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UNDERSTANDING THE CLIENT'S EXPERIENCE OF COUNSELING IN BHUTAN

By

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Dissertation

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BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Sacra, Michaela, Ph.D., Spring 2017

Counselor Education and Supervision

Abstract

Chairperson: Kirsten W. Murray

Bhutan is a small Himalayan country experiencing vast changes as its traditional, Buddhist, collectivist culture meets Westernized culture in the process of globalization. The significant differences in culture and the idealization of the West has led to an increase in mental health issues in Bhutan, especially among the youth population. The government has recognized this and supports the growth of mental health professions. Currently, there are few mental health workers in Bhutan, but they have recently initiated a Bachelors-level counselor training program and have provided brief training to teacher counselors in schools to better address the rising problems. However, there is no information about how to internationalize the counseling profession to fit Bhutanese culture, and specifically to be most beneficial for clients. In this phenomenological study, I interviewed twelve Bhutanese mental health clients about their experiences with counseling. Their responses ultimately showed that the development of trust in the client-counselor relationship is the central component of the counseling process within the specific Bhutanese cultural context. Counselors established trust by conveying empathy for the client through their characteristics and qualifications, behaviors, and specific approaches to counseling. When clients perceived empathy, they felt understood, experienced relief, and then shared openly and honestly, engaging in the counseling process. This research has implications on the practice and training of counseling in Bhutan, as well as broader international communities. Future research is needed to establish standardization and evaluate effectiveness of counseling in Bhutan.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

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BHUTANESE CLIENT EXPERIENCES OF COUNSELING

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BHUTANESE CLIENT EXPERIENCES OF COUNSELING

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BHUTANESE CLIENT EXPERIENCES OF COUNSELING

TABLE OF CONTENTS

CHAPTER I. INTRODUCTION.....	1
A. Bhutan.....	2
1. Monarchy.....	3
2. Buddhism.....	7
3. Gross National Happiness.....	9
4. Power and privilege.....	10
5. Mental health in Bhutan.....	14
6. Bhutanese counseling.....	16
B. Globalization.....	21
1. Globalization and mental health.....	23
2. Globalization and mental health in Bhutan.....	25
C. Internationalization.....	28
1. Indigenization of mental health practices.....	29
2. Implications for mental health development in Bhutan.....	31
D. Counseling from the Client’s Perspective.....	36
E. Rationale for Study.....	38
F. Research Question.....	40
G. Social Embeddedness of Author.....	41
H. Methodology.....	43
CHAPTER II. METHODOLOGY.....	44
A. Introduction.....	44

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

B. Research Question.....	45
C. Cross-Cultural Research.....	46
D. The Phenomenological Approach.....	47
1. Epoche.....	49
2. Phenomenological reduction.....	51
3. Imaginative variation.....	52
4. Synthesis.....	52
E. Understanding the Client’s Experience with Counseling in Bhutan.....	53
F. Participant Selection Process.....	56
1. Working with translators.....	58
G. Data Collection Process.....	59
H. Data Analysis.....	62
I. Trustworthiness.....	64
1. Prolonged engagement and persistent observation.....	64
2. Triangulation.....	65
3. Member checking.....	65
4. Rich, thick description.....	66
5. Bracketing and clarifying researcher bias.....	66
J. Summary.....	67
CHAPTER III. FIRST ROUND ANALYSIS.....	69
A. Introduction.....	69
B. Description of Participants.....	69
C. Review of Procedures.....	72

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

D. Data Analysis.....	72
E. Themes.....	77
1. High power distance.....	78
2. Collectivism reflected in speech.....	79
3. Navigating societal stigma.....	80
4. Limited awareness of mental health and mental health issues.....	82
5. Counseling as part of holistic treatment.....	84
6. Sharing.....	85
a. Feeling understood.....	86
b. Relief and relaxation.....	89
c. Personal motivation.....	90
7. Trust.....	94
a. Counselor behaviors.....	94
b. Counselor characteristics and qualifications.....	101
c. Counselor approach.....	107
8. The cycle of sharing and trust.....	118
F. Context for the researcher.....	120
G. Conclusion.....	122
CHAPTER IV. SECOND ROUND ANALYSIS.....	123
A. Introduction.....	123
B. Bhutanese Context.....	127
1. Religion.....	128
2. Physical location.....	129

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

3.	Accessibility of treatment.....	131
4.	Lack of continuity of care.....	134
C.	Counseling Process.....	136
1.	Trust.....	137
2.	Client's response cycle.....	139
a.	Empathy.....	140
3.	Sharing.....	144
4.	Counselor characteristics and qualifications.....	146
5.	Counselor behaviors.....	149
a.	Judgment.....	149
b.	Confidentiality.....	151
6.	Counselor approach.....	153
a.	Making suggestions.....	153
b.	Psychoeducation.....	155
c.	Sharing personal experiences.....	157
D.	Conclusion.....	158
CHAPTER V. SYNTHESIS AND DISCUSSION.....		160
A.	Introduction.....	160
B.	Synthesis of the Phenomenon.....	160
C.	Trustworthiness.....	170
1.	Prolonged engagement and persistent observation.....	171
2.	Member checks.....	172
3.	Rich, thick description.....	173

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

4.	Clarifying and bracketing researcher bias.....	174
D.	Limitations.....	176
1.	Language.....	176
2.	Incomplete member checks.....	177
3.	Cross-cultural research.....	178
4.	Pace and timing.....	179
5.	Evolving space and time.....	180
E.	Implications.....	180
1.	Mental health practice in Bhutan.....	181
2.	Recommendations for counselors in Bhutan.....	182
3.	Training in Bhutan.....	184
4.	Training international counselors working in Bhutan.....	186
5.	International counseling.....	187
6.	Bhutanese clients.....	188
7.	Counselor education.....	189
F.	Future Research.....	190
G.	Conclusion.....	191
	REFERENCES.....	193
	APPENDIX	
A.	Institutional Review Board Approval.....	201
B.	Research Ethics Board of Health in Bhutan Approval.....	203
C.	English Informed Consent.....	204
D.	Dzongkha Informed Consent.....	209

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

E. Interview Questions.....	214
F. Figure 3.1.....	215
G. Figure 3.2.....	216
H. Figure 4.2.....	217

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

CHAPTER I.

INTRODUCTION

Bhutan is a nation relatively untouched by research. The Bhutanese government has gone to lengths to protect the traditional Buddhist culture from outside influence. However, in the past ten years, access to individualized Western culture has become widespread with the introduction of television and Internet. Mental health issues are increasing as a result of the confusion and competition between cultures (Nirola, Durham, & Kraus, 2015). Substance abuse and suicidal behaviors are rising, especially among the young adult population (Lhadon, 2014; Nirola et al., 2015). The mental health profession is young, with the first mental health plan in 1997, the first psychiatrist in the country in 1998, and the first psychiatric ward in 2003 (Calabrese & Dorji, 2014). Currently, few mental health practitioners exist, and they were all trained outside of the country. Professionals in Bhutan recognize the urgency for increased mental health care services and are developing a mental health diploma program to fill the need for additional personnel. However, there is no research on what Bhutanese clients find useful or the ways in which they experience counseling. Through conceptual context, I will highlight this gap in the research and elaborate on the current exigency to intentionally develop the mental health field in Bhutan.

In this chapter, I will introduce my conceptual context informing my perspective of the client's experience of counseling in Bhutan. As a nation, there are several key historical and current elements that are essential in understanding Bhutanese culture that influences the counseling experience. These include the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

hereditary monarchy in place from 1907 to 2006; the Buddhist philosophy that provides a framework for Bhutanese culture; policies of Gross National Happiness (GNH); power and privilege; the current state of mental health in the country; and finally, the definition of Bhutanese counseling and available services. I will synthesize existing literature that defines and describes globalization and internationalization processes, and specifically how they influence mental health practices. Finally, I will explore the importance of understanding the counseling experience from the client's point of view.

These areas of exploration will illuminate the necessity of increased research for the culturally appropriate development of the counseling field in Bhutan. This study seeks to add important information to the literature by elaborating on Bhutanese clients' experiences of counseling. In order to perform research competently, I will also discuss my investment in this particular study and my own cultural background. Last, I will indicate that the phenomenological method is the best fit for the present study and will briefly describe the methodology.

Bhutan

Bhutan is a small nation with a population of 765,554 in 2014 (WHO, 2015) in a diverse region, with the Himalayan Mountains occupying the north and subtropical valleys in the south. Many rural villages comprise Bhutan, leading to 19 different languages being spoken across the country. Dzongkha is the official national language and English is the language of education (Wangchuck, 2010). Three major ethnic groups exist in the population that are spread over 20 *dzonghags*, or regions. Traditionally, about 80% of the Bhutanese population

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

participated in agrarian lifestyles in rural areas, but now estimates are 50% to 60% due to rapid urbanization (Phuntsho, 2016; Walcott, 2009).

Bhutan is a unique nation with some qualities and policies unseen elsewhere. Throughout this section, I will strive to create a complete picture of Bhutan, its founding principles, and its current state. I will explore the monarchy and its efforts to protect Bhutanese culture, Buddhism, the policy of Gross National Happiness, elements of power and privilege at play in the social hierarchy, and the current state of the mental health field.

Monarchy. Understanding the historical context of Bhutan is essential in understanding its present day culture and worldviews. Despite its strategic location, Bhutan has never been colonized or overtaken, remaining an independent nation with ancient traditions (Mathou, 2000). Bhutan is comprised of land that initially represented many independent fiefdoms and was united as a nation by an exiled Tibetan lama in the 17th century (Wangchuck, 2010). The lama brought the Mahayana form of Buddhism to Bhutan, creating a shared system of government with both civil and spiritual ruling, incorporating Buddhism into the fabric of the nation. This remained until the Wangchuck family created a hereditary monarchy when the first *Druk Galpo* or Dragon King Ugyen peacefully joined warring tribes in 1907. The monarchy remained in power until the Fourth Dragon King Jime Singye installed a democratic government to rule alongside the royal family in 2006 before abdicating the throne to his son, Jigme Khesar Namgyel Wangchuck. The Bhutanese democratic government published the constitution in 2008 after seven years of

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

deliberation and construction, which finalized the shift to a constitutional monarchy.

The people of Bhutan take great pride in their country, and they revered the monarchy during its solitary reign from 1907 to 2006, trusting in the king's wisdom and strength to guide them. The monarchy operated on the basis of consensus, and was even formed at the unanimous request of the people (Galay, 2001). All decision-making occurred after long debates, and forward movement happened only after the National Assembly, which represented the interests of the people, had reached a consensus. A similar attitude was taken in the rural villages, which all operated under the rule of the monarchy, but also appointed local leaders to help organize village improvements (Galay, 2001). From the monarchy to the small communities, the people deliberated on whether changes would benefit everyone and preserve their traditional culture in the process.

Because Bhutan has never been under a foreign nation's rule, political parties and corresponding conflicts do not exist (Mathou, 2000). There was never a push for liberalism, socialism, or communism; the country remained unscathed after the World Wars and their resonating global political effects. Bhutan is its own sociopolitical microcosm where the monarchy identified beneficial movements in the greater world, and adapted them to fit within the traditional Bhutanese culture. Bhutan's education system, for example, developed from Western approaches, yet was created with the Bhutanese student and family in mind. The Bhutanese use Western practices of instruction but maintain a clear hierarchical structure and incorporate rituals and ceremonies throughout the day (Mathou, 2000). Another

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

example of this integration is present in the legal system that shifted to operations of checks and balances, heightening the capacity for justice, yet enforcing laws based in traditional Bhutanese Buddhist values.

This focus of balancing traditionalism with modernity is key in the monarchy's goal of preserving Bhutanese culture and customs. Located between British colonized India and the conquered Tibetan region of China, the Bhutanese see their culture as a mark of their independence and a resource to protect from outside influence (Mathou, 2000). Bhutan did not open its borders to outsiders until the 1970s when it joined NATO (Wangchuck, 2010). Government policies have been set in place to enhance tradition, requiring people to wear traditional clothing in all government buildings, including schools, and creating the slogan "One Nation, One People." The intention of the movement was to unite the Bhutanese people, though it also ostracized people who did not conform to the ruling elite's image of Bhutan (Rizal, 2004). This movement established Dzongkha as the national language, banning Nepali from being taught in schools and isolated people of Nepalese origin. The concept of protecting Bhutan from outside influences also included ignoring and disempowering other cultures that existed within Bhutan. These movements were further enforced with new citizenship laws in 1988 that ultimately led to the deportation of tens of thousands of Bhutanese citizens of Nepalese origin from the southern region of the country unless they could produce original documentation of their family's citizenship from 1958 (when the previous citizenship laws were enacted). To secure citizenship the original document must have been passed down from the previous generation, who were likely unaware of the future importance,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

and presented to governmental officials in order to stay in the country. Preservation of traditional Bhutanese culture and protection from the outside world are cited as reasons for this decree (Mathou, 2000).

The challenge of balancing tradition and protecting Bhutanese culture while cultivating positive change embodied the reigns of the third and fourth kings who collectively led Bhutan from 1952 to 2006. Each had initiatives that showed the importance of unity and growth. The Third King prioritized nationwide education for all children, joined NATO to increase beneficial relationships with the outside world, and supported infrastructure development to connect the Bhutanese people. During this time, Bhutan began its rapid modernization process, uniting the whole country with a road spanning the country east to west through dangerous mountainsides. Traditionally, the capital of Bhutan was officially wherever the king resided. Now, the formal capital was created in Thimphu, but the king released his role as the sole dominating power that was less in touch with the people and became more of a servant to the people through leadership. The benevolent monarchy gained additional trust from the people, securing a strong loyalty to the royal family.

The fourth king received the same loyalty from the people and created movement by instating a democracy at the end of his reign (Mathou, 2000; Wangmo & Valk, 2012; Avieson, 2015). The democracy was created to give Bhutanese people more voice in the systems of change, and was met with resistance (Avieson, 2015). Though the king made this transition with the people in mind, Bhutanese citizens struggled to understand why they needed to have power in the decision-making

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

process, as they had entrusted this responsibility to the King and his unending wisdom. The people ultimately used their faith in this wisdom to accept the shift to a constitutional monarchy. The fourth king ended the sole reign of the hereditary monarchy peacefully, providing the people with a say in the governmental makeup in the future. By giving people a vote, the interests of all Bhutanese people can be reflected in governmental decisions, which ultimately shows appreciation for the people and culture of Bhutan.

Buddhism. The people of Bhutan revered the monarchy partially because they trusted in the traditional Buddhist beliefs that informed the kings' decisions. The backbone of Buddhist beliefs supports Bhutanese culture. Based on these beliefs, all policies created via the government consider the interest of all sentient beings above anything else (McDonald, 2009). Nearly 75% of Bhutanese people identify as Buddhist, and these principles have been ever-present in decisions of the Kings since the monarchy came into being (Wangchuck, 2010). Approximately 30,000 monks and nuns live in monasteries throughout Bhutan (Avieson, 2015). Additionally, there are about 15,000 lay monks and lay nuns, who have extensive meditation training similar to monastic practitioners, but live in the community and offer religious guidance. The communities treat the laypeople with great respect and hold them in high regard, showing the valued position that Buddhist figures have in Bhutanese society.

In the Buddhist tradition of Bhutan, the emphasis on material wealth pales in comparison to the emphasis on holistic wealth, embracing spiritual health and happiness. McDonald (2009) describes how this informs the Buddhist society of

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Bhutan: “In a Buddhist way of seeing, craving, a disregard of others and disrespect for nature lead inevitably toward conflict and sorrow. Accordingly, the means to avoiding these conditions is to cultivate their ethical antidotes – care, compassion and self-restraint” (p. ix). The Four Noble Truths are the guiding beliefs of Buddhism. They identify the truth of suffering as a ubiquitous phenomenon, the cause of suffering as craving pleasurable phenomena or experiences that are ultimately dissatisfying, the cessation of suffering as an end of the craving, and finally the Noble Eightfold Path as the way to liberation from suffering. The Noble Eightfold Path, also called the Middle Path, consists of three basic quality divisions: higher wisdom, higher ethical conduct, and higher concentration. Wisdom is cultivated by practicing the “right view” and “right intention,” which speak to a selfless worldview, an understanding of the Four Noble Truths, and the resolve to rid oneself of immoral qualities. Ethical conduct refers to “right speech,” “right action,” and “right livelihood,” which entail intentional, thoughtful, and moral interactions with the world. Lastly, concentration consists of “right effort,” “right mindfulness,” and “right concentration,” which calls Buddhists to practice continuous abandonment of wrong or harmful thoughts, be aware of the present, and meditate regularly. These beliefs are represented in government, both nationwide and in the rural villages that comprise Bhutan.

One example of Buddhist principles informing Bhutanese culture can be seen in the ways individual communities throughout Bhutan approach change. Galay (2001) describes many rural villages in Bhutan that are isolated from urban centers and additional resources, so share resources and responsibilities in order to survive.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

They have their own small councils of influence that operate on the basis of consensus to promote beneficial change for all people in the small communities. One example describes the building of a small road to connect the village to the one main road spanning the country from east to west. Three leaders initiated a proposal, and a consensus was quickly reached among the village people that the road would benefit everyone. It was agreed that all people between the ages of 15 and 60 should contribute physical labor toward the road's construction, and members of the community could donate financially to the cause as was appropriate based on their circumstances. More than one hundred workers spent each day building the road, complete with drains and culverts. People also offered additional resources, from tractors to providing lunch for the whole crew. Care, compassion, and cooperation are all Buddhist qualities underlying this example of collectivist living that works to benefit the group with few signs of ego or selfishness.

Gross National Happiness. Gross National Happiness (GNH) is an example of a nationwide governmental policy that embodies Buddhist beliefs and has attracted worldwide attention to Bhutan. GNH is used to evaluate the country in a manner consistent with Buddhist principles, and also greatly contrasts with Gross Domestic Product (GDP), a global indicator of success rooted in material productivity. GNH applies Buddhist philosophy in a way that prioritizes the consideration of all living things when enacting governmental policies (McDonald, 2009). GNH is based on the Four Pillars: (a) Good Governance to ensure that the values of GNH are reflected in policies; (b) Sustainable Socio-economic Development, valuing material economy as a way to reduce suffering by increasing

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

access to basic needs; (c) Preservation and Promotion of Culture, protecting the cultural identity and making decisions for continued safeguarding; and (d) Environmental Conservation, which ensures the protection of the aesthetic and healing powers of nature (GNH Center Bhutan, 2012). GNH is evaluated through surveys that are gathered by governmental officials who travel from village to village, collecting information from a large representative sample of the population. These surveys identify discrepancies in wellbeing throughout the population based on gender, occupation, region of living, and age, to name a few categories. This policy shows the Buddhist framework underlying Bhutan's culture, and represents a mark of pride of the people who value qualities that benefit the community collectively rather than individual wealth.

GNH has been operationalized into nine measurable domains that are represented in the surveys. Psychological wellbeing is one category that falls under Good Governance, including classifications of psychological distress, emotional balance, and spirituality practices (Wangmo & Valk, 2012). Psychological wellbeing is greatly based on the Buddhist ideals of following the Middle Path to embrace compassion and release craving for material goods or pleasurable experiences. Diligent discipline of the mind is a necessary step in the path. When people experience mental distress, it obstructs their ability to be happy and "opposes the goal of GNH" (Wango & Valk, 2012, p. 74). Counseling is a recommended practice to remedy the inability to achieve happiness.

Power and privilege. Bhutan has a clear and unquestioned social hierarchy. Discrepancies are apparent based on this hierarchy and can be teased apart using

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

the GNH surveys that determine individual and collective wellbeing of the people. Major differences in wellbeing are found on the basis of social class, whether people live in urban or rural areas, and gender.

The social hierarchy identifies a ruling elite class that is of the same ethnic background as the hereditary monarchy. It is cemented by strict citizenship laws, which work on five levels and give advantage to educated Bhutanese people. Little is published about the different levels of citizenship because it is a taboo topic of conversation, especially with foreigners (Avieson, 2015). The first level is loosely formatted to include those born in Bhutan to Bhutanese ancestors who owned land registered with the government and who have not had issues with the government or the law within their immediate and extended family (Avieson, 2015). If a person is born in Bhutan to two people who legally reside in Bhutan, they must register their child or citizenship cannot be confirmed. In order to bypass registration, Bhutanese people need official documentation showing that their ancestors have resided in Bhutan since 1958. Another path to citizenship is to register as an immigrant and show proof of residence in Bhutan for 20 years (Rizal, 2004). People who claim citizenship using this route must also take a citizenship exam, requiring written competence in Dzongkha, the national language. In Bhutan, 50% of the population is illiterate (Wangchuck, 2010). This can result in a lack of education about policies, such as registering children, or the inability to pass a citizenship exam (Avieson, 2015). Consequently, there is a hidden underclass of people within Bhutan who are at risk to have no rights as citizens and may be deported at any time, even if they were born in Bhutan to Bhutanese parents.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

The disparity in access to education and resources increases when comparing rural and urban locations. Despite an increase in infrastructure since the late 1970s, Bhutan still has many relatively isolated areas that require travel for multiple days by foot in order to access urbanized centers. Until the early 2000s, approximately 80% of the country's population resided in rural areas where there are fewer educated people, and decreased access to education for children (Galay, 2001). However, current estimations show only 50% to 60% of the population in rural areas as a result of rapid urbanization with young people moving to city centers looking for more material wealth (Phuntsho, 2016). The rural areas are home to a greater percentage of people living below the global poverty line at 38.3% in comparison to 4.2% of their urban counterparts (Mehta, 2007). Most of these people are farmers and are more likely to have secondary employment than urban dwellers. Though it is customary for Bhutanese people not to idolize or strive for material wealth, money is recognized as a resource that contributes to happiness because access to basic needs decreases the stress of daily living (McDonald, 2009). Far more people are approaching and experiencing absolute poverty, or the inability to live, based on a lack of resources in rural areas (Mehta, 2007).

Finally, there is a gap in happiness between genders. Men have more power than women in a domestic setting. Linda Learning (2004) stated that there are equal opportunities for men and women in Bhutan, yet in the GNH survey of 2010, about half of the men reported being happy while only a third of women felt that way (Verma & Ura, 2015). One possible reason for this discrepancy could be the rate of domestic violence in Bhutan. In a 2007 survey of women, 77% reported

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

experiencing domestic abuse, and in 2010, 68.4% stated that being beaten was a reasonable expectation for not fulfilling their wifely duties (Nirola et al., 2015). Her Majesty the Queen Mother Sangay Choden Wangchuck founded a program entitled Respect, Educate, Nurture, and Empower Women (RENEW) in 2004 in order to empower women who have been victims of domestic violence to help counteract this trend. The continuing disparity between male and female happiness throughout the country signifies that Bhutanese society does not benefit males and females equally. The efforts by the queen and the development of GNH are both attempts to resolve the underlying issues behind this disparity.

Avieson (2015) draws a connection between the three elements of social class, rural living, and gender in the case of a housekeeper in Bhutan. She was born in Bhutan as the daughter of two uneducated parents who resided in rural Bhutan legally, and were of Nepalese origin. They did not know about the registration process, and did not register her birth, which would have made her citizenship official. She married a well-connected man who had citizenship and gave birth to two daughters. Her husband developed an alcohol addiction and was violent towards her and her children. Because the couple was not wealthy, they did not have a marriage ceremony and, therefore, did not have legal documentation of their marriage. Without proof of abuse, she would be solely responsible for the financial proceedings of any divorce. She also risked deportation with a divorce, as she was considered an illegal immigrant and would need to register with immigration services. Even in this case, she could be deported when she went to register. If not deported, she would have to wait 20 years until she was eligible for the citizenship

exam. With no formal education, she doubted her ability to pass the written test. She is an example of the underclass, people who may be uneducated or in positions of low power. They often remain unheard in the narrative of this nation.

Mental health in Bhutan. The mental health field in Bhutan is in its infancy. While mental health services are gaining in recognition, initial services began within the last 20 years, creating an attitude towards mental health treatment similar to the attitude held in the US in the 1950s and 1960s. In Bhutan there is significant shame and stigma remain attached to mental illness (Calabrese & Dorji, 2014; Nirola et al., 2015). Traditionally, people seek out religious assistance as the primary means for healing. Approximately 99% of the Bhutanese population tries at least one religious ritual before seeking medical help in times of physical or psychological pain (Pelzang, 2012). In Bhutan, mental illness can be caused by both naturalistic explanations (e.g., germs, parasites, and accidents) and personalistic explanations (e.g., witches, evil spirits, and deities; Calabrese & Dorji, 2014). Allopathic and traditional medicines are used to treat perceived naturalistic causes, and rituals, and prayers performed by monks or shamans treat perceived personalistic causes of illness. Spiritual forces most frequently explain symptoms of mental illness. The ritualistic treatment often provides hope and faith in a cure, and decreases symptoms, though this treatment is less successful with severe mental illness. Psychiatrists in the capital city often see patients who have developed chronic mental health conditions after having tried many other treatment options before pursuing medical assistance (Calabrese & Dorji, 2014). In order to increase the visibility of the mental health field and reduce stigma, mental health professionals

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

and religious personnel recommend working together to offer services that fit a traditional model, while also addressing psychological concerns from a clinical perspective (Lester, 2015; Pelzang, 2012).

Determining the prevalence of mental health issues is difficult due to large rural populations and an absence of trained mental health professionals in the community clinics (Pelzang, 2012). However, the two psychiatrists working at the National Referral Hospital in Bhutan's capital city of Thimphu note patients with symptoms that span the DSM-5 and ICD 10 (Calabrese & Dorji, 2014). Dr. Nirola, one of the three educated and practicing psychiatrists in Bhutan, identified 2,846 psychiatric cases in the hospital records in 2008. Of these cases, 41.5% were related to substance abuse, 29.3% were diagnosed with depression, 19.2% with anxiety, and 9.7% with psychosis (as cited in Pelzang, 2012). Patients often present with somatic symptoms and conversion disorders, which may partially be a result of the stigma of mental illness (Calabrese & Dorji, 2014). When patients present these symptoms, medical tests reveal no internal biological issues; trained psychiatric staff identify the culturally appropriate expression of emotional distress presented in catatonia, paralysis, and GI complaints (Calabrese & Dorji, 2014). Another contributing factor to the presentation of somatic symptoms may be the lack of knowledge of the connection between the brain and body, where emotions are rarely discussed and identified. However, currently there has been a widespread movement to train and install school counselors in each school nationwide, thus increasing education around social and emotional intelligence. Ways to improve the present systems include providing widespread comprehensive healthcare that

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

would incorporate mental health care and trained workers to effectively evaluate people's needs, establish mental health legislation, and educate the community around mental health issues, prevalence, and how to seek treatment (Pelzang, 2012). In order to meet these needs, an increasing focus on developing trained mental health practitioners would be beneficial. The current five-year strategic mental health plan offers an aggressive use of resources to close the gap of mental health treatment by addressing each of these steps.

Bhutanese counseling. For the purpose of this paper, a Bhutanese counselor refers to someone who has received training, professionally identifies with the mental health field, and seeks to help others alleviate their suffering. Counseling is not a developed profession in Bhutan. As of 2012, there are 63 community-based psychiatric units that communicate and refer patients to the three district hospitals (Pelzang, 2012). There are a total of 100 beds in these community units and no psychiatrists or mental health trained staff. Each unit has access to about one type of psychotropic medication in each of the main classes of medicine. There are three trained psychiatrists in the country, as well as three psychiatric nurses. Further complicating matters, there are no psychologists or social workers, and only 1% of the total healthcare budget is allocated to mental health resources. NBCC-I, the International Division of the National Board of Certified Counselors based in the USA, has sent counselors abroad to fill three-month positions within the National Referral Hospital in order to provide counseling services and offer trainings. Trainings are largely brief in nature following the Mental Health Facilitator standardized international training program. The fall of 2016 marked

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

the inaugural year of a Bachelors-level training program for mental health counselors in Bhutan (Lester, 2015). Additionally, there has been a great effort to train teacher counselors to educate and provide some counseling services to youth in a school setting. Initially these counselors received only brief training, but now receive formalized two-year training offered at the Samtse College of Education through the Royal University of Bhutan. However, currently there are no Masters-level practicing counselors that have been trained in Bhutan, nor Masters-level training programs in Bhutan. Pelzang (2012) has noted the lack of funds and inadequate resources in respect to medicine and trained personnel in the mental health field as contributors to the slow development of the field. However, with recent results from mental health research, more resources are being allocated to mental health services and development.

Bhutan, while known for its focus on happiness worldwide, struggles with increasing rates of substance abuse and suicide, possibly linked to the trauma and despair that accompany absolute poverty, domestic violence, and rapid modernization that is leading to stark clashes of cultures. Substance abuse, and alcohol addiction in particular, is crippling the middle age bracket of people in Bhutan and increasing in prevalence among young people (Calabrese & Dorji, 2014). Liver disease and complications from drinking became the leading cause of death in the National Referral Hospital for people ages 35-49 in 2009 and remains there. It also contributes significantly to the high levels of domestic abuse and divorce. This is a recent shift, as alcoholic beverages have been used for centuries in Bhutan as part of rituals and celebrations, but only in the past ten years have people had

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

abundant access to spirits with high alcohol content. With an increase in expendable income as well as commercial importation and production of alcohol, drinking culture has shifted so social use and abuse of alcohol is seen as acceptable.

Serbithang is a substance abuse rehabilitation center outside of Thimphu under the umbrella of the Youth Development Fund. There are twelve beds reserved for male and female clients, each allowed to stay 90 days, and wraparound treatment is provided for the cost of meals. Clients transition out and have access to three Drop in Centers (DIC) in different areas of the country that provide some counseling services, along with group meetings built on the Alcoholics Anonymous platform. The counselors at both the rehabilitation center and the DICs counsel based on their own experience with addiction and have no formal training. Additionally, half of the 18 beds at the National Referral Hospital are reserved for people suffering from substance abuse (Lester, 2015). Patients often go through the detoxification process as an inpatient at the hospital and are required to have a family member accompany them for the duration to provide support and understand the requirements to break the addiction cycle (Calabrese & Dorji, 2014). Additionally, Chithuen Phendhey Association is an NGO established in 2011 that is dedicated to a drug- and alcohol-free society. Their mission is to provide cutting edge programs in prevention and reintegration of people treated for substance abuse disorders. Finally, the royal family has historically provided sponsorship for people struggling with addiction to attend rehabilitation in India. Resources for people struggling with substance abuse are increasing, but the rates of substance abuse rise faster.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Suicide is another increasing phenomenon that concerns mental health and shows a need for additional support. From 2009 to 2013, the suicide rate in Bhutan increased 9.4% with a total of 364 completions over the four-year span (Lhadon, 2014). Lhadon (2014) studied an anonymous compilation of suicide data in order to abide by Bhutanese sensitivities, and provide information that can be helpful towards prevention of future suicidal behaviors. He identified trends within gender, age, occupation, and residential region. Of the total 364 people, the highest suicide rate among the five-year brackets occurred in people under 20 years of age, with 20% or 76 completed suicides, showing a large number of youth. The high completion rate may be connected to the college experience or the rise in substance abuse among this population that often results from urbanization in the quest for modernized forms of employment (Nirola et al., 2015). Furthermore, half of the suicides were completed by people under the age of 30, representing three of the age brackets (Lhadon, 2014). People who have lower status occupations, such as farmers and students, or people who are unemployed have a higher rate of suicide completion, pointing to the possible effects of financial distress. Finally, half of the suicide completions came from the southern region, which is an area that has faced discrimination and isolation based on their largely Nepalese-originated population. Bhutan has just started using the emergency phone line as a suicide help line, but could benefit from built in supports to the social system as the culture becomes more individualized and isolating (Lhadon, 2014). Access to mental health resources in remote areas of the country and trained professionals who understand the populations in these regions could ameliorate issues. Bhutan has a varied

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

population and, in order to increase safety among its members, counselors need to be present and understand the unique cultural circumstances of each area of the country.

Finally, domestic violence, as stated previously, has been a normalized behavior in Bhutanese culture. Currently, RENEW provides counseling and supportive services to women seeking help from relational violence. According to Lester (2015), RENEW has activists in all 20 regions of Bhutan, ensuring that women have a safe place to turn to in the event of domestic abuse. However, with strict citizenship laws, stigma around divorce, and fewer educated or job-trained women, many of these women stay in violent relationships. This can be mitigated in the future by providing healthy relationship curricula in schools, which may be part of the work being done by recently trained school counselors. By increasing the literacy around healthy relationships and trauma awareness, the general public will have more information regarding domestic violence. This information paired with the development of the mental health field may lead to programs for men who are prone to violent behavior.

Bhutan is making a concerted effort to meet the mental health needs of its people with the new counseling diploma program and brief formal training for teacher counselors within schools. There is great benefit to the field of counseling by training Bhutanese counselors in Bhutan because the program can be tailored to work with the specific cultural considerations of that population. Currently, Bhutanese counselors adapt their training a great deal and may add new techniques involving Buddhism or other cultural specificities in order to most effectively work

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

with their clients (Lester, 2015). However, there is no information from Bhutanese counseling clients about what has been useful or helpful for them in their counseling experiences. Due to the stigma around mental illness and the view of Westernized medicine as containing a “magic pill” treatment, many clients attend counseling for just one session (Calabrese & Dorji, 2014; Nirola et al., 2015). Psychiatrists have noted the importance of providing psychoeducation around conditions and medications, while also stressing the usefulness of coping skills (Calabrese & Dorji, 2014). Further research on the Bhutanese counseling experience and general education for the public around mental health is needed to gain commitment to a longer therapeutic approach to treatment.

In order to identify the most appropriate and beneficial counseling skills to endorse and develop within the new generation of Bhutanese counselors, further research needs to be completed on how Bhutanese clients experience counseling. Research data can be used to create a greater public awareness of the counseling process. The research can also inform the new training curriculum to include skills and approaches that are useful to the Bhutanese population, while providing critical feedback around techniques learned in training programs abroad that are unhelpful. Results of the research can improve the overall practices of counselors within Bhutan, creating the opportunity for a more satisfying and healing relationship between counselors and clients.

Globalization

Though there are many factors contributing to the rise in mental health issues in Bhutan, one could argue that the globalization process has either directly

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

or indirectly influenced each of them. In order to develop a culturally sound counseling profession within Bhutan, globalization and its potential effects must be understood. In this section, I define globalization, the role it plays in mental health worldwide, and then specifically in Bhutan.

Globalization was coined in the 1960s meaning, “to make global in scope or application” (Chanda, 2003), but has been practiced for thousands of years by travelers, traders, and conquerors. Though these roles still occur in today’s society, they take very different forms than the globalization practiced by Marco Polo and Genghis Khan. The modern form of globalization allows people separated by a great distance to interact in a trivial amount of time compared to the feat it was historically. The influence that cultures have on each other is expedited. This rapid globalization can have negative consequences. The term “McDonaldization” has been used to express frustration with Western cultures and values dominating others in a way that can be equated to colonization (Lorelle, Byrd, & Crockett, 2012). Additionally, this speaks to the rise of American-style capitalism spreading throughout the global economy, dictating how other nations interact in the world to achieve wealth and power. However, for others, globalization can hold the promise of positive progress. The ease with which nations can communicate has led to free trade and “the spread of ideas and information that promotes democracy and awareness of human rights norms” (Chandra, 2003). People are able to accept positive influences or enrich their own human experiences with the vast traditions, foods, and beliefs of many cultures.

With these views in mind, Ritzer (2003) noted that, “attitudes towards globalization depend, among other things, on whether one gains or loses from it” (p. 190). Ritzer points out that the multi-faceted term can be spun in any direction depending on one’s motivation behind using it. In a meta-analysis of hundreds of definitions for globalization across various fields in the literature, Al-Rodhan and Stoudmann (2006) proposed a comprehensive definition for the term: “Globalization is the process that encompasses the causes, course, and consequences of transnational and transcultural integration of human and non-human activities.” While this is a generalized definition, it seeks to address the complex nature of globalization and creates a definition that can encapsulate any use of the word.

Globalization and mental health. Similarly, within the mental health field, scholars can view globalization from multiple viewpoints depending on the overall message they want to send. One perspective held by mental health workers may note the invasion of Western practices into areas where these are not relevant or useful, and may even be harmful towards the population (Leong & Ponterotto, 2003). An example of this might be the use of Western theories prioritized in research with indigenous populations, valuing the diagnostic and standardized treatments more than the spiritual beliefs that are inherent to that culture (Norsworthy, Heppner, Ægisdóttir, Gerstein, & Pedersen, 2009). The counseling profession has been especially aware of the negative impacts of globalization and has written about how to grow and strengthen the counseling field abroad without dominating other cultures (Leung et al., 2009; Lorelle et al., 2012).

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

With the growing awareness and caution towards colonization of the mind, Lorelle et al. (2012) defined globalization as, “a continual process of interaction and integration among national economies, societies, and cultures” (p. 115). Though globalization refers to a dominant culture influencing local cultures, the local community can choose to absorb, adapt, or reject practices brought to them, ultimately influencing a shift in the dominant culture as well (Lorelle et al., 2012). In contrast, other scholars have noted that globalization is a movement towards homogeneity with a unidirectional force of influence (Ng & Noonan, 2012; Leung, 2003; McCarthy & Habedank, 2014). For example, counselor education departments increase international presence by sending professors to temporary appointments abroad far more frequently than they accept international professors for visiting positions in the U.S. (Shannonhouse & Meyers, 2014). For the purposes of this paper, I will rely on the following definition of globalization: the continual process of interactions between cultures with the dominant culture influencing local cultures towards integration (Lorelle et al., 2012; Leung, 2003).

There are many examples of globalization within the mental health field. For example, Westernized mainstream culture displayed through the media has shifted how disorders appear in other countries to reflect American symptomatology (Lorelle et al., 2012). Additionally, the influence of an individualized culture may be at odds with collectivist cultures, creating tension in people that leads to greater instances of mental health issues (Chen, 2009). While these examples were taken from Japan and China, Bhutan is another country that may be experiencing this shift.

Globalization and mental health in Bhutan. Until the early 2000s, the Bhutanese monarchy intentionally created policies to protect its culture from outside influences (Wangchuck, 2010). Even today, Bhutan has a strict policy on tourism, extending only so many costly visas at once and requiring guides to accompany visitors on specified trips (Brunet, Bayer, De Lacy, & Tshering, 2009). Additionally, in order to preserve culture, as dictated in GNH, people are required to wear traditional dress to work and within governmental buildings. Despite attempts to keep outside influence low, in 1999 television and Internet were introduced to the capital city of Thimphu, and then became more widely accessible throughout the country in 2006. With the current widespread exposure of Western culture, mental health issues have increased in prevalence and scholars identify at least part of the responsibility to the media (Nirola et al., 2015). The combination of the inherent collective Buddhist culture with the new capitalist individualized culture becomes difficult to navigate, creating distress.

In Buddhist culture, people believe that there is great suffering in the world, and that this suffering comes from a disparity in what one desires and what one has or receives (McDonald, 2009). The way to ameliorate this suffering is to recognize and abide by the Four Noble Truths, which ultimately identify that all pleasure-driven stimulation is temporary and craving these will not provide a person with satisfaction (Wallace & Shapiro, 2006). The only way to be satisfied is to give up all craving and follow the Noble Eightfold Path, or act with compassion, discipline, and nurture a mindfulness and meditation practice.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

In a capitalist society, however, the media functions as a conduit to produce or increase desire for material things that may not be necessary in order to sell products and stimulate the economy. Capitalist values are directly at odds with the Bhutanese culture. Policies, such as GNH, have attempted to mitigate the infiltration of individual, competitive, capitalistic culture, but cannot do so completely. As capitalist perspectives become present in Bhutan, a rift between generations and a tension within individuals negotiating multiple cultures is growing (Avieson, 2015). It is now common for youth to leave the rural agrarian lifestyle where they were raised and integrate into more urban areas. This change divides families, causing older generations to fear their children have lost the caring and compassionate ways of their people in the loss of communal values (Lester, 2015). Once in the city, young people look for jobs, and often are underprepared with a low level of education, no support network, and easy access to substances. There has been a distinct rise in substance abuse and suicidal behavior among urban young adults in the city, which could be tied to the decrease in collectivist values and changing family dynamics (Nirola et al., 2015).

Alternatively, globalization also spreads the message of moral human rights and advocacy. Though it is illegal to physically assault another person in Bhutan, domestic violence has become a normalized pattern in the majority of households (Nirola et al., 2015). Domestic violence also occurs in Western cultures, but it is looked down upon, as there is a greater push for humane behavior towards all people. This attitude discourages mistreatment of any person and ultimately contributed to the establishment of RENEW in 2004. The organization currently has

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

workers in each region of Bhutan, where they empower women who have experienced domestic violence to become active and successful members of society (Lester, 2015). At this point in time, the focus is on helping women who have already experienced domestic violence, but with growing resources, RENEW may seek to provide preventative services in the future.

Bhutan has experienced change over the last 50 years that most civilizations see over hundreds of years. The rapidity of change has increased as Bhutan is exposed to Western culture through globalization. The influence of Western culture can be seen through changes in behavior and shifting collectivist values, affecting mental health (Nirola et al., 2015). Though it is a country that has protected its culture as one of the Four Pillars of the GNH scale, frequent interaction with Western culture through television and the Internet leaves Bhutan especially vulnerable to counter-culture influence. This opens the possibility of influence on the developing mental health field, which could lead to a beneficial growth in numbers of trained professionals, and could also be detrimental by imposing Western ideals on a vulnerable population. Bhutan has relatively few mental health resources and is lacking in research on what might be helpful when developing mental health treatments. To avoid relying on Western counseling practices with the people of Bhutan, continual research is needed on the experiences of Bhutanese clients from a mental health perspective. The internationalization process helps develop culturally appropriate services.

Internationalization

Some say that internationalization is the solution to problems caused by globalization (Whitaker, 2004; Ng & Noonan, 2012). Rather than moving the global population towards homogeneity, internationalization keeps the preservation of the individual nation's culture as the primary focus in the country's continued interactions with the rest of the world. Internationalization specifically respects and maintains a nation's cultural context in the development of services. In this section, I define internationalization, describe the recommended approaches for international mental health practices, and identify how internationalization can be used in Bhutan to develop a culturally sensitive counseling profession.

The meaning of internationalization has been debated and clarified repeatedly, largely informed by institutions of higher education. Here internationalization is an ongoing, hegemonic process integrating international, intercultural, or global dimensions into practice in a context where societies are smaller subsystems of a larger world (Knight, 2015; Schoorman, 2000). This definition broadly encapsulates the term, and Ng and Noonan (2012) specifically investigated the meaning of internationalization from a counseling perspective. Through input from experts in the field, their research resulted in the following definition:

Internationalization of the counseling profession is a multidimensional movement in which professionals across nations collaborate through equal partnerships to advance the practice of counseling as a worldwide profession. The goal is to provide and promote mental health wellness and intervention by empowering individuals and communities to meet their needs in culturally respectful and informed ways. (p. 11).

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

They also determined a conceptual scope for the term, which delineated appropriate actions that individual counselors and larger organizations can take in areas of International Collaboration, Theoretical Foundations of Practice, Training and Development, Professional Advocacy, and Social Advocacy. I will remain consistent with the literature by also using this definition to describe internationalization, stressing equal partnerships between entities, accepting influence from local communities to improve the broader counseling field, and providing training to empower local people in developing mental health services that are best suited to their cultural context.

In this vein, scholars have noted that multicultural training is not sufficient to successfully proceed with internationalization (Leung & Chen, 2009; Lorelle et al., 2012; Ng & Noonan, 2012). Multicultural values and training specifically apply to the political and historical context within the United States (Leung & Chen, 2009). These same practices may not be relevant when working with international populations. In the following section, I will discuss the literature base for internationalizing mental health systems, namely through indigenization of practices, and the implications for the development of the mental health field in Bhutan.

Indigenization of mental health practices. In Bhutan, very few professionals are trained to provide mental health services, and none of them received education in Bhutan. In order for practitioners to competently work with this unique population, there must be indigenization of practices. In reference to the mental health field, indigenization is the need to consult with and teach people of a

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

given culture practices in mental health. They can then adapt or completely transform these practices in a way that is most beneficial when treating people of their own culture. The mental health field in the United States is so large that it could be considered a transgression against basic human rights to isolate this professional workforce when assistance is necessary to meet the needs of people around the world, especially in resource-poor areas (Leong & Ponterotto, 2003). However, it is necessary that professionals from Western or Eurocentric cultures enter these relationships as equal partners and work with local people to observe, research, and train them in a culturally appropriate manner (Ng & Noonan, 2012). Professionals may assume that they know how to assist people in a foreign culture, but the “primary goal of psychology is to understand how people function in their natural contexts, including the knowledge, skills and beliefs that people have about themselves” (Leung & Chen, 2009, p. 946). This attitude is essential to honor the people in need of assistance and not cause harm. Indigenization was initially grounded in the psychology field, and scholars in the counseling field use these writings as the philosophical background for use of indigenized counseling practices (Leung et al., 2009).

Enriquez (1993) writes about indigenization of psychology highlighting two aspects: *indigenous from within* and *indigenous from without*. “Indigenous from within” entails the new construction of psychological theories and practices based on the indigenous culture, whereas “indigenous from without” uses and adapts existing psychological theory and practices to fit the culture. In this process, leaders in the mental health field may identify qualities that are universal and need little

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

adaptation in order to use these techniques and conceptualizations ethically and effectively. Leung and Chen (2009) recommend using both adaptations of current Western practices, as well as culturally specific practices in the development of the mental health field in non-Western nations.

Despite this clear recommended practice, some researchers still evaluate the development and practices of mental health fields in other cultures with Westernized standards. For instance, Ægisdóttir, Gerstein, and Çinarbaş (2008) discovered that out of 615 empirical studies performed internationally, only 15 used a translation of instruments with nine of these showing an effort to evaluate the equivalence between measures of different languages. Leong and Ponterotto (2003) recommend using qualitative research with international populations first, so issues of language confusion and context can be clarified more easily. Through discussion with participants and use of translators, researchers can access meanings by questioning in the moment, rather than analyzing surveys or measure data where questions asked by the researcher may not have been fully understood. Employing qualitative methodologies also removes the need to categorize people based on Americanized standards and measurements. Using the results of qualitative work, researchers can later develop constructs to fit cultural contexts, thus avoiding issues of instrument translation altogether. These recommended international practices are useful in consciously developing the mental health field in Bhutan.

Implications for mental health development in Bhutan. Although Bhutan's mental health field is relatively young, there are examples of the use and misuse of internationalization practices in the field of education that best illustrate

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

how to proceed with the development of counseling. Sofo (2007) investigated the effectiveness of an out-of-country training program for Bhutanese employees in the Ministry of Education with workers from management, academic, and technical positions. When assessing the worker's motivation for training, most of the scores were very high, illustrating an agreement of goals with the direct supervisor, great potential for an increase in knowledge, and the transference of new skills. However, when employees returned to work after the training, there was a significant decrease in confidence to effectively implement the skills they had obtained. The employees cited reasons such as an overwhelming workload and the inability of supervisors to evaluate their new skills appropriately as the main barriers to skill transference. The example demonstrates that, despite providing training, equipped employees may not have the time, motivation, and systemic support to incorporate new learning in the working environment when their occupational culture is not considered in the training.

Alternatively, there are cases of U.S. trainers coming into Bhutan and adapting trainings to be most useful for the people. Levine, Telsey, and McCormack (2011) discussed a Special Education training where they were flexible with preplanned materials, determining that less content with more experiential learning allowed the Bhutanese participants to incorporate the most information. They stated, "Over time, we began to acknowledge that the workshops were not designed solely to impart our professional agenda, but rather to know our audience and empower them to make changes that would benefit their special education children" (p. 40). This shows an important shift in perspective when working within the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

internationalization process. The trainers took the opportunity to observe the Bhutanese people and adjust their plans by incorporating cultural sensitivities, like respecting the opening rituals and integrating practice opportunities to stimulate interactions. A similar tact can be used in the development of the mental health field, providing adapted trainings specifically geared toward increasing the skills and confidence of Bhutanese practitioners.

In the Bhutanese counseling field, preliminary research acknowledges the usefulness of creating partnerships with practitioners and adapting some Western practices while introducing others that are culturally appropriate (Lester, 2015). In a recently completed dissertation, Lester (2015) examined the influence and usefulness of Western counseling methods from the perspective of Bhutanese counselors by interviewing eleven practicing counselors in Bhutan. There are very few clinicians trained in mental health throughout Bhutan, and those that practice have been trained with Eurocentric models. According to the study, the basic skillset that Westernized institutions provide to Bhutanese counselors is useful, especially at the beginning of their practice. Specifically, participants indicated that eye contact and basic listening skills were invaluable in the early development of counselors in Bhutan. They also noted that some ideas were useful, but needed adapting. Bhutanese counselors focus on supporting the client's choice and agency rather than giving advice, which is also a main tenet of Westernized counseling. However, they stated that they usually work with clients often by externalizing personal issues and moving towards acceptance, while they said that Western counselors identify problems within the internal experience, and seek to shift the internal processing to

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

control external factors (Lester, 2015). For example, if a client was treated unfairly by an employer, in Bhutanese counseling the counselor might point to karmic beliefs and urge the client to accept that event, while encouraging kindness and compassion because future karmic destiny is within the client's control. On the other hand, a counselor practicing in the United States might go through the client's thought process and response, seeking ways to resolve this better in the future. Bhutanese counselors adapt their Westernized training to best fit the Buddhist framework of their own culture by using philosophies such as acceptance of external conditions rather than directly challenging them. These are illustrations of "indigenous from without" techniques where skills are shifted to fit the Bhutanese culture.

Evidence of "indigenous from within" practices also exist in the development of Bhutanese counseling, namely by using collectivist and Buddhist philosophies when working with clients (Lester, 2015). Bhutanese counselors cited Westernized practices as reinforcing an individualistic and competitive culture, which they see increasing isolation, family issues, and unemployment in their small country as Bhutan is rapidly modernizing. These are prominent factors in the increasing need for mental health treatment, especially among youth as alcoholism and suicide rates increase (Nirola et al., 2015). In order to use Buddhist and collectivist practices, Bhutanese counselors focus on interdependence and relationships with others, prioritizing the family as a sacred unit.

Lester (2015) recommends a model of counseling based on collectivism, karma, and compassion, stating that karmic principles match well with counseling,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

giving emphasis to the logic of cause and effect. Mindfulness also reflects collectivist and Buddhist values when implemented in counseling treatment, focusing on spreading compassion for the surrounding world. Pelzang (2010) recommends increasing the dialogue between spiritual lamas, shaman, and monks with the mental health field, noting that nearly all Bhutanese people seek religious interventions in instances of physical or psychological suffering. Nirola and colleagues (2015) discuss a monk's recommendation to a father to seek mental health treatment for his son as a show of compassion in a hypothetical scenario. By building the mental health field to work side by side with religious advisors, Bhutanese people may receive necessary care more expediently. In these ways, Bhutan is creating practices specifically tailored to its culture for the benefit of community.

Internationalization is a complex process that helps to check the potentially harmful effects of globalization by honoring indigenous cultures. While the process for developing the counseling profession in areas with high mental health needs and low resources has been discussed in the literature, it can be difficult to enact. Bhutan is at a crucial point in the internationalization process presently, as the country is quickly modernizing and does not have the mental health professionals to adequately address the rising needs of the population. As Bhutan's mental health field develops, continued research about effective counseling practice is necessary. Bhutanese counselors can offer helpful tools for mental health practice, and counselors can also misperceive what is effective for the client. In order to provide

Bhutanese clients with the best care, understanding the practices they find most beneficial is essential.

Counseling from the Client's Perspective

The majority of research performed in the counseling field often investigates outcome data on various interventions and programming. In this, the researcher and experimental counselors are viewed as the experts, imparting a manualized treatment on participants and analyzing them for symptom reduction afterwards. However, when therapeutic factors are disaggregated, clients' characteristics and circumstances account for 40% of change within therapy, the therapeutic relationship is responsible for 30%, and hope and expectancy of the client, as well as the specific model or technique are each responsible for 15% of the change in behavior (Lambert, 1992; Hubble, Duncan, & Miller, 1999). The client's experience, viewpoint, and outside life account for the majority of change along with the relationship created within clinical sessions. Therefore, the client's perspective on the impetus of change is essential information when evaluating the usefulness of counseling. Self-reports on systematic measures, such as symptom levels, do not relay important information around the meaningfulness of the counseling experiences.

The issue of client experience becomes even more important in multicultural and international settings. For example, in an experiment regarding counselors' multicultural competency in working with African American clients, counselors who believed they were competent actually presented racial microaggressions within sessions, validating the oppression that their clients received on a daily basis

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

(Constantine, 2007). This research represents the importance of checking in with the client regularly, especially when the client is from a different cultural background than the counselor. Similarly, in an international context, a counselor may be from a different culture completely, or may have received training from a different cultural framework. In Bhutan, there are no counselors trained within the country, and there are international partnerships that bring counselors into the country for three-month periods of time. In the U.S., it is customary for the counselor to elicit the client's opinion of their counseling experience during a session. In contrast, Bhutan has a more hierarchical social structure, potentially leading clients to be uncomfortable providing critical feedback to the counselor, who is perceived to be in a position of authority (Jaju, Kwak, and Zinkhan, 2002). One way to circumvent this is to perform independent research outside the authoritative counseling position, exploring clients' experiences of counseling in Bhutan. This information could have a large impact on the counseling field in Bhutan by influencing adaptations in current practices and informing the future direction of training programs.

In summary, the development of the counseling field in Bhutan can be greatly informed by the experience of the client and the overall worldview found in Bhutanese culture. Bhutan's unique cultural context is based on the deep blanket of Buddhist beliefs underlying everything from social etiquette to governmental policies. For generations, the monarchy has established laws to preserve Bhutanese culture from outside influence. Presently, Bhutan is experiencing rapid exposure to Western culture, which has at least partially influenced an increase in mental health

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

needs throughout the country as different cultures clash and begin to dramatically shift Bhutanese society. The counseling field is relatively young, with few trained staff in Bhutan and all Masters-level training completed in Eurocentric programs outside of the country. In order to meet the growing needs of the population with rising rates of substance abuse, suicide, and domestic abuse, there is brief, formal training for teachers to become school counselors, a series of NGOs, and a diploma program in mental health being offered through the medical college. The medical college is also developing a baccalaureate and Masters programs to train professionals in Bhutan. In this way, Bhutan remains consistent with recommendations from the literature to indigenize the field by training local citizens to provide mental health treatment to people of their same cultural background. At this point, there are few pieces of literature that show the usefulness of counseling practices in Bhutan and all of them relate the counselors' perspectives. Further research is necessary in order to identify techniques and practices that are helpful within Bhutanese counseling to further inform current counselors' adaptations of their Western practices and the curriculum for the program training native counselors. An essential perspective missing is the client's view of the counseling experience.

Rationale for the Study

Bhutan is a nation with a cultural context that does not exist elsewhere. As the last Mahayana Buddhist nation, Bhutan is built on values that are sacred to the people and represented in governmental policies, but are not valued largely throughout the world. This culture has greatly been protected from outside

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

influence until recently. The younger generation is experiencing the conflict of their ancestors' culture and dominant Western culture that streams through the Internet and television, which has been speculated as a reason for the increase in mental health issues. While domestic violence has been an issue in Bhutan historically, there have been rises in substance abuse and suicidal behavior, signifying a need for greater mental health support.

The mental health field is relatively young in Bhutan, and with the exception of recently trained school counselors, there are currently no mental health clinicians that have been trained in Bhutan. Research has shown that it is essential to have native people of the area be involved in the development of counseling support. There is preliminary research on adaptations that Bhutanese counselors have made to their training to better serve their clientele (Lester, 2015). Inclusion of the practices and opinions of local people is essential in both delivering and receiving counseling, to create a culturally conscious profession in areas lacking mental health services. However, there is no research on the client's perspective. A counselor's view of what is effective and influential in a clinical session can differ from the client's experience within the same counseling session (Kivlighan & Arthur, 2000). Gaining an understanding of the client's experience of the counseling process and what has sparked change is useful to better inform the field of practitioners. NBCC-International sends counselors to Bhutan for three-month periods of time to provide services, and the medical college has initiated a diploma program in addition to developing higher level training. Information gathered from the client's

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

perspective will help prepare foreign and new counselors to be effective when providing services to Bhutanese clients.

Research Question

In this phenomenological qualitative study, I will explore the lived experiences of Bhutanese people who have received counseling. In keeping with Moustakas' (1994) writings of phenomenological research, I will pose the following research question:

What are Bhutanese clients' experiences of counseling?

For the purposes of this study, counseling refers to the intentional interaction between someone who has received training, professionally identifies with the mental health field, and seeks to help others alleviate suffering, and someone who is experiencing distress. With an understanding of how Bhutanese clients experience counseling, the potential benefits to the developing profession are great. First, the public's current grasp of the mental health field in Bhutan is poor. Exploring clients' experiences can help illuminate the counseling process for others and reduce stigma around mental distress. The profession as a whole is in its infancy. Information provided by clients, including positive and critical feedback, can help shape a counseling profession specifically tailored to the Bhutanese population. As the globalization process becomes increasingly prominent, this research takes a step towards valuing and preserving Bhutanese culture through the counseling profession, rather than imposing foreign standards.

Social Embeddedness of the Author

Both cross-cultural and qualitative research necessitate some understanding of the researcher's lens. I am the ultimate filter of any information gathered in the research process. My background and beliefs can help illuminate any potential biases that I might hold, which is especially important when presenting the experiences of people who are culturally different from myself. In this section, I will describe my own cultural context while expanding on what led me to be interested in travelling to Bhutan to explore clients' experiences with counseling. I am a 30-year-old Caucasian woman who was raised in an upper middle class intact family in the Northeast region of the United States. While growing up, my family's values centered on morality and service as active members within the Catholic community, and stressed a commitment to family. We were financially secure, with the expectation that each of my three sisters and I would excel in school and identify a career path to ensure our own financial stability.

At this point, I have strayed the most from my family's religious beliefs, and in my adulthood, I have studied secular topics related to Buddhism, such as mindfulness practices. I have also become aware of the impacts of humans living within the United States as we move closer to depleting the earth's resources with unsustainable consumption habits. I moved to Montana for graduate school to have more access to the vast wilderness, which I enjoy for recreational activities and as a stress reducer. I was also attracted to the overall mindset within the Montanan community of enjoying and participating in life outside of work, or identifying a profession for its personal rejuvenating qualities instead of financial gain. When I

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

began researching Bhutan in the process of preparing for traveling, I realized that these beliefs are somewhat in line with Bhutanese values.

As a counselor and a counselor educator in training, I seek out opportunities that push me beyond my comfort zone. Under these circumstances, I was offered a position to work as the clinical director at the Royal Thimphu College, teach a class and identify and perform my dissertation research. I approach counseling from a solution-focused and person-centered perspective, honoring people as they are and working collaboratively to identify solutions. While I did not understand very much about Bhutanese culture at the time, I identified my desire to live abroad with the chance to expand my worldview through immersion in a new culture. After briefly researching Bhutan, I realized what a rare opportunity it was to be offered a visa to live within the country, making my decision to accept the position easier. I believe in a sense of serendipity, where when opportunities arise, it is for a reason and it is wise to take them.

In my process of preparing for this journey, I immersed myself in the literature around Bhutan and the stages of its mental health development. I noted my intrigue in the Buddhist values that are the basis for their culture. I started a meditation practice to prepare for my role as a mental health counselor in Bhutan in correspondence with the literature describing how best to work with a traditionally Buddhist population (Srichanill & Prior, 2013). My fascination with Bhutanese culture grew, and I was aware that I somewhat idealized what I read about Bhutanese culture. I understood the potential of my idealization to interfere with my research, and I strived to be aware and question it during my time in Bhutan. I also

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

began to feel dedicated to the counselor education field and was humbled by this chance to witness the development of the profession in such a unique place. I worked to arrive in Bhutan with a sense of openness and presence to the journey that lay ahead of me.

Methodology

In keeping with the recommendations for cross-cultural research, I performed this qualitative study using a phenomenological approach to empathically and curiously explore the lived experiences of Bhutanese counseling recipients (Ægisdóttir, Gerstein, & Çinarbaş, 2008; Creswell, 2007). I used Moustakas' (1994) writing as a backbone for this methodology. Phenomenology is a relational approach, which allowed me to use relationships to procure participants and reduce the power hierarchy with each individual participant. I performed one semi-structured interview, as well as a member check with twelve participants, using a translator with two individuals. I consulted with three inquiry auditors, including one Bhutanese psychiatric nurse and an American woman who had worked in the Bhutanese mental health field. I analyzed the interview transcriptions to identify invariant constituents and themes that texturally and structurally described the counseling experience. Finally, I constructed a synthesis of this information, relaying the essence of the Bhutanese counseling experience from the client's perspective to the audience.

CHAPTER II.

METHODOLOGY

Introduction

Bhutan has a rich history steeped in tradition and protection from outside influence. However, after the widespread introduction of the Internet and television in 2006, Bhutan is experiencing globalization and a surge of access to Westernized dominant culture (Calabrese & Dorji, 2014; Avieson, 2015). In this process, there have been positive impacts, such as the increasing awareness of and response to domestic violence (RENEW, 2014). Globalization has also instigated a negative shift, where the rapid influx of capitalist and individualistic culture has led young people to leave their rural agrarian lifestyles. They relocate to urban areas to seek better paying jobs only to be undereducated and unemployed in a city where they have no support system (Nirola et al., 2015). This is one factor in the significant rise in mental health issues. Others include the growing awareness of poverty and increasing access to potent alcoholic beverages. These factors have led to rising rates of substance abuse and suicidal behavior. Trained staff are also more recently able to accurately diagnose the psychological distress behind somatic symptoms, increasing the documented prevalence of mental health issues. In order to provide responsive services for the growing need, Bhutan is taking steps to increase the mental health resources available to its citizens with the implementation of mental health training programs. Currently, there are very few people providing mental health services in Bhutan, and similarly, there is little dissemination of information about what is helpful to people seeking counseling in Bhutan (Pelzang, 2012). This

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

study explored the experiences of Bhutanese counseling clients in order to augment the knowledge necessary to treat mental health needs.

Research Question

In this phenomenological qualitative study, I explored the lived experiences of Bhutanese people who have received counseling. In keeping with Moustakas' (1994) writings of phenomenological research, I posed the following research question:

What are Bhutanese clients' experiences of counseling?

For the purposes of this study, counseling refers to the interpersonal professional practice of mental health help in Bhutan. Counseling is the most prominent term used in Bhutan for mental health services, so this term was largely understood, but the qualifications of those practicing counseling can vary. A client is then defined as a person over the age of 18 who received treatment for some form of psychological distress and attended at least three sessions or consultations in Bhutan with a staff trained in mental health.

In preparation to best identify Bhutanese clients' experiences of counseling, I will discuss cross-cultural research and the phenomenological method, including the philosophical framework and rationale for using it. Further, I will describe the method for selecting participants, data collection strategies, data analysis strategies, methods for establishing trustworthiness and transferability, and comment on ways to adapt this methodology to Bhutanese culture throughout.

Cross-Cultural Research

Though Bhutan has never been colonized by another nation, the recent infiltration of media adds exposure to individualistic and competitive culture, and has widespread effects on the people of Bhutan. When performing research, it is easy to impose standards of Western society on other cultures, contributing to the modern concept of colonization. Quantitative methods often seek to confirm colonizing logic of a certain place or measure it against the researcher's familiar culture without seeing the inherent value in indigenous culture (Liamputtong, 2010; Denzin, Lincoln & Smith, 2008). In order to ethically and morally perform cross-cultural research, qualitative methods should be used (Leong & Ponterotto, 2003; Ægisdóttir, Gerstein, & Çinarbaş, 2008). The researcher's responsibility is to present the perspective of people that may not have a voice, sustaining and empowering that culture by accurately representing it in context, rather than using predetermined Western measures that are not grounded in the cultural context and often disregard it (Liamputtong, 2010; Clarke, 2005). Qualitative methods are, therefore, essential for depicting the essence of a phenomenon accurately within its unique cultural context. In this process, the researcher seeks to indigenize the information as much as possible by texturally conceptualizing the holistic picture of language, traditions, and knowledge held by the participants (Tillman, 2002; Kaomea, 2004).

I also strived to clarify my lens in order to provide the audience with a better understanding of the Bhutanese counseling experience by realizing the potential biases that filter the information (Tillman, 2002; Liamputtong, 2010). In this way,

the phenomenological approach described by Moustakas (1994) was most appropriate to present culturally sensitive and empowering research in this context. The phenomenological method requires the researcher to deliver the essence of an experience after taking efforts to bracket and set aside biases. I also used practices of situational analysis, described by Adele Clark for use with grounded theory (2005). Instead of only portraying the commonalities of the experience of Bhutanese counseling, I present a holistic picture including differences in experiences and even contradictory comments (Clarke, 2005). The phenomenological methodology integrated with situational analysis fits well with the idea of de-colonization through accurate and sensitive cross-cultural research by depicting the full experiences of Bhutanese clients within their cultural context. In the following section, I will describe these philosophies and my rationale for using them in more depth.

The Phenomenological Approach

The phenomenological approach explores the research participants' lived experiences with a sense of empathic curiosity (Creswell, 2007; Wertz, 2005). The idea of lived experiences encompasses the full reality of the world in relationship to and in the context of a particular phenomenon. This is the intentional consciousness, or the subjective experience that represents what the participants choose to attend to in their lives (Moustakas, 1994; Wertz, 2005; Farber, 1943). Phenomenological researchers understand that natural scientific methods of collecting only observable data are not sufficient for understanding the intimate human experience that is captured and consolidated in the mind (Wertz, 2005). Participants embark on personal experiences, and what they come to know is based on a multitude of

qualities within their individual person, extending beyond the occurrence of objective facts. It is the researcher's responsibility to tap into this reality by conducting extended interviews with participants (Creswell, 2007). This is a crucial piece of phenomenological research because participants' decision-making processes and actions are based on these subjective realities, which may not match what is observed.

The researcher has a responsibility to make a "commitment to copresence" with the participant, opening the interview into an opportunity to co-create a reciprocal understanding of the participant's lived experience (Moustakas, 1994, p. 57). The researcher's goal is to depict the "essence" of the experience (Moustakas). The essence is comprised of both objective and non-objective realities, including thoughts, perceptions, memories, judgments, and feelings. Through the participant's reflective process, the researcher comes to know the true experience more accurately than if they were to observe the participant during the phenomenon being addressed. During the interview process, the researcher has access to the experience that has stuck with the participant emotionally and cognitively.

In order for the researcher to meet the participant in a place of mutual understanding, the researcher must make efforts to cleanse themselves of biases, including prior experiences or ideas involving the phenomenon being explored. This is the ideal state that ultimately can never be reached, but efforts are continuously made to ameliorate any effect of biases. The researcher approaches the participant with an open and nonjudgmental stance to receive information about their lived personal experience. In this process, the researcher intentionally moves forward in

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

coming to know the participant, using perception and intuition, the initial means of creating knowledge of an experience. Within the interview setting, the researcher and participant co-create reality based on the participant's previous lived experience. The researcher then strives to accurately depict this reality through a rich and textural conceptualization of the holistic experience. It is essential to always tie the thorough description back to the research question as the guide of the experience. The essence of the phenomenon comes from a mutually created reality in the interview process, and yet the written depiction is still coming through the researcher's filter. Steps are taken to remove bias, but nothing is objective. In this way, it is necessary to request and receive feedback from the participant as a co-researcher around the accuracy and completeness of the synthesis.

Moustakas provides a framework for how to perform phenomenological research in a four-stage process. For the purpose of this study, I will describe each stage from a philosophical standpoint with the understanding that I will explore my own process for completing each stage in my completed dissertation. The four stages of phenomenological research are: (1) epoche, (2) phenomenological reduction, (3) imaginative variation, and (4) synthesis.

Epoche. Epoche is a Greek term, meaning to abstain from. This is a process of bracketing bias and setting it aside. In order to fulfill this process, it is useful to create a somewhat meditative state, where one can simply exist fully in the present moment with no previous knowing entering the experience. The researcher strives to eliminate bias and receive information that is understood and unfiltered through

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

a previous set of expectations or stereotypes. Moustakas (1994) describes it as follows,

As I reflect on the nature and meaning of the Epoche, I see it as a preparation for deriving new knowledge but also as an experience in itself, a process of setting aside predilections, prejudices, predispositions, and allowing things, events, and people to enter anew into consciousness, and to look and see them again, as if for the first time. (p. 85)

In order to do this, a researcher might engage in reflective writings throughout the process to remain aware of emotional reactions and responses. They may also continue or develop a meditative practice, as this can help create a state of nonjudgment and nonstriving. Regardless of the steps a researcher takes in the epoche process, it is acknowledged as an ideal state that is not achieved, but a continued process for engagement. Epoche practices will consequently help raise awareness of researcher bias and make these explicit in the narrative report.

In this project, I engaged in the epoche process by keeping a reflective journal about my lived experiences and emotional reactions before leaving for Bhutan through my time there. I frequently consulted with my clinical supervisor, who had worked in the mental health field in Bhutan, about questions and biases that I noticed while I practiced as a mental health counselor at the Royal Thimphu College. I also developed a meditation practice before leaving where I spent at least 30 minutes per day engaged in formal meditation practices or unstructured mindfulness-based activities. I practiced either silent or guided meditations at least four days per week, and other times I took mindful walks, knit, or colored mandalas with students. Writing and mindfulness practices each helped me become more aware of the thoughts and reactions I had during my time in Bhutan and helped me

set them aside. This ultimately helped during the interview process to completely focus on the present moment with the participant, and keep this focus while analyzing the data later.

Phenomenological reduction. The second stage of the four-step process is called phenomenological reduction. Here, the researcher has developed a cleansed state and can be clear and focused on the phenomenon when interacting with participants. This describes a stripping of any distractions from previous knowledge and an attunement to the participant in the present moment to explore the phenomenon fully. The researcher receives a textured and detailed view of the phenomenon, and will often ask participants to return to the experience with them in the interview process. This takes advantage of the power of reflection and might include asking the participant to close their eyes, take several deep breaths, and return to the experience in their minds. From here, the researcher asks participants to describe the experience in detail, from what was going on in the room, to what was going on in their bodies and minds. This allows for layers of meaning to unfold in the reflective interview process.

In Bhutan, people are uncomfortable with non-directive exploration. I developed more interview questions than is typical in phenomenological research to be more aligned with Bhutanese culture. My meditation practice assisted me in being completely present with the participants. This was helpful in blocking out other sensory stimulation during the interviews and helped me become attuned to the participants. The attention I had in the present moment also informed me about

participants' discomforts, allowing us to take time to do deep breathing exercises or take breaks.

Imaginative variation. The next stage is imaginative variation and occurs after data collection during the analysis process. It entails moving around the phenomenon by exploring multiple and conflicting perspectives, using the imagination to create mental models of meaning. This stage requires intuition and reflection on the part of the researcher to take all of the collected textured information regarding the phenomenon and establish themes or underlying meanings that exist. This process is completed by reading, re-reading and coding interviews, while also taking universal structures, such as space, time, causality, and relation to self or others into consideration.

Phenomenology primarily focuses on universal aspects of participants' experiences, yet an essential piece of creating mental models of meaning in the present study will be the use of situational analysis. Situational analysis highlights similarities, differences, and even contradictory portions of the participants' experiences in order to present the audience with the most full and accurate picture of the phenomenon (Clarke, 2005). It was used in this study to attend to all significant pieces of each participant's experience in order to amplify voices that are not heard about an experience that has not yet been explored in Bhutan. This is a step to de-colonize the research, equalizing voices across gender, age, wealth, and social hierarchy.

Synthesis. Finally, I took the exhaustive amount of information from the imaginative variation and synthesized it through "textural and structural

descriptions” (Moustakas, 1994, p. 100). Synthesizing the material after the data analysis allowed me to fully depict the phenomenon to the audience. This holistic picture exemplifies the essence of the phenomenon at a particular time and place, fully recreating the reality through detailed and rich descriptions that is relayed in a thorough narrative. Through the synthesized narrative, I take the audience through the Bhutanese counseling experience fully, using quotes from the interviews and the mental models developed in the imaginative variation.

Understanding the Client’s Experience with Counseling in Bhutan

The phenomenological research method is the best fit for the current study in a variety of ways. As discussed previously, scholars of cross-cultural research have recommended using qualitative methods to explore phenomena in culturally sound and accurate ways (Ægisdóttir, Gerstein, & Çinarbaş, 2008; Leong & Ponterotto, 2003). In a meta-analysis of quantitative research performed cross-culturally, very few studies used translated measures or equivalency standards, showing that the obtained results were based on Western competencies and may not even be applicable to the populations studied (Ægisdóttir et al., 2008). As a potential solution, professionals can collaborate across cultures and disciplines, as well as use qualitative research methodologies. Similarly, Leong and Ponterotto (2003), called for an increase in attention to qualitative methods when researching cross-culturally to “give particular voice to previously silenced culturally diverse client populations” (p. 385). Qualitative research can illuminate human universality, as well as culture-specific traits more astutely than quantitative research (Leong & Ponterotto, 2003).

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

The early stage of research development in Bhutan is another reason to use qualitative methods. There are currently very few studies published concerning mental health practices in Bhutan (Lester, 2015). Of the small amount of professionals working in this field, most were trained in different countries with a variety of experiences based on the histories and contexts of the specific training programs. Therefore, Bhutan's small mental health field has no standardization of training or services. Evidence-based practices that are specific to the unique culture of Bhutan do not exist. Lester (2015) interviewed eleven practicing Bhutanese counselors and reported on their use of Westernized practices. She found that very few practices were used without adaptation. In order to expand into quantitative research, there must first be some standardization or operationalized quality to investigate. However, Bhutan is not yet at this stage in the development of the mental health field. Instead of identifying elements that are expected to be present for evaluation, the phenomenological approach allows for a continually constructive open-ended exploration. Specifically, it aims to create a complete picture of the counseling experience in Bhutan by engaging in multiple perspectives of the phenomenon. Using this method to depict the essence of the counseling experience can inform the growing mental health field of qualities and techniques that may be most useful or helpful to Bhutanese clients.

Finally, the phenomenological method responds well to the unique characteristics of Bhutanese culture. The approach is relational (Hays & Singh, 2012), with the researcher working to get to know each participant in order to re-create the essence of their authentic experiences. As a collectivist, compassionate

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

culture, relationships are crucial for survival in Bhutan, providing the support and the sense of belonging needed to thrive (Oyserman, Coon, & Kimmelmeier, 2002). Further, relationships built through the phenomenological interview process are necessary in order to access underprivileged voices of the society. Bhutan is a country where the majority of the population resides in isolated villages and 50% of the population is illiterate (Wangchuck, 2010). This is a large group of people who do not often have their voices heard, despite some regular attempts to draw them out. For example, the Gross National Happiness (GNH) survey is taken every five years, where governmental officials travel throughout the country trying to understand information about citizens' qualities of living. However, in an effort to please hierarchically superior government workers, destitute farmers often fabricate information to make them appear more content (Avieson, 2015). GNH surveys collect quantitative data through inefficient means due to the high illiteracy rate throughout the population, and still do not reflect the true experiences of the people. Here, it would be difficult to gather quantitative data that accurately represents the opinions or reality of the population. The phenomenological approach is well suited to this study because it gives the researcher an opportunity to decrease power differentials and build relationships with participants through multiple interviews (Knox & Burkard, 2009). In this way, authentic participant responses can help build an understanding of the essence of the counseling experience that privileges multiple voices.

Participant Selection Process

Bhutan is a nation structured around relationships, where the definition of family extends to one's community, village, and entire country (Learning, 2004). In order to be culturally attuned, I used this relational structure as a tool for receiving referrals for participants. In each aspect of this research project, I developed tools to be aware of and practice cultural humility. I established culturally sound research practices by developing personal relationships with mental health professionals who were native to the country, specifically Sister Sonam, the head nurse of the psychiatric unit of the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), Tshering Dolkar, the head of counseling at RENEW, and Tshering Choki, the coordinator of the Drop In Center (DIC) in Thimphu (Liamputtong, 2010). I built these relationships by spending time at all three sites, shadowing professionals at the hospital, assisting RENEW in services around the development of the Bhutan Board of Certified Counselors (BBCC), and by communicating regularly with people at the Youth Development Fund (YDF) that oversees the DIC. Creating relationships with an array of mental health professionals during my time in Bhutan served two purposes. My exposure to practices specific to the Bhutanese population helped in my development as a researcher because I was more familiar with styles of interaction and etiquette that were necessary in order to set participants at ease in the interview process.

I created positive relationships with these three professionals, as well as others, through whom I was able to receive referrals for possible research participants. Sister Sonam and a Bachelors-level trained counselor Ugyen referred

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

five participants to me at the hospital, helping to set up times with inpatient and outpatient clients, as well as a staff member, for interviews. Tshering Dolkar and I met multiple times to get to know each other and developed a working relationship, after which she referred three of RENEW's vocational employees for interviews. Finally, I worked with YDF and the Bhutan Narcotic Control Agency to gain access to the DIC in lieu of working with clients in the rehabilitation setting. At the DIC, Tshering Choki referred four relief counselors who had all experienced counseling to me for interviews. This process was in accordance with both the guidelines set by the Institutional Review Board at the University of Montana that required permission from each setting where I would interview participants and with the Research Ethics Board of Health in Bhutan that evaluated the cultural appropriateness of the research that I performed.

Other recruitment strategies, such as asking counselors to disperse pamphlets requesting participation in a research study, would not have been as successful. There are 19 languages spoken in Bhutan (Wangchuck, 2010), with Dzongkha, the official national language and English, the language of education both taught in schools. Bhutanese people hold varying levels of education, and a literacy rate of approximately 50%. Though this is a recommended and successful practice in the United States, communicating in writing in what might be a second, third, or fourth language would be a poor recruitment strategy for Bhutanese culture in particular.

I obtained referrals for twelve participants who were over the age of 18, native to Bhutan, and received counseling services in Bhutan from a Bhutanese

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

counselor. Participants attended at least three consultations or sessions with a counselor to have established a relationship and reflect on their overall experience with counseling. The quantification of twelve participants for one interview each is based on the idea that the sample should be kept small so the experience can be explored in depth (Carpenter, 1999), and Creswell's (2007) recommendation of 5 to 25 individual participants to reach data saturation in a phenomenological study. Additionally, Guest, Bunce, and Johnson (2006) established that very few coding categories are added after analyzing twelve interviews, noting that twelve interviews reach a dependable limit for data saturation. In order to participate, I read aloud an informed consent depicting the nature of the study and the details of participation. In accordance with the Research Ethics Board of Health, I provided written informed consents in English, Dzongkha, and provided the opportunity to consult with a translator for participants who could not read. Individuals were not official participants until they fully understood the study, what their roles were, and provided written permission to continue.

Working with translators. I tried to work mainly with Bhutanese participants who understood and could converse competently in the English language due to a lack of people who could serve as translators. In any instance where I worked with translators, I fully explained the research project beforehand and took time to make sure the translators understood the project. Ideally, translators were people that the participant knew to help set them at ease. In the instances when they were not relatives or co-workers, I described their role in the process as essential, not just to relay words, but to pass on cultural assumptions,

feelings, and values that were expressed in the participant's language, cadence, and body posture that I may not have been aware of as an outsider (Temple & Young, 2004). When possible, I debriefed with translators after the interview and consulted with a Bhutanese person when transcribing the interviews around meanings and cultural significance of the material.

Data Collection Process

I conducted one semi-structured interview with each of the twelve participants. In an effort to be prepared for this process, I conducted an initial interview with a student that I was seeing for mental health counseling at the college. We went through the rationale for the study, the informed consent process, and asking the interview questions. Through this dialogue, the student helped me to clarify any confusing interview questions and supplied information about our time working together. With the twelve participants, I met with each person in a private setting within the establishment with which they were associated. I audio recorded each interview and allowed the time of the interview to extend as long as the participant continued to add more information. I communicated to participants beforehand that the interview could take approximately one hour, but that it would ultimately last as long as necessary to receive a complete account of their experience.

Upon meeting, I did not begin audio recording until I had the opportunity to go through the informed consent process, with or without the assistance of a translator. In the informed consent, I elaborated on the terms of confidentiality, the possible risks associated with participation, the requirements of involvement, and

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

the option to be removed from the study at any point in time. The terms of confidentiality were adhered to in accordance with the University of Montana Institutional Review Board and the Research Ethics Board of Health in Bhutan. Specifically, I audio recorded each interview on two devices, stored the recordings on password protected devices, and uploaded them to an online storage site that encrypts submitted files. Afterwards, I transcribed the interview within one week excluding identifying information. I performed the same steps when I met with participants to complete the member checks interviews. Whenever a translator was present they were present only after agreeing verbally to protect the participant's confidentiality.

The risks that were possible from participation were a breach in confidentiality, and the emotional stress that can arise from speaking about the counseling process. This was considered a risk because the person may have had experiences within the counseling process that were hurtful or invalidating, in addition to the possibility that the individual spoke of traumatic events within the counseling setting. In the event that one of these risks surfaced during the interview process, I gently asked the participant if they would like to continue, ensuring them that it was acceptable to terminate their participation if it was causing distress. I also made a referral if participants appeared distressed, which only occurred in one instance. The participant was immediately able to see her counselor at the end of the member check. Participants were requested to meet for one extended interview, understanding that they could leave the study at any point if desired. Participants were also requested to attend a member check within three weeks of their initial

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

interview. Once the informed consent was clearly understood, I received written consent to proceed before starting the audio recording in accordance with the requirements of the Research Ethics Board of Health in Bhutan. If a participant was illiterate, I provided them with an informed consent that allowed them to enter a thumbprint as permission to continue with the research. In any instance of needing that option, a third party would have to be present to sign confirming that the participant understood and consented to the research process.

I interacted with participants using relationship-building dialogue with the aim of creating an open and trusting environment throughout the process, especially initially. In an effort to receive honest and realistic responses, I informed participants that the information they provided would be used in the development of the counseling profession in Bhutan, assisting future clients in receiving the help that they need. To begin the interviews, I asked participants to take a deep breath to become more relaxed and comfortable within the interview setting. I used my written interview questions found in Appendix E as a guideline to help structure the interview, but ultimately responded to the direction of the participant. At times, this entailed asking questions that were not previously indicated on the interview protocol, probing and following up on certain topics, or skipping questions that were answered in an earlier response.

I transcribed and poured over the data of the first interviews to identify themes and construct a mental model before conducting the member check. In the member check, I presented a fully constructed mental model that depicted the meaning I had made from all of the twelve initial interviews. In the presentation, I

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

used examples from each specific participants' initial interview to help describe concepts depicted on the mental model. I requested feedback around the conclusions, especially as they related to the overall themed analysis, checking for accuracy and completion of their initial responses. I then transcribed and poured over the data collected in the member checks to construct a new, more comprehensive mental model based on the essence of the client's experience with counseling in Bhutan.

Data Analysis

After the first interview and the member check, I gathered, read, and re-read all transcripts. As part of this process, I initially horizontalized the data by identifying any expression from the large amount of raw data that was relevant to the Bhutanese clients' experiences of counseling (Moustakas, 1994). From there, I entered the second round of coding by reducing and eliminating any expression that did not fit the following two requirements: first, it must contain a moment of the experience that is necessary and sufficient for understanding it, and second, it must be able to be abstracted and labeled. The remaining expressions were identified as Invariant Constituents. The third round of analysis involved clustering the invariant constituents around themes. These groupings made up the "core themes of the experience" (p. 121). In the fourth round, I validated the chosen themes by comparing them to the complete interview transcript to ensure that it was either directly represented in the transcript or relevant to the experience in the transcript. If it was not, I removed that theme. Finally, I constructed a mental model displaying the textural and structural relationships of all of the information collected from

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

participants. This was synthesized into a rich narrative description of the phenomenon, allowing the audience to truly understand the essence of the experience.

In order to fully ascertain important cultural information, I consulted with three inquiry auditors. Sister Sonam at the hospital agreed to be an official research assistant for the project. She was available to look at excerpts of transcripts when I had any question about meaning or cultural significance. Judi Durham, my clinical supervisor who has worked in Bhutan in the mental health field over varying periods of time, was also available weekly by Skype and during my continued writing and analysis process in the US. She helped me present a more comprehensive understanding of all of the cultural underlying factors that participants discussed. Finally, I discussed my research and its progress on weekly Skype calls while I was in Bhutan and weekly advising appointments when I returned to the US with my dissertation chair, Kirsten Murray. While she did not have any experience in Bhutan, she was reflective in how to group and relate themes together to present a more holistic representation of the counseling experience.

After the coding process, I created a mental model of the themes, including the superordinate and sub-themes of the underlying meanings behind participants' experiences. I used situational analysis to influence this process, so I was careful to include similarities, differences, and contradictions to give a holistic representation of the lived experiences of Bhutanese counseling. This process occurred after the first round of interviews, and then was presented to participants for review and confirmation of meaning. I then created a final thematic coding development after

two full sessions of coding the initial interviews and the member checks. From this information, I developed a final mental model and thematic representation of the interviews with regard to the research question (see Appendix H). Taking this material, I synthesized and described the essence of the counseling experience in Bhutan through rich detail gathered from the interviews. I continued to work with my clinical supervisor and dissertation chair as inquiry auditors during this process as a checking mechanism.

Trustworthiness

Trustworthiness is a term originally introduced by Lincoln and Guba in 1985, and is a quality that is important for determining the worth of qualitative research. The criteria for establishing trustworthiness include: (1) credibility, or displaying what has been described; (2) transferability, where enough detail is included to understand whether the information would be applicable to other populations; (3) dependability, or clearly describing and purposefully following the methods; and (4) confirmability, which is the ability to support the findings. Creswell (2007) recommends that researchers use at least two strategies to establish trustworthiness. In this section, I will describe the practices that I used in this study to establish trustworthiness: prolonged engagement and persistent observation, triangulation, member checking, rich and thick description, bracketing, and clarifying researcher bias.

Prolonged engagement and persistent observation. In using prolonged engagement and persistent observation, I made a concerted effort to create a trusting and open relationship with participants during the interview process. I was

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

also immersed in Bhutanese culture for five months during the time of the research, observing and conducting counseling sessions. With my exposure to the culture, my awareness of my own cultural background and biases increased, allowing me to more clearly and consciously set them aside. This involved my epoche processes, such as reflective daily writings through my experience in Bhutan, meditation practice, and frequent consultation. Reflective daily writing helped me be aware of my own reactions to the culture and to participants when I was researching, and meditation helped me move towards a nonjudgmental, nonstriving, and open view of humanity, allowing me to set my previous beliefs aside. Finally, I consulted with my Bhutanese colleagues and Sister Sonam about cultural experiences and meanings that I needed clarification on, as well as consultation with my dissertation chair and clinical supervisor.

Triangulation. I used triangulation as a form of confirmability by comparing my findings with the literature. While there is not an extensive amount of research about Bhutanese counseling, I reviewed and addressed literature on mental health in Bhutan, Buddhist counseling, and internationalization of the counseling field. Additionally, in order to determine credibility, I used triangulation to seek multiple perspectives of the Bhutanese counseling experience from twelve individuals. This allowed me to identify frequently occurring qualities of counseling from multiple people, triangulating and reporting important aspects.

Member checking. I brought completed mental models as well as recalled information from each participant's initial interview during the member check. In this way, I corroborated the information that I found to be important, clarified, and

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

built on themes during the member check. Participants had an opportunity to redirect me if I misunderstood or misinterpreted their meanings, affecting the outcome of the research with an increase in accuracy of the participants' experiences. This ensured the accuracy of the material presented in the final synthesis of the experience.

Rich, thick description. I used a rich, thick description with direct quotations from participants in my narrative report. In order to portray a complete picture without my bias, I used abundant and interconnected details provided by participants to create a holistic portrait of the essence of the counseling experience in Bhutan (Stake, 2010). A complete synthesis provides a true sense of the counseling experience in Bhutan from multiple perspectives, which allows readers to identify whether the reported data is applicable to other settings.

Bracketing and clarifying researcher bias. Finally, in phenomenological research, Moustakas (1994) described the process of bracketing bias by acknowledging and setting bias aside so the researcher can be an open, clean slate, ready to experience the information that the participant provides. This is the first step, or the epoche, in a four-step research methodology process. As part of bracketing my bias, I engaged in reflective writing about my experiences and expectations before arriving in Bhutan, when I was in Bhutan but had not yet started researching, and throughout the research process. I noted my emotional responses, hopes, and fears for the process, knowing that by building awareness of these, it was easier to set them aside. I also began a regular meditation practice four months

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

before arriving in Bhutan that continued through my experience in Bhutan to practice cultivating an open and nonjudgmental mind.

Throughout my time in Bhutan where I taught, provided counseling, and researched, I received supervision from Judi Durham, a counselor from the United States who has worked and lived in Bhutan in the past. She served as my inquiry auditor (Lincoln & Guba, 1982), which augmented the confirmability of the research. In my work with her, I explained any of my reactions to Bhutan, the culture, or specific clients and research participants. She understood the cultural context and spoke with me from the point of view of a Westerner that has a strong understanding and appreciation for Bhutanese culture and customs. Through this consultation process, I continued to become aware of my biases and work towards setting them aside.

Summary

Through the changing globalization process, Bhutan is seeing an increase in mental health issues, especially among youth (Nirola et al., 2015). In an effort to meet the growing need for mental health help, Bhutan is starting a Bachelors program to train mental health professionals at the new medical university. When developing mental health programs, literature shows that the local people should be adapting and creating techniques within counseling to best fit their native culture (Leung et al., 2009; Leong & Ponterotto, 2003). In order to add to the information about what might be useful for the education of counseling students in Bhutan, I conducted a phenomenological study around the central question: What are the experiences of people in Bhutan who have received counseling services? I

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

conducted one semi-structured interviews with twelve participants who were referred to me through personal relationships with local mental health professionals. From there, I analyzed and coded the data, resulting in a synthesis of the essence of the counseling experience in Bhutan. I established trustworthiness by showing prolonged engagement and persistent observation, triangulation, member checking, rich, thick description, and bracketing and clarifying researcher bias.

CHAPTER III

FIRST ROUND ANALYSIS

Introduction

Bhutan is a country experiencing dramatic shifts during the globalization and modernization processes. Increases in exposure and idealization of Western culture has led to significant cultural clashes as the Buddhist, collective, cooperative Bhutanese culture meets the capitalist, individual competitive culture of the West. As people navigate this new territory, mental health concerns have increased, leading to the need for and development of mental health services. In the early stages of the mental health professions, there is little information on how to culturally appropriately and effectively treat Bhutanese clients. The aim of this study was to gather information from Bhutanese mental health clients about their experiences with counseling in an effort to support continued development of useful mental health practices. In this chapter, I will identify the twelve Bhutanese mental health clients who agreed to participate in the study. I will discuss the procedure for engaging in semi-structured interviews with these participants. Finally, I will discuss the emerging connected themes that encompass the realities of the participants' counseling experiences, as described during the interviews. I will also consider my own impressions and reflections on the interview process.

Description of Participants

The Institutional Review Board at the University of Montana and the Research Ethics Board of Health in Bhutan granted permission to interview twelve Bhutanese mental health clients who will be referred to by pseudonyms. All participants except one, who had attended a rehabilitation center in India, received services from a Bhutanese

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

counselor. At the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), I conducted seven initial interviews and transcribed and analyzed five interviews. Two interviews were discarded. The first was terminated because the client did not meet the requirements of receiving counseling services. The second interview was discarded due to significant language barriers where it was clear the participant could not understand the researcher and claimed not to have experienced counseling. The remaining five participants from the hospital included Tshewang, Chimi, Sonam, Lhamo, and Kesang. At the time of the first interview, Tshewang, Chimi, Sonam, and Lhamo were receiving counseling treatment. Tshewang is a twenty-three-year-old male who was treated as an inpatient client at the psychiatric ward in the hospital for depression over a duration of six weeks. Chimi is a twenty-six-year-old female who was treated for one week in inpatient care for depression and suicidality. Sonam is a twenty-three-year-old female who sought inpatient care twice for one month each time for depression and suicidality, and is currently accessing counseling within outpatient care. Lhamo is a twenty-six-year-old female who has only accessed counseling services from outpatient care for anxiety and phobias. She has been attending counseling sessions once or twice per week for about six months. Finally, Kesang is a thirty-three-year-old male who works at the hospital as a security guard. He previously received services at a rehabilitation program for three months, remaining sober and not seeking any additional counseling services for the eight months since termination.

I interviewed four clients at the Drop in Center (DIC) associated with the rehabilitation program in Thimphu. These participants included Jigme, Namgay, Norbu, and Phuntsho. At the time of the interview, none of the DIC clients were actively

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

receiving counseling services, but Jigme, Namgay, and Norbu stated that they could each call their personal counselors from rehabilitation or another DIC to check in periodically. Jigme is twenty-four, male, and was operating as a relief counselor at the DIC. In the past, he attended two rehabilitation centers, the second for over one year while he pursued his studies in Paro, Bhutan. Namgay is a thirty-year-old male who participated in rehabilitation treatment for five months in India, has been sober for one year, and regularly attends Narcotics Anonymous support groups run by the DIC. Norbu is a twenty-two-year-old relief counselor at the DIC and received individual and group counseling for his alcohol addiction at a different Drop in Center in Bhutan. Finally, Phunthso is a twenty-seven-year-old female who attended Serbithang, a rehabilitation program in Bhutan, for three months and is currently struggling with issues related to her recovery while also providing relief counseling services at the DIC.

Last, I interviewed three participants at Respect, Educate, Nurture, and Empower Women (RENEW) who had all received counseling services in some capacity, and were all currently operating as employees of RENEW through their vocational training program. Rinchen is a twenty-three-year-old female who sought services from RENEW when she was 18 and continues to see a counselor on a monthly basis. Yangden is a thirty-five-year-old single mother of two who came to RENEW for grief counseling services in 2010. She met with a counselor monthly for three years. Tshering is a forty-six-year-old divorced mother of four who is 11 years sober after struggling with alcohol addiction and attending a rehabilitation program in India for seven months. She received counseling during her time at the rehabilitation center and also from RENEW when she returned to Bhutan, and referenced each of these experiences in her interview.

Review of Procedures

A staff member of each facility identified participants by acknowledging that they had received mental health services across at least three individual counseling sessions or consultations and could competently communicate in English. Sonam was the only participant who requested a translator for the initial interview and Chimi's husband was present during the interview for translation services. Sonam Choki, the head psychiatric nurse at JDWNRH, Tshering Choki, the coordinator of the DIC, and Tshering Dolkar, the clinical services coordinator of RENEW each assisted in identifying appropriate participants.

Each participant discussed their experiences with individual mental health counseling in an interview that lasted between 25 minutes and 1.5 hours. I developed eleven interview questions (see Appendix E) to guide the interviews, and took the liberty of asking additional questions to clarify points and further understand the participant's experience. The quantity of interview questions is abnormally large in phenomenological research. However, using eleven questions was determined to be appropriate in accordance with the cultural considerations, where Bhutanese are more comfortable with directive questions rather than open-ended exploratory questions. I recorded and transcribed each interview, reviewing the transcripts for accuracy as I prepared for data analysis.

Data Analysis

With each transcript, I proceeded with three rounds of coding where I first horizontalized the data by identifying expressions that were relevant to the Bhutanese client's experiences with mental health counseling. In the second round of analysis, I

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

reviewed the identified expressions eliminating those not necessary in understanding the experience or those that could not be abstracted. Finally, I clustered the remaining expressions to identify larger core themes of the experience. I grounded these themes in the data by identifying direct quotes from several transcripts that illuminated each theme. In the following section, I will create a textural-structural description of the Bhutanese client's experience with mental health counseling by explaining the core themes using descriptive quotes from twelve transcripts. I will also include necessary information about the Bhutanese context critical to understanding participants' experiences of counseling. These contextual factors will also be supported using direct quotations from the twelve interviews.

I constructed an original mental model of the relevant themes, including larger superordinate themes, themes, and sub-themes (see Figure 3.1). The first figure depicts the mental model that I presented at the member checks after having analyzed all twelve initial interviews. Due to an expedited six-week research schedule, I was not able to write this chapter while I was in Bhutan. As a result, during the writing process, some aspects of the Bhutanese context and how I depicted a few of the themes shifted in order to more simply and clearly display the information that I collected. Therefore, the Figure 3.1 contains information that participants were presented with at their member checks. Figure 3.2 provides the final framework for how I understand the client's experience of counseling in Bhutan, given all of the information collected in the initial interviews. One shift that is present combines "Counseling Occurs within Other Services" and "Counseling Context – Different Issues Are Treated Differently" from the mental model delivered at the member checks into "Counseling as Part of a Holistic Treatment." During

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

the writing process, I realized that my explanations justifying the first two items were nearly identical, and through consultation, decided to combine them into one theme that encompassed all relevant information. I also added two themes to the Bhutanese context: “High Power Distance” and “Collectivism in Speech.” These themes arose during consultation when I became aware of elements within the Bhutanese communication style and pattern that could be confusing to a Western audience. These themes were not mentioned specifically by participants, nor did I notice them explicitly because they are deeply engrained in Bhutanese culture. They are included here to clarify cultural and speech aspects present in the quotations to a Western audience. Finally, I adjusted the superordinate theme titles to “Sharing” and “Trust” in order to simplify the graphic, returning to details in the definitions of these terms.

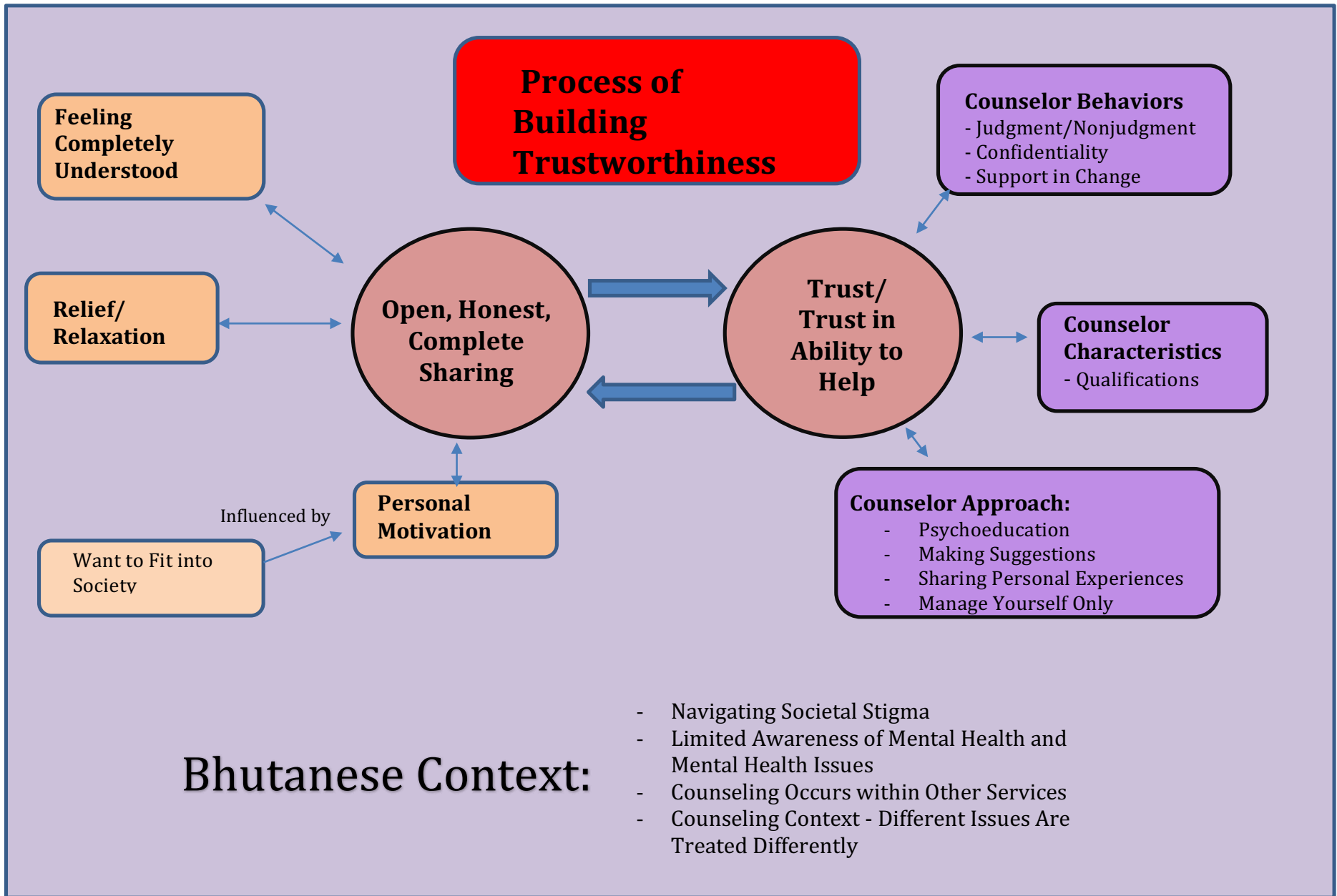


Figure 3.1. The process of building trustworthiness. This figure illustrates the mental model presented during the member checks showing open, honest, complete sharing and trust and the trust in the ability to help as the central components in the Bhutanese counseling experience.

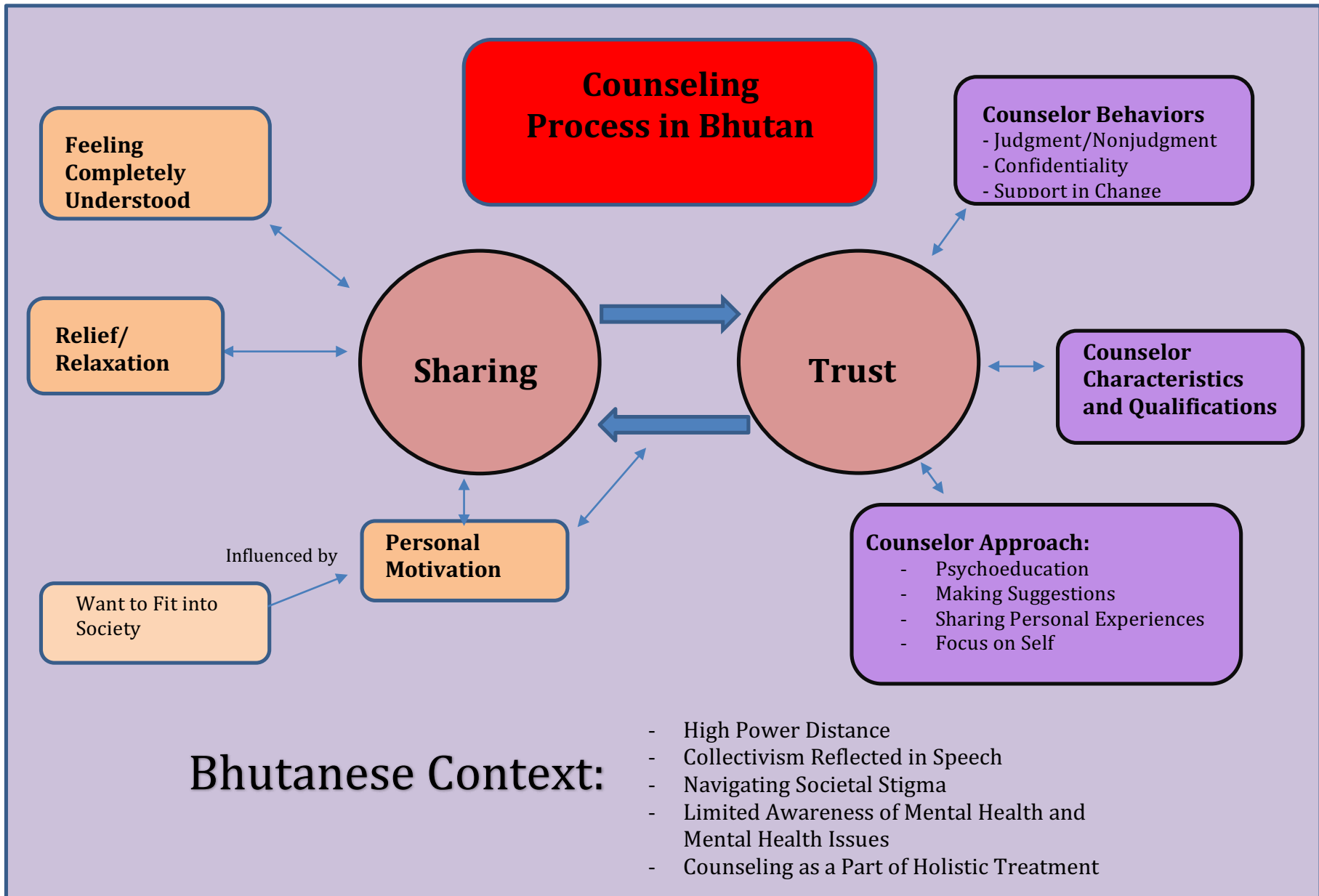


Figure 3.2. Counseling process in Bhutan. This mental model depicts the counseling experience as related by the initial interviews of the participants.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Themes

The client's experience with mental health counseling in Bhutan focused on two main superordinate themes: the client feeling comfortable to openly, honestly, and completely share with the counselor and the client's ability to trust the counselor and trust the counselor's ability to help. Sharing was influenced by the themes of the client feeling understood, the client experiencing relief and relaxation through sharing, and by their own personal motivation. Personal motivation also influenced the sharing-trust cycle and was affected by the sub-theme of the client's desire to fit into society. Clients varied on how understood they felt, if sharing provided relief, and their degrees of personal motivation. Given these variations, their willingness to share changed. Similarly, trust was moderated by three main themes: the counselor's behaviors, the counselor's characteristics and qualifications, and the counselor's approach to counseling. The sub-themes within the counselor's behaviors are whether they expressed judgments or were nonjudgmental, whether they honored the client's confidentiality, and whether they noticed and supported changes in the client's behavior. Finally, the counselor's approach contained several sub-themes, including providing psychoeducation, making suggestions, sharing their personal experiences, and advising the client to focus on themselves. Similar to the experience of sharing, the client's perceptions of the counselor's behaviors, characteristics and qualifications, and approach could increase or decrease their trust in the counselor.

The core superordinate themes of open, honest, and complete sharing, and trust in the counselor and the counselor's ability to help have a cyclical relationship. In some instances, the client may experience or perceive something that decreases trust in the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

counselor, which will consequently decrease the client's ability or willingness to share. In contrast, the client could also try sharing openly, and the counselor could respond in a way that increases the client's trust and reinforce the sharing behavior. This chapter will explore the sharing and trust-building process for clients in Bhutan in great detail, specifically identifying defining components of Bhutanese clients' experiences of counseling with Bhutanese counselors.

The individual counseling experience is also influenced by the specific context of Bhutan and how mental health treatment is viewed there. Five main themes became clear in relation to the Bhutanese social context, including: (1) the high power distance ; (2) collectivism reflected in speech; (3)navigating the societal stigma that exists with mental health; (4) limited public awareness of mental health wellness and mental health issues; and (5) counseling localized as a component of a holistic treatment model. In order to contextualize the interview data within the unique cultural aspects of Bhutan, I will discuss these five themes first.

High power distance. Bhutanese culture is shaped largely by compassion and collectivism where the success of the individual depends on the success of society as a whole, yet there exists a large power differential between people in positions of authority and laypeople. The main form of parenting is from an authoritarian standpoint, which is then echoed in school systems and in working environments. It is not unusual for parents, teachers, or bosses to take a harsh and punitive tone with others, and for the subservient person to take a submissive position. In the client-counselor relationship, the counselor is considered to be in a position of authority. It is then a cultural norm to speak forcefully, telling the client what to do. When discussing the counselor's characteristics that

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

influenced clients' trust, participants stated that it was more helpful for them to engage in counseling with someone who is friendly and polite than with someone who is harsh and serious.

Counseling can offer clients a unique opportunity to experience empathy and compassion from a person in a position of power; this in and of itself is countercultural. Tshewang, a participant who was experiencing inpatient treatment at the hospital, was said not to have engaged very much in the counseling process. He also stated that he did not deserve to be treated with respect as an inpatient within the psychiatric ward, which demonstrates the cultural pervasiveness of the power differential. This may have led him to disengage the relationship with his counselor and the process in general. Other participants who experienced being heard, understood, and cared for increased their engagement and experienced benefits from the counseling process. Counselors who operate against the cultural norms and offer clients empathy provided participants with a unique experience of connection, while services based on the medical model can be more hierarchical and punitive.

Collectivism reflected in speech. Bhutan has a collectivist society, which means that people often think and make decisions based on the interests of a group rather than on their individual interests. Throughout the rich and detailed quotations from participants in this research, they refer to themselves by their larger community, using words like "us" and "we." Using words like "I" or "me" is not the norm in Bhutan because the societal structure does not allow for people to consider themselves only, thus influencing the language to represent this concept. Participants are speaking of themselves in these instances, and place themselves in the context of their communities,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

which might be inpatient clients, people struggling with addiction, women, or mental health clients in general.

I observed this to be true of students in Bhutan as well. During the time of this research, I worked as a counselor and adjunct faculty at a college in Thimphu. I asked my Orientation to College Learning classroom of freshmen, “What are the differences between college and high school?” One student responded, “In college, we can wear our hair however we want. In high school, we had to have it cut a certain way.” This statement uses the term “we” to speak about all fellow classmates, which is accurate here as all students attended high schools in Bhutan where haircuts are part of the dress code. However, another student stated, “We feel more independent from our families.” The student is speaking on behalf of all students in the class in this example, but may not know how others feel. This is not seen as offensive or overstepping in authority. It is uncommon for people to refer solely to themselves, but often only have the authority or knowledge to speak on their own behalf. The words that they use present the collectivism, showing that they are members of a group where language does not allow them to consider themselves as a sole entity. Therefore, in the following excerpts, participants will say “us” and “we” speaking of their larger communities, but for the purposes of this research, they can only speak to their own experiences.

Navigating societal stigma. Another aspect of the Bhutanese culture is that societal stigma towards mental health issues and mental health treatment is pervasive. Clients have to navigate both seeking help for their mental health concern and dealing with the stress of feeling constant judgment from the outside world while they are receiving treatment. Two participants talked explicitly about the stigma that they feel

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

when seeking care. Further, many of the participants with a history of addiction also stressed the importance of confidentiality, which could be largely associated with the judgment that they receive from society as a whole when treatment for their addiction becomes known. In Bhutan, alcohol use and abuse has become an accepted practice.

When someone then cannot manage this habit and needs to seek treatment because they can no longer function in society, society impresses shame upon them. Namgay explained the process of initially starting to go to Narcotics Anonymous meetings, which is the format that is used in Bhutan to treat drug and alcohol addiction in an open community forum. He identified the struggle of not being able to advertise the support group on the radio and strategically finding a meeting place where people would be completely anonymous due to fear of judgment for their disease and for the need to treat it. When clients agree to participate in the NA program, the experience is like hiding.

There's a radio page and things, we are not allowed to release this program [NA], whether in the media, whether on the radio, it's not allowed. So, we [NA community] are really, we are like terrorists hiding. Before, we don't have a meeting. Only one meeting's there, one this only near the DIC, above that one. We used to hide. We'd gather there. We used to hide. There's no light like that here. We used to burn the candle, then we make the coffee. That time, a few fellowship [members of the NA community], we were there.

As an outpatient client, Lhamo felt similarly to Namgay. At three different times throughout her interview, she detailed accounts of what she believes other people think of her entering the psychiatric ward at the hospital to attend her usual counseling meetings.

Here is one example,

When they [Bhutanese people] see you outside, they [Bhutanese people] say maybe she's a psycho? Maybe something like mental disorder's going through her? She's not strong is what they're [Bhutanese people] saying. You have to be strong, you have to be strong. That's what Bhutanese think.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

These are two depictions of what it feels like to try to access mental health treatment in Bhutan for those who are worried about what other people think. In Bhutan, it is difficult to disregard judgment, because gossip is a normed part of the culture. The small town atmosphere throughout the country allows people to feel close to their community, and also facilitates the fear and possibility that judgments will be shared throughout the community and escalate. It would be reasonable to think that many people do not access treatment because the perceived consequences of judgment seem so high.

Limited awareness of mental health and mental health issues. The limited awareness of mental health and possible mental health issues contributes to societal stigma that exists around mental health treatment in Bhutan. The mental health field is just beginning, with very few mental health professionals working in Bhutan. Those that are working are often volunteers from Westernized countries or Bhutanese that are trained internationally through Westernized programs. The capital city is the only place that offers psychiatric care outside of medication consultation, and even then, they see very few outpatient clients, treating only the most severe psychiatric cases. There is a very limited amount of information available to people on mental health illness, how symptoms present and how concerns might be treated using counseling or medication. People often seek traditional healing techniques for issues related to mental health, which can be helpful and psychiatrists have noted people's severe mental health conditions continue to exacerbate when seeking ritualistic healing (Calabrese & Dorji, 2014). In Thimphu, there is a school that trains doctors in traditional medicine. In the villages where many Bhutanese reside, there is often a monk, lay monk, or spiritual figure that people visit in cases of mental illness instead of traveling to the city to seek psychiatric

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

care. Often people do not even know that this option exists. Scholars have suggested that in the future development of the mental health field, mental health workers should work in conjunction with spiritual figures in order to address concerns in ways that Bhutanese will understand (Lester, 2016; Pelzang, 2012). Lhamo noted that, as an employee of a school system, she was friends with teacher counselors and noted that students have more understanding of mental health than most adults in Bhutan. She made a case for educating more Bhutanese about mental health issues so they understand enough to seek treatment when it is appropriate and normalize counseling.

Lhamo: Um, if you were a health official, if they had like come to me and wanted to give me some feedback or something, why don't they like give some more awareness [of mental health], like because not many Bhutanese know about this thing [mental health and outpatient counseling].

Researcher: Yeah, so like a mental health campaign kind of thing.

Lhamo: The therapeutic division [department within the hospital]. Only I have seen like they come to the schools and like give this awareness [mental health] to the children. But why don't they like give more, educate, create more awareness of this counseling therapy session. Why don't they expand? The therapy setting there, it's like merged with the one thing or whatever it is, the detoxification, everything has been merged here [detoxification, inpatient, and outpatient in one building]. Why don't they separate it and create more education.

Researcher: And normalize it.

Lhamo: Yes. But it will help people. I know. It will help people. Because not many people know this. Not many people. Because even an educated Bhutanese, my uncle, a government official, even he didn't know we have this therapeutic division [department within the hospital].

Lhamo speaks to the vast misunderstanding of mental health issues in Bhutan. She wants people to be able to access treatment because it would help, and it would reduce the stigma that she feels when she uses counseling services. She appreciates the services since it has contributed to vast improvements in her anxiety, but expressed concern over what people think when she walks into the psychiatric ward. By normalizing mental

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

health treatment and issues, she would feel unencumbered relief when attending her counseling sessions.

Counseling as part of holistic treatment. Out of the twelve participants that I interviewed, only Lhamo was receiving regularly scheduled individual outpatient counseling sessions without further services provided. Others experiencing addiction were admitted to rehabilitation programs for three to seven months where they had an array of services, including psychoeducation classes, medical treatment for withdrawal or any complications from addiction, counseling sessions, and sober housing. They could then seek counseling or community support at drop in centers throughout the country upon their completion of the program with options to continue in AA or NA. Other participants were admitted to the psychiatric ward at the hospital for inpatient treatment. There they were prescribed medication, meditated regularly, exercised, had the 24-hour support of a family member, and received group and individual counseling. The women from RENEW had wraparound care in the manner of vocational training and empowerment, shelter if necessary, and monthly counseling appointments. It is rare for counseling to occur as the only treatment for mental health issues currently in Bhutan. These intensive services differ dramatically depending on the treatment, which contributes to differences in the counseling experience based on the presenting mental health issue. This holistic model fits both with the collectivist model in Bhutan and also with the early stages of the mental health field. The collectivist model incorporates the belief that people are happy and well as part of a group. Individual counseling, therefore, can be one intervention but is countercultural in nature. When it is combined with group meditation, exercise, and support of one's family, treatment then addresses the collective

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

aspects of society. Additionally, only cases that are seen as severe within society are treated with mental health services, where wraparound care is most appropriate. In this way, the Bhutanese seek to improve the wellbeing of the patient by addressing concerns in all aspects of life.

These five overarching cultural themes are necessary components in understanding the client's experience of mental health counseling in Bhutan. Through the remainder of the chapter, the Bhutanese cultural context will be referred to, elaborated and expanded upon to help ground a Western audience in the reality of the participants' world. In the following section, I discuss themes that emerged from my initial interviews with participants, focusing on displaying data in the form of direct quotations.

Sharing. The first superordinate theme in the client's experience of counseling in Bhutan is the client's sharing. In this context, sharing is the process in which the client reveals to the counselor personal information about themselves and their struggle with mental health in an open, honest, and complete manner. Jigme succinctly explained the concept of open, honest, and complete sharing within his relationship with his personal counselor in the rehabilitation program. In a country where there is stigma around mental health illness, and particularly with addiction, it is rare to have someone with which a person can share openly about these struggles.

Jigme: Counseling, as such, we [I] used to share our [my] problems. Our [my] difficult days in recovery, no? The day to day problem that I'm facing without the use of drug and alcohol. So I used to share with them [my counselor].

Similarly, Phuntsho experienced an inability to speak with others about her addiction. During the time of the interview, she was struggling because her friends were all drinkers. In an effort to be with people who support her, she had difficulty maintaining

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

her sobriety. When she reminisced about her relationship with her personal counselor through the rehabilitation program, she found that sharing was less complicated than with her current friends.

Phuntsho: Yeah. It's easier [to stay sober]. I always used to share with her. I always used to talk with her.

Additionally, Chimi, with the help of her husband's translation, spoke of her experience in the hospital where she was urged not to hide any of her feelings or experiences,

Chimi: I open...

Husband: She is not hide anything, so she is just open.

Chimi: Open, open.

Husband: She is just open when she is doing counseling... They are doing, they [the counselor], are asking take out all of your bad feelings so you can share it. No hiding. Just share. Take it out.

Participants spoke specifically about sharing and factors influencing it (feeling understood, experiencing relief, and personal motivation), which include attitudes that clients had formed about counseling before participating and attitudes that developed as a result of engaging in the counseling process.

Feeling understood. The first factor affecting sharing is feeling understood, where the manner in which the counselor responds to the client allows the client to feel as if the counselor has experienced this specific element of their lives. In Bhutan, there is very limited awareness of mental health. Clients often believe something is severely wrong when experiencing symptoms, and that they are the only one to have these experiences. Upon attending counseling sessions with a counselor who has awareness and knowledge of the mental health field, several participants described the normalizing effect of sharing and feeling completely understood by someone else. When someone

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

else recognizes and has words for the client's experience, they know that others have lived this, they are not alone, and their counselor fully understands.

For example, Lhamo struggles with anxiety that disrupts her ability to attend necessary meetings and fulfill daily requirements of her work as an elementary school teacher. She often spoke of not understanding what was wrong and the helplessness and isolation that ensued. She commented on her experience of being understood:

When you look for someone who can totally understand you, like what you're talking they can understand you because they don't judge you because they totally understand what's going inside your mind. It's normal. It's a big relief when you hear them say. It's [feeling understood] not a normal kind of feeling that you get [in Bhutanese culture about mental health concerns].

The counselor fully understanding Lhamo lets her know that she is normal and can continue participating as a member of society, providing her with relief. Among the participants with a history of addiction, nearly all of them stated that they preferred a counselor who also had experienced addiction. Namgay described the process of feeling understood by someone who had lived his struggles:

Actually staying in rehab, my own personal CP, you know counselor?... They also recover addict. And they understand. They, when I share with them, when I share to them the point, they know everything. And they [counselors with addiction background] come naturally because we have done *same* thing in life and even that counselor, they have done it.

His description of the counselor coming naturally shows the counselor's apparent authenticity when being able to discuss addiction and mental health struggles due to his personal experience with the same struggle. Namgay also described the dissatisfaction he has with his counseling experience when partnered with a counselor who does not have experience with addiction. His concern is not with the competence of the counselor, but

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

with his own inability to open up with someone who he assumes cannot fully understand his experience.

So I don't mean to say that, I don't mean to say that counseling are not doing their, you know giving good counseling. They does it. But uh for us [people struggling with addiction], a small lag, something's lagging behind them which we need it [shared experience] and we don't get it. So we [I] really feel awkward to share the counseling who haven't come from a background of a recovering addict and drug user and the person who can from the background, you know? We [I] can share with them [counselors with addiction background] freely.

This example shows the influence that experiencing being fully understood has on the client's openness to share and engage in the counseling process. When looking for suggestions to improve counseling in Bhutan, Norbu echoed Namgay's sentiments,

Counselors should be needed in Bhutan where they've had experience in addiction because they *know* what addiction is. I would suggest that.

In stressing that Bhutanese counselors with addiction experience know what the client is experiencing, they offer a service where the client can be fully understood. This consequently influences the client's willingness to share in that setting. This sentiment continued with Phuntsho and Tshering.

Phuntsho: It was like maybe we're [Phuntsho and counselor] both struggling and we have the same disease addiction.

Researcher: Yeah and you really understand each other.

Phuntsho: Yes. Normal people they don't understand.

Researcher: When you say normal people, what does that mean?

Phuntsho: Normal people, the person who don't drink, who don't take anything. Normal people. They don't understand. Especially with people like this, alcoholic and addict. But some of them are good, understand you, but some of them, not really good, we don't believe.

Tshering: The problems I have, also she [counselor] helps me. She understands my problems. Because others they don't understand. In this office, I don't know, the addiction people, they [counselors not in recovery] don't understand. Only [my counselor], she understands what is addiction.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Participants also described the results of opening themselves up and then not feeling understood. When they perceived something in the counselor or the situation that showed the counselor did not understand them, this prevented continued sharing and progress. In the hospital, Tshewang offered that his experience there could have been better if people were more caring towards him. When asked to expand, he described that counselors, as experts in the field, should understand his mental health struggles and how they have occurred in his life.

Tshewang: Um, they should be knowing the right situation, what, how the, what the situation [mental health] is, uh, how the situation is part of us. They should know the real situation that like right now, facing from depression, right? Like, they should know the right thing. Right. What had happened [reason for depression].

Researcher: Yeah, so they should know what's going on in your life.

Tshewang: Yeah, what's going on.

Researcher: And how you're feeling.

Tshewang: Yeah.

Researcher: Yeah. So understanding. Yeah.

Tshewang: People should be, people should be understanding... the feelings. One each other's feelings.

Sister Sonam, the head psychiatric nurse at the hospital who referred participants for the study, stated that Tshewang did not engage strongly in counseling, showing that his resistance to sharing may be related to his experiences of not feeling understood. These examples illustrate how feeling understood can help participants open up more with counselors, while perceiving a lack of understanding from the counselor can decrease the client's willingness to share.

Relief and relaxation. Another theme that influenced sharing was the client's feeling of relief and relaxation after opening up to their counselors. This occurs when they reveal information that they may not have told anyone before, allowing a weight to

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

lift from their shoulders. Kesang explained his experience of opening up completely with his counselor,

I always used to engage with the counselors and I used to respect them and I used to share my feelings, inner feelings with them. I never used to tell lie. I always used to speak truth. And I try my best to pour out. Because, by doing this, I'm getting relaxed.

As a Buddhist, Lhamo appreciated being matched with a Bhutanese counselor even when her English was excellent, which would have allowed her to work with the multitude of volunteer counselors at the hospital who do not speak Dzongkha. Her counselor could understand the significance of her culture and its traditional practices in relation to her mental health, providing a feeling of relief when she shared,

Like my therapy [therapist], he asked me, "Why do you think you have this problem?" And the answer I gave was, like, maybe some evils got onto me. So I feel like maybe some evil forces are there, so. And like he being a Bhutanese, you know? A Bhutanese, a fellow friend, you know? Taking this [my anxiety], it was strange, you know? It's a big relief. He can understand this [my anxiety]. He didn't say like it's not evil or what sort of thing. He said like maybe why don't you do 50-50. Of course you can consult like monks and whatever from our custom you want to do, you can do that also. And then like you can do, like apply what he through our conversations what we [talk about in counseling]... So it's a big, big, big relief, you know?

These examples all show how the feeling of relief and relaxation acquired through sharing openly and honestly with a counselor increases the likelihood of continued sharing.

Personal motivation. Personal motivation is the final theme that influences sharing, but can also exist independently of sharing and directly influence the client's engagement in the counseling process. In some instances, participants developed their own motivation to change before attending counseling, understanding that by engaging in the counseling process they will increase the likelihood of positive progress in treatment.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

For example, Jigme described realizing the full potential of harm before he gathered motivation to participate in counseling at a rehabilitation program,

I was admitted to hospital 3 times because of drug and alcohol, so I realized, no? If I continue with my drug and alcohol, then I might land up in jail or might be dead. So that's why I stopped. I got willing to stop. So I decided to go to rehab.

Jigme understood that in order to remain alive and functioning, he needed to seek out and engage in treatment. Namgay experienced something similar, relapsing after his first admittance into a rehabilitation program and attested to this necessary determination,

It depends on the recovery of the individual. If you want to stay in the recovery, you need 100% effort.

For Namgay, 100% effort after being released from the rehabilitation center took the shape of multiple NA meetings per week in order to stay on track. Kesang saw rehabilitation as a second chance at life, and this attitude helped him gather his personal motivation. He saw his addiction as preventing him from enjoying company with other people and being a functional and productive member of society. He then received judgment and discrimination based on this, so decided that he needed to change what he was doing in order to be someone he would be proud of.

But regarding me, the day when I entered this ward [psychiatric ward for detoxification], I promised myself that, now please... no more with your friends [who drink]. I'm going to change. I'm a poor guy. I want to lead a new life. I also want to spend my life like others who are just enjoying the society, isn't it? But so now don't come with me [friends who drink]. It's just the sense of thinking [how I thought about it]. I thought like this [change to stay sober]. Then, but only thing is that, we have to behave properly in front of others. And if we came to, if we came to do good things, then no one is going to judge us.

The idea of helping others is something that influenced Phuntsho and her personal motivation when she was receiving counseling services. This idea directly corresponds

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

with the collectivist mentality in Bhutan, allowing her to be an accepted part of a group after the distress of confronting her addiction.

Um, actually, when I was in school, uh, my counselor always used to counsel me, uh, regarding my addiction. So, uh, when they started counseling me, I have a little bit of motivation, so I can also overcome through the addiction and I can also help another addict.

Other participants noted that their personal motivation grew from encouraging interactions from their counselor or from the organization housing their treatment. Rather than internal motivation that developed before counseling, this personal motivation came directly from engaging with the counselor and openly sharing. Tshering had been tricked into attending a rehabilitation program in India against her will. She discussed how she gained personal motivation in this setting as a direct response to the programmatic goals and counseling she received. As a recovering addict, she spoke about initially being out of rehabilitation and passing by places where she used to drink when she was in Thimphu,

Tshering: It [hanging out with old drinking friends] didn't affect me because I had completely decided it [sobriety] is something that you have to give from your heart only.

Researcher: Right. Did anybody say anything or do anything to help you make that decision inside of you?

Tshering: That decision is a fifth step and the fifth step in the twelfth step, the fifth step is something where you have to open up everything.

Whatever you have done. That is done in a room with just one counselor. And I have to take out everything, what I have done, no hesitation, nothing. Be frank.

Here, personal motivation developed as a result of engaging in the counseling process and sharing openly, which is asked of participants following the twelve steps of the Alcoholics Anonymous program Tshering, like many other Bhutanese people, was treated with the Westernized program that has largely been adopted to counteract the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

quickly rising rates of addiction. Tshering found comfort and motivation in the sharing required of the AA program and the twelve step process.

Want to fit into society. For several participants their personal motivation derived from a drive to fit into society, contributing to the formation of a sub-theme. They believed that if they addressed their mental health struggles, they could return to “normal” as functioning members of society. This idea corresponds with the collectivist nature of Bhutan. When a person is not part of a group, their distress is exacerbated and they strive to regain part of their collective status. As a recovering addict, Namgay explained,

But program says that we [people with addictions] are abnormal. We can't compare with the normal people because we are really sensitive. So, so that's the expectation. If I go to rehab, if I take the treatment, maybe I can be suitable in society.

Similarly, Kesang spoke of his desire to be accepted in society,

The rehabilitation program gave me many, many good ideas that how will we [I] have to, now regarding our character and all, how we [I] have to act in front of others, how we [I] have to deal with the peoples, and how we [I] have to face ourselves [myself] in the society.

Lhamo spoke of her counselor's encouragement, but when she notices shifts in her mental health, it compounds her stress because she can no longer identify as someone suitable in society,

So I keep telling, uh, my therapist he keep reminding that I'm absolutely normal. The only thing is I have this anxiety, you know like this self-created sort of thing. But then like he knows like it's been like 11, 12 sessions together. He keeps on telling me there's nothing abnormal to find in me. It's absolutely normal. Like I talk, talk normally. When he talks, it makes sense to me. But then like sometimes, yeah, I feel like I'm abnormal. Abnormal. Why me, you know? Why not other people? With this anxiety, phobia sort of thing. Like mentally disorder sort of things I feel. I feel, uh, I have this mental disorder problem. I don't fit the society sort of thing. Yeah once in a while I feel low.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

In these examples, participants discuss how fitting in with society or currently not fitting in with society influences their motivation to participate in the counseling process in order to be more suitable in a general population. Personal motivation to succeed in counseling can develop prior to the commencement of counseling or during the experience. With an increase in personal motivation, participants are more likely to share and engage in the counseling process, which can consequently lead to building trust in the counselor and in counseling.

Trust. In addition to sharing, the other major superordinate theme that exists for participants is trust. This concept of trust can be defined as the client's belief that the counselor will accept them and be able to help relieve the client's distress, resulting in a higher functioning, more fulfilled person. Tshering may have summarized this overall idea best when she admiringly described the faith she has in her counselor,

She [my counselor] comes and says, "Don't do that. Don't do this. Everything will work out." It worked out.

All twelve participants discussed the three themes that moderated their trust in the process of counseling and their trust in their counselor: the counselor's behaviors, characteristics, and approach.

Counselor behaviors. The first subcategory of the counselor's behaviors can be defined as anything that the counselor actively does within or concerning their relationship with the client. This theme has been further broken down into three sub-themes including judgment, confidentiality, and support in change.

Judgment. Through different participants' experiences, judgment was seen on a continuum. At one end of the continuum, clients perceived their counselors as holding

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

harmful pre-formed beliefs about them, while the other end of the continuum was an absence of judgment, seen as acceptance. This continuum then impacted the client's ability or willingness to trust the counselor and the counseling process with the higher perceptions of judgment leading to lower levels of trust.

Lhamo described her experiences with an open and accepting counselor,

He's a trained therapist so he's uh whatever we say, sometimes, like mood swings also. I just don't feel like talking. Sometimes I cry there and burst into tears. Sometimes maybe laughter and a smile. Whatever, this entire session, maybe it was 11, 12 session we have together. Whatever it was how it was like he took it, he took it as normal.

Lhamo's experience with her counselor allowed her to present authentically because she was accepted without judgment. Similarly, Kesang described the nonjudgmental way of his peer counselor, providing the comfort he needed to trust and consequently share more in counseling,

I feel comfortable to speak all my things in front of peer counselor. Peer counselor in the sense that, uh personal counselor. So they [my counselor] used to take us [me] out and they used to speak to us [me] and there I feel comfortable. So they never state that they are counselors and we are addicts and all. They never used to differentiate between us [clients and counselors]. They used to be colleague. So then we [I] can share our [my] feelings.

In Kesang's case, it was important not be treated as lesser than others in order to become comfortable and open within the counseling relationship. Coming from the Bhutanese culture, he expected to be treated harshly by counselors as people in positions of authority, but found that the decreased power differential and acceptance was helpful in trusting his counselor. In contrast, Tshewang's nurse said he had not fully participated in the counseling process. When asked what had been helpful for him at the hospital, he focused mainly on the benefits from medication and exercise. His inability to fully

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

engage in counseling may have been a result of how he felt within the counseling relationship,

Researcher: Yeah. Um, do they [the counselors] treat you with respect?

Tshewang: Uh... they respect?

Researcher: They respect you?

Tshewang: I don't think so.

Researcher: You don't think so. How's that?

Tshewang: Yes?

Researcher: How is that for you thinking that maybe they don't respect you?

Tshewang: Sorry?

Researcher: What is that like for you? How do you feel about that?

Tshewang: I don't feel anything. It's normal... Normal. For me why to, why to respect? I'm, I'm here, I'm sick here.

Tshewang had been admitted for inpatient treatment for over a month in the psychiatric ward at this point, but did not feel respected by the people working there. While this did not strike him as inappropriate, it may have impeded him from building trust with his counselor and fully participating in the experience. In a similar lens, Namgay explained repeatedly that he would not be able to share openly with a counselor who had not personally struggled with addiction. When pressed on this matter, he stated,

I used to share, I used to share, but not my own personal, not my really personal. I can't share them [counselors without addiction background] because they won't understand. Maybe they will feel laugh inside. But I don't know, outside they are staying as a normal, they are giving, they are really showing their face, you know. They are showing their face, but inside I don't know what they're thinking. So that's why I don't share the personal. But small, the problem which I can't solve, I get a solution from them. But not my personal problem. I'll share in the [Narcotics Anonymous] meeting because we in the fellowship [NA community], we understand and not that counselor who hasn't experienced addiction.

Due to the judgment he has received from society as a person struggling with and being treated for addiction, Namgay is much less likely to trust someone without this experience because of what they could be thinking about him. This lack of trust then

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

prevents real connection within the counseling relationship through open and complete sharing.

Confidentiality. The next counselor behavior that influences the client's trust is confidentiality, or the counselor guaranteeing the strict privacy of all divulged client information. This idea was a main concern for four members with histories of addiction, again emphasizing the judgment they have experienced from the outside world and the desire to not exacerbate it. Namgay succinctly described his experience:

I don't want to, you know, I don't want to, if I leave this room, if I go outside, I don't need to hear my words from other people, to say, "Oh this guy have done like that!" So we are already, we have a stigma and discrimination of our drug user and alcohol user, we already have it and we are facing and we are suffering. On top of all that, if my words goes outside, then again double I will face it [stigma and discrimination].

Norbu, Jigme, and Phuntsho shared the same opinion about wanting to be anonymous and concern that this is not always the case.

Norbu: We need a counselor who can keep the story of mine, of, uh the story should be anonymous, secret, it shouldn't be open to the other people.

In Bhutan, counselors dealing with addiction have often successfully completed rehabilitation programs for their own issues with substance abuse. Jigme explained that one factor influencing his selection for a personal counselor at the rehabilitation center was the counselor's length of sobriety. When discussing confidentiality, he also mentions that his trust is dependent on the counselor's ability to stay sober. As a person struggling with addiction, he understands that at any point someone can succumb to the temptation of drinking, contributing to the vulnerability of the confidential information that they hold.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Jigme: Anonymity about the clients and what I've shared right now with the counselors, they go and talk with the another people. Some counselors are there. These are the problems that I think I have seen in Bhutan with counselors.... it's in the counselor's hand to keep the anonymity of the person. But that's depend on the counselors, how they perceive the client's problem and, uh, keep their things on the track [resist substances].

Phuntsho: Some of them are really calm, really polite, but some of the counselors are really harsh. And they tend to talk about the client outside the rehab also, which is really...

Researcher: Not good.

Phuntsho: Not good.

Researcher: Yeah.

Phuntsho: The incident happened in reality they used to talk after rehab. That's not really good for me.

When Lhamo, a participant without a background in addiction, was asked about the idea of confidentiality, she spoke of the distinction between mental health issues saying that lack of confidentiality was not something that would prevent her from sharing within the counseling relationship,

I think it will depend on the kind of issues like you go through. Like mine is just a phobia. There's nothing for me to be like not to open up. So if there's something like a sensitive case, they feel open to an outsider. Maybe not talking to a Bhutanese because like it's a small country. You know everyone. So somehow we are like related. So maybe it depends on the kind of issue going through you. So mine is just a phobia, so.

In her response, she touches on some aspects that are specific to a Bhutanese context.

Bhutan, while being an entire country, has the feel of one big small town where everyone knows everyone else, or a close relative of the other person. Considering this, it may feel risky to open up about sensitive mental health issues for fear that the counselor will then report this information to others and it will get back to a family member or close friend who will further discriminate based on this information. However, for issues that are not highly stigmatized (such as Lhamo's phobia), the client may feel more at ease to share regardless of the counselor's likelihood to protect their information.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Support in change. The final counselor behavior that was shown to influence trust is the counselor and the wraparound program supporting the client in change. This experience is best described as the counselor noticing shifts in the client's progress and encouraging it with words or actions. Participants often spoke of this through the lens of their own feelings of gratitude for the counselor and the support of programs, especially when considering what life could be like for them if they had not received treatment. Six participants spoke explicitly about the support that their counselors provided in making positive shifts. Norbu briefly summarized this experience by crediting his counselor for contributing to his addiction recovery,

And still I'm clean. And I am very grateful to that counselor and still he's in contact. He's very friendly.

Tshering, a woman with a history in rehabilitation and at RENEW, entered the interview saying,

I'm a recovering addict. And, yeah, I'm happy and I'm so grateful to this office because this office picked me up from the streets, giving me this new life. And I'm able to stay face to face with you now, so this is my 11 years clean.

She expanded on the specific support she received during her time at RENEW,

I forgot to tell you about [my counselor]. She is the main one actually. She is my support also. She is also one of my backbone.

Commonly, Bhutanese people will express gratitude not only for the specific person who has influenced change, but for the organization and people who sponsored the development of that organization because the client sees every entity as having a hand in their recovery. Yangden, Kesang, and Rinchen, echoed these feelings of gratitude for their counseling experiences,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Yangden: That I'm thankful to madam, [my counselor] and counseling, those who are counseling me. If I not come to RENEW, I'm not living like this also. I may be dead also. So thankful to madam. This much I'm coming in from. I say to madam like that.

Kesang: So, as a whole, I'm very much thankful to both rehabilitation center and hospital. Because I have been in darkness for more than 9 years... But only these, these things made me change and came to stay as a proper human being. Not like a still drunk. So I'm basically thankful to my beloved doctors and counselors. If I could not meet them, then maybe I'm not here today in front of you right now and share with you these views.

Rinchen: This time I'm sooo, on my life was good. But she, [my counselor] she also helped, she was happy. First time when I'm sick, my husband and me's divorce case. The case is 20 some days and the material, they, I'm sick and nobody have, [my friend], she will help me. I'm stay with her [my friend]. Then I'm sick and change, no change for me, and giving for, uh, RENEW, [RENEW gave me] money and uh change happen. Winner. All things are giving for this RENEW office.

Rinchen expanded by talking specifically about the changes her counselor noticed and the support she provided to continue such changes.

Rinchen: She [the counselor] was giving my counseling, then she will say, she will help me.

Researcher: Yeah, what will she say?

Rinchen: That time, this time, she'll say you're good and well. Look healthy. First time I'm sooo thin. This time I'm sooo healthy.

Finally, Lhamo discussed both her gratitude for her Bhutanese counselor and how she made positive shifts directly because of her counseling experiences and support. She frequently commented on her awe of Bhutanese people taking Western practices and adapting them to fit the Bhutanese context and people.

Lhamo: It is like something, you know, every day on daily basis, I thank him, you know? And then I feel, last time, on one particular day, I told him like, "Deity has kept a right person here." Because outside it would be a bit challenging for a patient like us, you know. Going so much into the mind and everything all sort of jumbled. He can really, like solve things, you know? Like sometimes, like some words, which would apply to us, he use it in Bhutanese terms. It's a plus point I would say.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Lhamo: So much effort has been and the importance has been given all this physical pain, physical sickness. But then mental sickness, like, nobody understood this. It was like so difficult to like you know get people convinced to talk about what you can be going through. And suddenly walking into this thing, like, it was like, it showed us like some maybe some hope. Gave us hope. Encouragement. Like, maybe I took things positively. My outlook on the life has changed from negative to positive. So that's the thing.

Lhamo subtly mentions the normalizing effect that the counselor can have, which builds the client's hope in recovery. Clients described their gratitude for their counselor's support and belief in positive change. This constant support allowed the clients to trust in the counselor and engage in the counseling process, producing shifts in viewpoints and behaviors.

Counselor characteristics and qualifications. Counselor characteristics and qualifications were also an influencing factor on the client's ability to trust the counselor and their ability to help. Characteristics can be defined as descriptors of the counselor's physical person, personality, or experiences that contribute to the counselor's being. Qualifications refer to the counselor's experiences or education that improved the client's view of the counselor's ability to help. Counselor demeanor appeared as a counselor characteristic that influenced Sonam's experience at the hospital. She had worked with more than one counselor over her two separate inpatient stays at the JDWNRH and described characteristics that were more and less helpful to her in her treatment. She responded to a question about what was helpful through a translator, who often says, "no madam?" This phrase is a filler to check for understanding, similar to "you know?"

Translator: She asked what do I, who are giving good counseling, telling good things and polite, no madam? We [hospital staff] are not giving harsh words... In a polite way. Some are uh telling, no?, harsh, hard to hear.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Researcher: This is what I've heard, that sometimes Bhutanese can communicate in a very direct and harsh way.

Translator: Yes. Direct information, no madam.

Researcher: And so wanting information still, but wanting it in a nice way. In a polite way.

Translator: Polite way.

In Bhutan, people in positions of authority, such as parents and doctors, are inclined to speak to people in a punitive tone which is congruent with the large power distance within the culture. It is then outside of cultural norms for a professional to strive to be empathic when working with a patient or client. In the counseling process, if the counselor was polite, compassionate, and empathic, this often increased the client's trust and engagement in the relationship. Phuntsho echoed Sonam's sentiment,

Some of them are really calm, really polite, but some of the counselors are really harsh.

Tshewang valued similar characteristics when he responded to questions about what he wanted in a counselor,

Tshewang: Counselor... they're polite.

Researcher: They're polite. Yeah... Anything else?

Tshewang: They're, uh, helpful.

Researcher: They're helpful yeah. Is it, do you like that they're polite?

Tshewang: Yes ma'am?

Researcher: Is it good when they're polite?

Tshewang: Yes I feel happy.

Tshering, Jigme, and Kesang spoke of enjoying friendly counselors, but not wanting to work with someone too serious, while Norbu noted specifically how friendliness influenced his ability to trust his counselor.

Tshering: I think for the clients, counselors should be little bit like, uh, good. Smiley, good, healthy. So they [clients] can open up.

Jigme: He's [the counselor] not that much old also and not that much young. He is like in our age only. Three to four years elder than me. So I'm very much comfortable with him and I told him I'm very much

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

comfortable with you, so I want to, like, I want you to be my sponsor, you know? Please help me with my recoveries.... In my case, the counselor that I used to share with, he's friendly.

Kesang: Yeah, if, if, if the counselor is too serious and it's just like this, then we could not, uh, clients are unable to approach him. So then in this case I think it doesn't work and it makes no sense of helping.

Norbu: Because even the hospitality, the way they treat me. Whenever I come to that place [DIC], that man [the counselor], he gave me a hug. He said, "How is your life going on?" And he used to talk in a very humble way, very jolly, frankly, he used to smile always. He never show his emotion face, he used to smile always. And from that on, from that day, I trust him.

These clients speak of friendliness, which allows them to take steps towards creating a real connection with their counselors, increasing their engagement in the counseling process and their trust in the counselor as a person. Another characteristic that could be important is gender. Tshering spoke of her preference for females to be matched with female counselors in order to feel comfortable and develop trust,

Female to female. That is important I think... Because we are afraid to talk. When a female comes for the counseling and the counselor's male, automatic, you feel... suck it backward.

On the other hand, Lhamo stated that gender was not as important as having a Bhutanese counselor who could understand her cultural and religious practices,

So like, uh, one particular day he like even like me talk with like an American therapist and I said like no. I want to be with you because I'm the kind of person like the way I chant, I say my prayers, you know? I still believe in like evil spirits, ghosts, and like outer forces, like it gets into, it [evil forces] can get into us. So talking to a Bhutanese fellow and he's trained in all of these psychological things and it's a big relief.

Therefore, different aspects of counselor characteristics, such as demeanor, gender, and cultural background can influence a client's trust in their counselor and ability to open up with them.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Counselors' experiences and education, or their qualifications, were also important to clients. Qualifications of the counselor is an element of the theme that surfaced repeatedly throughout the interviews. Different participants mentioned various qualifications that they would need in order to trust the counselor to be able to help them. Namgay, who was recovering from addiction, considered the counselor's personal experience with addiction to be of utmost importance, greatly influencing his ability to trust and feel understood.

And the person who has come from addiction [one counselor] and went to training and become a counselor [separate counselor], it's really vast difference. And that's, that's true. That's a fact I'm saying. You know I can fully share to them [counselor from addiction background] in counseling because they know everything. When they, I don't need to speak anything else. But by judging my face, judging my words what I'm trying to say to them. They come, they speak from them [their experiences] actually. Because they have already been to that situation. Compare with that, uh, not being from addiction, counseling, coming from a background of, um, training. That's not satisfied for us [clients struggling with addiction]. And that's a problem for us [me].

Phuntsho, who also had experience with addiction, preferred that her counselor be trained specifically in counseling, as well as have a background in addiction.

Researcher: If you were to seek out counseling again, what kind of, how would you want that experience to go?

Phuntsho: Um, training.

Researcher: Training?

Phuntsho: Yes.

Researcher: So like having someone who has training.

Phuntsho: Professional, no? Training and past experiences too.

Researcher: Training and past experiences as an addict... Why do you think those would be good things for you?

Phuntsho: Really because of, because they understand us more. Maybe they have, uh, knowledge more than the experiences. Maybe they're really highly educated compared to us.

Phuntsho stresses on education here partially because the counselors within rehabilitation programs and at the DICs often do not have any formal training, but counsel based on

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

their personal experiences and what has been helpful for them. Jigme and Tshering agreed that people counseling someone with addictions should have at least a familiarity of working with addictions, whether they have experienced addiction or not.

Jigme: Because, I think those counselors [without training], they give wrong information because they might be lack of such trainings and they think refer, can't refer to program [Alcoholics Anonymous and other programming].

Tshering: Addiction counseling, it should be in a proper way because now, we're, what you say? Like, uh, famous. Addiction should be at least known, no? Like oh she gives good counseling. Of course only a few counselors are there in education.

Tshering stated that addicts and addiction counseling has become famous because the mental health field in Bhutan is in an early stage, but there has been a large focus on addiction and addiction treatment. Alcohol use and abuse has been rising dramatically in Bhutan, leading the government to focus on developing effective programs to reduce this epidemic. One reason that half of the participants in this study have experienced addiction is that addiction services are growing faster than other mental health services. Therefore, there will be more clients who have received counseling from addiction services than from any other mental health service. To further Tshering's statement that counselors should be understanding of addiction services, Kesang did not care if a counselor had experience with addiction, but trusted only formally educated counselors to be able to help him and provide adequate services to clients. He identified that he would be qualified to become a counselor within rehabilitation centers. This knowledge decreased Kesang's trust in the counseling process and its ability to help him, desiring someone with formalized training where they have scientific knowledge of the addiction and counseling processes.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Kesang: Qualified counselors, so, qualified counselors can give more vast informations which can help the clients, isn't it? But these peer counselors [untrained addiction counselors], they are just referring to the group like this and they are writing their note on the board ... Just through their experience, they are counseling us. So if this is the case, then, if you get a chance to meet, I can also counsel in the rehabilitation center just keeping myself as an example Then after treatment, then just to write one heading and to explain, I can definitely do. So I think such types of counseling will not benefit the client in the proper way.

Similarly, Lhamo, who did not have experience with addiction, also found a counselor's formal training to be reason to trust him and his ability to help as a counselor. She described talking about her counseling sessions with her relative that referred her to treatment,

And I was saying he's a Bhutanese trained and he said, "Oh Bhutanese fellow, you know?" Our same Bhutanese, like taking this [treatment], this is from research, and like this came up in another country, and like bringing it to Bhutan and it's new, and that doing that is like something, you know? Wow. It's a great thing.... That's what I like the most about this session. The Bhutanese taking this [counseling] because after attending this thing [counseling], I like, uh, me and my uncle together visit this YouTube and then we like check what CBT is about. It's for anxiety, phobia, all this counseling, the psychological words and, like, our Bhutanese doing this!

Lhamo's statement also brings to light the cultural aspect of Bhutan where anything that is Western is considered superior. She explains looking up the specific cognitive behavioral therapy treatment online, learning about anxiety and phobias, and increasing her trust in her counselor and the counselor's process by seeing that Bhutanese have adapted Western practices. She enjoys the best of both worlds where she receives qualified progressive service, while also meeting with a counselor who fully understands her belief system and traditional background. Counselor characteristics and qualifications influence the way they are received by their clients, thus affecting the client's ability to

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

trust them and their services. Clients are more willing to engage in the therapeutic process with a counselor based on anything from gender to educational background. The increased or decreased trust based on these factors then influences how they will share about themselves and engage in change.

Counselor approach. The final theme that influenced the client's ability to trust the counselor was the counselor's approach to the counseling process. The counselor's approach is defined as the manner in which the counselor conducts individual counseling sessions. Several participants spoke generally about styles or techniques that counselors brought into individual sessions that could be helpful, or in one case unhelpful, for building trust.

Norbu: Actually, what I've found, what I've noticed is that the counselor, they're not talking too much. The person who is talking too much is the client only. They are giving open ended question, the question is very simple, which we can understand easily. I would suggest that the question should be in a way that it should be, the person should get it, it should be in a simple way. I think that will be, that will be more helpful.

Norbu responded well to receiving space to speak as the client and understanding clear questions that were asked of him. When asked what was helpful about counseling,

Tshewang echoed Norbu's statements,

Tshewang: Simple talk.

Researcher: Simple talk? About, about what?

Tshewang: About like, counseling.

Researcher: Yeah.

Tshewang: How do you feel? What to do, how to do. How do you feel?

Like that.

While Tshewang and Norbu commented on specific communication styles within counseling that were helpful, Namgay identified the manner in which a counselor can approach counseling that decreases his trust and openness in the moment,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Namgay: Yeah, yeah, yeah, yeah. So, so that's a tough for the counseling who want to give a question to the client. And the client, we say that we are really sensitive. Really sensitive. So if we heard, if somebody heard us, if somebody says unwanted question, we get immediately become angry and we stop.

Namgay identifies the sensitive nature of counseling and how a counselor might unknowingly say something within the session that ultimately shuts the client down. To look at the counselor's approach in more depth, I have established four sub-themes within the overarching counselor approach theme: providing psychoeducation, making suggestions, sharing their own personal experiences, and encouraging the client to focus on themselves only.

Psychoeducation. Participants talked generally about psychoeducation, which entails the counselor providing the client with information about mental health and mental health issues within session. For example, Sonam was dealing with depression and suicidal ideations without understanding why it was happening. At the hospital, she received information about mental health and what might be going on in her life and in her body to result in her current state, which was helpful. Sonam's translator relayed her message,

They are counseling and sir and madam they are giving more information... She get a lot of, her parents also, they get a lot of um, information, no madam? From here, when they join the counseling she get a lot of information from counseling.

Lhamo, Jigme, Tshering, and Kesang took this idea one step further by describing what it meant to them within a society that is fairly unfamiliar with mental health to better understand what they were going through. This improved their ability to trust the counselor knowing that they fully comprehended the experiences of the clients.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Lhamo: I get these panic attacks. Like I feel a bit shaky, palpitations, I feel like, like, I don't breathe. I'm not breathing. So like my therapist, he noticed, like while I talk to you, all this, like I'm shaking, he says, "All this absolutely fine. This is not heart attack. And it's fine. It will go away." And then like he teaches me some like breathing exercises.

Jigme: Like professional counselors, they, um, scientific problems about our [my] use of, uh, when we [I] use drugs, no?...The causes of drug and alcohol to our body, they used to relate to scientific things and it's much convenient to convince the client to stop that drug and alcohol, so.

Tshering: Because, now, of course at that time we didn't know that we were disease people. Now only I know. I am a sick people.

Kesang: Yeah. Firstly, I really [learned] the main meaning of addiction and merits and demerits of addiction. So we have to choose uh we have to choose, we should be knowing how to choose the path, isn't it? The black path or white path... So we have to delay that black path. Then rehabilitation program gave me many, many good ideas that how will we have to, now regarding our character and all, how we have to act in front of others, how we have to deal with the peoples, and how we have to face ourselves in the society.

In these examples, psychoeducation provided clients with the ability to understand their own experiences better and make decisions based on their well-being. The knowledge held by the counselors in various mental health areas also allowed the clients to trust in the counselor's ability and in the guidance they provided towards changing the clients' lives.

Making suggestions. Another way that counselors often approach counseling in Bhutan is to provide suggestions. This can vary from counselor to counselor and between organizations, but it generally entails the counselor asking or telling the client to try a technique or strategy outside of the counseling session in order to reduce their distress. Some participants even stated that if they returned to counseling, they would consider seeing a different counselor just to receive new suggestions from other people. Due to the hierarchical nature within Bhutanese society, it is within cultural norms for people to seek

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

help from a counselor expecting to be directly advised. The majority of participants spoke of suggestions they received, which increased their trust in their counselor's ability to help them as this is an expectation of mental health help in Bhutan.

Jigme: They are counselor from the professional counselors because they have no, I say like, more knowledge about the two worlds. One thing is the normal world that people don't drink and all, then another is the drug and alcohol. They used to relate both the things and used to give us [me] the suggestions, so it's much comfortable, but it's very much useful from the professional counselors.

Jigme stressed the importance of someone being able to make suggestions based on personal experiences and understanding of the addiction world as well as the "normal" society. The guidance his counselor provided helped him to maintain his sobriety and deal with the everyday challenges of trying to function in the non-addiction world.

Similarly, Namgay explained the importance of having realistic expectations and suggestions in order to function successfully in this non-addiction world,

Namgay: It's basically a suggestion how to manage with the lust, how to manage the enjoyment, how to manage friends who are using. They say, they haven't said don't go with your friend who's using [substances]. You can go with them! But they give suggestion how to stay with the friends.... So that's really I used to take those words from that counseling in a good way. And I used to work hard and I used to utilize also. It works.

The success of the suggestions allowed Namgay to continue engaging in the counseling process and trusting his counselor's ability to help him. Norbu's trust was contingent upon the counselor's experience with addiction, but stated that he would benefit from multiple counselors' suggestions on how to proceed as a recovering addict,

Norbu: I think it would be, would be more beneficial if it was different counselor will have their... will have their own stories, will have more to suggest, will have their different experience that would benefit me. And also, from the different counselor, if I had been to get the counseling from the different counselor, it would be more beneficial to me. Only there's a condition, like I said, that stories should be secret, it should be

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

anonymous. And also, I'd go only if the different counselor are experienced, what I said earlier, are experienced in addiction. Only in that case I can trust them and I'll get counseled.

Norbu sees counselors as a wealth of knowledge with recommendations from personal experience. By having access to multiple counselors that he can trust, Norbu sees the likelihood of him identifying tools and strategies that work for him personally. Tshewang also commented on the benefits of receiving information from more than one counselor,

Tshewang: Like, giving different types of, different ways of counseling. Like, um, like giving different ideas. Different ways to change the people.

Researcher: Yeah. So almost like different options?

Tshewang: Options. Giving more options for the change.

For some participants, the suggestions could take the form of limit setting or empowerment to pursue actions that they may consider unacceptable to society, but were in their best interests.

Translator: Yesterday, uh, he's doing counseling, that time that counseling no longer allowed to use mobile. Disturbing her mind, no ma'am.

Sonam: Difficult yeah.

Researcher: So not using the mobile, that's hard.

Sonam: Better without mobile

Researcher: It's better without the mobile. So, so you can... what's different about not using it?

Sonam: Better without using mobile. (laughs)

Researcher: Better without mobile. Yeah. What's better about it?

Sonam: No chatting.

Researcher: No chatting? (Sonam laughing) Those are things that get you in trouble sometimes with yourself?

Sonam: Disturbing my whole life. Counseling. Sleep proper.

Sonam identifies a destructive pattern that she found herself in, and the limit setting that her counselor provided by asking her to stop using her phone. Sonam tried something she would not have otherwise put into action because she was asked to. Similarly, Lhamo struggled to deal with her anxiety and feared telling other people about it, but decided to try after receiving a suggestion to do so from her counselor,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

So now it's like, ok let's face it, if I can, I'll go there [meetings] and sit and if I can't I'll just walk out. Maybe I'll tell [the person next to me] like I'm getting anxious. Like if I have palpitation or whatever and I need to walk out, maybe I can tell that I'm feeling dizzy. I can like open up. You know, before it's like how am I going to say and share with my friends what I'm really going through. I couldn't share, you know. I couldn't share. But like inside I was like, I was like, what to say? Struggling you know? It's killing, the anxiety thing like has really been like killing me you know? I couldn't really share. Now like the therapist says sometimes like talking and then like sharing really helps, so whoever sits beside me like during the meeting, I say, I'm anxious, I have to walk out now. I have to go.

By telling people what she was experiencing, Lhamo reduced her anxiety around meetings dramatically, allowing her to function more fully at work. The success she felt with this shift in behavior created more trust with her counselor, allowing her to open up more and try more suggestions. Her counselor essentially gave her permission to try something she was afraid to do. Similarly, through RENEW, Tshering, Yangden, and Rinchen experienced their counselor often telling them what to do, empowering them within their positions and offering empathy and compassion throughout,

Tshering: I'm, how you say, I share my this to her and she say, "Oh you don't do this, huh, you no, no this." But she also, "You're great." Something about the seniors, no? [leaders within RENEW] Something [my counselor] appreciates what we do. Of course, it gives us something strong feelings. Happiness.

Yangden: [My counselor] told me that, "You should not be do like that. Every woman being gets problem, but you should not be like that. You have to be, you have to be strong. Uh we [you] have two child. Then you can give advice to your child. You can get good education."

In Rinchen's situation, she was urged to divorce her husband who would use drugs and allow his family to verbally and emotionally abuse Rinchen. Her counselor at RENEW empowered her to leave her husband, though there is a large stigma towards divorce in

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Bhutanese culture. Rinchen found strength through the advice in counseling to identify the action that would be best for her and developed happiness in her decision to leave.

Rinchen: Um, she, she tell, “Don’t stay, uh, don’t do like that. You can, you’re doing your own way for your life. Your husband, nobody giving. Your family, your friends not meeting.” There, she’s saying, then you’re giving counseling. Then I’m do, doing, then I’m getting for my life is happy.

In Bhutanese counseling, suggestions and advice can come in many forms. Participants who were interviewed found advice to be honest, helpful, and often based on personal experiences of the counselors, thus increasing their trust in the potential success of the strategy. This reaction continued in the next counselor approach where counselors share their personal stories with clients in order to invoke change in the clients’ behaviors.

Sharing personal experiences. Participants, namely the participants who were recovering addicts, found it helpful when counselors shared their own personal experiences in counseling sessions. This concept entails counselors recounting a story or strategy that they used when they were going through a similar situation, providing ideas for ways the client can manage their current dilemma.

Jigme: But whenever we [I] share our [my] problems and we [my counselor and I] used to talk about the problem, they [counselors] used to give us [me], uh, share their experience, how their journey of their trouble, how they came from the trouble [addiction]. Mostly people share here [in rehabilitation], the counselors or whoever counsel them, people share their experience and relate to, relate our problems, and they get suggestions.

Norbu: Before I got counseling from him [my counselor], actually at first he was sharing his own story. How he went into addiction, how he came out of addiction. And suddenly, I got motivated from the story he shared to me.

Phuntsho: For me, it’s, uh, it’s a motivation conversation only [counseling]. Usually we [my counselor and I] talk about our addiction life only. So she [my counselor] always used to talk about her addiction and how hard it is, so, uh, she always... when, whenever I go with other

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

friends, they used to drink. We [friends and I] talk, we talk, we support each other, but we used to drink alcohol. But during her case [my counselor and I], we used to talk but there's no alcohol, nothing. Only coffee. So I feel very much, uh, good.

Kesang: They [counselors] also used to speak truth. Then, while they are making a counseling session, they used to keep them [themselves – the counselors] as an example. How they stayed during their addiction time. So, from such things, uh, we can at least make up our hopes.

Namgay: Because when they [the counselors] speak, when they give input in the class, when they speak, when they share to us [recovering addicts], we feel we have done it. And we go in the deep image in the already past.

When Namgay states, “And we go in the deep image in the already past,” he is stating that he relates so strongly to the counselor’s experience that he can visualize his own previous experiences around addiction. In each of these cases, the client experienced addiction and built trust with their counselors when hearing the counselors’ stories of their trials through managing their own responses in recovery. Not only are the suggestions concrete, they have also been successful leading to hope within the client to achieve and maintain sobriety. The idea that the counselor can relate so deeply to their experiences allows them to be open to the counseling process, increasing trust in the counselor and their own sharing.

Focus on self. The final aspect within the counselor’s approach is the counselor’s attempt to have the client focus only on managing themselves and their treatment goals. This can be seen as the counselor providing suggestions or techniques for how the client might manage themselves, while also encouraging them not to worry about other people, judgments, or responsibilities during this time. Bhutan has a very collectivist society, so it is rare for people to feel comfortable prioritizing themselves. Participants experienced

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

this technique as a form of empowerment, urging them to take care of themselves before they can worry or take care of others.

For example, Chimi and her husband stayed in inpatient care for a week. During this time, she focused solely on herself and improving instead of worrying about her two children and additional responsibilities at home. She took full advantage of the inpatient care, meditating twice per day, having counseling sessions twice per day, and exercising. When asked if she had anything to add about what had been helpful, her husband translated,

Husband: So, daily counseling is good. In a day at least twice or thrice. Counseling is good for depression.

Researcher: Yeah. So, how do you think you will continue to be so successful with this when you're out of the hospital?

Husband: (speak back and forth in Dzongkha) So more meditation and exercise help us [her].

Researcher: Great, yeah.

Husband: By hanging with her friends. Before she didn't like to hang with her friends or gatherings, so now she feel like to enjoy, she feel like to roam, she feel like to eat, she feel like to sleep. She has sound sleep at night. Before she has, she can't.

Before going to the hospital, Chimi struggled to focus on herself and did not participate in activities that she enjoyed. After a week of inpatient treatment, Chimi and her husband were determined to persist with these activities when she returned home from the hospital in order to take care of her mental health. Similarly, Rinchen struggled to manage her feelings and situations at home leading to her depression when she was married to a husband abusing drugs and had a small child. She stated the helpfulness of counseling in figuring out how to let that piece of her life go and focus on being functional herself. By focusing on what she needed, she was able to make decisions, like getting a divorce, that were not looked highly upon by society but benefited her mental wellbeing. She

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

internalized her locus of control, learning how to manage herself and thus manage her life by focusing on her own health.

Rinchen: We [I am] are getting more and more [counseling]. I can think... Your [my] life. Then, you [I] manage this [difficult situation].

Researcher: Ok. So how did she [your counselor] help you manage the things in your life?

Rinchen: I think my, my life is... Gone and gone [marriage and family]. But, but I'm on my, my mind is managed with me.

Yangden suffered from depression and suicidality after the death of her husband. She stated that she had too much free time to think about how good her life was when her husband was living. She said that counseling allowed her to be an “empowered woman” and encouraged her to focus on herself and her development as a professional. She had only completed her education through class ten, or the equivalent to a sophomore in high school. Her counselor encouraged her to go back to school and follow her own dreams, so at the time of the interview, she was the head weaving instructor and was completing her class 12 exams to qualify for college.

Yangden: When I was thinking about my past life [before husband died], I got too much depression. My husband also is good job. He's a lawyer, lawyer. And always thinking of my past life. Then I got too much depression... Then I got thinking of past life, always going for counseling, how I will forget my past lives.

Researcher: Right. So counseling helped you put the past away and to focus on living now. Yeah.

Yangden: Yeah. Then I just spoke with [my counselor]. It was helping too much. Now I'm not much depression madam.

Researcher: Right, so what helped you to focus on your life now?

Yangden: I thought, um, my life, I'll change from my job now [stop weaving job]. Job. If I did good, I got good result [on school exams], but this is a good job [weaving job]. But for me, I know everything, I know how to teach them [weaving students], I know how to weave. But I thought of going to change it if I get good result. I'm too much interested in the sister [traditional nurse]? Traditional hospital, no ma'am? I got too much interesting to those who got problem and I can help them.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Through counseling, Yangden shifted her attention from her previous years and her kids to focus on her goals of completing her education to become a nurse of traditional medicine. Her focus on herself helped her to relieve her distress and be a better mother to her children. The success of her participation in school and as a weaving instructor in defeating her depression and suicidal thoughts also increased her trust in her counselor and the counselor's ability to help.

After experiencing relapse, Namgay developed techniques, such as attending Narcotics Anonymous meetings at least once per week and other ways to take care of himself. He does not share his struggles with addiction with his wife or family to spare them from worrying about him and not increase the stigma he feels. He depends on his group to keep him accountable and safe. In this excerpt, Namgay ends some phrases with the word "la," which is used in Dzongkha to show respect to the person being spoken to. Then when people speak in English, they often continue to use it within the English language to continue showing respect.

I need to take care of myself. Because I already lost my track [relapsed] and I already lost the trust la [of family]. So once I lost the trust, once I got relapsed, it was really terrible for me la because of guilt, I don't know, because of guilt or shame, so I could not get up easily la.

Finally, Lhamo's trust in her counselor increased when he recommended that she focus on herself because the rest of the world is out of her control. His acceptance of her allowed her to practice being more accepting of herself, shedding the self-consciousness she had around her anxiety and ultimately improving her mental health.

Our outlook has changed. The therapist keep on reminding you cannot change the outside world. You have the power to change the world within you. So why do you bother, who's going to judge you. It doesn't matter. So it worked into me so I don't care.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

While suggesting that the client focus on themselves only is a counterculture idea, clients have seen improvements in their own mental wellbeing with this advice. With this improvement and with the support of their counselors on their journey, their trust in the counseling process increases. Consequently, they participate more in the process, sharing openly and honestly, creating a cyclical pattern.

The Cycle of Sharing and Trust

While the counselor's behavior, characteristics, and approach to counseling moderate the client's trust in the counselor and their ability to help, the trust that may or may not develop consequently influences the client's willingness to share, creating a cyclical relationship. Some participants required time developing rapport within the relationship with their counselors to develop a level of trust that allowed them to feel comfortable openly and honestly sharing. For example, Norbu described his process of withholding information from his counselor until his counselor shared his own story with addiction.

I never open up my feeling. I have said earlier that for 3 months, I didn't open anything. It was all lie. I was talking shit to him. After 3 months, I would say it was my second home, that place [the DIC]. I would hang out 'til 10, late night with them. And then only I used to get more closer with them, the people, even the counseling, the counselor. Even then I opened up my feeling... And from that on, from that day, I trust him. I used to share every problem of mine to him. Then we get closer. I helped him to get counseling from him, and in return he helped me.

Other participants were motivated to be open with their counselors from the start of treatment. Their counselor's positive responses then increased their trust in the counselor and their willingness to share. Kesang illustrated his process of being admitted to the rehabilitation program,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

There I meet [the psychiatrist]. So I shared all my true feelings. I've never hidden anything. I poured all, so how it happened, how it was me. So then doctor kindly accepted me and she admitted me in this ward.

Kesang was determined to change before being admitted for treatment, so he was open and honest when he first spoke with the psychiatrist. In response to his openness, she accepted him into the hospital for detoxification and made sure he would have a position secured at the rehabilitation program after he completed the detoxification process.

Kesang built trust through this interaction and continued to be open with mental health workers throughout his rehabilitation treatment.

In contrast, some participants did not feel comfortable sharing, and their perception of the counselor did not lead to trust, decreasing any sharing or engagement in the counseling process. In Lhamo's experience at the hospital, she created a strong and trusting relationship with her counselor, and also described this scenario when she was asked to meet with another counselor for one session unexpectedly.

Maybe like I'm the kind of a person who takes time to open up and talk and then like get used to, you know? So like, uh, I remember like once like it's been like our 4th or 5th session, like talking, coming here and then like talking, continuing like where we stopped and talking about the thoughts and whatever experiences I've had and. And one time I walked here and, uh, I can't know the other therapies [therapists], you know like, so maybe therapists have come and then like, had he [my counselor] talked, uh, told me about these other therapists and made me talk, it would have been easier. So maybe like he was busy and like dealing with other patients and maybe forgot to like introduce but then just walked in and he meet me and said talk directly to the new therapist there. And then like, I was like, uh, what's going on? I was like we need to start, what to say? I couldn't really express myself like this.

Some participants felt comfortable sharing at first, but responses from the counselor did not lead to building trust, influencing the client to regress from sharing. For instance, when asked what was helpful about counseling, Tshewang responded, "medicine," and

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

later, “making our body fit,” showing that he felt like the medication he was prescribed at the hospital and the exercise were helping, but did not speak about the individual counseling experience at all. He stated, “I don’t used to keep words, or I don’t, I don’t keep the things inside. I’m open-ended, open-minded.” However, when asked what could be better, he replied, “I, I want more care,” making it plausible that he may not have fully engaged in counseling because he was not being completely cared for, despite his willingness to share.

This cycle depicts the building of trustworthiness with increased sharing and trust in the counselor, which is the essence of the counseling process in Bhutan. In cases where there is decreased trust and sharing, the counseling process is blocked, leading the client to disengage from the experience. In order for the client to fully engage in the counseling process, there must be trust in the client-counselor relationship. The client must feel safe sharing, and the counselor must respond in a way that communicates both acceptance and helpfulness. When sharing and trust increase together, the client relates the most success from their counseling experience.

Context for the Researcher

During the interview process, I became aware of the difficulty of working within a different culture with a different primary language. Before interviewing participants, I worked at a college in Thimphu for three months teaching and providing counseling services to Bhutanese college students. Schools in Bhutan provide English curricula from the first year in school. Therefore, by the time students reach college, they are proficient in spoken English, which allowed me the freedom of remaining comfortable in my native language. The general public, however, does not necessarily have a strong grasp on the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

English language. In the interviews, I found myself more engaged and present with participants who spoke English very comfortably. Not only could they relay information that I understood, but they were introspective, providing insights that genuinely helped me imagine their experiences. I felt this way in conversations with Lhamo and Kesang at the hospital, with Namgay at the DIC, and with Tshering at RENEW. I believe that I was able to gather a richness of their counseling experiences and connect with them personally through the interview process.

In contrast, some participants did not speak English well, leading to more difficult and stilted interviews. In these instances, I put great effort into reframing questions, providing hand gestures, and trying to make the interview process as simple as possible. I worked to create an environment that was supportive and patient while participants and I slightly missed each other. When there was a mutual understanding, the participant and I would each light up, noticing how it felt to truly comprehend another person for a moment. Despite these moments, the interview process became taxing and discouraging for the participant during portions. Even in the case of Sonam who requested a translator due to her discomfort with English, the nurse who provided translation services also had poor English skills. This produced the feeling of a game of telephone, where I would ask a question and receive a response that did not quite fit after two slight distortions of meaning. Similar experiences occurred with Tshewang and Rinchen. For this reason, they are somewhat underrepresented throughout the rich description of themes. The shallow nature of the interviews did not offer as much information that clearly depicted the themes, but I did gather a sense of their experiences. In response to the difficulties with language, I made arrangements to have translators with mastery in Dzongkha and English

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

present at the member checks for each of these participants and arranged to be in contact with Sister Sonam about excerpts from transcripts that required clarification on cultural meanings.

Conclusion

I interviewed twelve participants who had received mental health counseling in Bhutan in an effort to understand the Bhutanese counseling experience from the client's perspective. After transcribing and proceeding through three rounds of interview coding, I constructed a mental model that represents the counseling experience as depicted by the twelve participants. Superordinate themes were the client's open, honest and complete sharing with the counselor and the client's ability to trust the counselor. These created a cycle that was influenced by the following themes: the client feeling understood, relaxation and relief from sharing, the client's personal motivation, the counselor's behaviors, characteristics and qualifications, and approach to the counseling process. The experience of individual counseling occurs within the unique cultural context of Bhutan, including the high power distance and collective nature of society. In Bhutan, clients deal with the constant societal stigma that exists towards mental health issues and treatment, which is fueled by a lack of knowledge or awareness of mental health by the general public. Additionally, clients are treated dramatically differently depending on their presenting issues because counseling is not yet a standalone service, but exists within holistic programming.

CHAPTER IV

SECOND ROUND ANALYSIS

Introduction

Member checks were the primary method used to establish trustworthiness. Of the twelve participants, I conducted member checks with eleven. I was unable to contact the twelfth participant as he had been discharged from the hospital and changed his telephone number. To start the member check, I asked each participant about their experience with trust in the counselor-client relationship because trust was not directly spoken of often, but the concept came up frequently in the initial interviews. I then explained the fully developed mental model presented in Chapter III (see figure 4.1) based on the twelve initial interviews. During each member check, I asked participants if they understood each of the themes and how they interacted, if they would change or alter anything, if they would add anything, and if there was anything represented that was not present in their experience. Finally, I asked what aspects were most prominent in their experiences of counseling in Bhutan.

I attempted to contact the twelfth participant, Tshewang, on two occasions via phone through a translator at the hospital, but was unsuccessful in receiving an answer from the listed phone number. Due to the intensive short-term treatment model that currently exists in Bhutan and the large rural population that has limited access to telephone reception or Internet, this outcome was not wholly unexpected. At the hospital, clients who attend inpatient treatment complete paperwork requiring a phone number and address upon admittance. Tshewang's listed number was not answered, and there are no

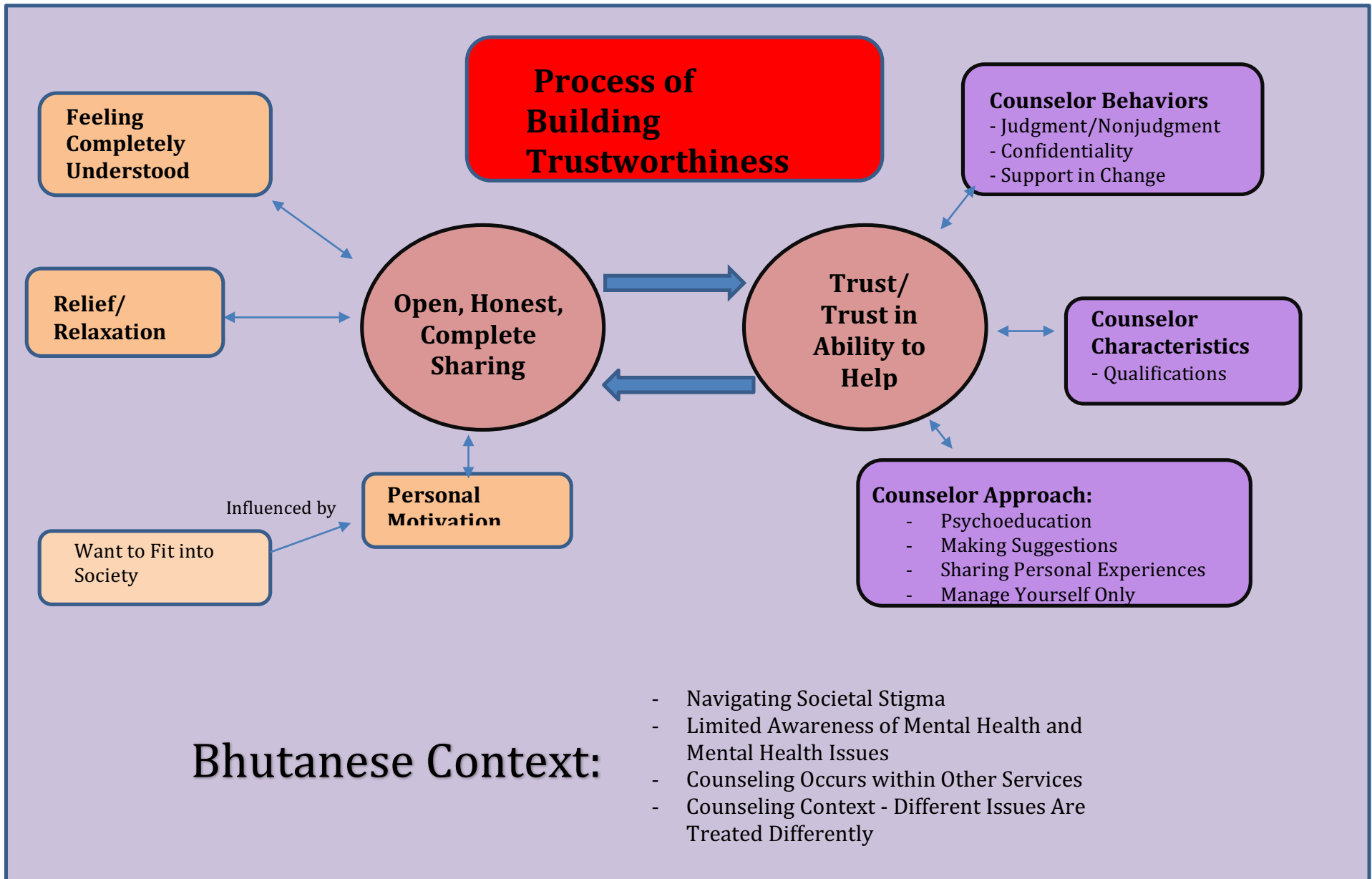


Figure 4.1. The process of building trustworthiness. This figure illustrates the mental model presented during the member checks showing open, honest, complete sharing and trust and the trust in the ability to help as the central components in the Bhutanese counseling experience.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

voice messaging capabilities on cellular phone services in Bhutan. Moreover, Sister Sonam stated that people often change phones and phone numbers when they move, speculating that Tshewang could have chosen a different phone or phone service when he moved back to his village.

The four remaining participants from the hospital, Chimi, Sonam, Lhamo, and Kesang, were able to participate in member checks. Chimi had also been released from inpatient treatment, and was available to speak on the phone with Sister Sonam. Chimi understood English, but had her husband present as a translator when necessary for the first interview. Sister Sonam acted as a translator and explained the mental model to Chimi, checking for understanding throughout. When the phone call terminated, Sister Sonam translated the information she received from Chimi to me, which I recorded and later transcribed. Sonam, a client who had received inpatient and outpatient treatment at the hospital, was contacted by accessing her phone number from her inpatient admission records. She agreed to come into the hospital for her member check. Due to the poor translation services she received initially that contributed to a shallow interview, I asked a nurse who was not a part of Sonam's treatment with excellent English language skills to translate for the member check. We sat in the same room together and went over a paper visual of the mental model. Lhamo was an outpatient client who regularly sought out counseling services at the hospital. I received her phone number from the security guard who has an informal friendly relationship with Lhamo, since people utilizing outpatient services leave no information at the hospital. She was unable to come into the hospital, but speaks English very clearly and provided an email address to receive the mental model. We were able to discuss the mental model on the telephone as she was viewing it

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

on her personal computer. Finally, Kesang, who completed rehabilitation treatment and worked at the hospital as a security guard, was available during one of his work shifts to sit with me and complete the member check at the hospital.

Next, I contacted Tshering Choki, the manager of the Drop in Center (DIC) in Thimphu where people receive follow up counseling and attend group meetings for addiction treatment, generally after the completion of a rehabilitation program. She contacted each of the four DIC members that participated in initial interviews. They were all able to come in one afternoon to complete the member checks. I spoke with Jigme, Norbu, Phunthso, and Namgay, each one-on-one with no outside translation necessary. While Namgay's member check was the longest at 48 minutes, we were interrupted with the start of a Fellowship or NA meeting. He had answered all of the questions from the member check and was expanding on his philosophical views of counseling in Bhutan at the interruption. We concluded our conversation quickly outside of the meeting room, but did not record the final several minutes of dialogue.

Finally, I conducted three member checks at RENEW. Rinchen had been uncomfortable with the English language at our first interview leading to an unclear and shallow interview. I asked Rinchen if she would be comfortable with Tshering sitting in as a translator for any confusing language during the member check. She agreed and proposed the option to Tshering who agreed to help. At one point, Tshering stated that Rinchen was wondering what her thoughts were on the mental model and relayed how she explained that Rinchen needed to answer the questions with her own thoughts. Towards the end of Rinchen's member check, Yangden arrived with limited time to do her member check, which rushed things slightly at the end. Yangden's member check

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

went smoothly, but the pressure of time and her sacrifice to come into work specifically for her member check on a day of exams led me to not follow up in some areas where I would have taken more time otherwise. Finally, I conducted the member check with Tshering. Since she had already heard my explanation of the mental model, our conversation was more free flowing and less structured than others.

The member checks ranged in time from 17 minutes to 48 minutes and averaged around 30 minutes in length. All of them were conducted within six weeks of the initial interviews. I transcribed each member check, revising them for accuracy. I then analyzed the data using the abstracted themes from the initial interviews and identified additional themes that emerged or built on existing themes. In the following section, I will highlight the participants' responses to the member check questions, including aspects of the mental model that were confirmed, aspects that were prominent in people's experiences, and additional themes that arose. First, I will discuss the Bhutanese context, followed by the counseling process.

Bhutanese Context

I began the description of the mental model by explaining elements of the Bhutanese context. The information presented to the clients at the member checks was slightly different than the model that was used to explain the Bhutanese experience in Chapter III. When I presented the superordinate theme of the Bhutanese context to participants during the member check, the themes included: (a) navigating societal stigma; (b) limited awareness of mental health and mental health issues; (c) counseling occurs as a part of a larger treatment model; and (d) different mental health concerns are approached in dramatically different ways. Participants confirmed each of these

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

contextual themes when explained. During the member checks, participants also offered new information about the Bhutanese context that was not represented in the mental model and can be seen in the updated model based on information from the member checks in Figure 4.2. Religion was introduced as a sub-theme within the holistic model of counseling in Bhutan and the physical location of counseling was identified as part of the process of navigating societal stigma. The themes of accessibility to treatment and the medical model of treatment each emerged as significant in the Bhutanese context of the counseling experience.

Religion. Namgay, a member of the Drop in Center (DIC) and interim counselor, brought up the topic of religion. In the rehabilitation center in Thimphu and in Siliguri, India where he was admitted, the treatment is modeled after the Westernized Narcotics Anonymous and Alcoholics Anonymous programs. Within these programs, members are urged to accept the will of a Higher Power. The majority of Bhutanese citizens are Buddhist, where the idea of one God or Higher Power is not within the belief system. However, Tshering explained how she understood this aspect of a Higher Power from a Buddhist perspective. The following is her account of waking up within the rehabilitation center that she was tricked into attending,

And then, this is something like, as a Bhutanese, “Oh Christian, all Christian.” (laughs) In the morning when I got up [in the rehabilitation center], when I look back, I saw a big cross in the back [of the room]. Our owner [of the rehabilitation center] was a Christian. And I said no, I don’t want to go [to the program].... But once you got into class... Now only yes I understand that. God is God. God is God of our own understanding. Believe Him in our own understanding way. That is right actually. So now I believe everything. You pray in your own understanding way.

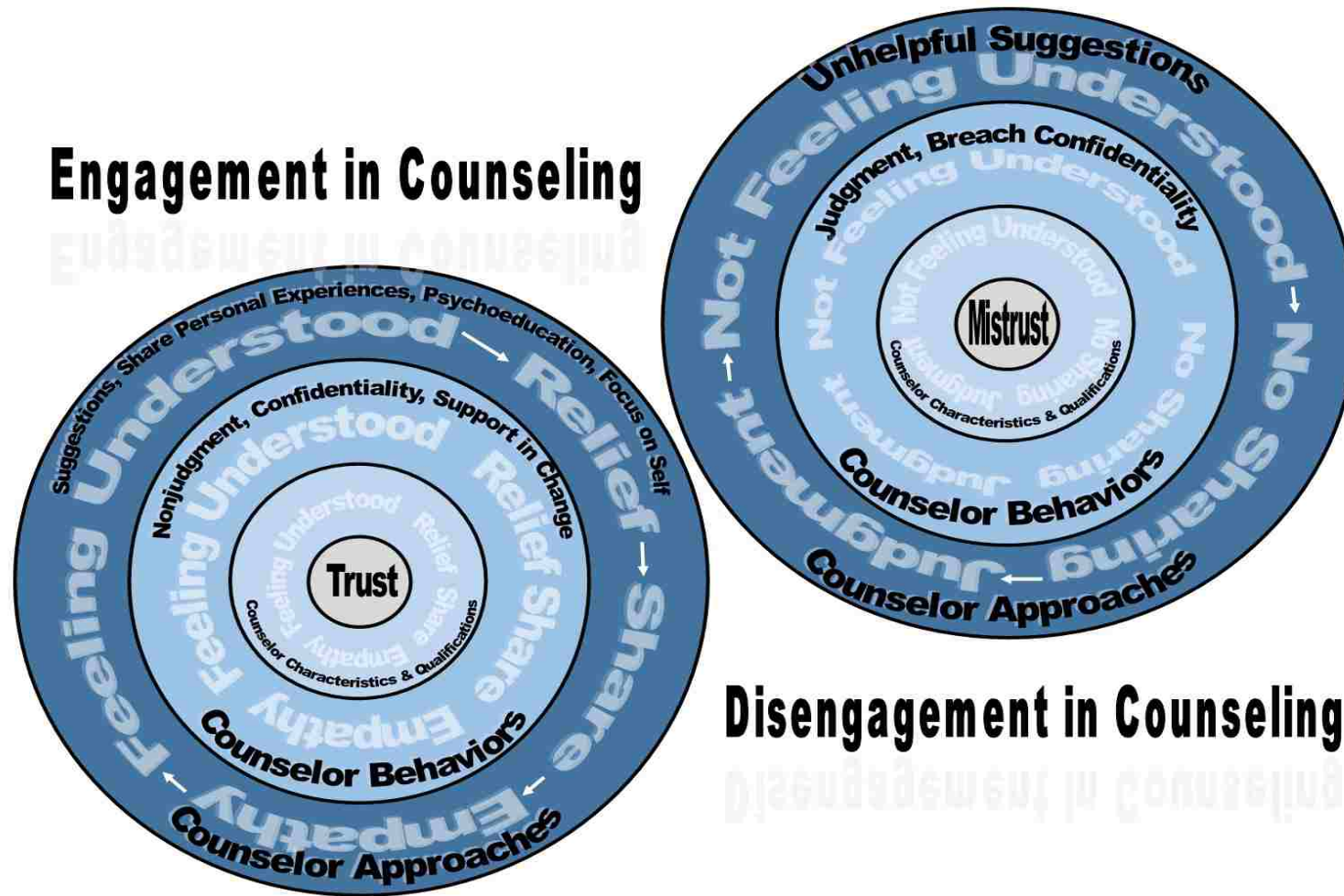


Figure 4.2. The counseling process. This figure depicts the final mental model explaining the experience of counseling in Bhutan, focusing on the parallel cycles of engagement and disengagement in the counseling process.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Tshering was able to adapt the ideas put forth by AA into her own worldview to help with her treatment progress. In his member check, Namgay insisted on the use of religion in mental health treatment. From the Buddhist perspective, he was not only including ideas of a Higher Power, but spoke freely about yoga and meditation as elements of religion and important practices within Buddhism.

Namgay: The client should just stick to their religion.

Researcher: Well what if, oh just stick to their religion.

Namgay: Religion. That teaching will help them. Guarantee. Because they can do the meditation, yoga. You know? Early in the morning, they get up, do yoga, meditation. The mental is gonna fix, but it'll take a year to form the right position. Because counseling, sometime, they know, this, this education [psychoeducation] will not work.... So most of the client who is never working for education, will go from the education for the religions. But what I mean to say hundred percent, thousand percent, they're gonna change with the religion because the person have to do meditation, yoga, but I don't mean that the person shouldn't go to monastery, be with lama, you know? I don't mean that one, but they can take the teaching. So that's last only now we have left that one only through the religion.

Where yoga and meditation are often seen as secular practices in Western cultures, they are directly tied to religious practices in Bhutan. Namgay sees religion, and specifically Buddhist practices like meditation, as a way to influence resistant clients to make a permanent change. The rehabilitation program and the hospital inpatient treatment provide meditation training and practice times in the daily wraparound care, which contributes to the idea of the holistic treatment model in Bhutan.

Physical location. Within the theme of navigating societal stigma, Lhamo also noted that the hospital psychiatric ward where she receives outpatient counseling could prevent people from seeking treatment due to perceived judgment. The small psychiatric ward houses ten beds for detoxification clients and eight beds for inpatient treatment, while also providing people with outpatient counseling services. In Bhutan, there are no

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

private practices and very few organizations that provide counseling. Therefore, when Lhamo walks into the psychiatric ward to receive counseling for her anxiety, she feels the judgment of others, understanding that they could see her as someone with severe psychosis or issues with addiction. She complained of this hardship as well as having to be around people that she also judges based on their mental health condition.

Lhamo: Yeah and then like another thing in the Bhutanese context, ours is like, like in your country also for words, like, but like, your therapy, like therapy is a different thing like you know? Here it's like put them together with the thing, with the hospital, you know? It's in the hospital.

Researcher: Right, right, right.

Lhamo: Everything is like full of like some addicts or detoxification and everything is like mashed together, so we don't feel comfortable going there.

In a country where there is stigma and discrimination around mental health issues, clients notice the location of services and may choose not to access them instead of risking judgment.

Accessibility of treatment. Accessibility to treatment in Bhutan refers to barriers that people meet when seeking mental health treatment. Some people do not seek treatment due to a combination of unawareness about mental health and anticipated judgment in the small country. However, when people struggling with mental health issues actively pursue help, they may still run into significant barriers. First, in order to be admitted into the psychiatric ward at the hospital, a person needs to be accompanied by a loved one who stays for the duration of treatment because the hospital does not provide a suicide watch. This is the only place to receive inpatient psychiatric care in Bhutan, and can lead to complications related to both travel and finance (for example, at least one salary is sacrificed in order to be present at the hospital). Additionally, the government supplies healthcare received at government-run institutions, but rehabilitation is run by an

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

outside organization in Bhutan. Some scholarships and sponsorships exist, but families are largely responsible for the cost of services. Phuntsho spoke of the issues surrounding accessibility during our conversation about the Bhutanese context,

Phuntsho: What, what about financial?

Researcher: What about financial, yeah, could you talk to me about that?

Phuntsho: Especially in Bhutan, most of them are very, very in difficult days and its not financial and nobody can pay their fees.

Researcher: Yeah, so accessing treatment requires money?

Phuntsho: Yes and especially with the women. Most of the women who is into alcohol, they're, most of them are uneducated, most of them are from southern Bhutan.

Researcher: Yeah.

Phuntsho: And they're uneducated, no? They have to depend on their husband. So, so when they come for, for the treatment, they don't have family and the biggest problem is the financial or there is nobody to support them.

Phuntsho points to the picture of accessibility for women struggling with addiction, and it applies on a larger scale for people throughout Bhutan with a variety of mental health problems. Giving up work and traveling from rural villages to receive treatment is not very realistic for some people, or they might lack the social supports that are necessary in order to be eligible for treatment.

Another issue within accessibility of treatment is the language barrier that may exist. In a small country, it may be surprising that there are about 18 different languages spoken. English and Dzongkha are both taught in schools from an early age, but many people are largely uneducated and live in isolated rural villages. In these villages, people will often speak only the village language or a regional language. At times Sonam, who was admitted twice to the inpatient services at the psychiatric ward and then returned for outpatient therapy, was counseled by volunteer counselors who only speak English at the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

hospital. Sonam does not feel comfortable with the English language and spoke of this concern through a translator,

Translator: The other thing she said is about the language. [One counselor] speaks Dzongkha so she says she feels comfortable. In English, she cannot understand and she gets stuck, so...

Researcher: Yeah it's hard to get treatment when you don't understand what's happening.

Similarly, Norbu noted language accessibility as a main concern,

Norbu: The counselor should be versed in language. As a counselor I would say that for he's, just assume that for a counselor he knows only one language which is the national language, but he don't know other local languages. And in that case, and in that situation the client is from Sharchop, and he's, and he, he, he couldn't even speak Dzongkha. The counselor couldn't speak Sharchop at that time. Both of them they can't.

Researcher: Yeah, they can't work. Yeah, yeah.

Norbu: They can't work. The counselor should be linguist.

Finally, the number of mental health treatment workers and the limited options for treatment impede accessibility. Even at RENEW, an organization sponsored by Her Majesty, the Queen Mother Sangay Choden Wangchuck, with outreach offices throughout the country and many formally trained staff members, they can only offer clients one counseling session per month. The hospital has one Bhutanese counselor and two to three volunteer counselors at once from other countries. There are three psychiatrists who lead the treatment teams at the hospital, and they are the only psychiatrists in the country. At the rehabilitation center, and the three Drop In Centers nationwide, the counselors work based on their own personal experience with addiction and counseling. When speaking of mental health services, Namgay noted that there need to be more counselors, and specifically more Bhutanese counselors. Without knowledge of Bhutan and Bhutanese culture, it is difficult for the majority of Bhutanese people with mental health difficulties to receive adequate care.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Namgay: I think, uh, Bhutanese and mental health and the mental health issues, um, I think we need to more counselor, you know.

Researcher: Yeah.

Namgay: Who can deal with that, the clients in a proper way. You know, no...

Researcher: Yeah, so like increasing the resources and then probably also increasing awareness of those resources.

Namgay: Resources like those best counselor. Even the counselor we have, they came and then go to another country so they can take a class, you know train them? Learn from them? You know? So I think we need lots of the, uh, best counselor, human resources, you know the counselors. That's, that's like I think like that because nowadays lots of mental disorders, you know?

With so few people operating within the mental health field, awareness of mental health and accessing services when in distress is a continuing problem. Overall, finances, travel, language, and availability of services are aspects that impede access to mental health treatment in Bhutan. This is further exacerbated by the inconsistency of treatment seen often in the hospitals that has been adopted by the burgeoning mental health field.

Lack of continuity of care. The medical model of treatment in Bhutan crosses over into the mental health field. When people go to the hospital to see a doctor, there is no continuity of care. If a person visited a psychiatrist one day and had an unwanted side effect from the medication, they would probably not have an opportunity to see the same psychiatrist, but hopefully would bring the notes written on the prescription so another psychiatrist would be able to help them. In the psychiatric ward, people can stop in for outpatient therapy where they will meet with an available counselor. They do not make appointments, leave contact information, and the counselor does not record anything from their meeting. For example, in order to contact Lhamo, an outpatient client, for the member check, I acquired her phone number from the security guard of the psychiatric ward because they have an informal friendly relationship. Participants commented on the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

interfering factor of having multiple counselors where they are expected to repeat their story in order to receive appropriate treatment. Rinchen explained how she felt weary retelling her story to other counselors in order to get help,

Translator: Here in this she said, if we completely understood, but she said here sometimes she doesn't like to do counseling. Why? Every time she have to take out all the one which is gone out of her memory, out of her mind. So repeatedly taking out her story, repeatedly telling her whatever it is in her mind, it makes her uneasiness. So that time she feels, I don't like to do counseling.

Rinchen mostly visited with two counselors through RENEW, and even then it was difficult to feel the beneficial effects of counseling when she was repeating her story frequently. Similarly, Sonam commented on the difficulty of being assigned to multiple counselors.

Translator: The extra thing she'd like to say is she likes to attend the counseling session with only one counselor. Because here we have different, no? Sometimes we have to change. So she says she feels comfortable with only one counselor.

Researcher: And is it, is it sir [her counselor]?

Translator: Yes, yes.

Researcher: Is there anything specific about him that helps her to be comfortable with him?

(Translator relates question and Sonam answers)

Translator: So what she's saying is that uh [her counselor] is polite, so that's why she is feeling comfortable with him. Secondly she's saying that he knows everything about her, so if she sits with another counselor...

Researcher: She has to start over. Yeah.

Translator: Yes.

In order to engage in the process of counseling, clients find it helpful to continue confiding in the same person. However, in the early stage of mental health development in Bhutan, there can be inconsistencies in counselors due to the adoption of practices from the medical field.

Counseling Process

After explaining the initial mental model to participants during the member check, themes that emerged in the first interviews became explicitly linked together to explain the counseling process. Trust was identified as the most important factor in the client's engagement in the counseling process. Sharing and trust were equally prominent superordinate themes in the first set of interviews. Now, as seen in figure 4.2, sharing is part of a cycle that revolves around the central concept of trust after incorporating data from the member checks. When clients share and the counselor responds with empathy, the client feels understood, and consequently relieved, reinforcing sharing and continuing to build trust. Empathy emerged as a new idea during the processing of the member check data and will be explained in further detail in the following section. Because empathy can be conveyed to the client through multiple avenues, this cycle occurs through each layer of building trust. Trust is further mediated by three themes: counselor characteristics and qualifications, counselor behaviors, and the counselor's approach. Counselor characteristics and qualifications are addressed first because this information is often most immediately apparent to the client, affecting whether they build trust in the counselor. In this progression, the counselor's behaviors are next to influence the development of trust in the counseling experience, followed by the counselor's approach.

In contrast to the development of trust, the client may also have experiences within the counseling process that decrease their trust in the counselor and the counselor's ability to help, leading them to disengage from the counseling process. Similarly, this is moderated by the counselor's characteristics and qualifications, behaviors, and approach. The mental model displayed in figure 4.2 illustrates both the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

process of building trust in the client-counselor relationship, which leads to engagement in the counseling experience as a whole, and the process of the client disengaging from counseling. Throughout this section, I will explain each element of the model in more depth, while also using situational analysis to discuss ways that individual participants differ from the majority represented in the depiction of counseling in Bhutan.

Trust. In the member checks, trust, or the client's willingness to trust the counselor and the counselor's ability to help relieve their distress, became the most prominent aspect in the counseling process. Trust was identified initially as a superordinate theme that grew in conjunction with the client's sharing to define the counseling process. During the member checks, participants often identified trust as the most important factor in their ability to engage in the counseling process leading to its placement as the central component. Similarly, a lack of trust, or mistrust, is the central component of the corresponding process of client disengagement from the counseling process. When asked to reflect on the mental model, Jigme named trust as the main aspect of counseling, while explaining that there are few counselors practicing in Bhutan that he would trust. Trust may be so important because the combination of counselor characteristics, behavior, and approach that leads to client trust is rare in the mental health field of Bhutan for several participants.

Jigme: For the, for the counselors and in between the counselors and the client, the main thing is trust.

Researcher: The main thing is trust.

Jigme: Yeah, yeah I believe the main thing is how, how the person and counselors and, as I've seen 'til now in Bhutan, few counselors are there only. And you can trust and anything many are like they're, when they approach that they are, they are not in the mood to give suggestion or not in the mood to help the client.

Similarly, Norbu noted that trust is the key to engaging in counseling,

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

I would say that, um, before we get into, into counseling, the trust is the most important between the client and the counselor because without trust that person, we don't get confident to share.

Here, Norbu explains that trust is the most important factor to engage the client, and the client's engagement is evident through his choice to share personal experiences and feelings with the counselor.

On the contrary, Namgay viewed trust as similar to dependence and stated clearly that he did not trust his counselor because he could only trust himself. Earlier in the week, Namgay received news that his personal counselor had relapsed, which caused him to question the effectiveness of his counseling and the tools his counselor had passed on to Namgay. The counselor's behavior, even a year after terminating treatment at the rehabilitation center, still affected Namgay's ability to trust in him and the counseling he provided.

So, I have the trust, but not too much, you know? So when I needed, when I ignore the problem, the obstacles, you know, the pain which suffered, it's all, you know, have trust by myself rather than trust in... because uh it's just how I say it, you know? In recovery, there's no guarantee. There's no guarantee so, there's a professional counselor, no? And they give the professional counseling to them. To the person, maybe a 10 or 20 and they can stay clean. And some they get relapsed. That's why I can't trust the, I don't trust to even to my counselor, even to my family, nobody else. I trust to myself, that's it. So I trust to myself and right now where I reached because I trust to myself to get here.

Namgay highlights the struggle to continue trusting a counselor that he once trusted. In the initial interview, he described feeling relief by just hearing his personal counselor's voice on the phone, but his counselor's relapse led him to distrust his counselor's ability to help. Other participants discussed how they developed trust for their counselors, confirming aspects of the initial mental model, such as the importance of the counselor's characteristics and qualifications, behaviors, and approaches. They also identified aspects

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

that were not previously included in the mental model, including empathy, and provided more information to understand the connections of themes in a different, more comprehensive way. The client's response cycle resulted from the reorganization of themes.

Client's response cycle. As seen in figure 4.2, the client's response cycle can be initiated by the client sharing or the client's perception of empathy from the counselor. When the client shares and perceives empathy, they experience being understood which offers relief. As this contributes to the development of trust in the counselor, the client continues to share, restarting the cycle. Empathy is a new component in the reimagining of the client's contribution to building trust in the counseling setting, and will be discussed in detail.

As stated by Norbu previously, the development of trust leads to the client's ability to share, thus actively engaging in the counseling process. In the continued development of trust, the counselor will be empathic towards the client in some form, as empathy can be displayed as a general characteristic of the counselor, as a behavior, and through the counselor's approach to counseling. When the counselor expresses empathy, the client feels understood and, as a result, feels relief. In Bhutan, people in the general population are more likely to show judgment or confusion around issues of mental health due to the lack of awareness and stigma that exists within the cultural context. Clients may also expect this from their counselor due to the steep power hierarchy, leading people in positions of authority to scold or talk down to other members of society. When a client then speaks to a counselor about their distress and the counselor demonstrates a true understanding of the client as a person, there is a great feeling of relief. The

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

interaction of sharing honestly and being greeted by a person who understands and communicates this in a respectful and caring manner is not within the societal norms of Bhutan. The client is then more likely to continue sharing, as their trust in the counselor and the counseling process increases. Lhamo's experience depicts this process within the Bhutanese context when she was asked about gratitude in the counseling relationship,

For my personal thing, like you know this mental thing [mental health issue], it's very difficult for the other person [anyone else] to really understand. Like, you know, like what we really go through, you know? And then this counselor thing is a new thing in town, this therapy and then the things and then like when we go there [to counseling] and then like when we talk, that person [the counselor] will understand what you're really going through. So like maybe because of that, like, you know, people [clients] like really feel the gratitude. Maybe these are the two things, like, I feel. Like in the Bhutanese context if we say like, uh, because here, like if it's supposed, like if you talk about, like my problem is like phobia and anxiety. But they don't know if I explained it to my best friend in a Bhutanese society, they don't understand what's going through like, they just feel like you're not being strong, you know? She's always like full of thoughts in her mind. They think something like that. So when we go through like that uh counseling thing, it's a different, totally a different person. Because of that, like people explain a lot of gratitude because there's other people who understands you.

Lhamo describes why she or other clients are grateful for their counseling experience.

Clients do not often feel understood in Bhutan when they are struggling with mental health issues, so the unique experience of empathy within counseling offers validation that provides relief and comfort. Here I will define empathy, show evidence of its presence throughout the development of trust in Bhutanese counseling, and then describe the distinct elements of the cycle with rich quotations for the participants' member checks.

Empathy. Empathy was not specifically identified in the initial interviews, and is added now after the member check. Empathy is defined here as the counselor conveying

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

to the client that they fully understand and feel their experience. Empathy can be communicated through any way the counselor is or anything the counselor does, which are defined here as the counselor's characteristics and qualifications, their behavior, and the approaches they provide within the counseling setting. While these three themes emerged from the first interviews, empathy as an underlying current through each category and influencing the client's response cycle was added after the member checks.

Phuntsho stated that she is much more likely to engage with a kind and polite counselor than one who is harsh, especially when she is feeling low. As a person struggling with addiction, Phuntsho has experienced a great deal of stigma and discrimination from society. While it is the cultural norm in Bhutan for people in positions of authority to speak directly and punitively to people in subservient positions, this style of communication would increase Phuntsho's perception of judgment from the counselor. When a counselor can speak kindly, the display of empathy provides Phuntsho with the opportunity to develop trust with her counselor.

Phuntsho: So, it's basically those who depend, if we trust our counselor from the very bottom of our heart, then there will be a good relationship.

Researcher: Yeah, so what, did you feel that way with your counselor? Did you trust them from the bottom of your heart?

Phuntsho: Uh, I have two counselors. But sometimes it's situation depends, no? Sometimes when I'm really low when they tend to talk very harsh to me, so I get really frustrated and I don't trust them.

Researcher: Yeah.

Phuntsho: At the first days [early in the relationship], I don't like to talk with them [counselors]. So especially when I'm in a good mood or bad mood, then they talk with the soft and the good, I feel very much comfortable and I tend to trust them more.

Here, Phuntsho describes a showing of empathy through soft and kind communication style, a characteristic of the counselor, when she is feeling down, which helps her to open up and trust.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Tshering responded similarly when asked how her trust developed with her counselor, describing empathy in her counselor's behavior. In Tshering's case, her counselor was able to create a connection by showing she fully understood Tshering's story throughout their time working together. The counselor remembered and expressed an interest in Tshering as a person and her history. This empathic act was essential in the foundation of trust and sharing in their counseling relationship.

Tshering: What I experienced was you feel more comfortable with the persons whom the counselors share a little bit of your heart. Little bit of my heart. Then you feel when they do counseling, not ta ta ta ta (using hand gestures to show levels) going up, but feeling the counseling [counselor] sharing a little bit of my heart. Then you feel more comfortable. Then you feel good and I take out everything [share everything]. So there's no hesitation. So you keep on telling them [the counselor] whatever it is that's in your heart. For example, of course [my counselor] is my everything to me now. And uh 'til now I don't hesitate anything to share and whatever problem I have I go and ask her, "please do help me this this and that." So something like that I can do it...

Researcher: I want to just make sure I understand the part you were talking about before. You were saying that when they share a piece of their heart with you?

Tshering: No, no they know my story. And when they start the counseling to me, "I know you went through this." So that word makes me more to open up.

Researcher: Yeah, so just showing that they understand your story and they know where you're at and they know you.

Tshering: Yeah, "I know you, you went through this, I know that."

Something like that. It's encouraging counseling. So encouraging counseling that means it makes me to open up my mouth. Others, we [people struggling with addiction] are such people that we really don't want to take out our, we don't want to take out everything [share] to the counselors. So when they say that yes, they say yes. It automatically comes up.

Tshering's example shows that when a client has an empathic and compassionate counselor, they are more likely to trust them, and consequently to share their story and feelings, engaging in the counseling process. One way to show empathy is to remind the client that they know them and their story, thus encouraging sharing within counseling.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Counselors also show empathy in their approach and techniques used in counseling. Tshering described how some counselors may pass judgment on someone struggling with alcoholism, but that in order to build trust, a counselor must build rapport by showing they understand the client's struggle. This idea aligns with the overwhelming preference of participants who experienced addiction desiring a counselor with a similar history. In addictions counseling, the counselor will often share their personal experiences to provide suggestions for how clients can successfully manage challenges in their recovery. By speaking of shared experiences when offering interventions, the counselor expresses empathy, showing they fully understand the client and their struggle with addiction.

Tshering: In the addiction field, counselors with the big knowledge [formal training] or the, it doesn't work with the addict people. The counselors with the same disease [addiction], oh yes, even I'm like that [prefer a counselor with addiction experience]. So only they can, the rapport building starts from our sharing [the counselor's sharing] only then. At the moment I do like this. Now the youngsters are coming here. Since I'm aged, so they don't feel to talk to me, but once I said, "Oh no, auntie [myself] also being that way [struggle with addiction]. Yes it's very difficult to stay one day also [stay sober]. Then you feel something like frustration. You feel something like." "Oh auntie! I did that auntie! Yes!" And then we start chatting.

Tshering has started to counsel young people struggling with addiction and is careful to open sessions in an empathic and understanding way. By stating that she has also experienced addiction and has fully felt and resisted the desire to have a drink, she develops a rapport leading to trust and sharing with the client. The counselor's expression of empathy occurs at every step of the cycle in the development of trust, helping clients to feel understood, feel relief, and share.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Sharing. In the original mental model, sharing was presented as a superordinate theme, showing that client sharing was bolstered by feeling understood, feeling relief and relaxation, and by having personal motivation to engage in counseling. Sharing then contributed to the development of trust, which consequently reinforced and increased the client's sharing in a cycle. These aspects of sharing and the trust and sharing cycle were confirmed in the member checks. However, no participants mentioned sharing or the themes that influenced sharing as being a prominent aspect of their experience. Trust then became the more central focus of the counseling experience, with participants identifying aspects outside of themselves as the main reasons for the development of trust in their counseling relationships. Participants also did not identify anything to add to the explanation of how sharing is influenced by feeling understood, feeling relief, and personal motivation or how sharing and trust influence each other. Sharing, feeling understood, and feeling relief were confirmed as a part of participants' experiences. For example, Yangden confirmed sharing and the themes that influence sharing as contributing to her ability to trust her counselor,

Yangden: If I get motivation, I can come to counseling and to share my whatever I can think.

Researcher: Yeah. Is that how counseling started for you? Were you motivated at the beginning?

Yangden: Motivated by myself.

Researcher: Yeah. Great. Does that seem like it happened in your experience [referring to the section on sharing from the mental model] or would you say something different? For how you were open to sharing.

Yangden: (Reading aloud) For my trust I can go through these four [sharing, feeling understood, feeling relief and relaxation, personal motivation] and these I have already talked I can go for trust.

Similarly, through a translator Rinchen explained the connections between trust, sharing, and feeling relief during her counseling experience.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

I'm just explaining like ok the first place she got counseling, she have trusted the counselor, so by trusting and of course she have problem inside her [mental health issue]. So trusting the counselor, she would take it out everything [share openly] which made her more open to her mouth so where she can trust the counselor, so it was going up [sharing and trust] and up as well as she's getting peace in her mind [relief], ok? As it was going up [sharing and trust].

Lhamo also spoke of the calming factor of sharing and being understood by someone.

Researcher: Then when people were sharing they said often they would feel feelings of relief or relaxation.

Lhamo: Yeah, yeah. Yeah it calms us down. It's not like totally that, you know, it's a complete recession, and then like it's a big relief. Last time I told you, you know? Someone who totally understands me, like what's going through your mind. All the physical things like you can show signs and symptoms but something mental thing which people don't understand, like in like he's [my counselor] like when they look at my physical appearance, I can appear totally normal, I talk normal, but there's a lot of things going inside my head. When we [I] go to the therapist, it's totally a different situation. So it's a relief. It brings some relief and some calmness in you [me].

Finally, Tshering spoke of her experiences with sharing as the client in her counseling relationship.

Tshering: But with my own counselors, I had, I had few counselors whom I really feel comfortable. And I should say when I do counseling, when I get counseling from them, it makes me more strong. Something that the burden which I have is taken out. So you [I] feel more free, you [I] feel more, free to talk to them [my counselor].

Researcher: Yeah and I know for you sharing has been an important part of that, so it's almost, so would you say that that corresponds with this piece [points to relief/relaxation on mental model]?

Tshering: Yeah relief. Relief.

Researcher: When you're able to share, that kind of like lifts that weight off of you? Ok.

Tshering: So which is always, it is all to suppress [mental health struggles] down until now. So when I have a counseling, when I do a counseling, then you, when it is all out and you [I] feel good, happy some relaxation, you [I] feel a little bit relief.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Here, elements that were defined more distinctly in the initial interview coalesce into overlapping aspects of the counseling experience. Trust influences sharing, which, when greeted with an empathic response, leads to the client feeling understood and relieved. The feelings of understanding and relief consequently increases the client's personal motivation to engage in counseling, leading to further sharing. The client's response cycle occurs within each stage of interaction in the counseling experience, and is therefore present through the themes of the counselor's characteristics and qualifications, the counselor's behavior, and the counselor's approach, which will each be discussed in greater detail in the following section.

Counselor characteristics and qualifications. Participants confirmed counselor characteristics and qualifications as critical in the development of trust between counselors and clients. For a few participants, their counselor's manners of speaking, like speaking politely and kindly, was most important to them. Phuntsho and Sonam are similar; both experienced harsh or rude interactions with counselors in the past. This led to a vocal appreciation for politeness in the client-counselor relationship that Sonam expressed through her translator.

Translator: She says she feels comfortable with only one counselor.

Researcher: Is there anything specific about him that helps her to be comfortable with him?

(Translator and Sonam speak back and forth)

Translator: So what she's saying is that uh [her counselor] is polite, so that's why she is feeling comfortable with him.

One characteristic not mentioned in the initial interviews, but came to light in the member checks, was the counselor's tendency towards honesty. This goes hand in hand with politeness, where a counselor is able to express humility when he is unsure of

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

something, contributing to the development of trust. Kesang described developing trust by initially judging his counselor,

Researcher: Yeah, so what were, what were the things that you were judging him [counselor] for or what was, what sort of helped you build that trust up?

Kesang: I could ask some questions, then... I let him to share his experience. Then I used to ask many tough, tough questions. So, so how we can cope with such circumstances if they might occur in our way [issues dealing with alcoholism] and like this and I show then the counselor used to be open minded.

Researcher: Yeah.

Kesang: So he, what to say now? He, if, if he don't know how to explain or how to experience or how to share, so he speaks honestly that, "I can't." Yeah.

Researcher: Yeah. That's important too, huh? To be able to be honest.

Kesang: So do like this, I could do all these things.

Kesang spoke of his own ability to use judgment to identify whether a person was safe to share information about his struggle. He was comforted both by the counselor's ability to help him deal with certain difficulties relating to coping with alcoholism on a daily basis and by the counselor's honesty in acknowledging when he did not know something. This helped him trust in the suggestions that the counselor did provide in helping to stay sober and meet the demands of the world as a former alcoholic.

Additionally, participants who felt strongly about qualifications of their counselors continued to express this desire. Qualifications can be seen as education, training, or experiences that contribute to a counselor's ability to address mental health concerns. People with a history of addiction generally tended to want to work with a counselor who had also experienced addiction. Jigme explained the only way that he would be able to trust and work with another counselor:

Jigme: Uh, I think there have been more, less of suggestion uh for the client. Because he don't have any background, experience.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Researcher: Yeah, so it might be less helpful because they don't have experience with it to share what, what's gone on and what's been useful.

Jigme: And they might be having the knowledge, like, from the book only. But they didn't experience personally so they don't, they don't, I think they don't, wouldn't be able to let the...

Researcher: Yeah like something realistic?

Jigme: Yeah... The thing about the counselor, I don't, if the counselor, if they don't, if he, if he don't have like the background thing, experience or he's like just, he don't have any personal experience, but he's a counselor so he, what the counselor needs to give him, to identify the main root cause of that problem.

Researcher: Yeah.

Jigme: If you can find that problem, then I think that counselor might get some ideas and like solution for that problem.

While Jigme initially stated that he could only see a counselor with a background in addiction, he was able to identify a way to trust a counselor without the specific experience. However, Tshering, Norbu, Namgay, and Phutsho, continuously expressed the need to only see a counselor with a background in addiction. Without this qualification, they stated that they would not be able to completely trust the counselor because the counselor would not be able to empathize with their experiences as people struggling with addiction. Consequently, they would disengage from the counseling process, as there would be no foundation of trust.

Those who felt strongly about formal training continued to stress this as a primary factor in their ability to trust in the counselor. Lhamo discussed the importance of her counselor's education in her ability to trust him,

When I first went there [to counseling], I didn't have the full trust. Because I didn't open up, I couldn't open up and I couldn't like throw out whatever I feel inside me. Maybe I said like few things, but it's not really in depth. But then I have some trained counselors at my school and like what, uh, I think she explained to me the code of conduct and the ethics and everything. Like how they [counselors] are trained, you know like 4 or 5 years in the training thing and then like she gives me a bit of background to your [counselor's] code of conduct and everything... My friend, she said maybe like, she said you can say whatever you want to say to him

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

[my counselor], you know she explained it to me. This way he [my counselor] is trained, you know four or five years trained and those things, all these things she gives me this background and then like I Google, I search around. She knows all this. Then like I develop like some trust.

The counselor's characteristics and qualifications continue to influence the development of trust in the client-counselor relationship, allowing the client to engage in the counseling process. With the comfort developed in a trusting relationship, clients can then feel comfortable sharing.

Counselor behaviors. The counselor's behaviors also contribute to the development of trust in the counseling relationship. Those that positively influence trust in the client-counselor relationship are non-judgment, confidentiality, and support in change. Participants confirmed each of these during the member check. In contrast, participants described counselor behaviors that decrease a willingness to trust and result in disengagement from counseling. These include experiences of judgment and lack of confidentiality. Information that was added during the member check process includes a slight differing in opinion about the theme of judgment from one participant and a prominence of the importance of confidentiality.

Judgment. The presence of judgment from the counselor has largely been seen as a hindrance to the development of trust in the client-counselor relationship. For example, Phuntsho noted that she has experienced discrimination from counselors before, and it is important to her to avoid this. As a person struggling with addiction, she perceives judgment from society frequently, which has a negative impact on her life and sense of self-worth. Therefore, in order for Phuntsho to have a safe and growth-oriented experience in counseling, the counselor must provide an environment that is free from discrimination.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Researcher: Is there anything else that you think you'd like to add that seems important about your experience with your own counselor?

Phuntsho: Um, very open-minded.

Researcher: Yeah. Tell me about how you experience that. What does that mean?

Phuntsho: When I was, eh, don't have to feel shy. They [I – the clients] don't have to feel uncomfortable, no? The client is from very mental class [low or mentally unsound group within society] or very high classes they don't have to in a sense discrimination [they aren't treated differently]. Some counselor, they used to discriminate, no? She's very good, she's rich, she's very poor.

Phuntsho states that her counselor needs to be open-minded to her, as a person who is struggling and treat her as well as someone who may be seen as a person in high society.

Tshering was very blunt about her feelings around judgment when she was helping to translate Rinchen's member check. When I explained participants' general responses to the idea of judgment and nonjudgment in the counseling relationship, Tshering, as the translator, immediately chimed in and stated, "Judgmental, that is one of the worst!"

However, when speaking with Yangden, she stated that judgments from her counselor are helpful for her in her process of changing. Where other people see judgment as the counselor not accepting them as a person and begin to disengage from counseling, Yangden sees judgment as helpful in correcting aspects of her character that are unwanted.

Yeah, yeah, trust completely, counselor behaviors, no? The judgment. If the counselor can judge to me, I'm very happy because of the helping of the character, no? That's what I can help, the counselor can trust me, I can be happy to listen whatever they, if the counselor can judge me, I have done mistake and I have to change my character. I can think like that.

Yangden was the only participant to speak positively of receiving judgment from a counselor within the counseling setting. She sees judgment as a change agent for her

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

moving forward in the counseling process and continues to develop trust in the presence of judgment.

Confidentiality. Unlike judgment, the participants' opinions on the confidentiality remained consistent from the initial interviews through the member checks. The counselor's assurance and ability to not disclose information discussed in counseling was, in fact, seen as one of the more prominent themes that led to the development of trust. Five participants specifically mentioned the importance of confidentiality when asked what aspects of the mental map were prominent in their experience. For example, without the belief in confidentiality, Jigme stated that he would not be able to open up in counseling and engage in the counseling process.

Jigme: So I had the trust in my counselor that ok, I can share my feelings and uh problem that was secret and I can share with my counselors. So I shared and I have gratitude for my counselors.

Researcher: Yeah.

Jigme: But not with all the counselors.

Researcher: Yeah, your one right?

Jigme: Not all the same as some are like they don't keep anonymity. They share with others also.

Chimi did not mention confidentiality in her initial interview, but when talking through a translator, this was the most important aspect for her to engage in the counseling process.

Translator: She [Chimi] wanted to share in the beginning she had little reservations she was saying because, uh, she was not really sure of, like, you know? Confidentiality and all those things and then Bhutan being such a small society, she feared that ok, if some of her family members or some relatives come visits hospital, they may come to know about her and all those fears were going on in her in the, um, in the early settings. But then gradually she said after one or two sittings she became comfortable and then because the counselors, they kept like, you know? In between they kept saying whatever information she provides will be kept confidential. So that way she felt comfortable... And, uh, regarding the, um, trust, uh, she was saying like, uh, in the beginning she had little doubts about whether this, whatever she shared would be like, you know, uh would go out or not. And then, but eventually, like gradually, she, she

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

could like you know? Feel that ease. And then she thought ok, whatever she shared would not, like you know? Go out. So that's one factor which was like, um, especially the confidentiality was one factor which was, uh, I think making her not really like completely trust the, uh, counselors.

Chimi's experience reinforces the idea that stigma around mental health is prevalent in Bhutan, making confidentiality an essential aspect in her ability to trust her counselor and engage in the counseling process. Namgay expanded on the importance of confidentiality from a societal perspective, stating that people may not participate in counseling because they fear counselors will turn them into police instead of help them. Whether this fear is due to lack of awareness on the part of the potential clients or is a legitimate fear based on counselor's actions in the past, it stresses the need for an assurance in confidentiality before even seeking counseling.

Namgay: That's the problem, you know with our, you know, in our society that uh most of our counselor is not good and they're really, you know, really worried if the client need help, then they say the most stupid people, they're really hurt, you know. So even the client, they're really worried. Even the addiction, they need help from the counseling, but they're afraid why. Because maybe they [the counselor] will say to the cops, the police [turn them in]. They are really scared. So that's why they can't go there to the counseling. So that's, we have problem in our society. Researcher: So there needs to be the initial trust even that if I approach you [counselor], you won't tell an authority figure about it.

Namgay: So that's why, before the counselor needs to do like that [create an initial trust], no?

Researcher: Yeah that makes sense.

Namgay: So that's why the counselor, or the drug abuser or the colleague or the sex worker also, they can't go there and take a counseling because they are really scared. They'll give it, they'll give forward this case to the police and our police are all ready to catch and put in the custody.

The importance of confidentiality was present in the member checks, where a lack of confidentiality in all contexts would have undermined trust and engagement in the counseling process. In some instances, it also would prevent clients who need help from seeking it due to a fear of imprisonment. Even the worry of loved ones coming to know

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

about mental health issues may prevent people from seeking treatment due to the stigmatization. While the counselor's behaviors were less prominent in the development of trust compared with the counselor's approach, confidentiality was the most prominent of the counselor's behaviors discussed in the development of trust.

Counselor approach. Overall, the counselor's approach was discussed most during the member checks as the reason for development of trust in the counseling setting and the participant's willingness to engage in the counseling process. The different interventions used by the counselor include making suggestions, providing psychoeducation, sharing personal experiences, and helping the client focus solely on themselves. Participants acknowledged that the counselor's encouragement to focus on themselves occurred during counseling, but it was not emphasized during the member checks. Making suggestions, providing psychoeducation, and sharing personal experiences were all specifically mentioned as areas that were pivotal in the client's development of trust in the counselor.

Making suggestions. Participants most consistently stated that making suggestions, or the counselor providing options or techniques for the client to try in order to reduce distress, contributed to the development of trust in a counseling relationship. Many responded with enthusiasm when explaining this aspect of counseling, seemingly showing that suggestions are the main reason for pursuing counseling. Participants repeated that they developed trust by receiving suggestions from the counselor, attempting to use them in life, and finding them helpful in recovery. Not only does this bolster trust in the client-counselor relationship, it also enhances trust in the counselor's ability to help the client and trust in the counseling process as a whole.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Yangden relates that receiving suggestions from her counselor on how she could change is helpful in her ability both to change as a result of counseling and to trust the counselor.

Researcher: did you develop trust in that [client-counselor] relationship?

Yangden: Yeah I did! I, maybe helpful to me.

Researcher: Yeah, how, how did you, so you developed trust by them being helpful? And then you could trust in them?

Yangden: By giving counseling to me.

Researcher: Yeah.

Yangden: Uh, whatever they have, for example, for me, I have done bad to other. If they give, uh counseling I can listen to that counseling.

Researcher: Yeah, and then you see that that's helpful in your life. And that helps you trust them. Yeah. Is that right?

Yangden: Yeah, yeah, yeah that's right.

Jigme also found suggestions to be one of the most helpful pieces of the counseling experience.

Jigme: Yes, yes that's a very important thing that a counselor should give some suggestions, some ideas so how can, uh, that the person can cope up with the problem. If he can give more suggestion, the client, uh yeah, the person will get more idea for his own problems. So it's very important to make some suggestions from counselors.

Similarly, through a translator, Sonam discussed the main factor in her development of trust in the client-counselor relationship,

Translator: So she says she can trust her counselors because uh they like tend to advise her in good ways. And she says that if people, if other people, or even if the counselor advises her something which is not appropriate, then she says she will not trust him or her.

Sonam stressed the importance of meeting with one specific counselor at the hospital.

She has received suggestions that have been useful from him, developing a trust that she has not experienced with other counselors. In order for her to continue engaging in counseling, it is helpful for her to continue to see the counselor that provides useful suggestions and that she trusts. Kesang came from a similar mindset, where he received

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

helpful suggestions, leading to trust in his relationship with his counselor and engagement in counseling.

Researcher: What kind of things, like how did that [trust] develop? Or what was good for that and what was not good for that?

Kesang: No, trust as uh personal between myself and my peer counselor because whatever he uh counseled me and in this case, always used to be in the right position.

Researcher: Yeah, what does that mean?

Kesang: So, what it means that he counseled me so, “You should not do like this, you have to do like this.” He have just counseled me like this.

Researcher: Yeah, mhm.

Kesang: But, in, in, in the other side, if he does any wrong [suggestions], then I can’t trust him, isn’t it? So whatever he counseled me, I took in the, in the right way [to be correct] and whatever I saw in him was really made him with the words he taught me so I trust in him.

Researcher: Yeah, so did he ever give you suggestions that were maybe in the wrong? That weren’t right?

Kesang: No.

These examples show that it is expected that counselors in Bhutan provide suggestions to their clients. The success of these suggestions in helping to reduce the client’s distress contributes significantly to trust in the counselor and their skills.

Psychoeducation. Psychoeducation was also an important factor when trusting the counselor’s ability to help. This points to the cultural norm, where the counselor takes on the position of expert, while also normalizing the client’s experiences by explaining aspects of mental health and distress. The importance of psychoeducation in the development of trust compliments the participant’s desire to have a counselor with formal training. Kesang and Lhamo were the two participants who were most vocal about judging their counselor’s competence based on training and valued receiving psychoeducation about counseling and mental health.

Researcher: So, in this big thing [mental model] I know that was a lot of information to give, um, is there anything that you would change about it? Or that doesn’t seem like it quite fits with your experience?

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Kesang: From this?

Researcher: Mhm.

Kesang: Regarding counselor, isn't it?

Researcher: Yeah.

Kesang: Yeah I have already mentioned regarding the qualification.

Researcher: Yup.

Kesang: It's a necessity. Then...

Researcher: Then it would be easier for you to trust in them to be able to help you.

Kesang: Sure. And then counselor approach, counselor approach, psychoeducation. It should be a must.

Researcher: It should be a must?

Kesang: Yeah.

Researcher: So they need to include psychoeducation.

In the initial interview, Lhamo discussed the relief of having her counselor describe her anxiety, normalizing it and providing a reason for her to experience it. In the member check, she focused mainly on the psychoeducation that she provided herself. When introduced to the ideas of anxiety and cognitive behavioral therapy, she went online and watched counseling sessions and informational pieces about CBT on YouTube. Since counseling was a new concept, she desired to know more about it before opening up. By understanding, she could trust in the counselor's ability to help her.

And I like, I like went on the computer and search for like what is counseling and therapy and all these things. And then like I got some idea about what all these things [counseling] about and then like after that, like, like, then I started opening up and I developed some trust. But not at the beginning because this thing, this is a new thing in Bhutan which I didn't even have an idea about what, about all these things.

Lhamo's experience with using the Internet to provide her own psychoeducation expands the definition of the usefulness of psychoeducation in counseling. While she benefitted from the counselor's ability to provide psychoeducation within session, she also found her own resources, which contributed to her development of trust in the counseling process.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Sharing personal experiences. Finally, three participants stated that the counselor sharing their personal experiences in session was a primary factor in their development of trust. In the initial interview, Norbu stated that he only admitted to his counselor that he was struggling with addiction after his counselor revealed his own story. In the member check, Norbu said,

Before we get into the counseling, the counselor should uh share their experience to the client, I once was, I did the problem and problem. Then the client can feel comfortable that, ok this counselor has also had, he had also felt the same problem as me. At that time, both of them can have good conversation.

This exemplifies the feeling of understanding that comes for the client when the counselor has lived through similar struggles. The client can then trust the counselor's ability to help because the counselor has successfully found tools to live through their mental health issues. Phuntsho expressed the gratitude that she feels as a result of her counselor sharing personal experiences with her addiction struggle.

Phuntsho: I feel very grateful.

Researcher: Yeah can you tell me about a little bit more about that? Like why?

Phuntsho: Happy, I feel happy also because in my cases, is my, is my counselor, our counselor was uh recovering addict, so they used to share more about the hardest things happen in addiction life.

Researcher: Yeah.

Phuntsho: So they share about their hardest things and how to overcome.

Researcher: Yeah.

Phuntsho: So (small laugh)

Researcher: Yeah that makes sense.

Phuntsho: And I feel very much grateful during this, talk more about their own life.

The element of gratitude continued in Yangden's response about counselor's sharing personal experiences,

Researcher: Sometimes counselors share their own experiences.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Yangden: Yeah, yeah, it's true. If the counselor can share their own behavior, we are so happy, no? We got, we got lot of idea we are associated. If the counselor can share personal, we are so pleased to share our personal, no?

These responses display the solidarity that a Bhutanese client feels when counselors disclose information about their own personal experiences that are similar to the client's struggles. Counselors' sharing normalizes the hardship of mental health issues and provides hope for a successful recovery through the counselor's role model behavior. Sharing a history develops trust between the counselor and client, encouraging the client to engage in the counseling process.

Conclusion

With information gathered from the member checks, participants helped shape the phenomenology of client experiences of counseling in Bhutan. The experience revolves around trust in the counselor and the counselor's ability to help. This trust is created by the client's perception of counselor empathy, which was displayed through their characteristics or qualifications, specific behaviors, and counseling approaches that show they truly understand the client's experience. As a result, the client feels understood and experiences relief and personal motivation to continue engaging in the counseling process by sharing. The data gathered from the member checks shifted the understanding of the client's experience with counseling in Bhutan. Aspects of the cultural context, such as religion, the physical location of counseling, accessibility of treatment, and lack of continuity of care, were added to create a more comprehensive picture of the context in which clients are seeking counseling services. Empathy became an added theme involved in the reconstruction of the client's response to counseling and trust became the centralized component of the process. In the following chapter, I will illustrate the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

phenomenology of the Bhutanese client's experience with counseling by providing a rich textural-structural depiction of the lived experience of receiving counseling in Bhutan.

CHAPTER V

SYNTHESIS AND DISCUSSION

Introduction

The following chapter presents the essence of the Bhutanese client's experience with counseling. The synthesis is the textural-structural culmination of all of the data provided by the participants represented in a narrative of the experience. I also describe methods of trustworthiness, as well as limitations to the transferability of the results. I discuss implications of the study and propose future areas of research.

Synthesis of the Phenomenon

The client's experience of counseling in Bhutan is defined by interactions with their counselor and the initial treatment context. Clients' parents, neighbors, and friends are often unaware of mental health issues and treatment options, reinforcing the belief that people seeking help for mental health issues lack mental fortitude. Clients experience a trapped feeling, seemingly losing control of their minds without any reason while cultural norms reinforce feelings of shame. They protect their struggle, knowing once a single person discovers their mental health concerns, the information is likely to spread to others. Bhutanese society is structured around relational gossip and collectivism, resulting in quick dissemination of news that reflects upon the whole family. Feelings of shame are tied not only to personal experience, but to the harsh perceptions of loved ones. Bringing shame to the family exacerbates the distress of the client's mental health struggle when initiating treatment. Further, the client must then navigate the obstacles of accessing treatment. They often have to travel and need the physical and emotional

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

support of at least one other person in order to access counseling services, which are largely only offered in the capital city through a few organizations.

Feelings of helplessness and hopelessness about mental health conditions in a culture that prizes emotional restraint and mental fortitude can lead to suicidal behaviors rather than treatment. Similarly, substances are used in an effort to numb the pain of mental distress. Alcohol consumption is an accepted part of Bhutanese culture. However, people are viewed as a weak embarrassment when drinking interferes with the functions of daily living and abstinence is necessary to remain functional. The shame associated with needing treatment has a strong influence on client despair. Clients either reach a level of distress that is so debilitating that they are personally motivated to seek psychological services, or a family member is so worried that they bring the client to a treatment facility. They have often sought out religious services, sometimes multiple times, before seeking out mental health services. When the only means of healing that they know of is unsuccessful, it only increases the client's level of distress.

This is the particularly fragile state of the client upon their first visit with a counselor. The most pivotal element of the client-counselor relationship is the client's ability to trust the counselor. A counselor must convey that they understand the client's struggle within the Bhutanese context in order to begin developing this trust. The expression of empathy is crucial to the client feeling safe within the counseling environment. Expressing empathy can take a multitude of forms, from counselor characteristics, to specific behaviors, to interventions. An empathic counselor can greet the client politely and softly, showing they understand the client's distress. They can assure the client of confidentiality, which expresses sensitivity grounded in the Bhutanese

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

context where gossip and shame are present when seeking treatment. Counselors can also provide the client with information about mental distress, explaining the physiological process in the body and brain, normalizing the client's experience.

In the outside world clients experience hopelessness of regaining control over their minds. When a counselor can greet them and normalize this process, clients feel the weight of being completely alone with their distress lift. In this act, the counselor conveys that there is not something fundamentally wrong with the client, nor has the client done anything wrong to deserve their mental anguish. By identifying and defining mental health issues, clients understand that they are not the first to experience this type of distress, that the counselor has seen others in similar conditions before, and an experience of being completely understood is fostered. On the contrary, if the counselor approaches the client harshly or with judgment (as is expected from people in positions of authority) the client will disengage from the counseling process. Disengagement often means that the client is cautious about the information they share with the counselor, preventing the opportunity to be completely understood because it has been deemed unsafe. When the client disengages, they may still improve from treatment, but often from other aspects of wraparound treatment, such as meditation, exercise, or medication. The resounding relief in being completely understood does not occur.

When greeted openly and empathically, clients continue to engage in the counseling process. Their experience of the counselor expressing understanding offers great relief in knowing they are not alone, nor fundamentally flawed. This acceptance inspires hope and an openness to share personal experiences. Sometimes clients wade slowly into the waters of trust, testing for safety in an empathic relationship because of

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

previous experiences of judgment within Bhutanese society. Once choosing to share, clients perceived a cycled response, where they would share, be greeted by some form of empathy from the counselor, and feel understood and relieved anew, encouraging continued sharing. The trust that developed in order to engage in counseling and the cycled response to counseling was built upon the counselor's characteristics and qualifications, behaviors, and approaches within the counseling context.

Characteristics that endeared the counselor to the client conveyed empathy and the counselor's ability to understand the client. When the client perceived empathy and felt understood, trust developed in the client-counselor relationship. When the counselor talked politely and softly, especially when the client was feeling low, they showed an understanding of the client's fragile state and inspired trust. Counselors who were friendly and positive in greeting and speaking with the client communicated they would always be pleased to see them, regardless of the client's state.

Clients also felt understood when counselors displayed characteristics similar to those prized by the client. Often in Bhutan, women do not speak as openly to men as they do with other women because men hold a privileged position in the social hierarchy. During counseling, some women felt more open and understood when they were seeing a female counselor. Bhutan is also home to many traditional beliefs surrounding the spiritual world. Religious clients often prioritized having a Bhutanese counselor, grounded in the Buddhist values that shape the Bhutanese cultural context, over a female if the female was foreign. Clients felt they could be better understood by someone who fundamentally understands their belief system.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Clients also took note of the particular qualifications or experiences that the counselor had, influencing how they presented themselves in the counseling context. Clients who had a history of addiction often felt as if no one could understand their experience unless they had also gone through the same debilitating struggle. Because alcohol use and abuse is widely accepted in Bhutan, clients find great shame in not trusting themselves to be able to handle this culturally normed activity. Trust arises when the counselor fully understands the shame and helplessness accompanying loss of personal control. Trust in the counselor and the counseling process develops when the counselor uses tried and true techniques that have been personally helpful blending into the “normal” world without detection of alcoholism, all the while maintaining sobriety. Clients with addiction histories and struggles strongly desire these successful life skills.

Formal training represents another qualification that clients desire in a counselor. In Bhutan, many are uneducated at a time when society has been shifting toward Western ideals as access to these norms flood into the country. Formal training is recognized as a foreign value, and at a time when services influenced by Western values are considered more credible. Clients are appreciative of formal training they can trust. Counselors use their training to normalize client experiences, describing the scientific rationale behind client distress. When articulating diagnoses and predicting elements of client experiences based on diagnostic standards or experiences with mental illness, clients felt relief. They no longer felt alone in their distress or deserving of the pain. Formal training was an indicator of competency for clients, allowing them to fully embrace the counseling experience. Without these qualifications, some clients questioned their counselor’s ability

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

to understand them or to be helpful. The resulting doubt closed them off to possibilities of engagement.

Specific counselor behaviors also affected the trust building process. Clients' engagement was largely dependent on perceived empathy, becoming more invested or disengaging from the counseling process. For example, judgment created an unsafe environment for the client. In Bhutan, a great stigma exists around mental health issues and mental health services. A person's inability to function in their own lives while experiencing mental distress is interpreted as a lack of strength to deal with their problems. When the distress progresses to a point where they need additional help from someone outside of their collective group, people experience great shame and helplessness. If the judgments of society are also perceived within the counseling office, clients continue sinking into their despair. On the other hand, if clients are met with acceptance regardless of what they bring to counseling, they can have a corrective emotional experience. Clear acceptance, the behavioral expression of empathy, allows the client to feel both understood and normal. Often clients are encouraged by the desire to fit in with society again, pointing to the collective nature of Bhutan. They often feel abnormal, crazy, or different when they seek counseling treatment, and the consistent acceptance of one person allows them to start feeling accepted by society. When behaviors, attitudes and stories are met with nonjudgment, the clients can begin to release shame, and accept themselves.

Confidentiality is another essential aspect of trusting a counselor. In Bhutanese society, a person might worry about what others think of them and the rumors that could spread if they even enter the psychiatric ward for something as innocent as donating a

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

bag of clothes. In order to engage fully in counseling, the client needs to know that the information they share will not be revealed to others outside of the session. The ideal counseling setting is one where the client feels safe and secure, allowing them to open up about anything, which in and of itself can provide relief and healing. Bhutanese people have very diffuse boundaries, where they fill multiple roles in each other's lives and gossip freely. Social norms are not built around secrecy, nor around separating work and personal life. Therefore, if a client feels shame about what is divulged in treatment, or even feels shame from receiving treatment, they want information protected, even though rigidly bounding information is not customary in Bhutan. Confidentiality is not an assumed part of treatment; in order to assure confidentiality, the counselor must explain the terms clearly and actively practice them. Clients share more openly and honestly when they understand and believe in the safety of confidentiality, thereby increasing their trust in counseling and the counselor. In contrast, if clients do not believe counselors will maintain their confidentiality or if they hear counselors speaking freely about other clients, they are less likely to engage openly in the counseling process.

Counselors also support clients' positive changes in session, creating investment and persistence in the counseling process. When clients begin to adjust their behavior in a noticeable way, and their counselor or a loved one comments on the shift, trust in the counseling process and hope in their ability to change increases. Counseling is a new practice in Bhutan and is received as an experimental treatment by people. When clients begin counseling they feel hopeless and distraught, expecting that the state of their mental health is fully out of their control. When adjusting behaviors in accordance with counseling interventions, clients often feel and act differently. When others notice this

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

effort and shift in energy, the client's hope is restored that they may once again fit into society with continued work. Awareness of positive changes increases their engagement in counseling, their trust in the counseling process, and their appreciation for the services. Counselors contribute to the development of trust within the counseling relationship by providing interventions that are useful and demonstrate an understanding of the client's world. Moreover, when interventions are successful, clients also view their counselors as more esteemed and qualified to provide help, further encouraging their engagement in the counseling process. Counselor approaches that clients experience as particularly helpful include: making suggestions, sharing personal experiences, providing psychoeducation, and encouraging the client to focus on themselves.

Clients actively seek out and appreciate their counselor's helpful suggestions. When clients are feeling hopeless, lost, and judged by the outside world, a helpful counselor has the ability to understand their trouble and provide ideas to decrease their distress. The client may then implement the suggestions and if they perceive even a slight decrease in distress, they are once again filled with hope of rejoining society as a fully functioning adult. Because the counselor conveys empathy when providing effective suggestions, showing they truly understand the client's world, the bond between counselor and client is strengthened. When relying only on feedback from Bhutanese society, many clients view their distress as symptoms of insanity, and ultimately believe such symptoms are deserved due to karmic destiny. Keeping this in mind, even a slight reduction of symptoms invites a different or more nuanced explanation of their illness and bonds them to their counselor, strengthening the trust in the counseling relationship.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

A similar process occurs when counselors share their personal experiences with clients. Sharing similar experiences normalizes the client's struggle and provides hope for interventions and strategies that have worked before. Personal stories are especially helpful with clients experiencing addiction. They move through a world they label as "normal" and perceive themselves as "abnormal" within it. When these clients meet with a counselor who has a personal background of addiction, they trust that the counselor can fully understand their struggle because they have lived it. Here, empathy runs deep and is offered without judgment. These counselors provide strategies for clients to spend time with friends who drink, deal with romantic relationships, and navigate stressors all while maintaining sobriety and an appearance of normalcy. Clients' trust in these strategies increases with the duration of the counselor's sobriety, showing that the strategies can withstand the test of time in the face of the constant threat of relapse. One prominent strategy shared in counseling is to attend NA meetings regularly to share an honest space with others engaged in the constant struggle of recovery, while at the same time covering up this aspect of their lives beyond these meetings. Sharing of personal experiences (particularly those that embody the counselor's success) provides clients with strategies and hope in the recovery process. Hope in recovery, in turn, increases their trust in the counselor and the counseling process.

When counselors provide psychoeducation about mental health illness and wellness in the counseling setting, it normalizes the client's experience. In Bhutan, clients may understand their symptoms through narratives of spirits and karma. For example, the symptoms are a result of being filled with evil spirits or doing something to deserve the plague of mental illness based on karma. When counselors provide information about

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

addiction as a disease or anxiety as a mental health issue that can be addressed in counseling, clients feel relief understanding that their struggle is not their fault. Within counseling, clients become aware of jargon used to describe commonly occurring conditions, such as “depression,” and begin to understand the physiological explanations that underlay their distress. The counselor’s knowledge, and ability to predict and explain aspects of the client’s experience using this knowledge, ultimately leads to a feeling of relief in the client: relief that there is a logical explanation for their feelings of being out of control; relief in not being the only person who has experienced this; relief in feeling understood by the counselor; and relief in the hope of recovering. Physiological explanations increase the client’s faith in the counselor’s understanding of their own job and ability to help.

Trust is developed in the client-counselor relationship when the counselor recommends countercultural practices that are effective. For example, counselors encourage clients to focus on themselves as a strategy to aid in recovery. In the collective community of Bhutan, people very rarely put themselves first. The cultural norm and construction of society revolves around consideration of a group and the group’s wellbeing superseding any individual person’s wants or needs. The counselor’s endorsement of a client focusing on themselves only directly conflicts with this norm. However, when clients prioritize the counselor’s suggestions, which may include shifting their role in their family slightly or taking time for self-care practices, they often see an improvement. The improvement increases their trust in counseling, hope for recovery, and ability to give back to their group. This ultimately promotes the client’s functioning to the benefit of the group and the client individually.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

The engagement of the client in the counseling process in Bhutan depends on the trust built in the counseling relationship. Counselors can begin the trust development by offering a nonjudgmental, compassionate space where they normalize the client's struggle. When the client feels completely understood, counseling provides them with a greatly contrasting experience than they have received from the outside society, increasing their trust and engagement. Engagement can often be seen by the client's willingness to openly and honestly share with the counselor, trusting the counselor to hold their information and provide interventions that show a true understanding of the client and their struggles. The client can also be greeted by characteristics, behaviors, and approaches that decrease their experience of being understood, preventing them from sharing and ultimately leading to their disengagement from the counseling process. Participants with positive experiences in counseling focused on the trust that developed within the counseling relationship, which allowed them to take risks and make personal changes that supported their recovery from distress.

In the following section I will verify this information by discussing efforts to establish trustworthiness, as well as the limitations. Further, I will explore the implications of this phenomenology on the practice of counseling in Bhutan and present areas for future research.

Trustworthiness

Trustworthiness, introduced by Lincoln and Guba (1985), establishes the integrity of qualitative research. While this idea may be foreign to Bhutan, it is essential to demonstrate that the information presented represents participants, especially when conducting cross-cultural research. By verifying results, participant experiences are

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

confirmed and consumers of the research can determine if and how the results are transferable. When establishing trustworthiness, I used methods of prolonged engagement and persistent observation, member checking, rich and thick descriptions, and bracketing and clarifying researcher bias.

Prolonged engagement and persistent observation. I utilized prolonged engagement and persistent observation by immersing myself in the literature around Bhutanese culture, worldview, and mental health in order to prepare for my employment in Bhutan. I lived and worked in Bhutan for four months as a mental health counselor on a college campus before beginning my research. While counseling and teaching at the Royal Thimphu College, I consulted regularly with mental health workers in Bhutan and Americans who had counseled in Bhutan. They helped me gain a greater understanding of mental health issues in Bhutan and culturally appropriate approaches to treatment. I provided counseling services to over 40 students, and became familiar with beneficial practices, cultivated a richer picture of how culture influences mental health presentation, and understood more about people's willingness to seek treatment. Before beginning my research, I sought approval from the Bhutanese Research Ethics Board of Health protocol. This process prompted contact with three organizations providing mental health services in Bhutan. I created and maintained relationships with staff at the Jigme Dorji Wangchuck National Referral Hospital (JDWNRH), Respect, Educate, Nurture, and Empower Women (RENEW), and the Youth Development Fund (the overseer of the Drop in Centers (DIC) in Bhutan). I connected with leaders of these organizations on a weekly basis for four months before my study was officially approved. During these contacts, I answered questions about the research and identified areas of the research the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

organizations were particularly interested. When leaders of the organizations fully understood the study and the study was approved, organizations referred appropriate participants for interviews. By being immersed in the culture, working closely with Bhutanese students, and creating working relationships with many Bhutanese mental health professionals, I experienced prolonged exposure to Bhutanese culture and mental health work. As a result, during the interviews, I felt more connected to the participants and asked more appropriate follow up questions after having experience with communication patterns in Bhutan. Prolonged engagement also allowed me to more fully understand the Bhutanese cultural context, which helped ground the participants' data, ultimately leading to a more trustworthy presentation of the counseling experience.

Member checks. During the research procedure, I conducted twelve interviews, transcribed and analyzed them, and developed a mental model of the client experience of counseling in Bhutan. This mental model and a description was presented at the member checks conducted with participants within three weeks of the initial interviews. I presented a mental model with fully formed themes of the client experience. The model displayed the major themes of the counseling experience, allowing participants to see the comprehensive accumulation of information from all interviews. They had the opportunity to picture how the elements of the entire experience interacted and how their information intersected with others', noting their overall contribution to the depiction of the counseling experience.

I contacted Sister Sonam at JDWNRH, Tshering Dolkar at RENEW, and Tshering Choki at the DIC to organize the member checks. Member checks were conducted in person with all participants from RENEW and the DIC. I scheduled in-person member

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

checks with two participants from the hospital, with Kesang, a participant and employee, and Ugyen, a counselor, assisting me in contacting the individuals. Sister Sonam provided translation for acquiring one member check on the phone and I spoke to the fourth participant from the hospital via cell phone. I was unable to contact the last participant from the hospital, resulting in eleven of twelve completed member checks. During the member checks, I explained the mental model using participants' responses as examples to improve communication and understanding of how I interpreted the interview data. Participants then had the opportunity to add, change, remove, or emphasize elements in the initial phenomenology of client experiences represented in the mental model. Participant responses were very affirming overall, often stating that the mental model described their experiences well. After persistently inquiring about adjustments, several participants added items not represented in the mental model, and we discussed how the new element could be incorporated or expressed. Participants enjoyed speaking to aspects of their experience that were the most meaningful. Based on the information gathered in the member check, I confirmed that I was representing the Bhutanese participants accurately. Member check procedures were the most critical form of establishing trustworthiness in this cross-cultural research.

Rich, thick description. Throughout the data analysis and writing of the results, I provided a rich, thick description of the Bhutanese client's experience with mental health counseling by including quotations from participants and interweaving an understanding of the Bhutanese culture. While some interviews were shallower than others, I made an effort to represent each participant's voice and show how participant's experiences were interconnected and also different. Throughout the in-depth and semi-structured

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

interviews, participants provided a wealth of information about their experiences with mental health counseling in Bhutan. By presenting rich, direct quotations from these interviews, I provide transparency in the data and a full account of the counseling experience with participants' own words.

Clarifying and bracketing researcher bias. Before going to Bhutan and throughout my experience there, I developed regular practices to become aware of and bracket my biases to the best of my abilities. I began keeping a journal of epoche writings one month before leaving for Bhutan and continued writing on a daily basis throughout my time there. I wrote about my experiences, emotional responses, and thoughts. In this way, I increased my awareness of specific thoughts and opinions to help me recognize and bracket them during the interview and data analysis processes. The epoche writing allowed me to process emotions that arose during my entire experience in Bhutan, preparing me to have open weekly discussions about these feelings with my clinical supervisor.

In addition to epoche writings, I kept reflective journal entries concerning the interview processes. The reflective entries contained information about the setting, the pace and style of the interview, how it felt, how we understood or did not understand each other, and so on. The process of keeping a reflective journal helped to inform the context in which I grounded the data and clarify participants' contributions to the essence of the counseling experience.

I also engaged in at least thirty minutes of meditation or mindfulness-based practices daily. This practice was varied and included silent meditations, guided meditations, mindful walks, knitting, or chores around the house. I engaged in formal

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

meditative practice, which involves sitting or lying down for a set period of time with a mindful awareness of breathing, at least four times per week. Both formal and informal mindfulness practices helped me be aware of my thoughts and set them aside in order to be more present in the moment while maintaining an open and nonjudgmental mind. My mindfulness practice aligned with Moustakas' (1995) suggestions to be more present and centered during the semi-structured interviews and data analysis process. Regular mindfulness practice allowed me to call on the skill of bracketing while researching. As a result, I believe I was more present and attuned to participants during interviews and was more aware of my thoughts during analysis. Overall, my ability to focus specifically on the participant's reality was enhanced.

Finally, I used three inquiry auditors as another means to clarify and bracket my biases. Weekly, I discussed my experiences and the research process with Kirsten Murray, my dissertation chair, who helped me make sense of how the data interconnected. Because she had never been to Bhutan and the majority of her exposure to Bhutanese culture was through our conversations, our discussions helped me identify covert elements of Bhutanese culture to make overt when presenting the phenomenology to a Western audience. Further, I had weekly meetings with Judi Durham, my clinical supervisor who is from the US, but has extensive mental health work experience in Bhutan. She has a tremendous understanding and respect for Bhutanese people and culture. While focusing largely on my clinical work, I would also speak to her about the research process and shared the data that I collected and organized. She helped me make sense of some of the information and recognize meanings within some statements for which Bhutanese participants might not have words. Both Kirsten and Judi read my

results sections to confirm or question if the data presented supported identified themes. Finally, I consulted regularly with Sister Sonam, the head psychiatric nurse at JDWNRH, who agreed to look at sections of transcripts whenever I was unsure about meaning or feared I was missing a cultural component imbedded in the data.

By being aware of my thoughts, opinions, and reactions, I was able to set them aside more easily. I focused on the participants and the essence of their experience with counseling minimizing my presence in the data as much as possible. I also understand that I will never be able to fully remove myself from the information I present, and took several steps to preserve and convey the participants' realities.

Limitations

Although steps were taken to establish trustworthiness, circumstances beyond control arose that limit the transferability of the study. The limitations include language barriers, incomplete member checks, inherent complications in cross-cultural research, the pace and timing of the research, and the evolving process of space and time. In this section, I will describe each limitation and efforts taken to minimize compromising effects.

Language. The most apparent limitation while conducting this study was the language barrier. In the initial interviews, it was difficult to understand participants at times or know if they understood me. In three interviews (Sonam, Tshewang, and Rinchen), there were moments of clear understanding when the participant and I connected, and these moments were few and far between. These individuals were not very comfortable with the English language. In Sonam's case, she requested a translator, and the translator's English skills were similarly limited. For each of these participants, I

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

arranged to have adequate translation services present at the member checks. As a result, many of the issues developed due to the language barrier were clarified in the member checks.

Contrary to these experiences, some participants were very comfortable with English and able to communicate their multi-faceted experiences with counseling more fully. I found that I was more engaged with these individuals, asking follow up questions and genuinely understanding them. These participants (Lhamo, Kesang, Namgay, and Tshering) had more influence in how I came to understand the Bhutanese counseling experience. I worked to triangulate their sentiments within the less clear interviews and engaged Sister Sonam to understand as much information as possible when language barriers were present. Nonetheless, some participants are represented at a higher rate in the research, while others contributed less data due to language clarity.

Incomplete member checks. When I returned to the hospital to complete any remaining member checks, I was unable to contact Tshewang. His initial interview was shallow, so I arranged for Sister Sonam to speak with him on the phone and translate the information he provided to me. This was in an effort to better represent his experience with counseling in the data synthesis. Tshewang had been discharged from inpatient treatment at the hospital and we attempted to call him on three different occasions. In Bhutan, there are no voicemail options on cellular phones, so we were unable to leave a message for him if his number had remained the same. Consequently, Tshewang's voice is not as present in the data as the rest of the participants. As a person from a rural area with a somewhat negative experience in counseling, his voice was valued and could have added more texture to the overall synthesis.

Cross-cultural research. Cross-cultural research provides some inherent complications. In this process, the researcher collects information from participants speaking in a second, third, or fourth language, and attempts to fully understand and convey this message to an audience. Qualitative research methodology is appropriate when eliminating risk of imposing standards that are irrelevant to the culture on the participants, yet the researcher ultimately cannot understand the culture in the same manner as someone native to the community. In order to overcome this, I originally planned to recruit two college students to code each of the interviews with me, anticipating they would identify cultural information I might miss. Once in Bhutan, however, I was unable to secure students or another Bhutanese person to commit to the research project due to time constraints. Sister Sonam agreed to look over portions of transcripts in order to clarify meanings that I was unsure about or identify cultural components I might have missed. No other person looked at the complete transcripts. I consulted with Sister Sonam about three segments of transcripts to ensure I understood the information. I also worked with my clinical supervisor to understand the implicit meanings behind some of the quotations collected. For example, she asked about a larger thread of empathy that connected several themes. The word “empathy” does not appear in the transcripts, nor is it commonly used in Bhutan, but the sentiment behind the word was present throughout the interviews and clarified the connection between other themes, like the client feeling understood and the counselor using a nonjudgmental stance. In order to depict the reality of the participants’ experiences, I consulted with people familiar with Bhutanese culture, and ultimately interacted with the full transcripts of data alone.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Pace and timing. I taught and counseled as a temporary college faculty member in Bhutan for five months. I received conditional approval from the Institutional Review Board (IRB) at the University of Montana prior to leaving for Bhutan, and was committed to receiving approval from the Research Ethics Board of Health (REBH) in Bhutan before commencing with the research. I submitted my REBH protocol, and then the protocol with recommended updates promptly, with the final application submitted for review on August 16, 2016. Due to complications in the review process, I did not receive permission from the REBH to commence research until October 20, and final approval from the University of Montana IRB followed on October 31, 2016. With a December 9 departure date, I had under six weeks to conduct twelve initial interviews, transcribe and analyze the data, and conduct twelve member checks. In order to complete data collection, analysis, and member checks during the remaining time in Bhutan, I conducted member checks with the fully analyzed data and mental model from the initial interviews and had not yet written the results of the first interviews into a complete dissertation chapter (see chapter 3). As a result, data became even clearer during the writing process, shifting the mental model slightly from my initial understanding of the first data analysis. I combined aspects of the cultural context and added more to fully represent the Bhutanese context to a Western audience. I also simplified titles to better explain and encompass the experience of counseling. Ideally, I would have been able to complete the writing before engaging in member checks so all relevant information could evolve and be presented to the participants. In the chapters of this dissertation, I explain how information changed based on the writing process. While this does not correspond with the original timeline and procedures proposed for this study, I have remained

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

transparent about necessary shifts in the research process and protocol in effort to aid the transferability process as audiences determine the credibility and applicability of the phenomenon.

Evolving space and time. In the past 50 years, Bhutan has undergone shifts that industrialized nations experienced over hundreds of years. Currently, the need for mental health services is rising, and the Bhutanese government is spearheading an initiative to meet the mental health needs of the people. Given the rapid changes in the larger context, I am keenly aware that this study represents a small cross-section of time during the developing stages of mental health treatment in Bhutan. I believe that this is advantageous due to the influence these results can have on the development of the counseling profession within Bhutan. However, when this research is reviewed in the future, it is critical that the results are grounded in this particular place and time. The reader can then determine the aspects that may still be applicable in the ever-evolving Bhutanese and international counseling contexts.

Implications

The purpose of this research is to provide an opportunity for the underrepresented population of Bhutanese clients to have a voice influencing how mental health services develop in Bhutan, allowing the benefit of the clients to serve as a focal point. In the following section, I describe how the information collected in this study can be applied within Bhutanese and international counseling practice. I offer these ideas from a place of humility, understanding that I have been exposed to a small section of the Bhutanese population for a relatively short period of time. My training is grounded in Western, colonialized, capitalist culture found in the US. I struggled with adapting my practices to

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

work with Bhutanese students, and frequently sought consultation about culturally appropriate and beneficial treatment. While recognizing these challenges and limitations, knowledge of participant experiences receiving services from Bhutanese counselors in Bhutan holds great potential to influence counseling practices to best serve Bhutanese patrons. I will discuss the implications for counseling practice in Bhutan, the influences on counselor training in Bhutan, and training for foreign counselors practicing in Bhutan. Last, I will discuss the implications for the field of Counselor Education, the international counseling community, and for Bhutanese clients.

Mental health practice in Bhutan. Currently, Bhutan mental health services are often provided in alignment with a medical model prominently practiced in the country (Calabrese & Dorji, 2014). At times, there is limited attention paid to bedside manner and there is a lack of continuity in care. To improve mental health services, the Bhutanese government has identified the international counseling profession to assist in building treatment services in Bhutan, as noted by the specific request and involvement of NBCC-I in the development of mental health services. Counseling as a profession identifies with a wellness model and at times resists medical models of practice (ACA, 2014). A wellness model focuses holistically on the benefit and wellbeing of the individual, which in turn can benefit the person's larger group. The wellness model aligns with Bhutanese collectivist culture and the Buddhist value of compassion.

Presently in Bhutan, counseling services are relatively unknown and accessibility to treatment can be impeded by finances, language, and geographical location. Based on this information and on Lhamo's recommendation, the study indicates that Bhutan could benefit from a mental health awareness campaign. Currently, people are striving to

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

increase awareness of mental health by hosting a large National Suicide Awareness Day and the new Mind over Matter mental health awareness page on Facebook. However, these efforts are not apparent to the general Bhutanese population unless they are looking for information. While I was in Bhutan, His Majesty Jigme Khesar Namgyel Wangchuck declared a holiday urging people of Bhutan to clean up the area in which they live. People all across the country participated, leading to a more habitable and environmentally friendly Bhutan. A similar idea could be useful in creating awareness around the signs and symptoms of mental health in Bhutan, as well as the resources available to those struggling or their loved ones.

Recommendations for counselors in Bhutan. There has been no research on the client's experience with counseling in Bhutan until now. According to participants' experiences with counseling, the primary factor contributing to their engagement is trust in the counseling relationship, which is largely built on the perception of empathy. One participant described empathy within the counseling setting as the counselor, "sharing a piece of my heart." Qualities that can be helpful to convey are the Buddhist value of compassion and acceptance or nonjudgment. By speaking softly and politely with clients, counselors show sensitivity to the struggles that the client has faced before deciding to seek treatment. With a compassionate mindset, counselors exude caring and focus on being present with the client and their ailments. Counselors can present as open-minded and curious as they listen to their client's story. Counselor behaviors that are helpful, especially at the start of counseling, are ensuring confidentiality and taking a few minutes of the session to provide some education around mental health, normalizing presenting issues. The goal at this point is to develop an initial trust with the client by conveying a

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

true understanding of the distress that must be present for a Bhutanese person to seek treatment.

In order to understand a client's struggle, a counselor may find it helpful to consider the lengths required to access services. Additionally, by guaranteeing confidentiality and explaining the terms and limits, counselors provide a space that can feel safe to be open, taking the social stigma into account. Interventions that can be helpful are to provide or co-create suggestions that the client can employ outside of counseling to see change. The counselor can continue to normalize the struggle of mental health by providing suggestions and stories from their own personal experience. Finally, while working from a collective framework by keeping the goals of a larger group in mind, the counselor can also urge the client to focus on themselves to the extent that it helps them recover.

In the study, participants identified beneficial qualities of counseling practice; some aligned with cultural practices and others resisted cultural norms. Many of these ideas for a Bhutanese-specific counseling practice are or contain elements that are countercultural in Bhutanese society. In a country with a high power distance, the social hierarchy will be present in the counseling office. In order for the counselor to provide an open and empathic space, they show the client respect and care. The client may feel undeserving of this, may look away, and may have difficulty being open about their story (Lester, 2016). In contrast, the client could be someone of superior societal status when compared to the counselor. In this instance, the counselor may look away and show deference to the client. In both examples, the counselor will struggle to abide by societal practices and create an open and trusting environment. In counseling practice, the

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

ultimate goal of building a trusting relationship based on empathy and understanding is a focal point.

Similarly, the concept of confidentiality is not practiced or valued in Bhutanese culture. Rather, the societal norm is that people speak freely about others. Therefore, counselors may find it difficult to understand the importance of confidentiality and place limits around themselves to maintain a client's privacy. Counselors must display sensitivity to the stigma that exists in society around mental health and mental health treatment by allowing the client to dictate if and how their stories will be shared with the outside world.

Finally, the concept of counseling focuses in on the individual more than is customary within Bhutanese culture (Nirola, et al., 2015). Encouraging a client to focus on themselves in order to move recovery forward is an unfamiliar idea in Bhutan, and potentially uncomfortable for clients. The idea of remaining focused on themselves could feel selfish or individualistic, compromising elements of their own identity within their culture. They also may fear reactions from others around them, such as family members who rely on them for care. The wraparound institutional mode of treatment currently within the hospital and rehabilitation settings allows the client to focus inward on their own recovery for this period of time. However, transitioning back into their worlds and responsibilities may require altering in order to maintain and continue progress. Working with families and communities may be helpful in identifying how roles may shift to best support one another.

Training in Bhutan. The current study describes elements of counseling that are particularly helpful for people in Bhutan. Given this, the training model for counselors in

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Bhutan can incorporate input from Bhutanese clients, emphasizing compassion and wellness while shifting away from a competitive or individualistic approach. The leaders of a special education training in Bhutan noted that Bhutanese people benefit greatly from hands on experiential work (Levine, Telsey, & McCormack, 2011). By incorporating experiential activities with supervised practice, Bhutanese counselors may be more equipped to greet clients with an open, nonjudgmental stance. Previously, I mentioned working with families to develop strategies for helping the client continue recovering. Due to the collective nature of society, some training may be devoted to working with families. Further, addiction rates have been increasing steadily. Bhutanese counselors preparing to practice should have specific addiction training and an understanding of how to elicit and address issues underlying the substance abuse behavior. Jigme recommended that counselors without a history in addiction primarily address the underlying issues. Participants at the Drop in Center (DIC) all received counseling for addiction and provided relief counseling within that community. When discussing their work as untrained counselors, they clearly desired information about working with families and understanding how to address symptoms of distress underlying substance abuse.

Training Bhutanese counselors in Bhutan has already begun and is essential in developing an indigenous counseling practice. In order for this to be most effective and beneficial for Bhutanese clients, empathy and the concept of trust can be central components. Components of the Bhutanese cultural context are also essential in developing a culturally conscious practice (Ng & Noonan, 2012). Bhutanese people are, therefore, the most qualified to design courses and teach curricula specific to the culture

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

in Bhutan. Counselors can be trained to develop accurate empathy with clients, focusing on the effort that is required and the judgment that is perceived when people seek counseling services. Clients feel abnormal, hopeless, and rejected from the central collectivist culture when they arrive for counseling. Counselors-in-training, therefore, should have a basic understanding of the physiological underpinnings of mental illness and frequency of occurrence in Bhutan in order to normalize the client's experience. Finally, they should develop a variety of interventions that clients will unquestionably elicit from them, noting how the client improves over time.

Training international counselors working in Bhutan. In order to assist Bhutan with the development of the mental health services, international organizations provide volunteers to operate as counselors in Bhutan. Currently, there is no formal training process for these volunteers who will often shadow Bhutanese counselors, but will more or less begin practicing as soon as possible in order to meet the needs of the people. These findings indicate that the main avenue to produce positive change in counseling is to convey empathy. When practicing within a culture that is unfamiliar, counselors from abroad may have difficulty accessing accurate empathy. Familiarizing themselves with this study may prepare international counselors practicing in Bhutan to become familiar with the Bhutanese culture, worldview, and one understanding of the client experience in Bhutan. Participants of this study made it clear that it is particularly important to have an understanding of the traditional and religious beliefs practiced in the country and especially how these relate to mental health. Many international counselors receiving training in Western programs may find it difficult to adapt their practices from an individualistic, competitive culture to a collectivist, collaborative culture. A formal

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

training for international counselors could be developed focused on informing people about the Bhutanese worldview and how it relates to perceptions and beliefs around mental health. The training could present examples of how an effective Bhutanese counselor might practice, showing adaptations of Western practices that focus on individualism as well as Bhutan-specific practices. Finally, the counselors could meet with at least one client while receiving live supervision to inform a culturally appropriate counseling approach. Counselors would benefit from understanding and practicing the tenets of Buddhism, as well as consult with traditional healers to gain a better understanding of faith-based practices (Srichannil & Prior, 2013). International counselors working in Bhutan should be able to consistently consult with Bhutanese mental health practitioners in order to monitor their reactions and adjust their interventions accordingly. Finally, becoming familiar with what clients experience as most and least helpful in counseling can better prepare counselors to integrate a culturally competent approach to counseling in Bhutan.

International counseling. Although this study focuses on Bhutanese counselors working with Bhutanese clients, there remain implications for international counselors. These implications are similar to those presented to international counselors working specifically in Bhutan. In order to work effectively with clients in an unfamiliar culture, international counselors should do everything possible to familiarize themselves with the culture and the worldview of the people (Enriquez, 1993; Ng & Noonan, 2012). Historically, mental health professionals have been labeled “colonizers of the mind” as they enter new cultures with their own biases and ideas of how people should be in the world based on their own culture (Lorelle et al., 2014). The counseling profession has

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

shifted in this approach, understanding now that in order to work towards the wellbeing of people from a different culture, one must work within and value that cultural context within counseling. International counselors must approach new populations with cultural humility and an openness to learn, interact, and respect the cultural worldview of the people in order to be of service. Worldview examines how the people in the culture view social relationships, relationships with the spiritual worlds, relationships with nature, and the way they come to know. This information can help counselors determine how to adapt their current practices to best fit the local population. This study also indicates that conveying empathy, compassion, and a willingness to listen may be universal properties of counseling that are beneficial to clients. By understanding as much of the culture as possible, the counselor can more easily express accurate empathy and hold a safe space for counseling. Finally, counselors practicing abroad should consistently consult with local people in order to align services with helpful cultural practices.

Bhutanese clients. In Bhutan, mental health treatment is often stigmatized and people do not seek help unless they are experiencing significant distress or a loved one is severely worried. One goal of this study is to provide potential clients with expectations or a framework for the mental health counseling process in Bhutan. With this information, people can gain an awareness of mental health issues and wellness, understand some of the reasons to seek counseling, understand how counseling works, and learn where to access it. Optimistically, a fraction of the potential client population in Bhutan will be exposed to this research, in part due to the illiteracy rate and general access to scholarly material. In this study, five of twelve participants did not receive a formal education past class (grade) eight, yet were given a voice in this study. Their voice

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

reflects an oppressed population that has an opportunity to directly impact services offered in Bhutan. The contribution of these participants could potentially impact how counseling is conducted, leading to more effective and widespread treatment of future Bhutanese clients.

Counselor education. The implications of this study for counselor educators is two-fold. First, the study increases understanding for how to prepare students to work internationally or within culturally different communities. Within multicultural counseling courses, instructors can emphasize the importance of understanding the multi-faceted aspects of worldview and how these perspectives can influence perceptions of mental health. Counseling students can learn how to make culturally appropriate adaptations in their counseling practices when they understand how to pose questions and understand the essential aspects of a culture's views on healing. They can also become advocates for the integration of indigenous practices within counseling work, and embrace community resources to learn and consult with native practitioners (Ng & Noonan, 2012; Ægisdóttir et al., 2008). In a continuously globalizing world, the desire and ability for counselors to travel abroad in order to provide relief or initial mental health services in a resource-poor area will only increase (Leong & Ponterotto, 2003). Therefore, it is important that counselor educators have the skills in order to assist their students to prepare for a cultural immersion experience as a helper.

Second, by gaining an understanding of how other cultures view the world, counseling students can develop an appreciation for their own worldview. By practicing or preparing to practice within another culture, this study describes recommended steps for counseling students to adopt a self-reflective routine. One goal within counselor

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

education is to help students become more self-aware. With cross-cultural work, students have the opportunity to gain insights into themselves, how they view the world, and how they approach others within the world. The current study explored elements of counseling that may be considered universally relevant, such as empathy and compassion. By focusing on these basic skills, self-awareness, and cultural humility, students will improve their counseling work with their own and other cultures.

Future Research

Because development of the counseling profession is in the very early stages in Bhutan, there are many areas left to explore. The present study and Lester (2016) propose counseling practices that could be appropriate in Bhutan based on interviews with Bhutanese clients and Bhutanese counselors (Lester, 2016). Further research is needed on how effective these proposed Bhutanese counseling practices are in producing positive client change. This could be evaluated within the wrap around care settings within Bhutan, by monitoring behavior, current mood, and receiving client feedback. Additionally, a formal counseling training program has commenced in Thimphu during the 2016-2017 academic year. As mental health training in Bhutan grows, the counseling field is working on standardizing training requirements to create a competent field of Bhutanese counselors. Currently, the National Board of Certified Counselors – International (NBCC-I) has worked with local Bhutanese counselors to create the Bhutan Board of Certified Counselors (BBCC). Quantitative research on counselor effectiveness can help determine the specific knowledge base and skills required to seek certification from the BBCC. The standards can then be set by the BBCC to influence the training curriculum and hold all Bhutanese counselors to a certain professional expectation. These

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

projects could all help influence the development of the counseling profession in Bhutan with the benefit of the client as the central focus. In addition to providing standards for certification, the BBCC could work towards developing an ethical code for counseling practice within Bhutan that specifically addresses Bhutanese culture and elements within counseling that are somewhat countercultural. For example, if counselors or the BBCC determine that confidentiality should be an ethical standard within Bhutan, it would be important to specify this in an ethical code and make sure this ethical code is addressed when training Bhutanese counselors since this is not an intuitive practice. In order to develop the ethical code, research could include interviewing practicing counselors about their ethical decision-making and practices.

Conclusion

In this chapter, I presented the synthesis of the phenomenology of Bhutanese clients' experiences with mental health counseling. I also assessed the phenomenology for trustworthiness and presented the limitations. Methods of trustworthiness included prolonged engagement and persistent observation, member checking, rich and thick descriptions, and bracketing and clarifying researcher bias. The limitations concerned complications with languages; difficulties of cross-cultural research; the pace and timing of the research; and the evolving process of space and time. I discussed the implications of this study in relation to the developing counseling practice in Bhutan, training Bhutanese counselors in Bhutan, and training international counselors working in Bhutan. The study also has implications for the international counseling community on a whole, for Bhutanese clients and for the counselor education profession. Finally, I presented ideas for further research in the culturally conscious development of the counseling

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

profession in Bhutan. The field is currently in its infancy, leaving many areas open to exploration in order to influence the continuous development and evolution of mental health treatment in Bhutan to more effectively benefit Bhutanese clients.

This phenomenological study, placed in the context of a rapidly globalizing world, sought to gather information about culturally consciously internationalizing the counseling profession in Bhutan. I interviewed twelve Bhutanese clients on their experiences with mental health counseling to gain a better understanding of beneficial and harmful practices. Clients stressed the importance of developing trust in the counseling relationship in whether or not they felt safe engaging in the counseling process. Trust developed by the counselor conveying empathy through their characteristics, behaviors, and approaches to counseling. When greeted with empathy, the client felt understood, in large contrast to the experiences they have within traditional Bhutanese society where there is limited awareness or comprehension of mental health issues. Through this normalizing process, clients experienced relief, leading them to share more openly, honestly, and completely.

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APPENDIX A.

University of Montana Institutional Review Board Approval



INSTITUTIONAL REVIEW BOARD
for the Protection of Human Subjects in Research
FWA 0000078
Research & Creative Scholarship
University Hall 116
University of Montana
Missoula, MT 59812
Phone 406-243-6672 | Fax 406-243-6330

Date: October 31, 2016
To: Mikchaela Sacra, Counselor Education
Dr. Kirsten Murray, Counselor Education
From: Paula A. Baker, IRB Chair and Manager 
RE: IRB #136-16: "Understanding the Client's Experience of Counseling in Bhutan"

All conditions have been met, and your IRB proposal cited above has been granted **FINAL APPROVAL** under **expedited review** by the Institutional Review Board in accordance with the Code of Federal Regulations, Part 46, section 110. Expedited approval refers to research activities that (1) present no more than minimal risk to human subjects, and (2) fit within the following category for expedited review as authorized by 45 CFR 46.110 and 21 CFR 56.110:

7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

All consent forms used for this project must bear the dated and signed IRB stamp. Use the PDF sent with this approval notice as a "master" from which to make copies for the subjects.

Amendments: Any changes to the originally-approved protocol, including the addition of any new research team members, must be reviewed and approved by the IRB **before** being made (unless extremely minor). Requests must be submitted using [Form RA-110](#).

Unanticipated or Adverse Events: You are required to timely notify the IRB if any unanticipated or adverse events occur during the study, if you experience an increased risk to the participants, or if you have participants withdraw from the study or register complaints about the study. Use [Form RA-111](#).

Continuation: Federal regulations require you to file an annual Continuation Report ([Form RA-109](#)) for expedited studies. You must file the report within 30 days **prior** to the expiration date, which will be announced upon final approval. A study that has expired is no longer in compliance with federal regulation or University IRB policy, and all project work must cease immediately.

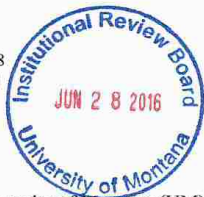
Continuation: Federal regulations require you to file an annual Continuation Report ([Form RA-109](#)) for expedited studies. You must file the report within 30 days **prior** to the expiration date, which is **October 30, 2017**. *Tip: Put a reminder on your calendar now.* A study that has expired is no longer in compliance with federal regulation or University IRB policy, and all project work must cease immediately.

Study Completion or Closure: Finally, you are also required to file a Closure Report ([Form RA-109](#)) when the study is completed or if the study is abandoned. See the directions on the form.

Please contact the IRB office with any questions at (406) 243-6672 or email irb@umontana.edu.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Form RA-108
(Rev. 05/16)



THE UNIVERSITY OF MONTANA-MISSOULA
Institutional Review Board (IRB)
for the Protection of Human Subjects in Research
APPLICATION FOR IRB REVIEW

IRB Protocol No.:
136-16

At the University of Montana (UM), the Institutional Review Board (IRB) is the institutional review body responsible for oversight of all research activities involving human subjects as outlined in the U.S. Department of Health and Human Services' Office of Human Research Protection and the National Institutes of Health, Inclusion of Children Policy Implementation.

Instructions: A separate application must be submitted for each project. IRB proposals are approved for no longer than one year and must be continued annually (unless Exempt). Faculty and students may email the completed form as a Word document to IRB@umontana.edu or submit a hardcopy (no staples) to the Office of the Vice President for Research in University Hall 116. Student applications must be accompanied by email authorization by the supervising faculty member or a signed hard copy. *All fields must be completed. If an item does not apply to this project, write in: N/A.* Questions? Call the IRB office at 243-6672.

1. Administrative Information

Project Title: <u>Understanding the Client's Experience of Counseling in Bhutan</u>	
Principal Investigator: <u>Michaela Sacra</u>	UM Position: <u>Doctoral Student</u>
Department: <u>Counselor Education</u>	Office location: <u>ED 212</u>
Work Phone:	Cell Phone: <u>(508) 934-6295</u>

2. Human Subjects Protection Training (All researchers, including faculty supervisors for student projects, must have completed a self-study course on protection of human research subjects within the last three years and be able to supply the "Certificate(s) of Completion" upon request. If you need to add rows for more people, use the [Additional Researchers Addendum](#).)

All Research Team Members (list yourself first)	PI	CO-PI	Faculty Supervisor	Research Assistant	DATE COMPLETED IRB-approved Course mm/dd/yyyy
Name: <u>Michaela Sacra</u> Email: <u>michaela.sacra@mso.umt.edu</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>10/24/2014</u> ✓
Name: <u>Kirsten Murray</u> Email: <u>kirsten.murray@mso.umt.edu</u>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>12/15</u> ✓
Name: Email:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Name: Email:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

3. Project Funding (If federally funded, you must submit a copy of the abstract or Statement of Work.)

Is grant application currently under review at a grant funding agency? <input type="checkbox"/> Yes (If yes, cite sponsor on ICF if applicable) <input checked="" type="checkbox"/> No			Has grant proposal received approval and funding? <input type="checkbox"/> Yes (If yes, cite sponsor on ICF if applicable) <input checked="" type="checkbox"/> No		
Agency	Grant No.	e-Prop #	Start Date	End Date	PI on grant

For UM-IRB Use Only

IRB Determination:

- Not Human Subjects Research
- Approved by Exempt Review, Category # _____ (see memo)
- Approved by Expedited Review, Category # 7 (see Note to PI)
- Full IRB Determination
- Approved (see Note to PI)
- Conditional Approval (see memo) - IRB Chair Signature/Date: _____
- Conditions Met (see Note to PI)
- Resubmit Proposal (see memo)
- Disapproved (see memo)

Note to PI: Non-exempt studies are approved for one year only. Use any attached IRB-approved forms (signed/dated) as "masters" when preparing copies. If continuing beyond the expiration date, a continuation report must be submitted. Notify the IRB if any significant changes or unanticipated events occur. When the study is completed, a closure report must be submitted. Failure to follow these directions constitutes non-compliance with UM policy.

Risk Level: Minimal

Final Approval by IRB Chair/Manager: Paula M. Baker Date: 10/31/2016 Expires: 10/30/2017

APPENDIX B.

Research Ethics Board of Health in Bhutan Approval



འབྲུག་རྒྱལ་ཡོད་རྒྱལ་ཁབ་ཀྱི་
 ལྷན་ཁྲིམས་ལྷན་ཁུངས་
 ལྷན་ཁྲིམས་ལྷན་ཁུངས་ ལྷན་ཁྲིམས་
 ལྷན་ཁུངས་

ROYAL GOVERNMENT OF BHUTAN
 MINISTRY OF HEALTH
 RESEARCH ETHICS BOARD OF HEALTH
 THIMPHU : BHUTAN
 P.O. BOX : 726




REBH/Approval/2016/046

20th October, 2016

REBH Approval Letter

<p>PI: Michaela Sacra Institute: Royal Thimphu College Thimphu, Bhutan</p>	<p>Study Title: Understanding the Client's Experience with Counselling in Bhutan</p>
<p>Co-PI: Sonam Choki¹ 1- Jigme Dorji Wangchuck National Referral Hospital</p>	
<p>Mode of Review: ✓ <i>Full Board Review (Meeting No. 4/2016-29th) for version 01</i> ✓ <i>Expedited review for Version 02</i></p>	
<p>Decision: Approved (Note: Abide by the conditions of approval)</p>	
<p>Conditions for Approval</p> <ol style="list-style-type: none"> 1. <i>This approval is granted for the scientific and ethical soundness of the study. The PI shall be responsible to seek all other clearances/approvals required by law/policy including permission from the study sites before conducting the study.</i> 2. <i>Report serious adverse events to REBH within 10 working days after the incident and unexpected events should be included in the continuing review report or the final report.</i> 3. <i>Any changes to the proposal or to the attachments (informed consent and research tools such as forms) should be approved by REBH before implementation.</i> 4. <i>Final report of the study should be submitted to REBH at the end of the study for protocol file closure.</i> 5. <i>This approval is valid through 19/10/2017. If the study has to continue beyond the approved period the PI has to apply for the continuing review two months before the validity of the approval expires.</i> 	



(Dr. Tashi Tobgay)
 Offtg. Chairperson

For further information please contact: REBH Member Secretary,
msgurung@health.gov.bt/tashidema@health.gov.bt; Tel: +975-2-322602 ext 333

APPENDIX C.

English Informed Consent

Participant Information and Informed Consent

This informed consent is for Bhutanese clients who have experienced counseling and who we are inviting to participate in a qualitative study, titled “Understanding the Client’s Experience of Counseling in Bhutan.”

Principle Investigator: Michaela Sacra – Doctoral student

Organization: Counselor Education Department, University of Montana, Missoula, Montana, USA

Sponsor: The Creative Research Grant from the University of Montana has provided some sponsorship for the project.

Project: Understanding the Client’s Experience of Counseling in Bhutan

This Informed Consent Form has two parts:

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

You will be given a copy of the full Informed Consent Form

Part I: Information Sheet

Introduction

My name is Michaela Sacra and I am a doctoral student from the United States, and I am currently working at the Royal Thimphu College. I am doing research to understand more about Bhutanese clients’ experiences with counselling in Bhutan. I am going to give you some information about the study and would like to invite you to participate in the research. You do not have to decide today whether or not you will participate in the research. Before you decide, you can talk to anyone you feel comfortable with about the research. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me.

Purpose of the Research

In Bhutan, many people are struggling to meet or maintain their mental wellbeing. There are counsellors who can provide services to them to become healthier, functional, and enjoy life more. The culture in Bhutan is very unique and we want to make sure that counsellors are using skills that best fit the Bhutanese population. We believe that you can help us figure out what parts of your counselling experiences have been the most helpful and which ones were less helpful. With this information and information from other people, we can help train counsellors to work specifically and more efficiently with Bhutanese people, which could help many Bhutanese people feel better faster in the future.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Type of Research Intervention

This research will involve you participating in an interview with me, which will really be more like a conversation. At any point during the conversation if you get uncomfortable or you would prefer not to continue, that is fine. The conversation should take between 45 minutes and 1.5 hours. I will also come back in the next 2 or 3 days to go over the information you provided. This is to make sure I fully understood you and am not missing or misunderstanding important pieces. It's very important to me that your experience is represented accurately.

Participant Selection

You are being invited to participate because we believe that your experiences with counselling can contribute to our larger understanding of how people in Bhutan experience counselling.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. If you choose to participate, you will also be able to stop the interview at any point in time. If you choose not to participate, it will have no effect on the services that you receive.

Procedures

A. We are asking you to help us learn more about how Bhutanese people experience counselling. We are inviting you to take part in this research project. If you accept, you will be asked to be present for an interview and a follow up meeting.

B. During the interview, I will sit down with you in a comfortable, private place at the hospital. If you do not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question. No one else but the interviewer will be present unless you would like someone else to be there. The information recorded is confidential, and no one else except myself will access the information documented during your interview. The entire interview will be tape-recorded, but no one will be identified by name on the tape. I will listen to the tape and transcribe what was said, without any information that could identify you. I will then return for a follow up meeting within 3 days so that you may have the opportunity to look at the information that I gathered from you, and add, change, or remove portions so that you are accurately represented.

The recording from the original interview and the follow up will be kept stored on a computer in a password protected, encrypted file. That means even if people figure out the password, the file will be jumbled and will not be able to be accessed. I will be the only one with the password. The recording will be destroyed after no more than 6 months, once all data has been collected and analysed.

Duration

The initial interview will last between 45 minutes and 1.5 hours. It will only occur once, but I will come back within 3 days in order to follow up with the information you provided. This conversation should last no more than 45 minutes.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Risks

During the course of our discussion, I may be asking you to share some very personal and confidential information, and you may feel uncomfortable talking about some of the topics. You do not have to answer any question or take part in the discussion/interview/survey if you don't wish to do so, and that is also fine. You do not have to give us any reason for not responding to any question or for refusing to take part in the interview.

Benefits

There will be no direct benefit to you for participating in this research, but it is likely that your contribution can help improve our mental health treatment of Bhutanese clients in the future.

Reimbursements

You will not be provided with any incentive to take part in this research.

Confidentiality

Since the research is being done where you are staying, people outside of this setting will not know about your involvement unless you tell them. However, within this setting, researchers being present may draw added attention to people participating in the research. We will not be sharing information about you with anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your name. Only the primary researcher will know what your number is and I will lock that information up with a lock and key. It will not be shared with or given to anyone else.

Sharing the Results

Nothing that you tell us today will be shared with anybody outside the research team, and nothing will be attributed to you by name. The knowledge that we gain from your interview will be shared with you in the follow up session before the results are formally written up and dispersed. The information will be fully analyzed and then shared with the Ministry of Health and the Medical College before they are published.

Right to Refuse or Withdraw

You do not have to take part in this research if you do not wish to do so, and choosing to participate will not affect the services that you receive in any way. You may stop participating in the interview at any time that you wish without consequence. I will return within 3 days so that you may review your remarks, and you can ask to modify, add or remove portions of those if you do not agree with my notes or if I did not understand you correctly.

Who to Contact

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact me (Michaela Sacra) by:
Phone: 17333602

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Email: Michaela.sacra@mso.umt.edu

This proposal has been reviewed and approved by the IRB of the University of Montana and the Research Ethics Board of Health, which is a committee whose task it is to make sure that research participants are protected from harm.

If you wish to find about more about the IRB, you can contact the University of Montana Institutional Review Board at +1-406-243-6672, or the Research Ethics Board of Health at +975-2-328095.

You can ask me any more questions about any part of the research study, if you wish to.
Do you have any questions?

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

Part II: Certificate of Consent

I have been invited to participate in research about my experiences with counseling in Bhutan. I will be asked to participate in two sessions of information gathering, including one longer interview and a follow up conversation.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.

Print Name of Participant _____

Signature of Participant _____

Date _____

Day/month/year

If illiterate*

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Print name of witness _____

Thumb print of participant

Signature of witness _____

Date _____

Day/month/year

Statement by the researcher/person taking consent:

I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this ICF has been provided to the participant.

Print Name of Researcher/person taking the consent _____

Signature of Researcher /person taking the consent _____

Date _____

Day/month/year

*A literate witness must sign (if possible, this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

APPENDIX D.

Dzongkha Informed Consent

བཅའ་མར་གཏོགས་མི་གི་བདེ་དོན་དང་གནང་བ།

འ་ནི་ཡི་གུ་འདི་ འབྲུག་མི་ཉེ་མ་ལས་བསྐྱབ་སྟོན་གྱི་སྤྲུལ་འབྲུག་ཡོད་མི་དང་ ལྷན་ཚད་ཅན་གྱི་སྤྱོད་བཅས་ནང་ལྟ་ བཅའ་མར་གཏོགས་མི་གི་དོན་ལུ་ ང་བཅས་ཀྱི་མགོན་བདེ་ལུ་མི་ཚུ་གི་དོན་ལུ་ཨིན། སྤྱོད་བཅས་ཀྱི་མིང་ འབྲུག་ལུ་ བསྐྱབ་སྟོན་ནང་ལྟ་ བཅའ་མར་གཏོགས་མི་ཚུ་གི་ཉམས་སྤོང་ཏེ་གོ་ཐབས།

- ཞིབ་དཔྱད་འབད་མི།** མི་ཅེ་ལ་སྲག་ར། མཆེ་མཚོའི་ཤེས་ཡོན་སློབ་ཕྲུག
- ལས་ལྗེ།** བསྐྱབ་སྟོན་ཤེས་ཡོན་ལས་ཁུངས། མོན་ཏེ་ན་ གཙུག་ལག་སློབ་གྲྭ། མི་ལོ་ལྷུ་ལ་ མོན་ཏེ་ན་ ལུ་ཨིས་ཨི།
- ཐད་འཕྲོ་གནང་མི།** མོན་ཏེ་ན་གཙུག་ལག་སློབ་གྲྭ་གི་ གསར་ཚལ་ཅན་གྱི་ཞིབ་འཚོལ་ཤོགས་རམ་གྱིས་ རྒྱབ་སྐྱོར་ཨ་ཙེ་གནང་ཡོད།
- ལས་འགུལ།** འབྲུག་ལུ་ བསྐྱབ་སྟོན་ལས་རིམ་ནང་བཅའ་མར་གཏོགས་མི་ཚུ་གི་ཉམས་སྤོང་ཤེས་ཐབས།

གོ་བདེ་སྤྱོད་ཡོད་པའི་གནང་བའི་འབྲི་ཤོག་འདི་ལུ་དབྱེ་ཁག་གཉིས་སྟེ་ཡོད།

- བདེ་དོན་ཤོག་ལེབ་ རྒྱལ་སྤྱོད་འདི་གི་སྐོར་ལས་ བདེ་དོན་ཚུ་ལྷོད་དང་གཅིག་ཁར་ཅུབ་སྤྱོད་འབད་ནི་གི་དོན་ལུ་།
 - གནང་བ་གི་ལག་ཁྲུང་ རྒྱབ་ཚུལ་མར་གཏོགས་ནི་ཨིན་པ་ཅིན་ ས་ཡིག་རྒྱབ་ནི་གི་དོན་ལུ་།
- ལྷོད་ལུ་ བདེ་དོན་ཆ་ཚང་སྤྱོད་ཡོད་པའི་གནང་བའི་འབྲི་ཤོག་འདི་གི་འདྲ་གཅིག་བྱིན་འོང།

ཡན་ལག་དང་བ། བདེ་དོན་གྱི་ཤོག་ལེབ།

ངོ་སྟོན།
 དེ་གི་མིང་ མི་ཅེ་ལ་སྲག་ར་ཨིན། ང་ ལུ་ནའི་ཀྲུ་ཨིས་ཀྲུ་ལས་ ཆེ་མཚོའི་ཤེས་ཡོན་སློབ་ཕྲུག་ཅིག་ཨིན། ང་རང་ ད་རིས་ནངས་བ་ གེམ་ལུ་རྒྱལ་འཛུལ་མཚོན་མཚོན་མཚོན་སློབ་གྲྭ་ནང་ལུ་སྤྲུལ་འབད་དོ། ང་འབྲུག་ལུ་ འབྲུག་མི་བསྐྱབ་སྟོན་གྱི་ཞབས་ཏོག་ལག་ལེན་འཐབ་མི་ཚུ་གི་སྐོར་ལས་ཤེས་ནི་གི་དོན་ལུ་ ཞིབ་འཚོལ་འབད་མུ་ཨིན། ང་གིས་ལྷོད་ལུ་ སྤྱོད་སྤྱོད་འདི་གི་སྐོར་ལས་ བདེ་དོན་དག་པ་ཅིག་བྱིན་འོང་ དེ་ལས་ དེ་གི་རེ་བ་འདི་ ལྷོད་ཞིབ་འཚོལ་འདི་ནང་ལུ་བཅའ་མར་གཏོགས་བཅུག་ནི་སྟེ་ཨིན། ཞིབ་འཚོལ་འདི་ནང་བཅའ་མར་གཏོགས་ནི་ཨིན་ན་མི་ཚུ་གི་སྐོར་ལས་ ལྷོད་ཀྱིས་ད་རི་རང་སེམས་ཐག་བཅད་དགོ་པ་མེད། སེམས་ཐག་མ་བཅད་པའི་ཉེ་མ་ ཞིབ་འཚོལ་འདི་གི་སྐོར་ལས་ ལྷོད་རང་སྐོར་དག་པའི་མི་ཅིག་དང་གཅིག་ཁར་ གྲོས་བཟུལ་འབད་བ་གིས་མ་བཟུབ་མེད། འ་ནི་གནང་བ་གི་འབྲི་ཤོག་འདི་ནང་ལུ་ ལྷོད་ཀྱིས་ཏེ་མ་གོ་བའི་ཚོགས་རེ་འཛུལ་པ་ཅིན་ དེ་འཕྲོ་ལས་ང་ལུ་འདྲི་ནི་རང་ཨིན། ང་གིས་ལྷོད་ལུ་ཁ་གསལ་སྟེ་བཤད་པ་རྒྱབ་སྟེ་བྱིན་འོང། ལུ་ལས་དྲི་བ་རེ་འདྲི་ནི་ཡོད་ཅུང་ ང་གིས་དེ་ཚུ་གིས་ལན་སྐབས་སྟེ་བྱིན་འོང།

ཞིབ་འཚོལ་གྱི་དམིགས་ལུལ།

འབྲུག་ལུ་ མི་མང་ཤོས་རང་ རང་གི་སེམས་ཁམས་བདེ་ཏོག་ཏེ་སྟེ་རྒྱུན་སྤྱོད་འབད་ནི་ལུ་ ལཱ་ལག་གཏང་ལྟེ་འདུག་ཁོང་ལུ་ སེམས་ཁམས་བདེ་ཏོག་ཏེ་དང་ ལཱ་གོ་ལ་བཟུབ་ དེ་ལས་མི་ཚུ་སྤྱོད་བཅས་ལུ་ལྷན་ཏོག་ཏོ་བཟོ་ནི་གི་ཞབས་ཏོག་བྱིན་སྟེ་ལཱ་ལས་པའི་ བསྐྱབ་སྟོན་པ་ཚུ་ཡང་འདུག་ འབྲུག་གི་ལས་སྐོར་འདི་གཞན་དང་མ་འདྲུལ་ཅིག་འདུག་ དེ་ལས་ ང་བཅས་ཀྱི་ལ་ལུག་ལས་ ཁོང་བསྐྱབ་སྟོན་པ་ཚུ་གིས་ འབྲུག་མི་ཚུ་དང་མཐུན་པའི་བསྐྱབ་སྟོན་གྱི་རིག་ཚུ་ལུ་ ལག་ལེན་འཐབ་ཚུགས་པ་བཟོ་ནི་སྟེ་ཨིན།
 ང་བཅས་ཀྱི་ལ་ལུག་ལས་འབད་བ་ཅིན་ ལྷོད་ཀྱིས་ང་བཅས་ལུ་ བསྐྱབ་སྟོན་གྱི་ཆ་ག་འདི་གིས་ཕན་ཐོགས་ཆེ་བས་ག་ ག་འདི་གིས་ཕན་ཐོགས་ཚུང་མས་ག་ དབྱེ་བ་ལྟེ་ནི་ལུ་ཕན་ཐོགས་ཚུགས་པའི་རེ་བ་བསྐྱེད་པ་ཨིན། བདེ་དོན་འདི་དང་ མི་གཞན་ལས་ཐོབ་པའི་བདེ་དོན་ཚུ་ལུ་བརྟེན་ཏེ་ ང་བཅས་ཀྱིས་ བསྐྱབ་སྟོན་པ་ཚུ་ལུ་ སྤྱོད་བཅས་བྱིན་བྱིན་ནི་ལུ་ཕན་ཐོགས་ལས་ འབྲུག་མི་ཚུ་དང་གཅིག་ཁར་ བསྐྱབ་སྟོན་གྱི་སྤྲུལ་ དམིགས་གསལ་དང་ཕན་ཐོགས་ཅན་གྱི་སྤྱོད་འབད་དེ་ མ་འོངས་པ་ན་ འབྲུག་མི་ལེ་ཤ་ཅིག་ལུ་ ལེགས་

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

འགྲུལ་ཚུ་ ག་ཅི་དེ་མཚོན་གསུང་གི་ལྷན་ཚོགས་ཚུགས།

ཞིབ་འཇོམ་བར་ཞུགས་ཀྱི་དཔྱེ་ལག

ཞིབ་འཇོམ་འདི་གིས་ རྒྱུད་ ང་དང་གཅིག་ཁར་དྲི་བ་དྲིས་ལན་ནང་བཅའ་མར་གཏོགས་ནི་ནང་ལུ་ འབྲེལ་གཏོགས་འབད་བཅུག་ འོང་། འདི་ཡང་ མང་ཤོས་ཅིག་ ང་བཅས་གཉིས་ཀྱི་བར་ན་ ཏུས་རྒྱུན་གྱི་ཁ་སྐབ་དོ་བཟུམ་ཚམ་ཅིག་འོང་། རྒྱུད་པའི་བར་ན་ རྒྱུད་རང་ལུ་ བར་ན་ལས་ ལྷབས་བ་བདེ་ལ་དང་ ཡང་ན་ དྲི་བ་དྲིས་ལན་འཕྲོ་མཐུན་དེ་འབད་དགོ་མ་མཚོ་ལས་ བཞོལ་བཞག་ དགོས་འཚོན་ཅུང་སྐབས་མ་བདེ་ལ་མེད། དྲི་བ་དྲིས་ལེན་འདི་གིས་ ཏུས་ལུན་ ལྟམ་མ་ ༤༥ དང་ཡང་ན་ ལྷ་ཚོད་ ༡ དང་ལྟམ་ མ་ ༡༠ དེ་ཅིག་འགོ་འོང་། ང་གིས་ ཉེན་མ་གཅིག་གཉིས་ཅིག་གི་ནང་ན་ རྒྱུད་འབད་སར་ དྲི་བ་དྲིས་ལན་གྱི་སྐབས་ རྒྱུད་རང་ གིས་བྱིན་མི་བད་དོན་ཚུ་གི་ཚོགས་ལུ་ བསྐྱར་ཞིབ་འབད་ནི་གི་དོན་ལུ་ཚར་གཅིག་འཚོན་འོང་། དེ་ཡང་ རྒྱུད་ཀྱིས་སྐབ་མི་དོན་དག་ ལག་ཆེ་རྟོག་རྟོ་ཚུ་ ཆད་སྐྱག་མེད་པའི་ཁར་ གོ་ལོག་མ་འགྲོ་བར་ ཆ་ཚང་སྤེལ་གིས་ཉ་གོ་ཡོད་པ་དེས་རྟོག་བཟོ་ཐབས་ལུ་ཨིན། དེ་ གི་དོན་ལུ་ ང་གིས་རྒྱུད་ཀྱི་ རོ་ཚབ་སྤེལ་ རྒྱུད་ཀྱི་བཤད་མི་ཉམས་ཚུང་ཚུ་ འཇོམ་བ་ག་ནི་ཡང་མེད་པར་སྐབ་དགོས་འདི་ གནམ་མེད་ ས་མེད་ལག་ཆེ་རྟོག་རྟོ་ཅིག་ཨིན།

བཅའ་མར་གཏོགས་མི་གི་གདམ་ཁ་རྒྱབ་མི།

ང་བཅས་ཀྱི་ཁ་ཐུག་ལས་ རྒྱུད་བཅའ་མར་གཏོགས་ནི་ནང་ལུ་གདམ་ཁ་རྒྱབ་མི་དེ་ རྒྱུད་ཀྱི་ཉམས་ཚུང་འདི་གིས་ ང་བཅས་ལུ་ འབྲུག་ལུ་བསྐབ་སྟོན་གྱི་ལུ་ཚུ་ག་དེ་སྤེལ་འབད་དེས་ག་ རྒྱབ་ཆེ་རྟོག་རྟོ་སྤེལ་ཉ་གོ་ནི་ལུ་ཕན་ཐོགས་ནི་གི་དོན་ལུ་ཨིན།

ཁ་སྐབས་གི་ཚོགས་ལས་བཅའ་མར་གཏོགས་ནི།

ཞིབ་འཇོམ་ནང་ལུ་བཅའ་མར་གཏོགས་མི་དེ་ ཁས་སྐབས་གི་ཚོགས་ལས་ཨིན། བཅའ་མར་གཏོགས་ནི་ཨིན་ན་མིན་འདི་ རྒྱུད་རའི་ གདམ་ཁ་ཨིན། གསུམ་སྤེལ་ བཅའ་མར་གཏོགས་ནི་སྤེལ་བཅུད་པ་ཅེན་ བར་ན་ལས་བཀག་ཆ་ནམ་རང་འབད་ཅུང་འབད་ཚོག་ གསུམ་སྤེལ་བཅའ་མར་མི་གཏོགས་ནི་སྤེལ་བཅུད་ཅུང་ རྒྱུད་མེད།

བྱ་སྤྱིའི་རིམ་པ།

ཀུ། ང་བཅས་ཀྱིས་ ཉམས་ཚུང་ཡོད་མི་ཚུ་ལས་ཆ་རོགས་འཇོམ་ཞིན་མ་ལས་ རྒྱུད་ཀྱི་ཉམས་ཚུང་ཚུ་བཟུ་སོར་ཚོགས་ལས་ དེ་གི་ལས་འགུལ་འདི་ལུ་ཆ་རོགས་འབད་གནང་བཟུ་ རྒྱབ་འབད་མ་ཨིན། རྒྱུད་ཀྱིས་འདི་དོས་ལེན་འབད་བ་ཅེན་ རྒྱུད་ལུ་ དྲི་བ་དྲིས་ལན་གྱི་ལས་རིམ་དང་ ལལ་འཇོམས་ཚུ་ནང་ལུ་བཅའ་མར་གཏོགས་གནང་བཟུ་འོང་། ལལ། དྲི་བ་དྲིས་ལན་འབད་སའི་ས་ཁོངས་འདི་ ལྷན་ཁང་ནང་ལུ་ ལྟམ་གྱི་ས་ཁོངས་སྐབས་བདེ་རྟོག་རྟོ་ཅིག་ནང་ལུ་སའི་ འབད་ནི་ཨིན། ལན་སྐབ་དོ་མ་བདེ་བའི་དྲི་བ་འཚོན་པ་ཅེན་ ང་ལུ་སྐབ་ནི་རང་ཨིན་ ང་གིས་དེ་འཕྲོ་ལས་དྲི་བ་སོར་ གཏང་འོང་། དྲི་བ་དྲིས་ལན་འབད་བའི་སྐབས་ དེ་ཁར་མི་ག་ཡང་མི་བཞག་ གསུམ་སྤེལ་རྒྱུད་རང་ལུ་ ཆ་རོགས་གཅིག་ དགོ་པ་ཅེན་ འབྲུག་འོང་ཚོག་ དྲི་བ་དྲིས་ལན་གྱི་སྐབས་ རྒྱུད་ཀྱིས་སྐབ་མི་བད་དོན་ཚུ་ ག་ལུ་ཡང་ཉན་མི་བཅུག་ བད་ དོན་ཚུ་ རྒྱ་བཟུང་འབད་བཞག་ནི་ཨིན་ཅུང་ རྒྱུད་ཀྱི་མི་ག་ཨིན་ན་གསལ་སྟོན་མི་འབད། རྒྱུད་རང་གིས་མཚོ་མི་ཚུ་ག་ ཨིན་མ་སྤེལ་ རྒྱུད་ཀྱི་དོ་འབད་ནི་གི་དོན་ལུ་ ཉེན་མ་གསུམ་གྱི་ནང་འཁོད་ལུ་ ང་གིས་ལོག་སྤེལ་དང་གཅིག་ཁར་ཚར་ གཅིག་ལུང་འོང་། དེ་གི་སྐབས་ལུ་ ཉེ་མ་བསྐྱེལ་ལེན་འབད་ཡོད་པའི་བད་དོན་ཚུ་དཔྱེ་ཞིབ་འབད་ཞིན་མ་ལས་ དེ་ནང་ལུ་ རྒྱུད་ལུ་སྐབས་མ་བདེ་ལ་མེད་པ་ཅེན་ སོར་ནི་དང་ ཡང་ན་ བཏོན་གཏང་འོང་། རྒྱུད་ལས་བསྐྱེལ་ལེན་འབད་མི་བད་དོན་ ཚུ་ ག་གིས་ཡང་མ་ཤེས་པའི་ས་ཁོངས་ནང་བཞག་ནི་དང་ རྒྱོག་རིག་ནང་ལུ་ཡང་ གསལ་ཡིག་བཅུགས་ཏེ་བཞག་ཞིན་མ་ ལས་ གསལ་ཡིག་དེ་ ང་རྒྱུད་ཀྱི་གཅིག་མ་གཏོགས་ གཞན་ག་གིས་ཡང་མ་ཤེས་པ་སྤེལ་བཞག་ནི་ཨིན།

ཏུས་ལུན།

དྲི་བ་དྲིས་ལན་འདི་ ཏུས་ལུན་ ལྟམ་མ་ ༤༥ དང་ ལྷ་ཚོད་ ༡ དང་ལྟམ་མ་ ༡༠ གི་བར་ན་འགོར་འོང་། དེ་ཡང་ ཚར་གཅིག་རྒྱུང་ཅིག་འབད་ནི་ཨིན་མ་དང་ ཉེན་མ་གསུམ་གྱི་ནང་འཁོད་ རྒྱུད་ཀྱི་བྱིན་མི་བད་དོན་ཚུ་ བསྐྱར་ཞིབ་

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

དྲི་བ་རེ་ཡོད་པ་ཅིན་ ད་ལྟོ་འབད་བུང་ ལུ་ལས་འབད་བུང་འདྲི་ཚོག་ ལུ་ལས་དྲི་ནི་འབད་བ་ཅིན་ ང་དང་གཅིག་ཁར་
འོག་གི་ཁ་བྱང་ཚུ་ནང་འབྲེལ་བ་འཐབ་གནང་།

འབྲེལ་འདྲིན་ཨང་ ༡༧༩༩༩༥༠༢

ཨི་མེལ་ཁ་བྱང་ msacra@rtc.bt

གོ་ས་འཆར་འདི་ མོན་ཏེ་ན་ གཞུག་ལག་སློབ་གྲྭ་གི་ ཨའི་ཨར་བི་དང་ གསོ་བའི་ཞིབ་འཚོལ་ཁྲིམས་ལྷགས་བཀོད་
ཚོགས་ཀྱིས་ བསྐྱར་ཞིབ་འབད་ཞིན་མ་ལས་ གནང་བ་བྱིན་ཡོད་པ་ཨིན། ཚོགས་པ་དེ་ཡང་ ཞིབ་འཚོལ་ནང་བཅའ་མར་
གཏོགས་མི་ཆ་ལྷབ་ ཉེན་སྲུང་དང་ལྷན་མ་སྡེ་བཞག་ནི་གི་ལྷ་འབད་མི་ཨིན།
ཁྱེད་ཀྱིས་ ཨའི་ཨར་བི་ གི་སྐོར་ལས་ལེགས་ཤོམ་སྡེ་ཤེས་ནི་གི་འདོད་པ་ཡོད་པ་ཅིན་ མོན་ཏེ་ན་ གཞུག་ལག་སློབ་གྲྭ་
གཞུག་སྡེའི་བཀོད་ཚོགས་དང་གཅིག་ཁར་ ༠༡-༤༠༤-༩༤༩-༤༤༢༢ དང་ ཡང་ན་ གསོ་བའི་ཞིབ་འཚོལ་ཁྲིམས་
ལྷགས་བཀོད་ཚོགས་དང་གཅིག་ཁར་ ༠༡-༢༥-༩-༩༩༩༠༧༥ ནང་འབྲེལ་བ་འཐབ་གནང་།

ཁྱེད་ཀྱི་ཁ་བྱང་ལས་ གཞན་ཡང་ ཞིབ་འཚོལ་སློབ་སྦྱང་འདི་གི་སྐོར་ལས་ དྲི་བ་རེ་ཡོད་པ་ཅིན་དྲི་ཚོག་ དྲི་བ་ཡོད་ག

BHUTANESE CLIENT EXPERIENCES OF COUNSELING

ཡན་ལག་ ༢ པ། གནང་བ་གི་ལག་ཁྱེད།
ང་ལུ་ འབྲུག་ལུ་བསྐྱབ་སྟོན་གྱི་ཉམས་སྦྱང་གི་སྐོར་ལས་ གྲི་བ་དྲིམ་ལན་འབད་ནི་གི་དོན་ལུ་ ཞིབ་འཇོལ་གྱི་ལཱ་ཅིག་ནང་
བཅའ་མར་གཏོགས་གནང་ཚེར་སྐབ་ཅིག་

ང་གིས་བད་དོན་ཚུ་གར་སྟབ་ཅི། ཡང་ན་ ང་ལུ་སྟག་སྟེ་བྱིན་ཡི། ང་ལུ་དྲི་བ་དྲིམ་ནི་གི་གོ་སྐབས་བྱིན་པ་མ་ཚད་ ང་ལུ་
དྲིམ་ཡོད་པའི་དྲི་བའི་ལན་ཚུ་ ང་རང་སྐོར་འདོད་ལྟར་དུ་ ཡིད་ཚེས་ཉོག་ཉོ་སྟེ་སྐབ་སྐབས་ཅིག་ ང་གིས་ཁས་སྐྱབས་གྱི་
ཚོག་ལས་ བཅའ་མར་གཏོགས་ནི་སྟེ་འག་ཟེ་ཡོད།

བཅའ་མར་གཏོགས་མི་གི་མིང་..... བཅའ་མར་གཏོགས་མི་གི་ལག་མཐེལ།
བཅའ་མར་གཏོགས་མི་གི་ས་ཡིག་.....
ལྷོ་ཚེས་.....

འདི་ལྟག་མ་ཤེས་མི་མིན་པ་ཅིན།
ང་གིས་ འོས་འབབ་ཅན་གྱི་བཅའ་མར་གཏོགས་མི་ཚུ་ལུ་ བད་དོན་ཚུ་ འཛེལ་བ་ག་ནི་ཡང་མེད་པ་ ལྟ་བྱིན་ཡི། དེ་
ལས་ མི་དོན་དེ་ལུ་དྲི་བ་བཏོད་ནི་གི་གོ་སྐབས་བྱིན་ཡོད། མི་དོན་དེ་གིས་ གནང་བ་འདི་ ཁོ་མོ་ རང་ལྟོ་འདོད་ལྟར་
དུ་བྱིན་ཡོད།

འཛེམས་དབང་གི་མིང་..... བཅའ་མར་གཏོགས་མི་གི་ལག་མཐེལ།
འཛེམས་དབང་གི་ས་ཡིག་.....
ལྷོ་ཚེས་.....

ཞིབ་འཇོལ་པ་ ཡང་ན་ གནང་བ་ལེན་མི་གི་དག་བཟོད།

ང་གིས་ འོས་འབབ་ཅན་གྱི་བཅའ་མར་གཏོགས་མི་ཚུ་ལུ་ བད་དོན་ཚུ་ འཛེལ་བ་ག་ནི་ཡང་མེད་པ་ ལྟ་བྱིན་ཡི། དེ་
ལས་ ང་རང་ཁོ་ལུ་ལས་འབད་བཅའ་བཅུ་ བཅའ་མར་གཏོགས་མི་ཚུ་གིས་ཡང་ ཁོང་ར་ ག་མིན་ཅུང་ ཉམ་ལུན་སྐར་
མ་ ༥༥ དང་ ལུ་ཚོད་ ༡ དང་སྐར་མ་ ༩༠ གི་བར་ན་དྲི་བ་དྲིམ་ལན་འབད་འོང་ཟེར་ཉལ་སྟེ་ཡོད། དེ་ལས་ འཛོ་
མཐུད་དེ་ དྲིམ་ལན་འདི་གི་ཚོག་ལུ་ཤོམ་བསྐྱར་འབད་ནི་ནང་ལུ་བཅའ་མར་གཏོགས་ནི་དང་ ལྟབས་མ་བདེ་བ་ཅིན་ ཚོམ་
སྦྱང་འདི་ འཛོ་མ་མཐུད་པར་བཞག་ཅུང་བཟུབ།

བཅའ་མར་གཏོགས་མི་འདི་ལུ་ ཚོམ་སྦྱང་འདི་གི་སྐོར་ལས་ གྲི་བ་དྲིམ་ནི་གི་གོ་སྐབས་བྱིན་ཡོད་པའི་ཉེག་ཞིན། དེ་
ལས་ བཅའ་མར་གཏོགས་མི་གིས་དྲིམ་མི་དྲི་བ་གི་ལན་ཚུ་ ང་རང་གིས་ ག་དེ་དག་དུག་ འཛེལ་བ་མེད་པ་སྟེ་སྐབ་
ཡོད། བཅའ་མར་གཏོགས་མི་ལས་ གནང་བ་དབང་བཅོང་གི་ཚོག་ལས་ལེན་ལེན་མི་ཚུ་ལ་ ཁོང་རང་ལྟོ་འདོད་ལྟར་དུ་
ལས་སྐྱབས་གི་ཚོག་ལས་འབད་འབད་ལ་ཞིན།

མའི་མི་མེལ་ གི་འདྲ་གཅིག་ བཅའ་མར་གཏོགས་མི་ལུ་སྦྱོད་ཡོད།
ཞིབ་འཇོལ་པ་ ཡང་ན་ གནང་བ་ལེན་མི་གི་མིང་.....

ཞིབ་འཇོལ་པ་ ཡང་ན་ གནང་བ་ལེན་མི་གི་ས་ཡིག་.....
ལྷོ་ཚེས་.....

འདི་ལྟག་མ་ཤེས་མི་གི་འཛེམས་དབང་གཅིག་གིས་མ་ཡིག་བྱུང་དགོ། / རང་ལྷན་བཅུན་ མི་དོན་འདི་ བཅའ་མར་གཏོགས་མི་གིས་གནང་བ་བྱུང་དགོ་པའི་ཁང་ ཞིབ་འཇོལ་པ་དང་
གཅིག་ཁང་འཛེལ་བ་མེད་ཅི་ཅིག་དགོ། བཅའ་མར་གཏོགས་མི་འདི་ འདི་ལྟག་མ་ཤེས་མི་ཅིག་མིན་པ་ཅིན་ ལག་མཐེལ་དེས་པར་དུ་བྱུང་དགོ།

APPENDIX E.

Interview Questions

Interview Questions

The introduction would include information about the point of this research where I would explain that I am specifically trying to understand what has been useful or less useful about their experiences with counseling in an effort to identify what should be incorporated into a training program. The information will help people develop skills to be most helpful when working with a Bhutanese population. Reflecting on the experience or discussing what was less helpful may be very difficult, but the accuracy and thoroughness of the information will help so many people in the future to receive help.

- (1) What problems were you having that brought you to the hospital?
- (2) Is this time at the hospital similar or different from when you were here before? In what way?
- (3) How are you feeling now compared to when you came into the hospital?
- (4) Have you experienced a change in how you are feeling (or ...a change in your problems) since you first came into the hospital?
- (5) Can you tell me what you think has caused the improvement?
- (6) Do you think the same change would have happened with another counselor? Why, or why not?
- (7) Was there anything that you and your counselor did/discussed that was particularly useful? or, less helpful?
- (8) If you were to come back to the hospital, would you want to meet with the same or a different counselor?
- (9) You said that next time you'd like to see a different Counselor. Are there specific things that you hope might happen next time that didn't happen this time?
- (10) What would you want more of, next time?
- (11) What would you want less of?

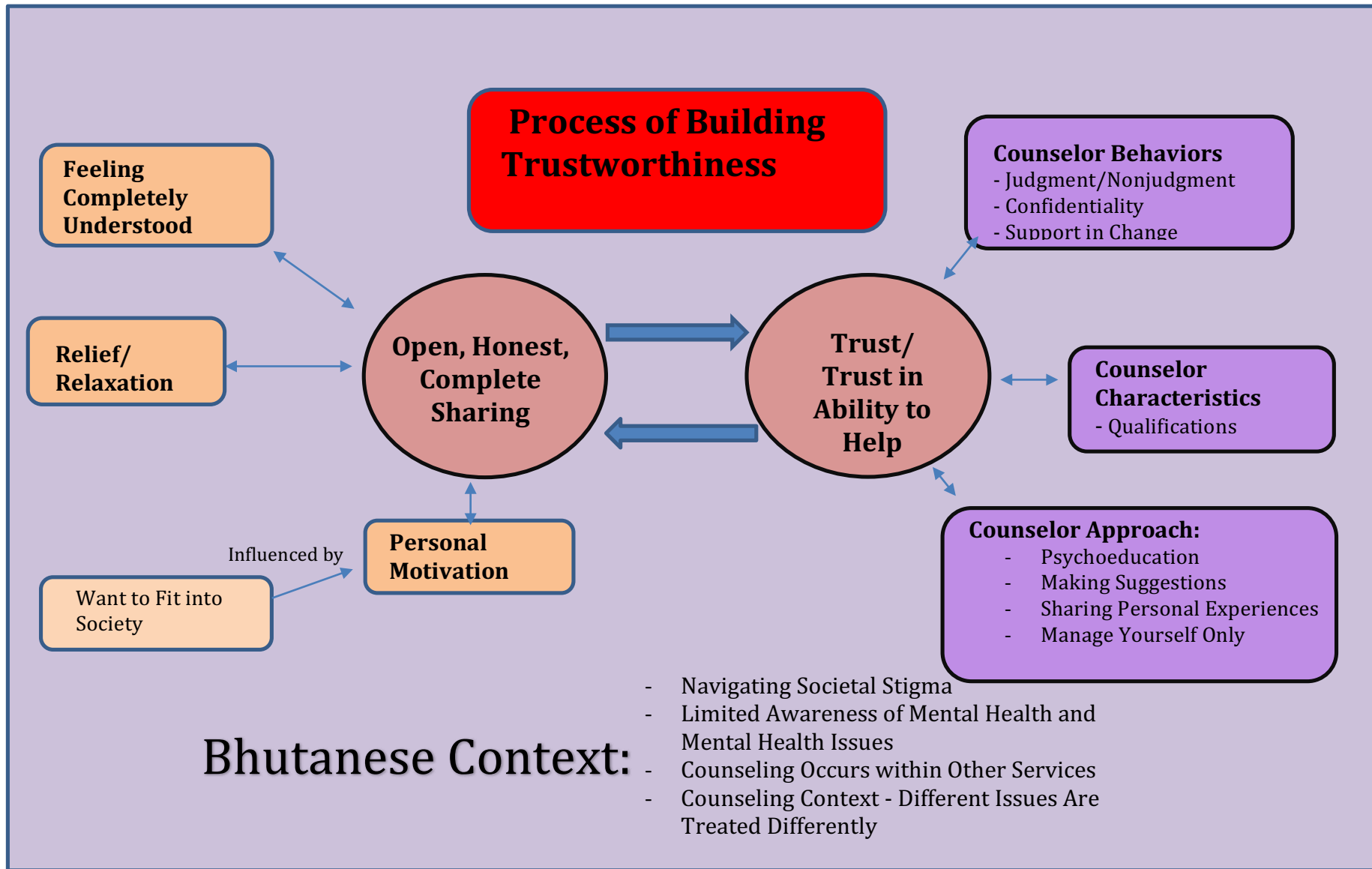


Figure 3.1. The process of building trustworthiness. This figure illustrates the mental model presented during the member checks showing open, honest, complete sharing and trust and the trust in the ability to help as the central components in the Bhutanese counseling experience.

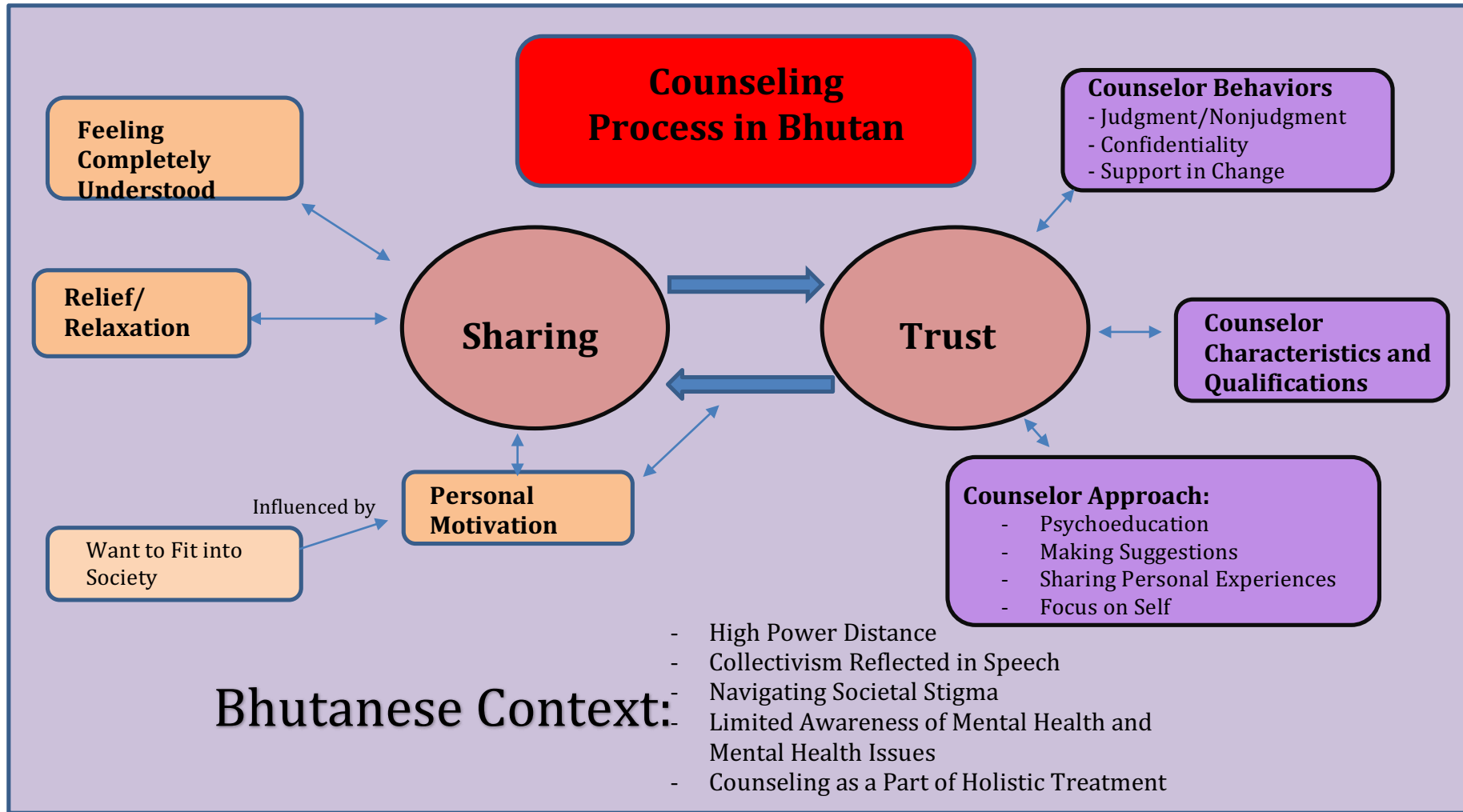


Figure 3.2. Counseling process in Bhutan. This mental model depicts the counseling experience as related by the initial interviews of the participants.

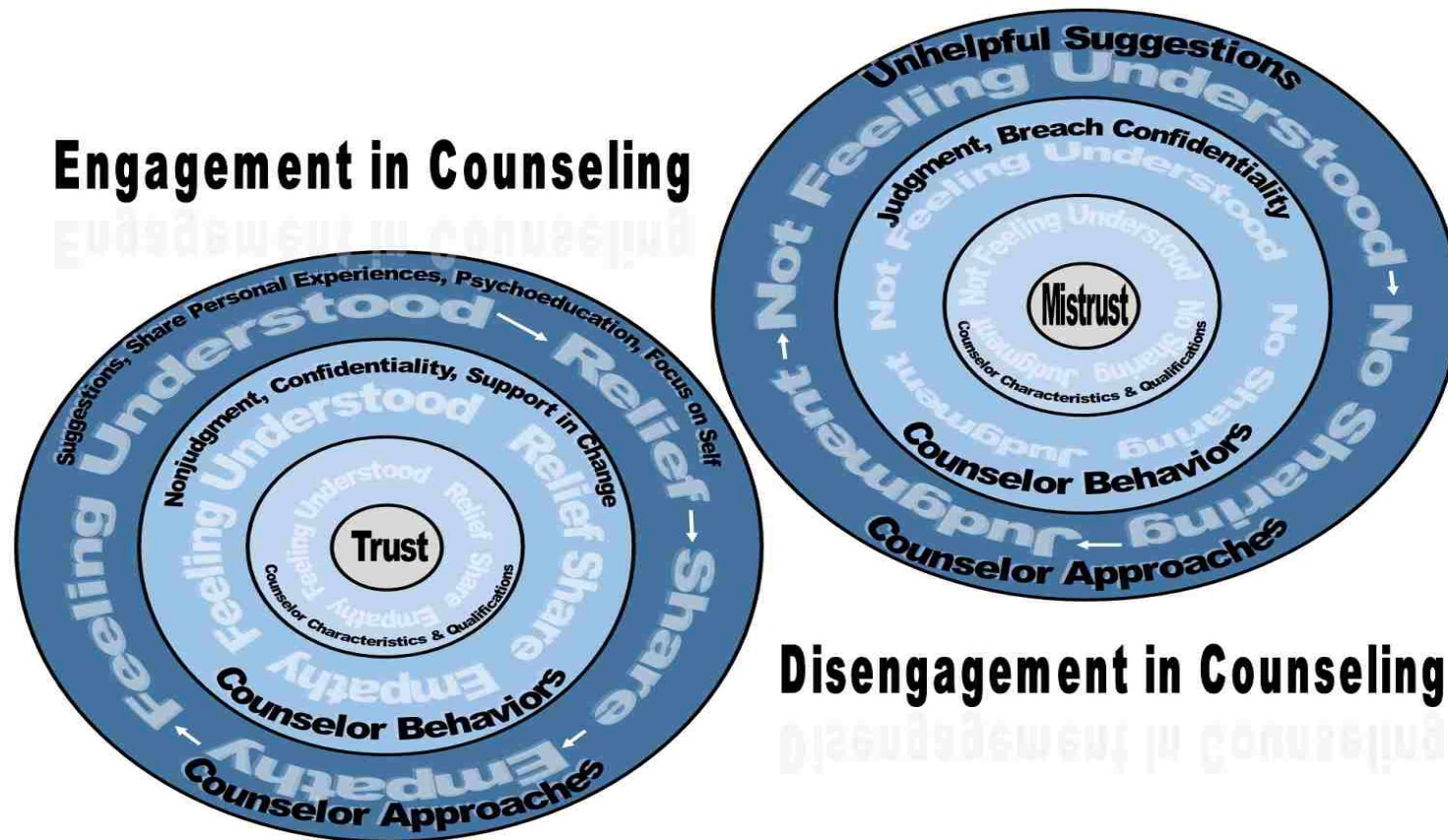


Figure 4.2. The counseling process. This figure depicts the final mental model of the counseling process in Bhutan.

BHUTANESE CLIENT EXPERIENCES OF COUNSELING