's going to happen, this is how you're going to feel, this is how it's going to be uhm but she'll be fine afterwards.*

Most participants felt that having a process around setting the frame made them feel less vulnerable in the space. It reduced anxiety and uncertainty by giving them a clear goal and strategy and knowing that therapy indicated that therapy would not be forever made it easier for them to engage in the therapeutic process. This was not the case for all participants; Kauthar felt that the increased structure in therapy pressured her to reach goals in a specific period. She felt the framework used was not tailored to her and did not consider the difference in culture, religion and disability between her and her therapist. To an extent, she began to feel suffocated and overpowered by the therapist to follow the scheduled framework.

Similarly, Fadwa expressed that each time she had to see a new therapist, the first session made her feel ashamed because she had to explain her religious and cultural context, *I felt ashamed of telling my story in the first session. It's just coming from a place of like just shamefulness because I was … And I, and I, I don't know like, and the more I would like go into like detail with my story with this person, the more I felt judged in a way.*

Fadwa indicated that with her first two therapists, there was a lack of setting the frame, and instead, she found that she needed to tell her entire story each time, which made her feel ashamed. She assigned feeling this way to cultural and religious differences. Zara mentioned that at first glance of her therapist, she was shocked because it was not the therapist she contacted; instead, it was another therapist who worked in the practice.

She was unprepared and immediately considered visible sameness and difference, *and it's not that I was like oh, is she not going to understand me, I was just like she's young, like I don't know where's this going but then like literally by the second session, I was like ah, I'm so glad I found her.*

The therapist, by using empathy, understanding, detailing expectations and the therapy process in the initial contact phase, was able to eliminate the concern around her age. When speaking about the same therapist she was initially wary of, Zara said, "*Uhm so like my therapist was amazing. I think she had just finished her doctorate."*

Setting the frame could be an essential aspect of the therapeutic alliance in standard factor theory. Unsurprisingly, two of the three requirements for a strong therapeutic alliance emphasise discussing the goals of therapy and an agreement about the tasks and expectations in therapy (Bordin, 1979; Wampold, 2015). In order to agree on the tasks and expectations in therapy, it is necessary to set the frame at the start of the therapy process. Therefore, it supports the findings of this study as participants indicated in various ways that those three factors were

enough to reduce any differences, they felt might have impacted the process negatively. Kauthar expressed needing someone to collaborate with to set goals*, "and I'm going to tell them, Let's work on a goal-setting plan together. Work with me and hold my hand."* Furthermore, it allowed them to feel a sense of agency over their therapeutic process, which likely reduced some of the power imbalance felt by the sameness and difference.

Socioeconomic status and the freedom to choose

Participants mentioned the barrier of socioeconomic status to access good mental healthcare. All participants mentioned the cost of therapy in various ways, either related to the number of sessions, their freedom to choose a therapist or needing to consult multiple therapists to find one with whom they could connect. The freedom to choose a therapist was removed, and when they did complain or asked for a more understanding therapist, they were refused this option. This severely impacts their sense of agency in the therapeutic process because the relationship is built on a false foundation. Kauthar noted, "*And I don't think that you have to go run and walk with so many different psychologists to find the right one. It's not cheap ... It's not cheap at all."* Kauthar expresses frustration at having to find the right psychologist because of the cost associated with it. This makes it nearly impossible for her to try out various practitioners to find the perfect match. Not being able to choose a psychologist to fit her needs severely impacts her agency in the therapeutic relationship. Various authors have indicated the importance of therapists disclosing their values and social position to reduce the power imbalance in the relationship by offering a choice to choose a different therapist (Watts-Jones, 2010; Ziemba, 2001).

However, as is the case with Kauthar, this is not always possible as the patients' social status would dictate their access to medical aids, wellness programs, government facilities or NGOs. Fadwa noted that when she had a poor connection with the therapist, she terminated the sessions early because the cost was too high, *"I think I did like four sessions, every, say every*

week I went for a session. And then I stopped going because this was like, this is a waste of money." Participants either terminated therapy early because the cost outweighed the benefit of therapy, or participants maximised the sessions allocated to them through organisations or medical aid by spreading those sessions out over a period.

> Zaib expressed having to maximise the sessions provided, *you know, you get your six sessions and then you have to move on, so. Um, cos some of my other friends that went to therapy, we were, like, okay, we get six sessions a year let's make the most of it. You can go for three now when you're feeling super stressed, and then maybe another one, and so on, and so on. So, you try to maximise the services you're getting*.

A wellness program at the university provided Zaib's sessions, so she could not choose her therapist or the number of sessions. This influenced the therapeutic relationship because although she had a poor connection with the therapist, her agency to choose a new one had been removed.

The dynamic of having a therapist allocated through a wellness plan could make patients feel judged or ashamed, especially when they assume the class of the therapist. Fadwa spoke about how the class assumption affected her therapeutic space, "*just like where she came from. Like you could see that she's old money, and I think that also played into me just feeling inferior."* The class issue creates a power imbalance from the outset in which participants were likely to feel they needed to prove why they were there or could pay. The belief is that engaging in these issues would assist in equalising the relationship and providing patients with a choice on whether to find another therapist (Watts-Jones, 2010). However, as indicated by the participants of this study, it is a challenging thing to do; they were constrained by finances, which in turn removed the option of choice. In contrast, two participants mentioned having the agency to choose someone whom they shared visible differences with,

Nadia mentioned, *I also very intentionally did not want sameness in that I did not want an Indian therapist, and I did not want a Muslim therapist, which is again challenging to sit with because that is kind of the bias that I am hoping to break at the profession with my patients.*

Nadia specifically chose someone different to her, and her therapist was carefully chosen based on specific characteristics; because Nadia had this agency, she could develop a strong therapeutic alliance with her therapist.

Amina also specifically chose a white female therapist because she felt she would be talking to an objective party, *so I never wanted this person to, like, be in my social circle, be... So, I chose literally a white lady that was not Muslim. So I did on purpose (laughs) um, and I liked it because I felt like, um, it was nice too, like, that initial, like, therapy... It was nice to speak to somebody that doesn't know anything. So firstly I think that one thing that I... I feel like I would have to take a lot of... In the beginning, a lot of time explaining to her context. For example, she was a white lady so, um, me being, like, coming from a completely different, like, what you call, like social class even.*

Even though she had to explain the context and noticed the difference in social class, it failed to affect the therapeutic alliance; this could indicate her ability to make that choice for herself.

Nadia shared that she intentionally chose a therapist different to her regarding race, culture, and religion because she felt safer sharing with a person not in her community or who looked like her. Similarly, Amina noticed the difference in class and race, but having to continuously explain context was better than feeling judged by people in her community. Therefore, individuals' motivations for seeing a specific therapist based on sameness and difference vary. However, not addressing specific issues in the therapeutic space, such as class, race, religion, and culture, could weaken the therapeutic bond regardless of the patient's

reasons. Many participants mentioned socioeconomic status and the freedom to choose a therapist. This influenced their sense of agency in the therapeutic space, especially around whether they could complain or find redress. Another factor that shapes the therapeutic alliance is the agency to choose their own therapist or feel in charge of their therapeutic process through collaborative engagement.

Collaborative engagement

Participants felt that collaboration and engagement provided them with agency over their therapeutic process; this, in turn, shaped the therapeutic alliance and strengthened the therapeutic relationship. Collaboration is imperative for a beneficial therapeutic outcome (Ryan et al., 2021). Researchers found that participants were more likely to engage in the therapeutic process if they perceived high agency (Huber et al., 2019). Levitt et al. (2016) conducted a review that found a link between warm, engaging, and caring therapists and an individual who recognises their agency to change. They found that change took place through deep engagement, developing self-awareness, a collaborative effort to discuss differences and recognition of the client's agency. Kauthar said, "*She was very interactive. I felt a little bit empowered with her. She was much older. I did feel very empowered with her. Um, I did lots of exercises. Lots of mind-power games with her."* She felt engaged and collaborated, which made her feel empowered by the therapist regardless of their similarities and differences.

Von Below (2020) found that when patients were unhappy with therapy, they were reluctant to criticise because they felt the therapist was disengaged. Ghayat states, "*I think I liked her because she could see when I was trying to talk something away."* The therapist must be aware of the therapeutic alliance and its fluidity to ensure they adequately engage and respond to patients. Nadia found that she was able to challenge or criticise her therapist because the therapist had provided her with the agency to do it, *"it was also at a point where I think she knew that I could say it back and I did in that moment that, no, actually this is where I*

would like to work, or things in that way." One main contributing factor to the therapeutic alliance is the collaboration between therapist and client to ensure both are invested in the therapeutic process (Horvath & Luborsky, 1993). Participants found that engaging with the therapist collaboratively resulted in them gaining personal insight into their growth.

> Zara indicated, *I think the way she helped me, uhm, and I felt like she was kind of on my side if that makes sense, but like she was hearing my side of the story, and she was interested to know who I am and what I feel about the world or my family or just everything.*

Zara found therapy helpful because it felt like the therapist was fully engaged and actively listening to her with interest, thereby reducing their differences. Carmen shared, "*she has helped me see certain relationships that I have had, you know. Um, so definitely she has helped me like pinpoint certain stuff that I would not have been able to pick up on my, on my own."* Carmen felt that the insight from having an engaged therapist strengthened the therapeutic alliance.

> Zaib spoke about her uncertainty in therapy and how collaborating with the therapist on her needs, *how do I know if what I'm making sense is actually, you know, not me being biased towards everybody? Or, am I being fair? So, that is kind of where my current therapist is able to help me untangle those strings a little bit. And help me make sense of it a bit more. And, you know, where are my strengths? Where are my weaknesses? Um, so she can match that energy for me. Instead of, like I said, me matching her energy or her expectations.*

The therapist's ability to engage in the relationship helped her make sense of her experiences and normalise it. All the participants found engagement and collaboration helpful in their growth journey and strengthened their therapeutic relationship regardless of sameness

and difference. Participants expressed the acquisition of tools received through engagement with their therapists.

Ghayat described how a good therapeutic relationship developed through engagement, *you know it was almost like you walked into a classroom, now we are going to learn things. It was not like I am just going to sit there and like I am going to talk the whole time and you are going to stare at me.*

Kauthar explained that even though she did not act on the advice, it taught her how to react, *I think the coping strategy actually helped me to assess and react to my relationships, whether they were work or personal. It will help me to see how I react towards them, and it helped me, but I didn't confront them.*

Collaboration on goals and task setting has been highlighted as critical to maintaining the therapeutic bond and, consequently, the therapeutic alliance (Bordin, 1979; Kozart, 2002). This is evident in the various responses received from participants that allude to tools, tasks, and goals.

As Zaib shared how therapy is beneficial even if you are not in distress because of the tools, *I think even that just made me see therapy as it's not something you have to do if you are, you know, mentally distressed, or if you're at that breaking point. It can also just be a useful guidance and a tool.*

Discussing and agreeing on goals and having tools provided enhanced the therapeutic process for Zaib, building a solid therapeutic relationship. Participants described having therapy homework or tasks to complete outside of therapy as having empowered them to put specific experiences into perspective. Sprenkle and Bow (2007) found that the patient must perceive the tasks as credible for those tasks to strengthen the therapeutic alliance.

Kauthar explained the homework she received from one of the therapists, whom she emphasised as helping her*, She would give me exercises. She would tell me to do things.*

She would talk me through it. She asked me to get my diary, which I did. She asked me to start documenting. She asked me to assist my relationship. She used to tell me to talk in front of the mirror. She gave me a long list of things to do. She gave me exercises to do, and there was a lot of things that I did.

However, in explaining her experiences with another therapist, she mentioned being engaged. However, the therapist could not listen to her, *"I even have notes that I've written about it. Like how would I go open up these conversations during the course of my treatment with her."* This indicates vastly different perceptions about her therapy processes based on feeling engaged with the therapist and like she had agency. This agency and engagement resulted in a strong therapeutic alliance, minimising the visible differences.

CHAPTER 5: CONCLUSION

This study sought to explore the relationship between a therapist and client by considering the aspects of sameness and difference and how they shaped the therapeutic alliance. Various factors could impact the foundation of psychotherapy. The therapeutic alliance is a significant contributing factor to beneficial therapeutic outcomes. These sameness and differences could refer to gender, sexuality, age, socioeconomic status, education level, race, ethnicity, religion and culture. Since the discipline of psychology in South Africa remains overrepresented by white women, and all 11 participants were women of colour, the likelihood that sameness and difference were encountered in participants' therapeutic experiences was heightened. This study used intersectionality as a theoretical framework, and reflexive thematic analysis allowed for an exploration of the nuances in sameness and difference depending on an individual's subjective experience. Participants' multiple identities like race, religion, culture and social class were particularly salient in this study and intersected to provide unique experiences of the therapeutic relationship. All participants had varying experiences of sameness and difference in the therapeutic space, but the way in which it shaped the therapeutic alliance varied. Some participants sought out experiences of difference, while others had no choice in the matter. The reason participants chose or would choose specific therapists depends on their own lived experiences shaped by their intersecting identities. For example, a participant who previously felt judged by the community was more likely to consider choosing a therapist who is an outsider. This might result from the patient prioritising anonymity and confidentiality in their relationship. On the other hand, participants who sought sameness suggest that they prioritised connection or understanding.

This study found that many participants struggled to find a therapist they felt they connected with, someone they felt understood by, and who they understood. They assumed that not being understood was because the therapist was because of the sameness and difference

in the therapeutic space. Participants had various reasons for choosing therapists based on similar or dissimilar characteristics, including affordability, medical aid provision, access to wellness programmes, recommendations, or therapists who were not part of the community or knew their family. Differences and the feeling of repeatedly explaining their context and culture were why many participants terminated therapy prematurely. However, those who found therapists with whom they shared culture, religion or race were generally satisfied and noted having a good therapeutic relationship.

Not feeling understood may, in part, be an indication of some participants walking into a therapeutic space, noting the differences, and based on assumptions, unconsciously determining that they would not be understood. Initial indicators and signs such as the psychologist's name, practice location, skin colour, language and education could lead to assumptions before therapy has even begun; this might impact the therapeutic alliance. These assumptions differed between participants. This is clearly seen when participants expressed their need to choose a therapist they thought of as different to them. In contrast, participants who chose therapists similar to them did so on the assumption that they would be validated when discussing conflicting feelings about their religious or cultural beliefs. However, some participants noted that they would still see a therapist of a similar race even if the religious values were not shared because, in South Africa, people of colour are generally aware of others' cultural and religious practices.

The findings suggest that clients' experience of validation, some forms of therapist self-disclosure, and therapists' cultural competence impacted the degree to which participants felt understood, regardless of their differences. For example, having a therapist admit to being ignorant about the client's culture could reduce the isolation from the differences because of the power rebalances. It could result from the admission of ignorance, reducing the feeling of shame or frustration attached to explaining personal aspects of culture and religion.

Those participants who felt they had agency in the therapy process, by either choosing the therapist, the homework activities or the method of therapy or by perceiving it as a collaborative process, experienced a more favourable therapeutic alliance. Differences were minimised when participants felt validated; this validation was perceived as evidence of the therapist understanding the client. Therapists' appropriate self-disclosure to highlight shared similarities and experiences also enhanced the therapeutic relationship for some participants, making them feel more able to relate to the therapist, trust them and feel understood. Sharing this knowledge appeared to tip the power imbalance to one that was experienced as more equal. While differences were consistently viewed as unfavourable to the therapeutic relationship, it emerged from the data that sameness could be disadvantageous, especially if the therapist was part of the community or shared a religion with their therapist. Regardless of whether sameness or difference caused the therapeutic relationship to weaken, if the therapist acknowledged or engaged with differences, there was potential to establish a good relationship.

Having agency in the therapeutic process resulted in feeling a strong therapeutic alliance because the client felt that the process was collaborative, lowering the power imbalance in the therapeutic space. It meant that the clients could experience a sense of control over the therapeutic process. The results suggest that a heightened sense of agency was related to positive therapeutic outcomes and contributed to a strong therapeutic alliance. Therefore, it stands to reason that when participants felt more in control, they felt less uncertain about the assumptions they formed linked to the therapist's differences. Participants experienced greater agency through therapists' setting the frame, participants' freedom to choose a therapist and collaborative engagement. These strengthened the therapeutic alliance by reducing the alienation felt by differences. Participants especially felt the therapeutic relationship was good if they were provided with tools or homework. A sense of contributing to their development allowed them to be active participants instead of passive recipients in their therapeutic process.

This indicated that the therapist was engaged in the process and willing to collaborate on an equal footing. Thus reducing the power imbalance resulting from the therapist having more knowledge than the client. Client agency also appeared affected by socioeconomic status and the freedom to choose a therapist that matched them. Participants expressed frustration at being allocated a therapist who was visibly different to them in race, culture or class. They seemed to have little regard for the patient's needs and, in some cases, imposed their personal value system onto the patient. From this, we can understand that removing their freedom to choose shaped the alliance as one that began with the expectation of being misunderstood.

Transparency and communication about setting the therapeutic frame and providing tools and homework activities suggested to participants that regardless of their core differences, the therapist was willing to listen, learn and work with them. Setting the frame emerged as a subtheme in which participants spoke about their ability to be in control from the beginning of the therapeutic encounter. It reduced the uncertainty they felt about being in therapy indefinitely. An excellent initial contact session determined whether the therapeutic relationship strengthened as time went on regardless of the race, culture, ethnicity, gender or social class of the therapist. If patients had the agency to choose, they would all have different motivations for choosing a therapist. These motivations would depend on the intersection of their multiple identities and life experiences. While race and culture played a significant role as a difference, there was no indication that all participants wanted to be matched to someone similar, as this would depend on their various needs. Therefore, a client's agency to choose a therapist does not necessarily mean they would avoid differences.

Identifying sameness and differences could result in the patient raising unrealistic expectations based on faulty assumptions. Patients appeared surprised when the therapist understood, validated, and engaged them when the assumption was present that a person of a different race or class would not be able to relate to their experiences. In this sense, experiences

of sameness and difference shape the therapeutic alliance through its mechanisms of power felt inside and outside the room. Therapists who engaged with the sameness and difference in the therapeutic process helped clients feel heard, consequently improving the therapeutic relationship. Participants who did not have positive experiences still expressed their belief in the therapeutic process and their desire to find a psychologist similar to them.

Sameness and difference play a palpable role in influencing the therapeutic relationship, especially in South Africa, where race is the first thing unconsciously noticed. Given South Africa's history, it is safe to assume that race is always consciously or unconsciously present in South Africans' minds. It extends to healthcare practitioners' relationships with their patients and the patients themselves. It stands to reason that if a woman of colour client entered the therapeutic space, race would be identified immediately as a factor of sameness and difference. Therefore, psychologists are not exempt from race playing a role in the therapeutic space; this is especially salient when considering that beneficial outcomes primarily depend on the relationship's success. In psychotherapy, the therapeutic relationship is the foundation of the therapeutic process because it leads to beneficial therapeutic outcomes. This sameness and difference come with biases, leading the client to hold certain expectations of being misunderstood or understood by the therapist.

Limitations of the Study

Understanding sameness and difference depends on the context and the participant's lived experience. All the participants had varying experiences of sameness and difference that shaped the therapeutic alliance. However, one cannot deny that sameness and difference are vital in shaping the therapeutic alliance.

Given the recruitment strategy of participants, it was likely that more participants would reside in urban than rural areas and people of middle-class socioeconomic status. This limitation became true during the data collection process. There might have been an issue with

using "woman of colour" since multiple requests asked if they met the criteria. This could be a result of the racial classification system of South Africa in which "coloured" is a specific race. A further limitation of the study was that while it proposes to address women of colour, it was conducted in English, excluding a large portion of the population. These issues should be addressed from an intersectional viewpoint, and various methods for reaching other sections of the population during times of no contact, like in the COVID-19 pandemic, should be explored.

Recommendations

Sameness and difference are essential aspects of identity that must be accounted for in the therapeutic space. Power imbalances often relate to these identity markers, and therapists must be trained to address them. Many therapists might feel uncomfortable exploring identity in therapy, but it is essential to acknowledge sameness and difference in a non-offensive way. Additionally, therapists should be open to their ignorance of culture and its practices. By acknowledging these things, therapists can create a safe space for learning and growth.

As a therapist, it is essential to be comfortable discussing racial, ethnic and cultural differences. The research has shown that if the therapist is compassionate and empathetic, these differences will play less of a role in therapy. Intersectionality allows practitioners to create space for conversations about power, oppression, and privilege. Addressing particular power dynamics in therapy would lay the foundation for addressing discrimination or microaggressions in therapy. There are multiple axes of oppression which shape our experiences. Validation of the patient's identity and experiences of oppression would strengthen the therapeutic alliance. Being intersectional in our approach can create a safe and inclusive space for all patients.

The therapeutic alliance is shaped by sameness and difference and various factors in therapy. This is a complex topic in which greater exploration is needed in the South African context. Therefore, a recommendation is to explore these experiences further by collecting data

in spaces with other South African populations of colour. Specifically, Black South Africans might not have responded to the term women of colour. Future research should focus on differences related to culture, gender or age, as the sample for this study was homogenous in this regard. It might be necessary to explore how to understand patients' needs and what they want to prioritise in the therapeutic relationship. Consequently, these findings highlight the gap in the literature to develop a valid and reliable instrument to assist public and private clients in referring to a therapist who could match their expectations, preferences and priorities. Also, given the increasing use of task-sharing approaches to therapy and mental health in public health settings, exploring the effects of sameness and differences between interventionists and clients seems warranted.

Significance of the Study

Research on common factors that bring about change through the therapeutic process is vital as it leads to knowledge that can be used in a public health context. Cuijper et al. (2019) note that in low and middle-income countries, therapy uptake is low, and this might be because there is a lack of understanding of what is sufficiently acceptable to clients. Most of the research on the therapeutic alliance is from the perspective of the expert therapist; this study adds to the growing body of literature on the client's perception of the therapeutic alliance. This study allows insight into how clients perceive their intersectional sameness and difference in the therapeutic alliance, allowing for contextual understanding rooted in the uniquely South African landscape. Further to this, it could assist in informing training for those in professional psychology training programs. Global and local health care disparities are a disadvantage to women of colour, who are more likely to receive subpar care and experience discrimination. In this regard, the study explored women of colour's experiences of sameness and difference and how it influenced the therapeutic alliance. A strong therapeutic alliance indicates beneficial outcomes that promote mental health and align with the third SDG and South Africa’s Mental

Health Act. This is the first study in South Africa that highlights the voices of women of colour who have been previously marginalised in a system of oppression. It highlights the importance of considering sameness and difference, historical context, and individual subjective experiences because it unintentionally or intentionally carries bias and expectation into the therapeutic space. Psychologists engaging with sameness and difference are likelier to have a strong therapeutic alliance. Therefore, all psychologists and counsellors in South Africa should attend cultural competence training. This study paves the way for future research to understand the intersection of identities in a country as diverse as South Africa and its impact on the therapeutic relationship; this could inform policy and raise awareness.

REFERENCES

Ahmed, R., & Pillay, A. L. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology, 34*(4), 630-656.

Altman, N. (2000). Black and White Thinking: A Psychoanalyst Reconsiders Race. *Psychoanalytic Dialogues*, *10*(4), 589-605. https://doi.org/10.1080/10481881009348569

Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Khan, K. B., Kirkham, S. R., Lynam, J., Semeniuk, P., & Smye, V. (2003). "Rewriting" Cultural Safety Within the Postcolonial and Postnational Feminist Project: Toward New Epistemologies of Healing. *Advances in Nursing Science*, *26*(3), 196-214. https://doi.org/10.1097/00012272-200307000-00005

Anderson, K. N., Bautista, C. L., & Hope, D. A. (2019). Therapeutic Alliance, Cultural Competence and Minority Status in Premature Termination of Psychotherapy. *American Journal of Orthopsychiatry*, *89*(1), 104-114. https://doi.org/10.1037/ort0000342

Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology*, *2*, 270-270. https://doi.org/10.3389/fpsyg.2011.00270

Arora, S., Gonzalez, K. A., Abreu, R. L., & Gloster, C. (2022). "Therapy can be restorative, but can also be really harmful": Therapy experiences of QTBIPOC clients. *Psychotherapy (Chicago, Ill.)*. https://doi.org/10.1037/pst0000443

Audet, C. T. (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers? *Counselling Psychology Quarterly*, *24*(2), 85-100. https://doi.org/10.1080/09515070.2011.589602

Audet, C. T., & Everall, R. D. (2010). Therapist self-disclosure and the therapeutic relationship: a phenomenological study from the client perspective. *British Journal of Guidance & Counselling*, *38*(3), 327-342. https://doi.org/10.1080/03069885.2010.482450

Babbie, E. R. (2016). *The practice of social research* (14th ed.). Wadsworth Publishing Company.

Balmforth, J. (2009). 'The weight of class': clients' experiences of how perceived differences in social class between counsellor and client affect the therapeutic relationship. *British Journal of Guidance & Counselling*, *37*(3), 375-386. https://doi.org/10.1080/03069880902956942

Berzoff, J. (2011). Why We Need a Biopsychosocial Perspective with Vulnerable, Oppressed, and At-Risk Clients. *Smith College Studies in Social Work*, *81*(2-3), 132-166. https://doi.org/10.1080/00377317.2011.590768

Berzoff, J. (2022). Intersectionality: Power Differentials, Impasses and Enactments in Clinical Practice and in Supervision. *Psychoanalytic social work* (ahead-of-print), 1-13. https://doi.org/10.1080/15228878.2022.2073457

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., II. (2003). Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Reports (1974)*, *118*(4), 293-302. https://doi.org/10.1016/S0033-3549(04)50253-4

Beutler, L. E., Forrester, B., Gallagher-Thompson, D., Thompson, L., & Tomlins, J. B. (2012). Common, specific, and treatment fit variables in psychotherapy outcome. *Journal of Psychotherapy Integration*, *22*(3), 255-281. https://doi.org/10.1037/a0029695

Biko, S. (2009). *I write what I like*. Johannesburg, South Africa: Picador Africa.

Bogdan, R., & Biklen, S. K. (2007). *Qualitative research for education: An introduction to theories and methods*. Prentice Hall.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy (Chicago, Ill.)*, *16*(3), 252-260. https://doi.org/10.1037/h0085885

Brabeck, M. M. (Ed.). (2000). *Practicing feminist ethics in psychology.* American Psychological Association. https://doi.org/10.1037/10343-000

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

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589-597. https://doi.org/10.1080/2159676X.2019.1628806

Brown, L. S., & Walker, L. E. (2013). Feminist therapy perspectives on self-disclosure. In G. Stricker & M. Fisher (Eds.), *Self-disclosure in the therapeutic relationship*. Springer.

Carbado, D. W., Crenshaw, K. W., Mays, V. M., & Tomlinson, B. (2013). Intersectionality: Mapping the Movements of a Theory. *Du Bois Review: Social Science Research on Race*, *10*(2), 303-312. https://doi.org/10.1017/S1742058X13000349

Case, K. A. (2015). White Practitioners in Therapeutic Ally-Ance: An Intersectional Privilege Awareness Training Model. *Women & Therapy*, *38*(3-4), 263-278. https://doi.org/10.1080/02703149.2015.1059209

Charmaz, K. (2001). *Grounded Theory: Methodology and Theory Construction.* In (Vol. 10, pp. 6396-6399). https://doi.org/10.1016/B0-08-043076-7/00775-0

Chenail, R. J. (2011). Ten steps for conceptualising and conducting qualitative research studies in a pragmatically curious manner. *The Qualitative Report*,16(6), 1715-1732.

Cheng, T. C., & Lo, C. C. (2018). A Longitudinal Analysis of Factors Associated with Therapeutic Alliances. *Community Mental Health Journal*, *54*(6), 782-792. https://doi.org/10.1007/s10597-017-0229-1

Chinwe, C. O.-I. (2015). Health Inequality in South Africa: A Systematic Review. *African Sociological Review*, *19*(2), 96-131.

Coetzee, O., Adnams, C., & Swartz, L. (2019). Finding Common Ground in the Context of Difference: A South African Case Study. *Culture, Medicine and Psychiatry*, *43*(2), 277-289. https://doi.org/10.1007/s11013-018-9615-6

Cook, J. M., Biyanova T Fau - Elhai, J., Elhai J Fau - Schnurr, P. P., & Coyne, J. C. (2010). *What do psychotherapists really do in practice? An Internet study of over 2,000 practitioners.*

Cooper, S. (2014). A synopsis of South African psychology from apartheid to democracy. *American Psychologist*, *69*(8), 837-847. https://doi.org/10.1037/a0037569

Cooper, S., & Nicholas, L. (2012). An overview of South African psychology. *International Journal of Psychology, 47*(2), 89–101. http://dx.doi.org/10.1080/00207594.2012.660160

Cooper, S., Nicholas, L. J., Seedat, M., & Statman, J. M. (1990). Psychology and apartheid: The struggle for psychology in South Africa. In L. J. Nicholas & S. Cooper (Eds.), *Psychology & apartheid: Essays on the struggle for psychology and the mind in South Africa* (pp. 1-21). Vision.

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241-1299. https://doi.org/10.2307/1229039

Creswell, J. W., & Poth, C. N. (2016). *Qualitative inquiry and research design: Choosing among five approaches*. SAGE Publications.

Cuijpers, P., Reijnders, M., & Huibers, M. J. H. (2019). *The Role of Common Factors in Psychotherapy Outcomes.* (1548-5951 (Electronic)).

Davies, J. E. (2011). Cultural dimensions of intersubjectivity: Negotiating "sameness" and "otherness" in the analytic relationship. *Psychoanalytic psychology*, *28*(4), 549-559. https://doi.org/10.1037/a0022393

Dryden, W., & Reeves, A. (2008). *Key issues for counselling in action*. SAGE.4

Doran, J. (2014). The working alliance: Where have we been, where are we going? *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, *26*, 1-18. https://doi.org/10.1080/10503307.2014.954153

Dowling, M. (2006). Approaches to reflexivity in qualitative research. *Nurse Researcher*, *13*, 7-21. https://doi.org/10.7748/nr2006.04.13.3.7.c5975

Eagle G. (2005). 'Cultured clinicians': The rhetoric of culture in clinical psychology training. *Psychology in Society*, 32, 41–64.

Esposito, J., & Evans-Winters, V. (2021). *Introduction to intersectional qualitative research* (1st ed.). SAGE.

Esprey, Y. (2013). Raising the Colour Bar. Exploring issues of race, racism and racialised identities in the South African therapeutic context. In C. Smith, G. Lobban, & M. O'Loughlin (Eds.), *Psychodynamic Psychotherapy in South Africa* (pp. 31-53). Wits University Press. https://doi.org/10.18772/2013046031.9

Fife, S., Whiting, J., Bradford, K., & Davis, S. (2013). The Therapeutic Pyramid: A Common Factors Synthesis of Techniques, Alliance, and Way of Being. *Journal of Marital and Family Therapy*, *40*. https://doi.org/10.1111/jmft.12041

Flückiger, C., Del Re, A. C., Horvath, A. O., Symonds, D., Ackert, M., & Wampold, B. E. (2013). Substance Use Disorders and Racial/Ethnic Minorities Matter: A Meta-

Analytic Examination of the Relation Between Alliance and Outcome. *Journal of Counseling Psychology*, *60*(4), 610-616. https://doi.org/10.1037/a0033161

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The Alliance in Adult Psychotherapy: A Meta-Analytic Synthesis. *Psychotherapy (Chicago, Ill.)*, *55*(4), 316-340. https://doi.org/10.1037/pst0000172

Fort, C. J. (2018). Intersectionality, Intersubjectivity & Integration: A Two Person Therapy. *Journal of Psychology and Theology*, *46*(2), 116-121. https://doi.org/10.1177/0091647118767987

Fors, M. (2018). *A grammar of power in psychotherapy: Exploring the dynamics of privilege: Exploring the dynamics of privilege*. American Psychological Association.

Fors, M. (2021). Power dynamics in the clinical situation: A confluence of perspectives. *Contemporary psychoanalysis*. https://doi.org/10.1080/00107530.2021.1935191

Freud, S. (1913). *The complete psychological works of Sigmund Freud Vol. 1: Pre-psycho-Analytic publications and unpublished drafts*. J. Strachey (Ed.). Random House.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice*, *21*(5), 372-378. https://doi.org/10.1037/0735-7028.21.5.372

Grzanka, P. (2020). From Buzzword to Critical Psychology: An Invitation to Take Intersectionality Seriously. *Women & Therapy*. https://doi.org/10.1080/02703149.2020.1729473

Grzanka, P., Santos, C., & Moradi, B. (2017). Intersectionality Research in Counseling Psychology. *Journal of Counselling Psychology*, *64*. https://doi.org/10.1037/cou0000237

Harrell, S. P. (2000). A multidimensional conceptualisation of racism-related stress: Implications for the well-being of people of colour. *American Journal of Orthopsychiatry,* 70, 42–57.

Hayes, J. A., McAleavey, A. A., Castonguay, L. G., & Locke, B. D. (2016). Psychotherapists' Outcomes With White and Racial/Ethnic Minority Clients: First, the Good News. *Journal of Counselling Psychology*, *63*(3), 261-268. https://doi.org/10.1037/cou0000098

Hook, J. N., Farrell, J. E., Davis, D. E., DeBlaere, C., Van Tongeren, D. R., & Utsey, S. O. (2016). Cultural Humility and Racial Microaggressions in Counseling. *Journal of Counselling Psychology*, *63*(3), 269-277. https://doi.org/10.1037/cou0000114

Horvath, A., & Luborsky, L. (1993). The role of the therapeutic alliance in Psychotherapy. *Journal of Consulting and Clinical Psychology*, *61*, 561-573. https://doi.org/10.1037//0022-006X.61.4.561

Horvath, A. O. (2001). The Alliance. *Psychotherapy (Chicago, Ill.)*, *38*(4), 365-372. https://doi.org/10.1037/0033-3204.38.4.365

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in Individual Psychotherapy. *Psychotherapy (Chicago, Ill.)*, *48*(1), 9-16. https://doi.org/10.1037/a0022186

Horwitz, L. (1974). *Clinical prediction in psychotherapy*. Jason Aronson.

HPCSA. (2017). *National Survey of All Registered Psychology Practitioners*. Health Professions Council of South Africa. Retrieved from http://psytalk.psyssa.com/wp-content/uploads/2017/08/HPCSA_Psychology_Survey_Report_FIN_320Feb202017.pdf

Huber, J., Born, A. K., Claaß, C., Ehrenthal, J. C., Nikendei, C., Schauenburg, H., & Dinger, U. (2019). Therapeutic agency, in-session behavior, and patient–therapist interaction. *Journal of Clinical Psychology*, *75*(1), 66-78. https://doi.org/10.1002/jclp.22700

Huber, J., Jennissen, S., Nikendei, C., Schauenburg, H., & Dinger, U. (2021). Agency and alliance as change factors in psychotherapy. *Journal of Consulting and Clinical Psychology*, *89*(3), 214-226. https://doi.org/10.1037/ccp0000628

Johnson, L. A., & Caldwell, B. E. (2011). Race, Gender, and Therapist Confidence: Effects on Satisfaction With the Therapeutic Relationship in MFT. *The American Journal of Family Therapy*, *39*(4), 307-324. https://doi.org/10.1080/01926187.2010.532012

Johnston, E. R. (2015). South African clinical psychology's response to cultural diversity, globalisation and multiculturalism: a review. *South African Journal of Psychology*, *45*(3), 374-383. https://doi.org/10.1177/0081246315575648

Johnston, E. R. (2019). South African clinical psychologists' multicultural clinical and supervisory experience. *South African Journal of Psychology*, *49*(2), 253-269. https://doi.org/10.1177/0081246318801122

Kastrani, T., Deliyanni-Kouimtzi, V., & Athanasiades, C. (2014). Greek Female Clients' Experience of the Gendered Therapeutic Relationship: An Interpretative Phenomenological Analysis. *International Journal for the Advancement of Counselling*, *37*(1), 77-92. https://doi.org/10.1007/s10447-014-9227-y

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

Kleinman, A. (2007). *What Really Matters: Living a Moral Life Amidst Uncertainty and Danger*. Oup Usa.

Knox, S., & Hill, C. E. (2003). Therapist self-disclosure: Research-based suggestions for practitioners. *Journal of Clinical Psychology*, *59*(5), 529-539. https://doi.org/10.1002/

jclp.10157

Kozart, M. F. (2002). Understanding Efficacy in Psychotherapy: An Ethnomethodological Perspective on the Therapeutic Alliance. *American Journal of Orthopsychiatry*, *72*(2), 217-231. https://doi.org/10.1037/0002-9432.72.2.217

Layton, L. (2006). Racial identities, racial enactments, and normative unconscious processes. *Psychoanal Q*, *75*(1), 237-269. https://doi.org/10.1002/j.2167-4086.2006.tb00039.x

Levitt, H. M., Pomerville, A., & Surace, F. I. (2016). A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda. *Psychological Bulletin*, *142*(8), 801-830. https://doi.org/10.1037/bul0000057

Linehan, M. (1997). *Validation and psychotherapy.* https://doi.org/10.1037/10226-016

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Newbury Park, California: Sage.

Long, W. (2013). *A history of "relevance": South African Psychology in Focus* [Doctoral dissertation]. https://core.ac.uk/download/pdf/185405458.pdf

Long, W., & Foster, D. (2013). The changing face of "relevance" in South African psychology. *Psychology in Society* (45), 03-16.

Longhurst, R. (2016). Semi-structured interviews and focus groups. In Clifford, N., Cope, M., Gillespie, T., & French, S. (Eds.). *Key Methods in Geography* (pp. 143-156). Sage.

Macleod, C. (2004). South African psychology and 'relevance': Continuing challenges. *South African Journal of Psychology, 34*(4), 613-629.

May, T., & Perry, B. (2013). *Reflexivity and the Practice of Qualitative Research.*

Mbali, M., & Mthembu, S. (2012). The Politics of Women's Health in South Africa. *Agenda (Durban)*, *26*(2), 4-14. https://doi.org/10.1080/10130950.2012.714674

Meissner, W. W. (2006). The therapeutic alliance—a proteus in disguise. *Psychotherapy (Chicago, Ill.)*, *43*(3), 264-270. https://doi.org/10.1037/0033-3204.43.3.264

Mhlanga, D., & Garidzirai, R. (2020). The Influence of Racial Differences in the Demand for Healthcare in South Africa: A Case of Public Healthcare. *International Journal of Environmental Research and Public Health*, *17*(14), 5043. https://doi.org/10.3390/ijerph17145043

Morales, K., Keum, B. T., Kivlighan, D. M., Hill, C. E., & Gelso, C. J. (2018). Therapist Effects Due to Client Racial/Ethnic Status When Examining Linear Growth for Client- and Therapist-Rated Working Alliance and Real Relationship. *Psychotherapy (Chicago, Ill.)*, *55*(1), 9-19. https://doi.org/10.1037/pst0000135

Myers, D., & Hayes, J. A. (2006). Effects of therapist general self-disclosure and countertransference disclosure on ratings of the therapist and session. *Psychotherapy (Chicago, Ill.)*, *43*(2), 173-185. https://doi.org/10.1037/0033-3204.43.2.173

Ngcobo, H. S. B., & Edwards, S. D. (2008). Self-Perceived Multicultural Counseling Competencies in South African Psychologists: A Basis for Practice Guidelines. *Journal of Psychology in Africa*, *18*(4), 647-652. https://doi.org/10.1080/14330237.2008.10820247

Norcross, J. (2019). *Psychotherapy Relationships That Work: Evidence-Based Responsiveness*.

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, *55*(4), 303-315. https://doi.org/10.1037/pst0000193

Painter, D., & Terre Blanche, M. (2004). Critical psychology in South Africa: Looking back and looking forward. *South African Journal of Psychology, 34*(4), 520–543. http://dx.doi.org/10.1177/008124630403400402

Petersen, I., Fairall, L., Bhana, A., Kathree, T., Selohilwe, O., Brooke-Sumner, C., Faris, G., Breuer, E., Sibanyoni, N., Lund, C., & Patel, V. (2016). Integrating mental health into chronic care in South Africa: the development of a district mental healthcare plan.

The British Journal of Psychiatry: The Journal of Mental Science, *208.* S29-s39. https://doi.org/10.1192/bjp.bp.114.153726

Pocock, D. (2002). Feeling Understood in Family Therapy. *Journal of Family Therapy*, *19*, 283-302. https://doi.org/10.1111/1467-6427.00053

Read, L., Nelson, H., & Korenda, L. (2021, August 5). *Rebuilding trust in health care*. Deloitte Insights. Retrieved February 1, 2023, from: https://www2.deloitte.com/us/en/insights/industry/health-care/trust-in-health-care-system.html

Republic of South Africa. (2002). *Mental Health Care Act 2002* (17). https://www.gov.za/sites/default/files/gcis_document/201409/a17-02.pdf

Rogers, C. R. (1951). *Client-centered therapy (New ed)*. Boston: Houghton Mifflin.

Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Harcourt.

Ryan, R., Berry, K., & Hartley, S. (2021). Review: Therapist factors and their impact on therapeutic alliance and outcomes in child and adolescent mental health – a systematic review. *Child and adolescent mental health*. https://doi.org/10.1111/camh.12518

Schmalbach, I., Albani, C., Petrowski, K., & Brähler, E. (2022). Client-therapist dyads and therapy outcome: Does sex matching matter? A cross-sectional study. *BMC Psychology*, *10*(1), 52-52. https://doi.org/10.1186/s40359-022-00761-4

Silverman, D. (2013). *Doing qualitative research: A practical handbook*. SAGE Publications.

Siyothula, E.-T. B., & Pillay, A. L. (2008). The training institutions of black African clinical psychologists registered with the HPCSA in 2006. *South African Journal of Psychology*, *38*(4), 725-735. https://doi.org/10.1177/008124630803800411

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). Quality in Qualitative Evaluation: A Framework For Assessing Research Evidence. *Government Chief Social Researcher's Office Occasional Papers Series No.2*.

Sprenkle, D. H., & Blow, A. J. (2007). The role of the therapist as the bridge between common factors and therapeutic change: More complex than congruency with a worldview. *Journal of Family Therapy*, *29*(2), 109-113. https://doi.org/10.1111/j.1467-6427.

2007.00375.x

Stamoulos, C., Trépanier, L., Bourkas, S., Bradley, S., Stelmaszczyk, K., Schwartzman, D., & Drapeau, M. (2016). Psychologists' Perceptions of the Importance of Common Factors in Psychotherapy for Successful Treatment Outcomes. *Journal of Psychotherapy Integration*, *26*. https://doi.org/10.1037/a0040426

Swartz, S. (2007). The power to name: South African intersubjective psychoanalytic psychotherapy and the negotiation of racialised histories. *European Journal of Psychotherapy & Counselling*, *9*(2), 177-190. https://doi.org/10.1080/13642530701368485

Terre Blanche, M., & Painter, D. (2004). Critical psychology in South Africa: looking back and looking ahead. *South African Journal of Psychology*, *34*(4), 520-543. https://doi.org/

10.1177/008124630403400402

Thomas, M. L. (2006). The Contributing Factors of Change in a Therapeutic Process. *Contemporary Family Therapy: An International Journal*, *28*(2), 201-210. https://doi.org/10.1007/s10591-006-9000-4

Tschacher, W., Junghan, U., & Pfammatter, M. (2014). Towards a Taxonomy of Common Factors in Psychotherapy-Results of an Expert Survey. *Clinical Psychology & Psychotherapy*, *21*, 82-96. https://doi.org/10.1002/cpp.1822

United Nations. (2022). Goal 3 | Department of Economic and Social Affairs. *Sustainable Development.* Retrieved February 1, 2023, from https://sdgs.un.org/goals/goal3

von Below, C. (2020). "We Just Did Not Get on". Young Adults' Experiences of Unsuccessful Psychodynamic Psychotherapy – A Lack of Meta-Communication and Mentalization? *Frontiers in Psychology*, *11*, 1243-1243. https://doi.org/10.3389/fpsyg.2020.01243

Watts-Jones, T. D. E. E. (2010). Location of Self: Opening the Door to Dialogue on Intersectionality in the Therapy Process. *Family Process*, *49*(3), 405-420. https://doi.org/10.1111/j.1545-5300.2010.01330.x

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World psychiatry: official journal of the World Psychiatric Association (WPA)*, *14*(3), 270-277. https://doi.org/10.1002/wps.20238

Ward, M. R., Linville, D. C., & Rosen, K. H. (2007). Clients' Perceptions of the Therapeutic Process. *Journal of Couple & Relationship Therapy*, *6*(3), 25-43. https://doi.org/10.1300/J398v06n03_02

White, D. A. (1980). Heidegger on Sameness and Difference. *The Southwestern Journal of Philosophy*, *11*(3), 107-125. https://doi.org/10.5840/swjphil198011341

Whitley, R. (2012). Religious competence as cultural competence: Rethinking Cultural Competence. *Transcultural Psychiatry*, *49*(2), 245-260.

Williams, L. I., & O'Connor, P. (2019). Power in the Counseling Relationship: The Role of Ignorance. *Journal of Human Services: Training, Research, and Practice*, *4*(2), 1-37.

Young-Bruehl, E. (1998). *The anatomy of prejudices*. Harvard University Press.

Ziemba, S. J. (2001). Therapy with Families in Poverty: Application of Feminist Family Therapy Principles. *Journal of Feminist Family Therapy*, *12*(4), 205-237. https://doi.org/10.1300/J086v12n04_02

Zur, O. (2009). Power in Psychotherapy and Counseling: Exploring the "inherent power differential" and related myths about therapists' omnipotence and clients' vulnerability. *Independent Practitioner*, *29*, 160-164.

APPENDIX A: PRELIMINARY SEMI-STRUCTURED INTERVIEW SCHEDULE

1. Overall, what was your experience of therapy like?
2. In the study's advert, we asked for participants who had identified at least one way in which their therapist was different to them. In what way is your therapist different to you? If you noticed any differences, did it affect your therapy experience?
3. Did you feel like you were able to establish a good working relationship with your therapist? And if so, what do you think made that possible?
4. Were there things that you felt the two of you shared; experiences that highlighted your sameness or similarities?
5. How do you think those similarities shaped/influenced your experience of the therapeutic process? What did it add to your experience?
6. Do you think those similarities or experiences of sameness took anything away from your experience of therapy?
7. In what ways, if any, did you feel like your shared or similar experiences got in the way of your working relationship?
8. How do you think those similarities shaped/influenced your experience of the therapeutic process? What did it add to your experience?
9. Do you think those similarities or experiences of sameness took anything away from your experience of therapy?
10. In what ways, if any, did you feel like your shared or similar experiences got in the way of your working relationship?
11. If you had to choose another therapist, are there any differences that would make you not choose that person?
12. What differences in a therapist might make you feel that you could not work with them? How do you understand that difference?
13. Was there anything about the experience you enjoyed?
14. Do you feel like your expectations of therapy were met?

APPENDIX B: ETHICS APPROVAL LETTER

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town Rondebosch 7701 South Africa
Telephone (021) 650 3417
Fax No. (021) 650 4104

29 April 2022

Faranha Isaacs
Department of Psychology
University of Cape Town
Rondebosch 7701

Dear Faranha

I am pleased to inform you that ethical clearance has been given by an Ethics Review Committee of the Faculty of Humanities for your study, *Intersectional sameness and difference in psychotherapy: Women of colour's experiences of the therapeutic alliance*. The reference number is PSY2022-006.

I wish you all the best for your study.

Yours sincerely

Lauren Wild (PhD)
Associate Professor
Chair: Ethics Review Committee

APPENDIX C: RECRUITMENT ADVERT

Hi Ladies,

I would like to invite you to take part in my research thesis. I am interested in hearing about your experience in therapy from an intersectional viewpoint.

The following requirements should be met to participate in the study:

- You self-identify as a woman of colour
- You reside in South Africa, and you are over the age of 18
- You are currently in therapy, or you have terminated therapy in the last year
- On reflection, you identified one way in which your therapist was different to you
- You were in therapy for a minimum of 5 sessions

Duration: 45-60min interviews
Place: you have a choice between telephone, Zoom or face-to-face

Please note the following:

- Participation in the study is voluntary.
- If at any point of the interview you feel anxious or distressed, you may withdraw at any point without any negative consequences.
- The interview will be tape-recorded for transcription purposes
- The information you give during the interviews will be stored on a password-protected cloud and laptop. There will be no identifier markers, pseudonyms will be used to ensure confidentiality and anonymity.
- The recordings and information will be kept safe for 4 years and later destroyed.

If you have any further questions or if you would like to participate in the study, please email Faranha Isaacs at MSJFAR002@myuct.ac.za

APPENDIX D: INFORMATION SHEET AND CONSENT FORM

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF PSYCHOLOGY

CONSENT FORM TO PARTICIPATE IN A RESEARCH STUDY

Study Title:

Intersectional sameness and difference in psychotherapy: Women of colour's experiences of the therapeutic alliance

RESEARCHER: Faranha Isaacs
SUPERVISOR: Dr Maxine Spedding

Dear _____

You are being asked to participate in a research study being led by a researcher from the Department of Psychology at the University of Cape Town. The purpose of this study is understand more about the patient's perceptions of sameness and difference within the psychotherapeutic relationship, and how you felt these shaped your experience of the working relationship with your therapist. The reason we want to know more about this is because this information could be valuable to understanding the therapeutic process in South Africa's context. Participating in this study is entirely voluntary. You are under no obligation to participate, and there will be no consequences if you decide not to.

Why are you being asked to participate?

You are being asked to participate because you meet the criteria of participation in this study: you are in South Africa; You self-identify as a woman of colour, you are 18 years of age or older; you are or have been in therapy for at least 5 sessions within the last year; and you identified at least one significant difference between you and your therapist. Your reflection on your therapeutic experience would provide invaluable information about the understanding of the experience of sameness and difference in the therapeutic alliance.

What does participation involve?

Participation will involve one individual interview of approximately 45-60 minutes in duration. An appointment for the interview will be made with you at a date and time suitable for you and the researcher. You can choose the platform for the interview: via telephone, on Zoom or in person. If the interview is in person, you will be asked to meet me at the Child Guidance Clinic in Mowbray, Cape Town. The in-person interview will be held in a private office at the clinic.

What will it cost to participate?

While it will not cost you any money to participate, it will require you to give up some of your time. We anticipate that we will need a maximum of 70 min of your time. If the interview is in person, you may incur transport costs. If the interview is online, you will be sent data to cover the cost of the video call. If the interview is in person, you will be provided with travelling cost remuneration.

What will you get in return?

You will receive R100 in cash to cover the transport or data costs that you might incur from participating in this study.

What are the risks associated with participating?

Participating in the study is likely to hold minimal risk to you. Some participants may find that talking about certain subjects is distressing, leading to the experience of some discomfort. You will not be asked about your reasons for attending therapy or the content discussed in therapy. You will also not be asked to share your therapist's name or any other information that might identify them. You are free to choose not to answer a particular question if you prefer not to, or you can stop the interview at any time. Again, there will be no consequences for you in these instances. If you do find that participating in this study has made you feel uncomfortable or has brought up difficult or painful feelings, please let me know so that we can talk about what kind of support you might need. In any event, I will provide you with a list of possible resources that you can contact if you would like to.

Are there any benefits to participating?

There are no direct benefits to you as a participant. We hope that the information gathered in this study will help us to understand more about the way sameness and difference shape the

therapeutic experience. We hope that you derive some benefit from making an important contribution to our understanding of this.

How will your identity and information be protected?

The interview will be audio-recorded and transcribed. This is to ensure that we are able we are able to provide as accurate a representation as possible of what you tell us. The recording will be kept on a password-protected computer that only the researcher has access to until it has been transcribed, and then it will be destroyed. In the event that professional transcription services are used, we will ask them to sign an agreement undertaking to secure all data and return them once the transcription is complete. They will also be asked to commit to keeping the data confidential. All of your identifying data will be removed from the transcription.

The information that you provide us in the interviews will be used to write a Master's thesis and may be published in an academic journal. From time to time, the popular media also takes an interest in the research that we produce. However, all of your identifying information, including your name, the name of your place of work, or any other information that makes you identifiable to someone else will **not** appear in this research report or in any publications.

What happens if you change your mind about participating?

Participation in the study is entirely voluntary, which means that you are welcome to change your mind, and there will be no consequences for you. If you decide to participate in the research project, you can decide to stop at any time, and you will not need to provide any explanation for why you would like to stop.

If you have questions about the study, please feel free to contact the following people:
Faranha Isaacs (Researcher): 082 318 2313 or MSJFAR002@myuct.ac.za
Dr Maxine Spedding (Supervisor): 021 650 3452

If you have any questions, comments or complaints about your rights as a study participant, please contact Ms Rosalind Adams at the Department of Psychology, University of Cape Town: 021 650 3417. or rosalind.adams@uct.ac.za

I _____ (name) have read the above and I am satisfied with my understanding of the study; its possible benefits, risks and alternatives. My

questions about the study have been answered. I hereby voluntarily consent to participate in the research study as described. I have been offered copies of this consent form.

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

I give permission for my interview to be recorded with an audio recorder to assist the interviewer with remembering the information.

Name of Participant (Printed): _____

Signature of Participant: _____