AN EXPLORATION OF OUTCOMES OF PSYCHOLOGICAL THERAPY FOR REFUGEES

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ABSTRACT

Refugees seeking asylum in this country have undergone multiple traumas. Many are fleeing persecution or have lived in war zones where there is a constant fear for one's life or safety. Some have lost loved ones, friends, or members of their community in brutal circumstances. Torture has been a factor for many, where the physical, psychological and social outcomes are far-reaching. All have fled their country of origin seeking refuge in a foreign land, where perhaps the language and culture is unfamiliar to them. The UK government has stated that refugees should be offered therapy in a psychology service once they arrive in the UK and a number of such services exist today.

It is difficult to ascertain what psychological help might be useful for refugees and asylum seekers from the current literature due to a number of difficulties with the research. Some have argued that a qualitative methodology is appropriate to use when conducting research with different cultures, as it allows the emergence of unexpected material and can privilege indigenous knowledge, rather than quantitative research, which forces expression within the categories provided by the researcher, thus imposing ideas by dominant cultures.

This research set out to explore how refugees and asylum seekers describe their experience of psychological therapy. The aim was to give a voice to those who are generally marginalised, with the hope that the information participants provide can be used to develop future therapeutic services for refugees and asylum seekers.

Interpretative Phenomenological Analysis was used to analyse interviews with eight participants who had attended an NHS primary care psychology service. Themes relating to being 'stuck in the past', 'searching for solutions', 'helping me to move on' and 'moving on' were discussed and implications of these themes on service improvements, clinical psychologists, and further research were considered. Conducting this research has led to the conclusion that despite the experience of

extreme events people show the strength, determination and resilience to find solutions to their problems thereby enabling them to 'move on' and to find lives that are meaningful to them.

CHAPTER ONE: INTRODUCTION

In the first part of the introduction I will outline some of the difficulties that people who seek asylum in foreign countries might have faced. Firstly, I will discuss the experience of war and conflict, I will then go on to the experience of torture and finally I will discuss the impact of arriving in a foreign land. This aims to highlight the importance of finding a way to alleviate some of the distress of those who seek asylum in the UK. The second part of the introduction critiques the trauma literature and the final part discusses the impact of using psychological therapies developed in the West with people from a non-Western cultural background.

1.1 REFUGEES AND ASYLUM SEEKERS

According to the United Nations 1951 UN Convention (United Nations, 1951) a refugee is defined as 'any person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself/herself of the protection of that country; or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it.' Persecution is usually carried out by a State or by parties or organisations controlling the State, and can involve brute force or administrative or legal measures (United Nations, 1951).

The United Nations High Commission for Refugees (2005) state that by the end of 2005 there were 9.9 million refugees, 744,000 asylum seekers and 12.8 million internally displaced persons, worldwide. In the UK the Home Office (2007) published statistics concerning the fourth quarter of 2007: 6,910 persons claimed asylum in the UK, of these 725 were fleeing from Iraq, 710 from Iran, 700 from Afghanistan, 650 from Eritrea, 610 from Zimbabwe, 495 from China, and the rest from other countries. Refugees and asylum seekers flee their country of origin for numerous reasons, including the persecution and torture that occur both in times of war and peace. War, torture and displacement create many difficult circumstances for refugees. If they

decide to seek asylum in a foreign land they face further adversities, such as multiple losses, unfamiliar systems, concerns of safety, alien cultures, a different language and detention. These issues are expanded upon below.

1.1.1 War and conflict

There were an estimated 160 wars between 1945 and 1990 where 22 million people died and at least 65 million were injured (Zwi and Ugalde, 1989). During the 1950s there were, on average, about nine wars active during each year, about 11 during the 1960s, 14 during the 1970s and 50 during the 90s (Summerfield, 1998). In 2006 there were 47 wars and conflicts throughout the world (Global Security, 2006). Most of these are civil wars fuelled by racial, ethnic and religious hostilities, where civilian casualties are steadily increasing (UNICEF, 1986). UNICEF (1986) suggests that while five per cent of the casualties in World War I were civilian over 90 per cent were civilian in the wars of the 1980s. Civilians who experience war face numerous issues: a life or death situation, health complications, infrastructural damage and food shortages.

People who live in war zones are in a constant state of fear of being killed or injured due to the fighting (International Committee of the Red Cross, 2008). Civilians can be accidentally killed by ammunition, but also deliberately killed because of their ethnic origins or religious beliefs (Summerfield, 1998). From early 2000 to the present the wars in Afghanistan and Iraq have probably cost the lives of hundreds of thousands of civilians (Burnham et al, 2006). Coghlan et al (2006) estimated that 3.9 million civilians were killed in the civil war in the Congo between 1998 and 2003. The actual number of casualties in war is not known because of poor record keeping in many countries (Fishcer, 2008; Zwi et al, 1999).

Health is both directly and indirectly affected by war. Directly, thousands of civilians are left injured by fighting as they are both targets (Summerfield, 1998) and casualties of war, where many civilians are injured due to misguided bombs (Human Rights Watch, 2007) and to landmines; one in 236 people in Cambodia is an amputee as a result of a landmine explosion (Stover, 1994). These casualties place excessive pressure on health services in such countries, services can be overwhelmed by the extra burden and equally rendered impotent by issues relating to water supplies,

sanitation, electricity and transport routes (Zwi and Ugalde, 1993). In Iraq during the war of 2003 to present, the frequent power cuts meant it was difficult to keep vaccines and medicines cool and without pumps water became scarce (Salvage, 2007).

In times of war, the disruption of services and communities impact on health. In Nicaragua cases of malaria soared as the programmes aimed at controlling it were abandoned during the war (Zwi and Ugalde, 1993). In Mozambique and Angola infant mortality rates rose whilst rates in surrounding countries, not affected by war, declined (Zwi and Ugalde, 1993). Zwi and Ugalde (1993) also argued that HIV infection would increase due to disrupted communities and health facilities.

Civilians who remain in war zones face a daily struggle with infrastructural problems, such as lack of fuel, electricity and clean water. During the 1991 Gulf war and 12 years of sanctions that followed, 350,000 children died mostly because of inadequate nutrition, contaminated water and shortages of medicines (Hoskins, 2008). Hoskins (2008) argues that these deaths were related to the destruction of health-care facilities, electricity generating plants and food supply systems. In the later wars in Afghanistan in 1991 and Iraq in 1993, infrastructure rebuilding was marred by a lack of engineers and people qualified and willing to work in hostile conditions (Human Rights Watch, 2007; International Committee of the Red Cross, 2008).

Another major indirect impact of war on individuals is food production. This issue is more acutely felt in countries where populations rely on agricultural land to grow food for local communities. Since the 1960s Africa, to a greater extent than other continents, has been marred by major civil wars (Global Security Organisation, 2006). It has been impossible for food to be produced in conflict areas, people fear remaining in villages where there is a threat of death or injury (Global Security Organisation, 2006). Transport is affected, which impacts on the procurement of seeds and pesticides, and thus famine often results (Global Security Organisation, 2006).

Finally, displacement is another issue during times of war. Individuals abandon their homes and possessions, without any clear idea of what might happen in the future. People in refugee camps can face prolonged squalor, malnutrition, lack of security and few opportunities for children to attend school or play normally (Burnett and Peel,

2001).The mental health of those living in camps has received increasing attention over the past two decades (Westerveld-Sassen, 2005). This has had a positive impact on the way governments and non-governmental organisations (NGOs) have set up refugee camps. For example, more thought has been paid to the need for communities to remain together. However, other basic needs have not always been met. Camps administer shelter, food and water but the food and water trucks can be unreliable (Westerveld-Sassen, 2005). People live in tents or huts made of scrap metal and many camps are in remote inhospitable areas.

1.1.2 Torture

Another distressing experience for many refugees and asylum seekers is torture. Many individuals have been tortured because of their ethnic, religious or political backgrounds and beliefs. The United Nations (1987) has defined torture as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Although the exact numbers of people who have survived torture is unknown a report by Amnesty International (2008) states that people are still tortured or ill treated in at least 81 countries. Torture methods have been described as both physical and psychological in nature.

1.1.2 Methods of torture: physical

The United Nations (2004) Istanbul Protocol lists the following methods of physical torture: beatings and other forms of blunt trauma, burning, violent shaking, falanga (repeated application of blunt trauma to the feet), suspension, positional torture (e.g. where the individual is tied or restrained in contorted, hyper-extended or other positions), electric shock, dental torture, asphyxiation and sexual torture, including

rape. Although physical torture can be brutal with severe physical damage and a high lethal rate, (Berlinger et al, 2004) states that most torturers do not want to leave evidence and so avoid visible bodily marks. This makes it more difficult for the torture survivor to prove their case.

Sexual violence is used as a weapon of war; rape can destroy communities and create fear and chaos (Bastick et al, 2007). The term "sexual violence" refers to acts of rape, sexual mutilation, sexual humiliation, forced prostitution and forced pregnancy (Jarvis, 1998). Although rape could be viewed as both physical and psychological torture there is a growing argument that it should not be categorised separately, as it has no meaning legally (Patel, 2008). A report on "Sexual Violence in Armed Conflict", by the Geneva-based Centre for the Democratic Control of Armed Forces, outlines documented sexual violence related to conflict in 51 countries (Bastick, et al, 2007). According to the report up to 50,000 women were raped during the war in Bosnia, about 40 percent of the population of Liberia were exposed to sexual violence during its 14 years of war, and in a randomised study in Sierra Leone just under half of those interviewed had been raped and more than a quarter gang-raped. In Rwanda, approximately 500,000 women reported being raped during the war in 1994 and an estimated 70 per cent of them were infected with HIV/AIDS (United Nations Development Fund for Women, 2002).

Perpetrators of sexual violence include members of official armed and security forces, paramilitary groups, non-state armed groups, humanitarian and peacekeeping personnel, and civilians (Bastick et al, 2007). It takes place in people's homes, fields, places of detention, military sites and camps for refugees and displaced persons, and occurs both during and after conflict (Bastick et al, 2002).

1.1.2.2 Methods of torture: psychological

The aim of psychological torture is to damage a person's self esteem and destroy their trust in their fellow humans (Berlinger et al, 2004). Psychological methods of torture include induced exhaustion and debility through sleep, water and food deprivation, isolation, threatened death or sham executions (Somnier and Genefke, 1986). Some have been a witness to the torture or death of another prisoner or family member (Quiroga and Curr, 1998).

Torture of individuals has been used at a social level to create fear and to intimidate rebel groups. Many authoritarian governments or groups have used torture as a political tool with the aim of preventing the population from expressing opposition (Berlinger et al, 2004). Summerfield (1998) points to some of the methods used by governments, for example in Guatemala and El Salvador individuals are abducted by security agents and then their mutilated bodies were placed in a public place in order to 'render whole communities a stunned audience' (Summerfield, 1998 pp.11). He suggests that oppression might begin with the killing of known activists but this develops into indiscriminate killing of individuals to create states of terror (Summerfield, 1998).

1.1.2.3 Impact of torture on physical health

Some of the physical consequences of torture are outlined by Burnett and Peel (2001). They suggest that many injuries sustained will not have received adequate medical treatment, either because it was unavailable, or to avoid authority. According to Burnett and Peel (2001) torture survivors might experience musculoskeletal symptoms, such as pain and weakness. Some methods of torture, such as 'Palestinian hanging' and the 'ghotna' can cause permanent difficulties, such as tearing of muscle and muscle weakness. Epilepsy is a factor for some who have been subjected to physical trauma to the head and problems with Otitis media (inflammation of the middle ear) and persistent hearing loss can occur when individuals are consistently hit around the ears (Burnett and Peel, 2001).

Sexual violence can lead to both physical and psychological damage. Many women are sexually violated to such an extent that they are no longer able to bear children. In many societies once a woman has been raped she is disgraced, her family shamed and she is deemed unmarriageable (Jarvis, 1998). It is also used to destroy male and community pride, as men who have failed to protect women are seen as weak (Richters, 1998).

1.1.2.4 Impact of torture on psychological health

The United Nations (2004) Istanbul protocol reminds us to take caution when ascribing Western psychiatric terms to people from non-Western contexts, as many from non-

Western cultural backgrounds do not follow the idea that mental suffering is something that resides within an individual and has a set of typical symptoms. However, they state that there is a body of evidence which suggests the psychological difficulties in response to torture are as follows: re-experiencing the trauma; avoidance and emotional numbing; hyperarousal; symptoms of depression; damaged self-concept and foreshortened future; dissociation (a disruption with the integration of consciousness, self-perception, memory and actions); depersonalisation (feeling detached from oneself or one's body); atypical behaviours (behaviours not previously seen in the torture survivor); somatic complaints; sexual dysfunction; psychosis; substance abuse; and neuropsychological impairment (United Nations, 2004)

After reviewing 46 studies Somnier et al (1993) suggest that the most common psychological reactions to torture are: sleep disturbances; nightmares; anxiety; depression; memory defects; loss of concentration and changes in personality. In order for us to make sense of the world we extract meaning from our experience and develop rules accordingly. For most people torture and organised violence are such extreme experiences that these normal systems are not able to cope (Blackwell, 1989). The individual's whole belief system is sent into disarray; their sense of identity and safety in relation to others is fundamentally subverted (Blackwell, 1989). For example, some authors have argued that psychological methods of torture, such as environmental deprivation and constraint techniques, affect an individual's 'sense-of-self', where dignity and identities are severely affected (Somnier and Genefke, 1986). Some methods of torture aim to destroy people's 'sense-of-self' by forcing them into situations of impossible choices where they act against their ideologies and ethics (Berlinger et al, 2004; Somnier and Genefke, 1986).

The consequences of torture on psychological health are influenced by the personal attribution of meaning, personality development and social, political and cultural factors (United Nations report, 2004). Therefore, it cannot be assumed that all methods of torture will have similar outcomes on individuals' psychological health (United Nations, 2004). Simpson (1995) reminds us that some symptoms should be viewed as adaptive, rather than pathological. For example, diminished interests in activities and feelings of detachment would be understandable for persons in solitary confinement; further, hypervigilance and avoidance behaviours would be functional behaviours in

repressive societies (United Nations, 2004). Burnett and Peel (2001) also suggest that many symptoms of anxiety, depression, guilt and shame should be viewed in context. They argue that only a minority of individuals will develop psychological problems due to the stresses of conflict and exile. Further, many of the difficulties people discuss are due to current experiences, as well as previous experiences of war and torture.

1.1.3 Seeking asylum in a foreign land

Mental distress is not only caused by the difficulties asylum seekers face in their country of origin but also by the journey they undertake to reach a country of asylum and by a number of issues once they reach their destination. This includes multiple losses, issues of safety, unfamiliar systems, alien cultures, a different language and detention.

Refugees seeking asylum in a foreign land face multiple losses: their home; family; friends; money; job; identity and status are but a few. According to Patel (2003: p18), 'loss of hope is a predominant theme: the hope of justice, the hope of recognition, the hope of safety and protection, and the hope of life without fear'.

Burnett and Thompson (2005) argue that there are a number of issues in relation to safety for a person seeking asylum. Many are fleeing unstable situations but the process of seeking asylum is long in the UK and until the individual is guaranteed leave of stay their fear of being deported back to their home country remains. Further, the MediaWise Trust (2006), highlight media portrayal of asylum seekers. They point to the usage of the 'spurious term bogus asylum seeker' (p3), in the Daily Telegraph, Express and Nottingham Evening Post in December 2005, which continues to create an unwelcome and, therefore, seemingly unsafe atmosphere for people seeking asylum.

Other issues facing refugees and asylum seekers include unfamiliar surroundings, a foreign language and different systems (such as legal, housing, welfare and health services). Burnett and Thompson (2006) suggest this can lead to feelings of helplessness and despair. One such system is the asylum process, which can be immensely confusing. In addition to this are the different cultures and customs of the person seeking asylum and the dominant culture in the country of exile (Burnett and

Thompson, 2006). They note that what is seen as normal in one culture can be seen as abnormal in another, for example, behaviours understood as aspects of mental illness in Western cultures are considered normal, or spirit possession in other cultures.

Finally, detention is a factor for some refugees and asylum seekers. Although the majority of people seeking asylum in Western countries have been allowed to live in the community, some are housed in detention centres while their applications are processed. Individuals' human rights have been questioned in independent enquires in many countries (Human rights watch, 1998). The facilities in some centres appear impressive but some detainees complain that they are treated like criminals by the staff and not allowed access to facilities unless official visits are taking place (Monahan, 1998). Although the government has stated that torture survivors would not be detained, it has been suggested this is poorly implemented (Dell and Salinsky, 2001). Bracken and Gorst-Unsworth (1991) describe the isolation, lack of support, and loss of hope in detention centres as a barrier to recovery from torture. Many have pointed to the further trauma detainees experience whilst they are imprisoned: the lack of information about the reasons for detention or the possible duration of stay, degrading conditions, and inadequate health care (Hughes and Liebaut, 1998; Chapman, 1999; Hayter, 2000; Wolton, 2000).

Considering the extent of this adversity, one might imagine that all of those seeking asylum in foreign lands would be 'traumatised' and in need of help. However, as Papadopoulos (2007: p302) points out, 'having survived adversity and many struggles, refugees tend to be resilient and resourceful and, if they encounter reasonably facilitative conditions, the majority of them can and do manage on their own with minimal or no assistance'. He also points out, however, that some individuals might benefit from help with some or with most of their needs.

1.1.4 Refugees and asylum seekers: summary

Refugees and asylum seekers face difficulties on a number of levels. Many have lived in wars, the impacts of which are far reaching. Civilians are killed or injured and they can lose family members or friends. Civilians who remain in war zones can face a daily struggle with health, food and infrastructural problems. Refugees and asylum seekers have faced persecution due to their ethnic, religious or political backgrounds

and many are survivors of torture. Torture has been described as physical and psychological in nature and the effects can be extreme and enduring. Displacement is another factor affecting refugees and asylum seekers. Refugee camps can be places of squalor, malnutrition, lack of security, few opportunities and with unreliable access to food and water. In seeking asylum in a foreign land refugees face further adversities where they must cope with foreign systems, an alien culture, a different language, and, at times, a hostile reception and detention. Thus, refugees and asylum seekers have faced multiple difficulties and the necessity to find something that might benefit those in need is an important endeavour. Although a broad range of research into what might help has taken place a number of problems have been identified. This is expanded on below.

1.2 TRAUMA RESEARCH

Reber (1995: p814) describes trauma as, 'from the Greek for wound, a term used freely either for physical injury, caused by some direct external forms, or for psychological injury caused by some extreme emotional assault'.

There is an extensive body of literature that looks at the medical (e.g. Burnett and Peel, 2001) and psychological consequences, (e.g. Somnier et al, 1993) and possible solutions, for trauma. For example, research has examined the usefulness of particular psychological therapies for survivors of trauma. Behavioural therapy (e.g. Becker and Abel, 1981), cognitive behavioural therapy (e.g. Frank et al, 1988), Eye-movement desensitisation and reprocessing (Rothbaum, 1995), have all been found to reduce symptoms associated with the diagnosis of Post Traumatic Stress Disorder (PTSD). However, there are a number of criticisms of the trauma literature (Bracken and Petty, 1995; Papadopoulos, 2007; Patel, 2003; and Summerfield, 1999). Firstly, much of the literature uses the diagnosis PTSD as an indication of the extent of suffering post trauma and improvement after therapy; this has been widely criticised (Summerfield, 1999). Secondly, the tools that are used in the research are ethnocentric and generally are not valid if used with other cultures (Patel, 2003). Finally, the trauma literature does not differentiate between the different types of trauma. For example, torture is unique and by placing it under the term 'trauma' it is depoliticised (Patel, 2003).

1.2.1 Development of the concept of Post Traumatic Stress Disorder (PTSD).

The symptoms of trauma have been documented as far back as 1666: Samuel Pepys' diary made references to nightmares and intrusive thoughts in relation to the Great Fire of London (Daly, 1983). In 1952 the American Psychiatric Association described a formal classification of reactions to trauma by including the category 'Gross Stress Reaction' in the first edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-I; APA, 1952). It was described as a reaction to severe combat or civilian catastrophe that may progress to one of the neurotic reactions, if the reaction persists. In the aftermath of the Vietnam War combat veterans reported high levels of mental health difficulties which, according to Schweitzer and Steel (2008), fuelled the impetus to include in the DSM III (APA, 1980) the diagnostic category Post Traumatic Stress disorder. The current diagnostic and statistical manual for mental disorders: DSM-IV, (APA, 1994) defines the disorder as a consistent pattern of three symptom clusters.

The first symptom cluster applies to intrusive re-experiencing of the event, which is defined by, for example: recurrent and intrusive distressing recollections of the event, recurrent distressing dreams of the event, intense psychological distress, or physiological reactivity, at exposure to cues that resemble the traumatic event.

The second symptom cluster relates to persistent avoidance responses to reminders of the event and a numbing of general responsiveness. This includes, for example, efforts to avoid things associated with the trauma or things that arouse recollections of the trauma, inability to recall an important aspect of the trauma, markedly diminished interest in activities, a feeling of detachment or estrangement from others, an inability to have loving feelings or a sense of a foreshortened future.

According to DSM IV (APA, 1994) the final symptom cluster corresponds to persistent symptoms of increased arousal. Indications of this are as follows: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance or an exaggerated startle response.

Most of the literature on refugees experiencing trauma tends to focus on PTSD (Papadopoulos, 2007). However, various clinicians have argued that the concept of

PTSD (Summerfield, 1999; Bracken et al, 1997) has developed in response to a number of assumptions embedded within Western psychiatry. These include the idea that symptoms of PTSD are universal and that severe reactions to trauma are abnormal and intra-psychic.

1.2.2 The assumption of universality

Summerfield (1999) argues that PTSD is as much a socio-political as a medical response to the problems of a particular group at a particular time. The Vietnam veterans returned to the US to find themselves condemned by their fellow citizens, consequently developing a sense of shame, guilt and a wasted sacrifice (Summerfield, 1999). The anti-war movement argued that the veterans were also victims of the military, who did not acknowledge there was a problem, and encouraged the development of medical acceptance of the symptoms they were experiencing, thus the concept of PTSD was established (Summerfield, 1999). Mental health professionals rapidly accorded it the status of scientific truth, arguing that it represented a universal and essentially context-independent entity (Summerfield, 1999).

Many authors have questioned the applicability of the concept to non-Western populations (e.g. Bracken, 2001). Although symptoms of PTSD have been found in non-Western survivors of war and torture (e.g. Crescenzi et al, 2002; Kinzie et al, 1990) it has been argued that the complexity of their experience cannot be fully explained by it. Ramsay et al (1993) reject the notion of a unique torture syndrome. They suggest that responses to war and torture should be viewed dimensionally, or holistically and not categorically. Zur (1996) argues that rather than seeking to prove the universality of the PTSD concept, it is important to look at how people make sense of their own worlds through cultural concepts.

1.2.3 The use of ethnocentric tools

Research into the universality of PTSD uses Western psychometric instruments that were designed by Western-trained psychiatrists. These instruments are then administered to people from a vast array of cultures and backgrounds and outcomes of this are used as evidence that the symptoms are universal (Mollica, 2000). There are two issues here: firstly, by using the very specific symptom-based psychometric instrument, research is focused on intrapsychic issues for individuals who have

experienced persecution, war, torture or exile, and other affects of the trauma are ignored (Summerfield, 1995). Secondly, although different cultures may experience similar symptoms, the value or meaning of the symptom may be completely different (Bracken, 1998) (for examples see section 1.3.1).

Further, all tools that are reliant on the concept of PTSD are problematic, especially in relation to cross-cultural validity, as PTSD was constructed in relation to a particular set of circumstances, at a particular time and place (Summerfield, 1999). The vast majority of the trauma research has relied on such tools to indicate difficulties following the experience of war and torture, and the outcomes of intervention.

1.2.4 Pathologising

DiSilva and Yule (2001) highlight the fact that clinical status has been accorded to common human reactions to disasters. The concept of PTSD is based on the assumption that reactions to traumatic events are abnormal, rather than normal. Distress is viewed as a disorder that is located within the individual (Summerfield, 1999). However, these ideas are not found universally. Bracken et al (1992) found that in Uganda distress associated with political violence was not seen as a medical problem; the most distressing impacts of the war for those interviewed were seen in social and cultural terms, rather than in intrapsychic terms. Eisenbruch (1990) argued that exile is a form of 'cultural bereavement' and suggests that a bereavement reaction is a fitting way of conceptualising what some refugees experience: a normal reaction to abnormal circumstances, rather than a sign of psychiatric disorder.

1.2.5 Depoliticising distress

Current trauma discourses assume that there are core features of a human response to trauma and that no matter what traumatic experiences an individual suffers (e.g. road traffic accident or long-term torture) all will develop the same symptoms. These ideas accord trauma responses disease status. This, Summerfield (1999), argues individualises distress and removes it from the social and cultural environment in which it is embedded, which places the blame on the individual and suggests a failure to cope (Bracken et al, 1997). By locating difficulties at the level of the individual, human distress is de-politicised and seen as existing independent of social and political context (Patel, 2003). As such, research is focused on the survivors rather than the

perpetrators of violence and abuses of power and systems of inequality are ignored (Patel, 2003).

1.2.6 The use of quantitative methodology

Considering the difficulties that refugees and asylum seekers have faced, research looking at what might alleviate distress, for those who need it, is important. There is a body of literature that outlines the outcomes of psychotherapy for this group. However, the majority of it has used a quantitative methodology where Western developed diagnostic interviews or psychometric instruments are administered before and after therapy and/or compared to a control group (Foa and Medows, 1997). Quantitative methodologies force participants to respond within the parameters set by the researcher, which restrict the possibility of them voicing their own opinions, in their own words. Schweitzer and Steel (2008) argue that a quantitative methodology is limited in its ability to capture the complex and multi-faceted experiences of refugees and asylum seekers. Schweitzer and Steel (2008: pp90) suggest qualitative and ethnographic methodologies are more adequately equipped to understand the 'full richness and complexity' of the refugee experience.

1.2.7 Trauma research: Conclusion

There is a vast body of trauma literature that examines the consequences and possible solutions for survivors of trauma. What is apparent from this literature is that there are many psychological therapies available, all of which have been shown to be, in part, useful. However, the vast majority of research does not differentiate between traumas, has used the concept of PTSD, assumes the universality of symptoms, assumes that reactions to traumatic events are abnormal and intra-psychic, and finally, has used ethnocentric tools and a quantitative methodology. So the possibility of a richer exploration is restricted. Although the majority of the trauma literature has focused on the concept of PTSD there is a body of literature that has attempted to understand the wider picture and find ways that might help those in need. Some of this literature, in relation to psychotherapy with refugees and asylum seekers, is outlined below.

1.3 PSYCHOTHERAPY WITH REFUGEES AND ASYLUM SEEKERS

According to the British Psychological Society website (2009) psychotherapy is, 'the practice of alleviating psychological distress through talking rather than drugs. The distress that therapists work with is generally severe enough to be affecting a person's well being, work, and/or relationships'. Considering the multiple adversities that refugees and asylum seekers have faced, it is important for professionals to find ways to alleviate some of the distress of people who present to services; psychotherapy has been suggested as one such way. Although some authors have criticised the use of Western psychotherapy with those of non-Western cultures (Patel, 2002), others have found it to be useful but point to the necessity of considering cultural factors (e.g. Ager, 1997; Mercer et al, 2005). This section will discuss cultural influences, critique the use of Western therapies with those from non-Western contexts, and discuss some of the literature that argues that therapy can both consider cultural influences and may help to alleviate some of the difficulties experienced by refugees.

1.3.1 Non-Western approaches to mental health

'Culture is a vast system of meanings, behaviours and rituals. Culture is a way of creating shared ways of functioning; in order to communicate effectively…we create shared events, practices, roles, values, myths, rules, beliefs, habits, symbols, illusions and realities… Cultural information is like a flexible dictionary, which is handed down and gives the appropriate cultural definition of every single event, object or concept'. (Eleftheriadou, 1994: pp1-2). In relation to mental health, cultural beliefs impact on perceptions of experiences, symptoms and coping strategies.

Woodcock (1995) comments that many refugees place a greater significance on the existential meaning of what has been inflicted on them rather than the intrapsychic symptoms, which are the focus of psychiatry in the West. Mercer et al, (2005) interviewed exiled Tibetan survivors of torture and found that mental health issues were closely linked to religious beliefs. For example, they believed that Karma played a part in both the experience of torture and the development of mental health problems. Some felt the torture was purging them of the bad acts they had carried out in this life and previous lives, which, Mercer argued, had a positive effect on their interpretation of being tortured.

Research has also pointed out that people from non-Western cultural backgrounds place vastly different value and meaning on symptoms. For example, Zur (1996) found that in some cultures dreams of the dead are perceived as positive and comforting, rather than as an intrusive psychiatric symptom associated with PTSD. Further, Giller and colleagues (1989) found that Ugandan survivors of torture experienced nightmares but they were understood to be directly linked to supernatural involvement, and so were not amenable to psychological intervention. However, although some research suggests that refugee survivors of war from non-Western cultural backgrounds do experience some of the symptoms associated with PTSD (Kinzie et al, 1990), this research should be viewed with caution. As Willig (2004: p.3) writes, it is generally agreed that when conducting research 'observation and description are necessarily selective, and that our perception and understanding of the world is partial at best'. In other words we approach research with biases and assumptions and invariably find what we set out to find.

In addition to the cultural impact on existential meanings and beliefs about symptoms Bracken (1998) suggests that different communities construct 'coping strategies' according to their local social, cultural and political contexts. Woodcock (1995) comments that some refugee survivors of torture choose to seal off their recall of past experiences while they get on with life. Mozambican refugees describe 'forgetting' as their usual means of coping with difficulties. Ethiopians call this 'active forgetting' (Carey-Wood et al., 1995).

Following on from the premise that culture greatly influences perceptions of mental health, it can be understood that culture will also impact on ideas of problem solving in relation to mental health issues, which is discussed below.

1.3.2 Psychotherapy: A Western concept

The use of psychotherapy with people from non-Western cultural backgrounds has been criticised (e.g. Patel, 2002; Summerfield, 1995), as it has developed through an ethnocentric philosophy, and because for many individuals the idea of sitting and talking, on an individual basis, to a professional stranger, about intra-psychic problems, is an alien concept.

Western counselling and psychotherapy training has developed through a predominantly ethnocentric philosophy. As most of the tutors, supervisors and clinicians are predominantly white middle-class, a particular ideology is placed on training and practice (Eleftheriadou, 1997). In the West it is a common belief that the distress caused by trauma should be dealt with by a professional, such as a doctor or therapist, but this idea is not universal. For example, in Uganda the distress associated with trauma is not thought of as being a medical problem; local family networks and traditional healers are believed to be the most appropriate people to approach (Giller et al, 1989).

Western psychotherapy predominantly looks at the intrapsychic aspects of the individual as the mode of change but this focus on the individual is not found in many cultures (Patel, 2003; Summerfield, 1995). Birkett (2006) reminds us of the value placed on the family or the social system and evidence for this comes from research conducted by Amris and Arenas (2004). They used a mixture of quantitative and qualitative data to look at perceptions of health and outcomes in four rehabilitation centres for survivors of torture in Indonesia, Bosnia-Herzegovina, Kenya and Guatemala. Qualitative data, provided by 20 participants, showed that expectations of treatment and of the health-related outcome of treatment, across centres, were embedded in physical and social dimensions: pain relief, improved physical function, improved individual function within the family, improved interpersonal relationships in the community, and return to work/being able to provide for the family.

1.3.3 Does Psychotherapy benefit people from non-Western cultural backgrounds?

Studies have found that individuals from some non-Western contexts do benefit from psychotherapeutic approaches, whereas others do not. Morris and Silove (1992) looked at outcomes of psychodynamic psychotherapy in treatment centres for Southeast Asian or South American survivors of torture and trauma. They found that South American refugees, across two centres, responded well to extensive psychodynamic psychotherapy. They argued this was due to participants being from Chile, Argentina and Uruguay, where the majority of individuals have European backgrounds. Further, they point to the wide practice of psychoanalytical psychotherapy in South America. However, in the treatment of over 800 Indochinese refugees in a centre in Boston, it

was found that psychodynamic psychotherapy could be detrimental for individuals. According to Morris and Silove (1992), in Indochina feelings or emotions are rarely, if ever, discussed openly, as complaining would be seen as a sign of weakness and lack of character. Further, uncontrolled catharsis is such an unfamiliar concept in Indochinese culture that it might induce further shame and further psychological difficulties.

Other research has also shown that following therapy, individuals' psychological symptoms have worsened. Mollica et al (1990) evaluated changes in symptoms and levels of perceived distress of 21 Cambodian, 13 Hmong of Laos, and 18 Vietnamese survivors of torture before and after a six month treatment period (which included psychotropic medication, a psychodynamic style of counselling and culturally specific social service support). The Cambodian group showed improvements on symptoms of anxiety and depression, the Vietnamese group showed no change and the Laotian group's symptoms had worsened. Mollica and colleagues attribute this to Hmong of Laos being a tribe who attribute physical, rather than psychological, meaning to their difficulties (Mollica et al, 1990). However, they also suggested the Hmong of Laos were experiencing greater prejudice than others Indochinese groups in the USA, which might have influences outcomes of this study.

In the UK, Summerfield (2001b) found that of 759 refugees and asylum seekers living in London, who responded to a questionnaire, 76% of those offered counselling or psychotherapy rated it as poor or very poor. Summerfield (2001b) argued that this might be due to the differences between Western approaches to mental health, where one might talk to a stranger about one's difficulties, compared to other countries, where this approach is unheard of.

Thus, some research suggests that psychotherapy is limited in its ability to benefit people from non-Western cultural backgrounds. However, some research does suggest that elements of psychotherapy could be useful when used in conjunction with cultural beliefs and traditions, which is outlined below.

1.3.4 A way forward

Many authors argue that there is a need to provide comprehensive and multifaceted treatment programmes for refugees who have experienced traumatic events; this would include psychotherapy (e.g. Ortmann et al, 1987; Mollica and Lavelle, 1988; Morris and Silove, 1992). This includes integration of Western and traditional methods and the acknowledgment of religion, language and acculturation issues in therapy.

Some authors have pointed to aspects of human nature that might benefit from psychotherapy, for example, the need of human beings for each other (Birkett, 2006), or that in order to grieve people need to, on some level, think about their experience (Woodcock, 1995). Psychotherapy might be a way for an individual to reconnect both to others and the past in a supportive and safe environment. Many authors who have worked in areas of war and mass torture believe that traditional methods are imperative but, at times, not enough to deal with the significant levels of emotional distress (see Giller et al, 1989; Mercer et al, 2005). However, it has been suggested that when working with the distress caused by war, torture and migration, therapeutic strategies need to be as diverse as the cultures within which one is operating (Giller et at, 1989).

Many advocate the integration of Western and 'traditional' methods as a way forward (Ager, 1997). In the few examples of such an amalgamation both difficulties and benefits have emerged. Mercer et al (2005) attempted to integrate Western and traditional methods with a group of exiled Tibetans living in North India. The accounts of the refugees suggested that, although they stressed the importance of using traditional methods, they used both Western and traditional practices to overcome mental health problems. Mercer and colleagues (2005) argued that the Western workers immersed themselves within the culture and so were able to effectively combine western psychotherapy with traditional practices and cited the example of using relaxation methods derived from Buddhist practice.

It is difficult for those living in secular societies to imagine the reverence placed on religious beliefs. For example, as mentioned above, Ugandans believe that nightmares are caused supernaturally and Tibetans believe that trauma and suffering are necessary challenges to enable them to attain a higher state of being in their next life (Cheung, 1994). Peltzer (1997) discussed the importance of the role of religion in counselling

survivors of organised violence. They argue that religion offers many persons comfort and strength to endure pain. Refugees can use their religious beliefs to help them to cope. They found that traditional and spiritual healers use ritual therapies to help survivors of war, torture, and exile, to regain power, cleanse themselves, decrease shame, guilt and rage. Many communities throughout history have created healing rituals to ameliorate the damaging effects of exile and use rituals to enable continuity of their beliefs and traditions (Eastmond, 1993). Religious acts, such as rituals, have been incorporated into therapy, thus reducing potential alienation (e.g. Gilligan, 1995; Woodcock, 1995).

Eleftheriadou (1997) argues that a number of issues should be considered when providing therapy for those of a different culture. Firstly, language: will the therapist's language be used, the colonial language of the client's country, or the client's preferred language? All involve issues of power. Secondly, rather than assessing for level of psychological mindedness they suggest an assessment of type of psychological mindedness. For example, how does the client conceptualise their emotional state? Thirdly, Eleftheriadou (1997) suggests that the level of acculturation of the individual and their family are important issues.

1.3.5 Psychotherapy: summary

Culture and religious beliefs have a significant influence on how individuals interpret mental health issues. As the central ideology of psychotherapy has mainly developed from the white middle-classes, many have questioned its usefulness for people from non-Western cultural contexts. For example, psychotherapy has an individualistic and intra-psychic basis and religion, the family and social factors are seen as of marginal importance. It has been argued that there are certain human universals that warrant the use of psychotherapy across cultures. Research has suggested that psychotherapy might not be beneficial for those from non-Western cultural backgrounds. However, some authors have argued that Western and traditional methods should be combined for treatment to be beneficial and that a number of issues should be considered, such as language, type of psychological mindedness and acculturation.

1.4 INTRODUCTION SUMMARY

Refugees have faced persecution, war, torture and exile. Those living in war zones are faced with the daily struggles associated with war. This can include the direct effects of the fighting, where people fear for their lives or lose members from their family or support systems. Indirect effects can be more difficult to cope with, such as inadequate food and water supplies, poor health care and access to fuel and electricity. In addition to these difficulties some refugees and asylum seekers have been tortured, the physical and psychological affects of which can be enduring. Refugees fleeing their country of origin face a harrowing journey, together with issues of a foreign language, culture and systems once they reach a host country.

It is clear from the literature that it is important for those working with refugees and asylum seekers to find ways to alleviate some of the distress for those who present to services. Psychotherapy has been suggested as one such way. There are many services in the UK that offer psychotherapy to refugees and asylum seekers, the primary care service in which this research was conducted was one such service. Although previous research has looked at the usefulness of certain therapies for this client group, this has generally involved administering psychometric assessment tools pre and post therapy, which forces the participants to respond within the parameters set by the researcher. To date there has been no published qualitative research in the UK exploring what, for refugees and asylum seekers, was the useful and the less useful aspects of psychotherapy. There is a need to develop a richer understanding of their experience across services and it is the aim of this research to begin to build that picture by using a qualitative methodology to explore how refugees and asylum seekers describe their experience of psychotherapy in a primary care service in the UK.

1.5 Research aim and research question

1.5.1 Aim

The aim of this research is to interview refugees who have attended a psychological primary care service in the UK.

1.5.2 Research Question

How do refugees and asylum seekers, who have attended a Primary Care psychology service, describe their experience of therapy?

CHAPTER TWO: METHOD

2.1 METHODOLOGY

This section will outline the methodology chosen for this research. This will include a discussion of the use of interpretative phenomenological analysis, the epistemological position of the research and a further section giving a rationale for the use of this methodology with refugees and asylum seekers.

2.1.1 - Interpretive phenomenological analysis (IPA)

The purpose of IPA as an analytical tool is described by Smith et al (1999) as:

> The approach is phenomenological in that it is concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself. [...] Access to the participant's personal world depends on, and is complicated by, the researcher's own conceptions and indeed these are required in order to make sense of that other personal world through a process of interpretative activity. Hence the term interpretative phenomenological analysis is used to signal these two facets of the approach.
>
> (Smith et al, 1995: 218-219)

IPA is an approach that involves the development of themes through a process of reading and analysis (Smith and Osborn, 2006). This process begins with the description of the participants' experience of the phenomena. However, IPA recognises that these descriptions will be influenced by the participants' experience: their family, culture etc (Smith, et al, 1995). These descriptions are then subjected to a process of analysis, which is based upon the terminology that participants use, but it may go beyond this (Smith, 2004). A wider social, cultural and, at times, theoretical context is used to position these descriptions (Larkin et al, 2006). IPA recognises that the researcher's own view of the world is implicated throughout the research process

(Smith and Osborn, 2006). An essential part of the analysis is that these subjectivities are reflected upon and made explicit (Elliot et al, 1999).

2.1.2 Epistemological position

Smith (1996) developed IPA from a broad range of theoretical influences: social cognition; phenomenology and social constructionism. Various epistemological positions have been suggested for different aspects of IPA (Willig, 2001). Firstly, the aim of IPA is to produce knowledge of what and how people think about a certain phenomenon (Larkin et al, 2006). There is an assumption here that individuals are able to give a true account of their experience of an event. This aspect of IPA could be said to follow a realist approach to knowledge production (i.e. reality exists independently of our representations of it) (Willig, 2001). Secondly, although individuals' experiences are the focus of IPA, it does not make any theoretical assumptions about what can be learned from the descriptions of experience (Larkin et al, 2006). The epistemological openness of this aspect of IPA allows the researcher to make cautious inferences about affective, discursive and cognitive phenomena (Larkin et al, 2006). The analytical aspect of IPA also acknowledges that the researcher's interpretation of participants' thoughts is influenced by their own beliefs and assumptions and, as such, can be thought of as reflexive. Finally, IPA does not make any claims about the external world. It does not ask if participants' accounts are a true representation of an external reality. What is important in IPA is how participants experience the situation or event. Here then, it could be said, that IPA corresponds to a relativist ontology (Willig, 2001).

This thesis adopts the epistemological position of critical realism. This marries my own beliefs with those outlined above. The critical realist position assumes that there is a reality that exists independent of human interpretation (Caldwell, 2003). However, rather than adhering to a positivist epistemology, critical realism recognises that human perception, cognitions, ideologies, etc. impact on our interpretation of the world (Caldwell, 2003). It is recognised, therefore, that participants' previous experiences will impact on how they interpret their world and will influence the information they give in the research interview. In addition to this, my own life experience will be implicated in the wording and focus of the questions and in the interpretation of the data.

2.1.3 Rationale for methodology

A qualitative methodology was thought appropriate for this research for a number of reasons. Rather than confirming or refuting a set of predetermined hypotheses, it was the aim of this study to allow the emergence of data that the researcher may not have expected. "The objective of qualitative research is to describe and possibly explain events and experiences, but never to predict" (Willig, 2001: pp 9). Interpretative Phenomenological Analysis and semi-structured interviewing (a method of data collection compatible with IPA) were chosen as they allow the richness of individual meaning to emerge.

There is a lack of literature regarding the use of IPA with those where the language used in the research is not the participant's first, or preferred, language. Indeed, there is a dearth of literature about using IPA with refugees and asylum seekers per se. However, Schweitzer and Steel (2008) argue that there are a number of reasons why IPA is an appropriate methodology to use in studies with refugees. The assumptions underpinning this methodology are an openness to human experience, which allows the acknowledgement of experience that may be unexpected by the researcher (Schweitzer and Steel, 2008). The methodology also has the capacity to privilege indigenous knowledge and experience as no assumptions about the outcomes of the research are made prior to its commencement (Schweitzer and Steel, 2008).

A further argument for using IPA with refugees and asylum seekers is that many have experienced situations, such as the immigration process and the media, where their stories are questioned and, at times, not believed (Patel, 2003). IPA advocates that individuals are able to give a true account of their experience (Larkin et al, 2006) and stories are listened to and accepted by the researcher. This goes some way to redress the power imbalance experienced by many refugees and asylum seekers. Although there are also a number of limitations in using this methodology with refugees and asylum seekers (see section 2.2.6), I believe the benefits of giving a voice to those who have been marginalized and ignored outweighs the costs.

2.2 PROCEDURE

The following section outlines details about the clinic the participants attended, recruitment, inclusion/exclusion criteria, participant information, a discussion about

interpreters and interviews, ethical considerations, and the analysis and evaluation of the data.

2.2.1 The Clinic

The clinic where participants attended therapy was a primary care setting that provided a psychologically oriented therapy service to refugees and asylum seekers. At the time of writing, referrals were made to the service by self-referral, through GPs, or voluntary services. Each referral was assessed and prioritised. Complex cases were seen by one of the clinicians specialising with this client group. For this research the four therapists who had worked with the participants were clinical and counselling psychologists who had worked with this client group for a number of years. The main therapeutic approaches of cognitive-behavioural, systemic, psychodynamic, and person-centred were used in the team. On average clients were seen for between 15 to 20 sessions.

2.2.2 Recruitment

The clinical lead for the refugee and asylum seeker's service was contacted and a copy of the research proposal was sent to her, which both she and the head of primary care psychology read. In line with the recommendations outlined in Patel (1999) the research was discussed thoroughly with the clinical lead. This included an outline of and background to the research, the process that would be involved and ethical considerations, including issues of confidentiality. The team agreed to the research, after a number of potential problems were discussed and reflected upon.

Clinicians from the team identified potential participants and contacted them, outlining the research. All potential participants who were interested in taking part in the research, gave clinicians consent for me to contact them. An information sheet outlining the research was then sent to participants and interviews were arranged (see Appendix 1).

2.2.3 Inclusion/exclusion criteria

Inclusion criteria All refugees and asylum seekers who had completed therapy at the primary care service were included. For ethical reasons, (i.e. so as to have no impact

on therapist-client relationship) only participants who had completed therapy were included.

Exclusion criteria – Any clients who were not refugees or asylum seekers were not included in this research. This was justified as there is limited research with this group and, further, the process of fleeing one's country of origin due to persecution is unique.

2.2.4 - Participants

The table below shows participant information. It gives the range and mean.

Table 1: Participant information

	Range	Mean
Gender	4 males and 4 females	
Age range	21 – 48 years	30
Country of origin (Participants requested that the specific African country of origin not be disclosed)	5 from Africa 2 from Afghanistan 1 from Iran	
English language knowledge	4 participants were fluent in English and 4 were able to converse but had some difficulties	
Number of therapy sessions	2 - 24	14
Previous experience of therapy	Four participants = 0 Two participants = 1 One participant = 2 One participant = 4 (according to the participant she attended each therapy for no more than a few sessions, due to dissatisfaction)	1

Participants were not newly arrived to the country; most had been in the country for five years or more. Five had refugee status and three had been refused asylum but were waiting for the conclusions of their appeal.

The clinical lead for the refugee service said, in written correspondence, that the experiences of those attending the service included: fear of persecution; detention;

detention and being tortured; being raped; the loss of homes; the witnessing of family members being killed; and family members and friends being killed for political reasons.

2.2.5 Interpreter

It was the aim of this study to interview a range of participants from the service. However, due to funding issues it was only possible to include participants from one other language group apart from English. It was decided that a large percentage of clients attending the service spoke Farsi, so potential participants speaking this language were also approached. Two of these agreed to participate. They were offered the use of an interpreter in the interviews but they declined. These participants said that although they had used an interpreter during therapy sessions they had acquired sufficient knowledge of the English language since then to conduct the interviews with me in English.

2.2.6 Interviews

As mentioned above one of the benefits of IPA is its ability to reveal unanticipated phenomena, as the methods of data collection that are compatible with it are more flexible and open-ended: semi-structured interviewing is one such method. In comparison with other less flexible quantitative methods, it allows a richer source of information to be obtained, as participants are able to describe their experience with less restriction. The interview schedule was developed so as to explore participants' experience and thoughts about psychological therapy. The schedule was used as a guide during interviews but participants were encouraged to express any views that emerged.

When interviewing people from a non-Western cultural background and whose first language is not English, a number of difficulties are likely to be encountered. Tribe (2003: pp207) points out that 'words relating to psychiatry, trauma, psychology, counselling/therapy, stress and mental health, may not exist or have the same meaning or resonance in other languages'. Various points were considered in an attempt to counteract potential problems. Firstly, it was important that the interview schedule was reflected upon. The schedule was shared with my thesis supervisor, the lead clinician and a clinician from the centre and suggestions were taken into account (see Appendix

2 for original version). Further, after two interviews it became apparent that the schedule should be refined (see Appendix 3 for the updated version). Secondly, it was important to monitor the interviews as they took place and when it became apparent that the questions had not been understood a number of prompts were used to aid understanding. Also, I attempted to remain curious as to the meaning of particular words the participants used; I verified that my understanding and the participants' understanding were the same.

Participants were interviewed at the clinic where they attended therapy. Interviews lasted between 50 minutes and 2 hours.

2.2.7 Ethical considerations

Difficult material was discussed in therapy and, for some, the experience of being interviewed might cause them to re-experience some of this material. This was reflected upon prior to interviews and it was agreed that firstly, I would remain vigilant to difficulties within the interview, such as signs of increased levels of distress, and discuss these with participants, should I have any concerns. Secondly, should participants experience high levels of distress they could self-refer to the service.

As mentioned above, there is a limited amount of qualitative literature with refugees. Research using an IPA approach views the participants as experts in their own experience who can provide the researcher with an understanding of their thoughts and feelings (Larkin et al., 2006). Qualitative research in general provides individuals with the opportunity to tell their own stories, in their own words and with as much detail as they wish to convey. This type of research goes some way to redress the power imbalance of those who have generally had their voice subjugated by the dominant culture.

As many participants had fled persecution and, due to their experiences, had lost trust, it was deemed necessary to follow an outline suggested by Elam and Fenton (2003) for researching sensitive issues and ethnicity. Firstly, once participants had given clinicians consent for me to contact them I telephoned them and discussed the research in detail. This covered many concerns they had regarding confidentiality. We agreed on a number of issues before participants felt comfortable taking part. For example, I

agreed to show the transcripts and analysis section to participants, who requested this, before sharing it with anyone else who had not participated, I agreed to not include the names of some countries of origin. Once this had been agreed participants gave written consent. Secondly, I further built trust and confidence by discussing confidentiality issues relating to the information they gave, which would not be discussed by myself outside of the interview in a way that identified participants. Thirdly, I began interviews with less sensitive questions and moved to more sensitive ones. Finally, I spent about 10 to 15 minutes before and after the interview to build rapport and to ensure that the participants felt comfortable at the end of the meeting.

Ethical approval was obtained from the University of East London Ethics Committee (see Appendix 4), and Barking and Havering Local Research Ethics Committee (see Appendix 5). All participants gave written consent for the interview to be tape-recorded and for anonymous data to be used in any write-up and publication of the research (see Appendix 6).

2.2.8 Transcriptions

The data was transcribed verbatim. All identifying information was changed. All transcribed data was kept securely using a password. Codes identifying participants were kept separate from this, also using a password.

2.2.9 Analysis

Smith (1999) states that there is no single way to do qualitative analysis. I have drawn from the recommendations of Smith et al (2003).

1. Firstly, the transcript for participant 1 was read and re-read to develop an intimacy with the account. Any thoughts, observations or comments were jotted down in the right hand margin. Any emerging potential themes were written in the header and footer section.
2. Next, the transcript was re-read and initial themes or connected parts of the text were written in the left hand margin.
3. An 'initial themes' word document was created where sub-ordinate theme titles were placed in a left hand column, participant and line numbers were placed in the central column and corresponding quotes were placed in the right hand column.

4. These sub-ordinate themes were initially sorted into groups. This was done via a process of creating an 'initial super-ordinate themes' word document. Each theme was written in a word box. These word boxes were grouped together as links became apparent. This generated initial 'super-ordinate' themes (see Appendix 8).
5. This process was followed for each participant. Any further data that connected with initial sub-ordinate categories were noted and any further ones that emerged were written down.
6. Any new sub-ordinate categories identified were either incorporated into existing 'super-ordinate' themes, or placed on their own.
7. During this process it became apparent that some sub-ordinate themes could be moved and merged within and between the initial super-ordinate themes, as it became apparent it was necessary to do so. Connections between sub-ordinate themes were noted through the use of arrows linking word boxes (see Appendix 8) and the text was read again to confirm my thinking.
8. A further reading of each participant's transcript was carried out at this stage to see if any other data corresponded to the final list of themes. Once no further data could be taken from the transcripts it was decided that analysis of the transcripts was complete.
9. A final process of collapsing, merging, and dividing sub-ordinate themes then took place by re-reading all quotes to make sure themes were distinctive and these became the final group of sub-ordinate themes.
10. Finally, the super-ordinate themes were analysed further to make sure all sub-ordinate themes corresponded to them. Any sub-ordinate themes that did not correspond to the super-ordinate themes were dropped.

2.3 PERSONAL REFLEXIVITY

This final section summarises my personal reflections at this point in the research. Few researchers now believe in a pure form of empiricism. It is now widely accepted that research is influenced by researchers' biases and assumptions (Willig, 2004), Reflexivity is viewed as an important part of research where these are continually made explicit, which helps the reader understand their contribution to the construction of meanings.

I was initially drawn to this research because I believed that media portrayal of asylum seekers and refugees was unfair and created added difficulties for a group of people who had already suffered extensively. However, being a white, middle-class British person it is difficult for me to fully understand the extent of that suffering.

Through my clinical psychology doctoral training at University of East London and through reading extensively in the area I began to question whether 'talking therapies' could be useful for groups of people where talking to a stranger about personal information was such an alien concept, and wanted to explore this further.

CHAPTER 3 – ANALYSIS

3.1 PRESENTATION OF TRANSCRIPT MATERIAL

Minor hesitations (e.g. erm) and particular words and phrases (e.g. 'like', 'you know', 'kind of', 'I mean', 'really', 'at the end of the day', 'and everything') have been removed. When removed, sentences which included these words were still complete and the words did not add anything to the understanding of the sentence (e.g. "Well he was a proper doctor and he was in hospital, I was there for probably for a week or so, they told me that I have lost my, *if you like*, I have lost water from my body, so they gave me this medication *and everything*. But that was the two things they told me."). Inserted information, for the purpose of clarity, is square bracketed. For the purpose of brevity repeated information has been removed (e.g. "I was like, *I was like* scared…") and when data in different parts of a paragraph correspond to a theme, the text in between, which was not deemed as necessary by the researcher in the interpretation and analysis, was removed; this was denoted by […]. Identifying information has been removed and denoted by […]. In extracts of dialogue 'R' refers to the researcher and 'Pn' to the number of the participant. Participant number and line number are at the beginning of each quote.

3.2 INTRODUCTION TO ANALYSIS SECTION

All participants had fled their country of origin at least five years prior to this research. They had all spent significant amounts of this time searching for solutions to their problems and some had attended therapy for a number of years. The following super- and sub-ordinate themes have been arranged into participants' journey of healing, which tells the story of their journey from a painful past to a life where they are able to think about the future. This involved being 'stuck in the past', then participants 'searched for solutions' and there were a number of things that 'helped them to move on' before finally they 'moved on'. The chronology below is my attempt to make sense of participants' stories. However, participants' journey did not flow from one super-ordinate theme to the next; they moved between each theme and were in different stages at different points. For example, although all participants had 'moved on' to some degree they were all still experiencing some difficulties, which caused

them to be 'stuck in the past'; they were all still searching for solutions to some old and some new problems.

3.3 SUMMARY TABLE

The table below shows the super-ordinate and sub-ordinate themes.

Table 2: Summary of super-ordinate and sub-ordinate themes

3.4 Super-ordinate theme 1: STUCK IN THE PAST
3.4.1 A painful past: loss and remembering
3.4.2 Flashbacks
3.4.3 No one can understand
3.4.4 Hate and anger
3.4.5 Fears of others: scared and distrust
3.4.6 Keeping things in
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3.4 STUCK IN THE PAST

This group of sub-ordinate themes relates to participants' experiences in their country of origin and the difficulties they had been left with. This included the death of family members and friends and remembering a painful past. Other difficult memories they described came in the form of 'flashbacks'. Participants' experiences were so extreme that they believed others, who had not been through something similar, could not understand. They described being left with feelings of 'hate and anger' towards those connected to their extreme events. Participants talked about the fear and distrust they experienced, which affected them talking to others about their problems, which was described as 'keeping things in'. Finally, participants' asylum claims were also affecting their options of moving on. These multiple difficulties were so overwhelming that many participants considered committing suicide.

3.4.1 A painful past – loss and remembering

Some participants talked explicitly about a past where family members and friends had been killed in war, (P8: 119) "I was there when they killed my mum and my dad and my two brothers"; (P3: 237) "I suffered for the loss of my parents, my family and my friend". Participants talked of the difficulty involved in remembering the past, a difficult part of therapy for most:

> P7: 361: "I think and to come in and sit in the psychology some times and explain yourself all the time, it was very hard to again remember what happened to you, [name of therapist] she was asking me what happened back home for you, [...] but if you have a pretty bad memory you don't want to remember it."

> P4: 165: "Sometimes when asking you about your past and about your worries, my mind was getting more so heavy and so I getting [inaudible] and sometime, my mood was not good, my heart was already black but [the therapist] asking me everything and I told her everything, the question she asking."

The language that participants use in these extracts indicates the extent to which remembering the past was difficult for them (e.g. remembering was hard, bad memory, a heavy mind, a black heart, mood not good).

Participants found that current stories could trigger memories for them:

> P6: 231: "I was very, very ill when it happened again in [name of African country]. In January to see people running and the burning the houses and killing people, burning the churches, everybody saw it. I didn't know where my son was by then, I was very very depressed."

> P3: 887: "I refused to watch the news and I don't watch news at all, because it does affect me in other way, it does bring me my memory back."

Memories of the past were a recurring theme throughout participants' journey. For some there was a wish for therapy to remove the memories, (P1: 217) "I couldn't erase those [flashbacks of the war] things from my head, but that's what I wanted when I went to therapy". Further along in their journey many participants found the need to make a conscious effort to not think about the past, as for many remembering was too painful.

3.4.2 Flashbacks

In addition to memories of the past, some participants described the intrusive uncontrollable experience of flashbacks. These are vivid memories that intrude into ones' current life (e.g. Brewin and Holmes, 2003).

> P3: 732: "I see the things different, like I am here in the room but I am back in my office [...], I am running here in [name of London street] but to me I am running in my street [referring to street in country of origin]."

> P1: 217: "Like in my situation I have those nightmares, I had flashbacks of the war and everything. I couldn't erase those things from my head."

Flashbacks associated with extreme events have been well documented in the literature (see Kinzie et al, 1990). Flashbacks in this research were also part of participants' stories where they wanted to find a way to make them stop but once they realised this was impossible, they found ways to have more control over them.

3.4.3 No one can understand

Participants described their experience as being so extreme that those who had not experienced what they had could not possibly understand:

> P1: 44: "...according to what I went through, my past, the war and all the problems that I went through, I didn't think a therapist would understand what I had gone through."

> P7: 146: "They are very different to me, they are very good friend, but the thing is they are from a different culture, [...] another problem is, they don't have my problem [...]. In my country we have got a saying, it says: you can't stand beside the fire and tell to person which is in the middle of the fire I can understand you, because you can't feel him exactly, you can feel that it is so painful to be there but you don't know how painful it is."

Participants' belief that others could not understand their extreme events might have increased their sense of being alone and isolated in a foreign land. Research suggests that the experience of being isolated from others is one of the factors associated with low-mood (Beck, 1976), which would have added to participants difficulties at this point in their journeys.

Participants said that those they saw as having had a similar experience to themselves were more able to understand their problems and thus help them on their journey:

> P1: 59: "Because, someone convinced me because, it had helped her, she had gone through [description of problem], so she was like in the same problem like me, she wasn't facing the truth and she was keeping the secrets inside, and she told me how [therapy] had helped her."

> P3: 326: "Someone from my background, I mean any third world [...], different. [...] [there is] lack of understanding as well, the way the people they feel, the way they talk, the way they came from, and I think that it's very important because when I done with [name of person] I felt more comfortable because he came [from] background where we was."

It seems here that certain individuals acted as a bridge between participants' cultural background and experiences and Western systems; participants seemed more likely to take the advice of individuals who were familiar with both systems and this encouraged participants to try things they would not previously have thought of.

3.4.3 Hate and Anger

Participants described feelings of hatred towards others. This included hatred towards those who were involved with the extreme events but also some described a general feeling of 'hating people'. According to participants hatred was "mixed up with aggression."

> P8: 424: "I hate those [African tribe] people who killed my family."
>
> P8: 316: "If I be going home [...] I will revenge for what they did."

> P5: 412: "Before [therapy] I used to be scared of a man and I never date before, I used to hate men, I hate men, I hate men."

Participants also talked about feelings of aggression towards others:

> P3: 420: "I was violent, it's mixed up, I was violent because I was doing things, with my own experience, I was hating people, I don't like people, I don't trust no one."

> P7: 501: "Just to be all the time, just can't control yourself, just be angry with others, not necessarily with others, don't have the patience to talk with others, all the time feel like, [....] you just feel very aggressive, yes a little bit."

Again, the language that participants use here points to the extent of emotions they were experiencing at the time (e.g. hate, revenge, scared, violent, aggressive). It could be that once participants in this research unexpectedly experienced the brutal capabilities of others they felt unable to assess who else might be capable of brutality and so general hatred developed. The higher levels of aggression they experienced at this time could be understood as the body being prepared so that they could protect themselves from unpredictable others.

3.4.4 Fear of others: feeling scared and not trusting others

Many participants had fled war and persecution in their country of origin. They had witnessed and experienced the murder of their family and friends. For many this created an environment of fear on many levels. For some they feared that people in the host country would report them to the government in their country of origin and they would be sent back:

> P7: 541: "My problem was with my government and I had some kind of scare to explain why I came here and what's the matter, because it was all the time scared probably they going here to the embassy and reporting me."

> P3: 197: "I was thinking sometimes, talking to [First therapist's name], are you sending this to Embassy here, are you sending this to the government?"

For others their fear was connected to being sent back to their country of origin:

> P3: 184: "I had a lot of untrust and was afraid if I say something they will send me back [...] back to my country, it's not back to my country, send me back to the army."

> P8: 381: "I've got a fear to go back home, made me [feel] like I don't want to do anything, I say why should I do [anything], maybe I shall do this and then tomorrow they will send me home. Maybe I'll be killed."

Participants described general feelings of fear of being scared of the dark, of being out walking and even being in one's home:

> P4: 195: "I don't like so much people around. I feel like scared when I hear shouting."

> P1: 333: "[My problems were] getting scared, thinking someone was banging on my door, anytime of day, getting anxiety attacks, just even hearing the bell."

Distrust of others was a significant theme for seven participants. Some talked about being unable to trust people due to fear of who they might know:

> P6: 216: "[The therapist] caused me to cry because [the therapist] is asking me everything what happened and I don't trust her. Because I don't know why she

is asking me, somebody who ran away like me, I don't know what connection somebody may have. So I didn't feel comfortable."

P8: 103: "I don't where is [the therapist] from and I don't know if [the therapist] has other relatives which can be this, to be honest I didn't trust anyone, to talk about my situation."

As Tribe (2002: pp 243) points out, 'refugees have experienced many losses, including perhaps a view of the world as a safe and benevolent place upon which they could have an impact.' Blackwell (1989) states that the experience of war and torture affects peoples' ability to trust others. Participants' experience of fear and distrust can be considered in relation to these ideas. The extracts in this sub-ordinate theme point to the powerlessness that participants experienced at the time. This was in relation to the power of the host government, over the decision to grant asylum, and also to the potential power of others to be able to influence the process of sending participants back to their country of origin. Some had also fled tribal warfare and they feared others because they did not know what connections they had or the sympathies they held. It could be understood that these fears and issues of power would have controlled what could and could not be said to others at this time.

3.4.5 Keeping things in

Their fear and distrust of others appeared to be a factor which stopped participants from talking about their difficulties:

P8: 48: "I didn't even like to talk about my situation to anyone else because [...] I couldn't trust anyone."

P3: 284: "Here in this country I didn't want to mix, I didn't want to talk because I was scared, especially when I came to this country I didn't trust nobody, [...] I lost trust for everybody."

Although 'keeping things in' could be explained as participants' way of protecting themselves from others who they did not trust, they were able to understand that 'keeping things in' could add to people's distress:

P2: 559: "My [family member] was worrying a lot and keeping things into her heart, not taking it out like tell it to others [...] she has this problem, from that she passed away and it came back to [another family member] and she still have the problem of the worrying and it comes back to me."

P5: 570: "[So everybody holds] their stuff with them until they die because you will go crazy, so many people are suffering from depression now, [...] because they don't have somebody to talk to about these things [...]. At the end you might kill yourself or you might die because of that problem, keeping it, a secret is painful is really painful."

Many refugees and asylum seekers have experienced persecution and torture and have learned that talking about their beliefs and experiences has had serious consequences in their country of origin (Tribe, 2002), thus the idea of 'talking' to others about their experiences could understandably create feelings of fear. This fear becomes a factor in rendering participants powerless to talk about the unjust extreme events.

3.4.6 Negative experiences of the asylum claim

The asylum claim was talked about as a negative influence on some participants' lives. Participant 7 had been waiting for an answer for his asylum application for a number of years. It was important for him to be self-sufficient but as he was not allowed to work this was impossible. For another, she believed if she was sent back to her country of origin her life would be in danger. She felt that her asylum application was the only thing stopping her from fully moving on:

P8: 511: "I prayed, God if this happened and I don't expect anything will hurt me any more, in my mind I said maybe I could die as well, but I had that I am not go in my country, maybe they will take my body. But apart from that I have to do things as I can."

P7: 259: "This country is talking about democracy or whatever, or human rights, and to be honest, and I am sorry to use this word, but they treating me as an animal, they don't care what is going to me, they stop my benefit and I am not allowed to work, how can I support myself?"

As Tribe (2002: pp244) points out, 'This is an extremely stressful and uncertain time, when asylum-seekers are unable to make plans for the future and may be terrified of being returned to their country of origin". Although their asylum claim was more of a current issue it was something that was affecting participants' ability to 'move on' in their lives.

3.4.7 Suicide

According to some participants they had considered suicide, or the wish for someone to take their life, on numerous occasions. For some this had developed into attempted suicide:

> P7: 130: "Before the psychology, many time I was decide to kill myself because life is so hard but when I was talking to the [name of therapist] she has been very care about this matter and she has tried to help me."

> P4: 321: "I was so much getting worry and depression, I was trying to hurt myself by knife [...] I was in the hospital [...] I was still worries so one day there was tablet and I was taking in the hospital, I taking some more 50 tablet".
> R: "Because you wanted to end your life?"
> P4: "yes."

Participants were facing multiple difficulties at this point in their journey. They had experienced events that were extreme in nature. They had lost family members and friends in brutal circumstances. They had fled their country of origin and the familiarity associated with it and arrived in a host country where the systems and language were alien and the reception hostile. They were alone in a foreign land attempting to cope with extremes of emotion but also needing to survive. One can understand that the culmination of such extreme experiences would have been difficult to bear. Although to date research has not been conducted looking at the suicide rates in this particular population, suicide has been associated with elements of the refugee's experience. For example, Burnett and Thompson (2006) suggest that dealing with a foreign language and alien systems can lead to feelings of helplessness and despair, which, together with the experience of isolation from others, has been linked to suicide attempts (Lester, 1998).

3.5 SEARCHING FOR A SOLUTION

All participants talked of a desire to get better, to find a solution to their problems and to find something that would help them to move on. Participants were willing to follow the suggestions that others' made. Friends and family also played a part in wanting to find a solution for participants' difficulties.

3.5.1 Searching for a solution

Participants searched for solutions to problems for both mental and physical health. They described being sent from place to place hoping to find solutions to their problem, whether this was going to a therapist, a solicitor, head massage, the gym or other medical interventions. Mainly this involved approaching GPs about problems and being referred for therapy:

> P2: 317: "So when I was going there still I was having hope that these guys are there to help me so I would go there and whatever they required of me I would give it 100% because the problem is one I want a solution for".

> P5: 272: "Those days I was feeling down, I was really down and I could not take it any more and I had had enough of life. I talked to my doctor about this and asked him to refer me to a therapist."

Many participants had experienced extreme powerlessness in war, torture and exile. However, they were able, on some level, to believe that they could influence their future. In psychological terms, the traits that participants displayed might be explained by the idea of an 'internal locus of control', which refers to people who hold the belief that they have some control in their lives (Rotter, 1966).

3.5.2 Trying things out

For many participants their journeys involved trying things that they might not normally do or had actively avoided. For some that involved going to therapy, (P1: 62) "she told me if I tried [therapy] for like two or three days and it wasn't working then I could stop anytime I wanted, so I just took a gamble and tried it." For others this meant connecting with family members, taking medication, or trying strategies suggested by others.

P2: 614: "Let me try the other person, my doctor told me, I give you the medication what I could, I told him at that time it helped about 50 or 60% so he told me let me try to this psychology person, let's try, if he helps so probably this is 60% help and that can be 40% so we can bring it together and take away the problem."

P6: 429: "[The therapist] will help you [with …] taking of your medication she will tell you what to do because she told me to put stickers on my fridge and they really helped."

Others were avoiding things or situations they feared, so 'trying things out' meant they did something they feared in an attempt to overcome it.

P1: 195: "I had problems like facing up to some problems in my past and she would set me tasks […] and I would go and do it and try to do it actually".

P5: 412: "Before [therapy] I used to be scared of a man and I never date before […] but now I feel different, I date them, they can't make me do what I don't want to do".

These actions can also be understood in relation to an 'internal locus of control' (Rotter, 1966). Participants appeared to believe, on some level, that there was a solution to their problems, which they actively pursued.

3.5.3 Help and persuasion from others

The idea of going to talk to a stranger about one's problems was an alien concept for many participants, (P3: 148) "I didn't know that therapist was someone who was going to sit down and maybe talking to you […] I came from a country which it doesn't exist therapy." Family and friends suggested they should seek professional help:

P1: 46: "Everyone was advising me, because you're having problems, you're crying every night, you're having flashbacks, you need to speak to somebody who can help you maybe overcome that kind of thing."

P8: 59: "The situation I was that time [when P8 first arrived in the UK] was very bad. [people at the refugee service] say that maybe I really need to see someone."

Other participants talked about the help they had from family and friends:

P7: 309: "Mostly I think [what has helped is] the friend they have been around me and they have been so care. When they start to look after you, I never get any financial support from them but I get good advice and they have been encouraging me to get to the course."

P2: 52: "[My mother] took me to my uncle and they said, well these things are coming up sometime, then they took me to a religious person, kind of scholar."

As Tribe (2002) points out, it is not psychiatrists [or, it could be argued, psychologists] that are usually associated with a healing role, rather, it is community elders or family members. It seemed that family and friends who were more familiar with Western customs persuaded participants that therapy might help them.

3.6 HELPING ME TO MOVE ON

There were a number of things that helped participants move on with their lives. For some, religion provided comfort and had helped them to overcome a number of problems. Participants talked about being disconnected from others and connecting and building trust was important. This allowed them to talk about their problems, where releasing emotions created a 'lighter heart'. For the majority of participants therapy was a positive part of their stories. Some believed that they were 'mad' and talking about and understanding problems was a relief. Participants described many aspects of the therapeutic relationship that had had a significant influence on their journeys to the hope of a better future.

3.6.1 Importance of religion

For many participants religion had been a significant part of their lives and, in their country of origin, a place of worship would be somewhere people would go to for help.

P1: 109: "Most people go to the religious side when they have problems [...] most times it is the religious leaders."

P3: 84: "When you have this kind of difficulty [psychological problems] most of the time people go to the mosque."

For some participants they found comfort and solutions to their problems in religion:

P2: 150: "Most people believe in the scholar [...] they don't give as much respect to [...] the doctor in this matter as they do to the scholar. [...] I found [the supplication upon me] very useful so when I look at it now I see that the scholar is the solution for this problem."

P8: 602: "Every time when I dreamed about [P8's brother] I wake up and I pray [...] I feel like I am going to cry, or I am going to lose it, and I am going to explode. I say God please help me, help me God, God make me strong, make me strong."

These extracts suggest that it is God and religion that participants turn to when they have problems. The descriptions also show the reverence placed on religion and the fundamental part it plays in participants' cultural, social and personal lives. Religion had implications on help-seeking behaviours, it was a social place where participants met family and friends, and it was a place that participants went to for comfort and support.

3.6.2 Connecting and building trust

Reconnecting with others and building trust appeared to be significant for participants. Some participants talked about reconnecting with others:

P7: 560: "One of [the therapist] advice, was to prepare and to start to have a communication with them [inaudible] I been but I try my best to go more and later on when I start to go between people, when you have a good friend they try to care about you, and just they asking you some questions and little by little, you just start to get close to someone and just start to be able to explain yourself."

P8: 771: "The Counsellor they advised me to get friend, I didn't have much friend before. But I tried to get the friend [...] even my brother did tell me, you don't have to be on your own all the time, but at the time I wouldn't feel like I can have close friends."

Building trust with the therapists had been an important part of therapy:

P1: 307: "I would say that it was an easy going relationship, because I came to trust [the therapist] and I found myself after a couple of weeks that I was pouring all the problems that I had."

P5: 150: "I felt immediately like I can trust [the therapist] and I can tell everything to [the therapist]."

Many aspects of the first super-ordinate theme 'stuck in the past' could be described as participants' disconnection from others. Birkett (2006) argued that a universal human need is the need of human beings for each other. Building trust appeared to be one of the first steps that enabled participants to begin to re-connect and build relationships with others. However, connecting with others and building trust seemed to occur on different levels, some participants had been able to trust the therapist and their close family and friends but some described continuing problems in relation to trusting people who were less familiar.

3.6.3 Talking

It seems that once participants had built trust and connection they were able to begin to talk about their difficulties, which for many was a significant part of their journey; they were able to discuss issues related to their past and present and bring about change to both their beliefs and actions. However, as already mentioned, talking to strangers was an alien concept and many had been silenced through persecution and fear so for some it was difficult to begin talking: (P3: 819) "I think [the therapist] found a way to let me start talking, I wasn't talking, I didn't trust."

P2: 170: "You go [to therapy and the therapist] ask you the information what happened in the past, they tell you to bring back the memories so they can talk to you and take away the stress from you and you solve the problem through the talking way."

P5: 190: I was not even embarrassed to talk about my thing, it was difficult to talk about it but I was not embarrassed at all. He made me feel better about a lot of the stuff that used to bother me a lot [...], he gives you the way, an easier way to talk about those stuff and make you more understanding."

According to one participant talking in therapy was not enough and she wanted the therapist to give advice:

P6: 134: "So I don't think [the therapist] ever helped because all they did is to talk to you, but I don't think they can remove what was put there originally. It's like you lost some families and somebody is trying to talk to you to get over it."

P6: 409: "She didn't do anything, she was just talking like we are talking. I wanted action, I wanted something to happen, some changes. Something which can bring healing in my life."

It seems that P6 had hoped that therapy would help her to heal but her expectations of what would happen in therapy did not marry with reality, which could have added to her sense of hopelessness.

3.6.4 Releasing emotions and a lighter heart

Participants talked of releasing emotions as being an important part of their journey. This was generally done once trust had developed in the therapeutic relationship but it also occurred with friends and for one participant talking to herself in the mirror had provided a relief. Many used the imagery of a 'heavy heart' becoming lighter through the release of emotions:

P4: 80: "Sometimes [therapy] was helpful."

R: "In what way was that helpful?"

P4: "Because we was talking about, I was trying to do bad things, and I was telling that all things and she was asking me all the question and my heart was getting a little bit lighter when I was speaking sometimes."

P5: 104: "If I talk about my experience, when I used to come first it used to be like heavy [indicating chest area] and when I left it used to feel like very light and a relief and happy."

Spurling (2004) draws a parallel between Turner's (1967) study of ritual healing in Africa and modern day therapeutic practice and argues that an important element of both is the cathartic expression of feelings. The idea is that a verbalisation of one's problems into a narrative structure renders suffering meaningful and hence tolerable, which can be used to explain a 'lighter heart' in this research.

3.6.5 Power dynamics

Power dynamics between professionals and participant appeared to be an issue for two participants. It seemed that participants did not feel they had a choice, or that they could put their own points across.

R: 30: "If you'd have been told what psychological therapy was about by your first Doctor, would you have gone?"

P2: "Well, probably, I should have because if I [had said] do I want to go there? Then [the doctor] would ask me back, don't you want to go there? So then I would have been stuck in the middle, so I didn't have a choice so I have to go there."

R: 240: "Ok, so were you pleased that you stopped going to see [name of therapist], or would you have liked to have carried on?"

P4: "I was sorry, [the therapist] said, she is closing the file because, she said, 'you are a little better than before', and that is why."

R: "Stopping and did you want to stop or not?"

P4: "I did not say anything, but when she say, stop, so I say ok."

R: "Would you have liked to have carried on seeing her? Would that have been helpful?"

P4: "Yes, I never said I stop it, she stopped it."

The powerlessness that many participants' experienced in their country of exile and in the experience of being a refugee in a foreign land might explain power being an issue for participants.

3.6.6 The therapeutic relationship

There were a considerable amount of suggestions for what made a 'good therapeutic relationship'. The importance of this was outlined by one participant, (P1: 515) "If you don't have trust with your therapist if the relationship is not good nothing is going to be solved". It has been well documented that one of the fundamental aspects of therapy is the therapeutic relationship (see Roth and Fonagy, 1996). The following aspects of this sub-ordinate theme are placed in order of importance (i.e. beginning with the aspect that most participants talked about).

3.6.6.1 Listening and empathy

For most participants, listening and empathy were significant parts of the therapy:

> P8: 188: "I am talking to you and you show me that you need to listen to me, it's what I always wanted, if you don't help me at all, but try to show me that you listen to me."

> P3: 845: "[The therapist] bring home that someone is listening."

3.6.6.2 Practical advice

Another aspect of the therapeutic relationship that most participants valued was practical advice. This included setting tasks, giving advice and role plays:

> P6: 42: "I forgot to take [medication], so she told me to put stickers on the fridge [...] things like that. So she did help."

> P2: 246: "Well in a way I did [find the exercises useful] at that time because on that moment when he was telling me this exercise I was in the pain [...] so when I put my focus on this exercise [...] the pain was just gone."

3.6.6.3 Confidentiality

Participants talked about the importance of confidentiality, where the therapist was not going to (P1: 313) "spread out my news."

> P6: 89: "I was concerned he would tell others [...] what [the therapist] said was that he might tell others but within the hospital."

P7: 483: "[Helpful things about going to therapy] Just talking to someone and you can confidential explain yourself because when you say the interview it will be confidential and you can trust someone."

In their country of origin participants had been persecuted, and friends and family members killed, for their beliefs. It could be argued, therefore, that a space in which individuals can confidentially talk about anything they want, without the fear that they will be punished for their beliefs, would have been a positive experience and would have helped them reconnect with the idea that relationships can be helpful.

3.6.6.4 Am I crazy? Naming and explaining problems

Some participants talked about the fear they had that they were "mad" or that others might think they were "crazy." For these it was important to have their problems explained. P3 talked about the importance of recognising the stage of healing for an individual, according to him naming and explaining problems was an important part of the beginning of his journey.

P3: 675: "[The therapist] explained and he said to me how my brain is working and what is depression, what is anxiety, how it fits together, [...] he give me example then he said [...] if this thing is PTSD you are going to have flashback and you will live in different world and I said, [...] this is what happened to me."

P5: 531: "Now I know, it is not only me, there was some other doctors who had this problem, so it makes you feel like you are not the only person and other people have, so this is a common thing, it is not an unusual thing, [...] some people have it and they are not crazy at all, that was a big relief, seriously, because I used to think that maybe I am crazy."

3.6.6.5 Client-led sessions

'Client-led' sessions (a term from psychological therapy meaning that the client decides on the direction and pace of the sessions) were also discussed, this allowed participants to use the sessions in the way they thought most beneficial, such as crying, talking or not talking about the past, and shorter sessions:

P4: 150: R: "Was [the therapist] able to notice that you were having a difficult time sometimes?"

P4: "No, I don't think so."

R: "Would it have been useful for her to stop at that time and just let you do something else?"

P4: "No, because we had one hour with the interpreter, she was continuing asking the questions."

R: "Did you always have one hour?"

P4: "Yea"

R: "Would you have liked some sessions to be shorter or longer?"

P4: "Yea, like half an hour"

P8: 668: "[The therapist] listen to me first and they asked me if I want to talk about something which maybe I can tell you the details, if you want to talk to me just talk to me, but if you don't want, no problem."

The former extract again points to power issues. It seems the participant felt powerless to say what he wanted within the session.

3.6.6.6 Noticing participants' distress and acting accordingly

For some participants symptoms affected their ability to attend during therapy. It was important for them that the therapist noticed this and acted accordingly. This was connected to 'client-led sessions' where, should it be necessary, the sessions could be shorter, breaks could be taken, or the direction of questioning could be changed:

P4: 124: "Sometime I was feeling alright I was listening good, sometime I was thinking, even I don't understand what [the therapist] is thinking, I didn't get her proper."

R: "So you didn't understand what she was saying?"

P4: "No, because my mind was somewhere else, I was thinking, I never understand."

P3: 708: "[The therapist] can see when I become stressful and I start crying or shaking, he used to give me break, we used to go together, I used to wash [..]

my face [...] [the therapist] did stop me sometimes [...] he does change the subject quickly."

The experience of participant 4 and participant 3 described in these extracts appear markedly different. In the former extract it seems that therapy was pitched at a level the participant could not understand. As Burnett and Thompson (2006) point out, the foreign language and systems in a host country can lead to feelings of helplessness and despair. It could be that for participant 4, that therapy was confusing could have added to his distress. Participant 3's description of his experience was that the therapist was able to notice his distress and react accordingly, which, it could be suggested, might have helped him to experience the therapist as someone who could contain his emotions.

3.6.6..7 Future and positive thoughts

Some participants talked of "low-self esteem" and that previous to therapy there was "no future". Aspects of therapy that encouraged future and positive thoughts were something that participants discussed as a significant part of their journey. For some the therapist was someone who helped participants to begin to build their confidence:

P6: 156: R: "How did he help you to feel better about yourself?"

P6: "He said I'm important and he say good words to me."

P2: 292: "R: Right, so he was able to find positive things and talk about those."

P2: "Yes and if you will find a lot of good things in there and not to think about the bad things."

R: "So it was good that it was kind of positive and not negatively focused."

P2: "Yes."

3.6.6.8 Sharing healing stories

Another factor that gave participants hope was hearing 'healing' stories. It seemed especially important to hear about those who had also experienced a traumatic past but had recovered. This gave participants concrete examples of others who had survived atrocities and gave them hope that they too could 'move on' from their difficult past.

P3: 579: "I never forget this when he said to me, look at Mandela what he did he was in prison [...], he was whatever they called him, look at now. You see it's something bring you like a life, you don't know. everything which is..."

R. "Pointing out the good things?"

P3. "Yes, the goodness which I was looking everything is dark I didn't see no light nothing."

P8: 251: "When it helps, is sometimes when [the therapists] talk to you and probably give me example of someone, maybe who has been in the same situation like me, who recovered. They give it to me the positive example."

3.6.6..9 Talking about medication

Medication was another factor in participants' stories. For some the opportunity to discuss this in therapy was useful:

P8: 559: R: "So they listen to you, they receive you well, they try and empathise. What else do you think a good therapist does?"

P8: "And they try to help you with medicine as well."

P4: 266: "[in therapy] we are doing conversation and I asked question and answer and the thing is she, sometime she speak with the doctor and the doctor was give me another medication."

R: "Was that useful?"

P4: "Yes"

3.6.6.10 Passionate therapist versus someone just doing their job

In one participant's discussions about her different experiences of therapy she pointed out the difference between a "passionate therapist" versus someone who was just "doing their job"; this was also talked about by another participant who said that some professionals made her feel she did not want to tell them her story. This appeared to be related to experiencing others as caring about their situation.

P5: 203: "[The therapist] born with these passion things, passionate about people and he gives you all the time, and he is good person to talk to [...]. It is not something that other people can act, you have to be born with it, he is born with it. He is not acting."

> P8: 367: "There is someone who can listen to you and can show you, you are normal person like others, they've got to give you advice, and there is someone else who is there doing his job, like a GP or counsellor for you, but makes you feel unhappy inside, rather than not go to see him."

This sub-ordinate theme, named 'therapeutic relationship' is linked to the ideas of social interaction and focusing on solutions. It appears to outline the important aspects of a relationship. For example, 'listening' and 'empathy', 'confidentiality', 'power issues' – in that clients needed to experience sessions as client-led, and finally, 'passionate therapist', which was talked about as someone who appeared to care. It could be suggested that participants' experiences of extreme events will have affected their expectations of 'good' relationships with others, so the importance of their experiencing a 'good' relationship, in order to build trust that such relations with others can develop, can be understood.

This super-ordinate theme 'helping me to move on', shows participants were able to utilise different aspects of their lives to help them to progress. For example, they were able to be resourceful and use religion, relationships with others, expressing emotions, advice, understanding their problems further and others' healing stories, all as a means to improve their quality of life. This can be explained by the ideas of refugees as survivors, who are resilient and resourceful (Papadopoulos, 2007).

3.7 MOVING ON

All participants had, to some degree, moved on from their difficulties. However, as mentioned in the introduction, this process was cyclical, as there were still issues that kept participants 'stuck in the past'. There were old and new difficulties for which they were searching for solutions and there were still things helping them to 'move on'. Moving on involved, for some, ending therapy, realising life would never be perfect, and finding ways to cope. Studying, and positive thoughts of the self and the future, had all helped to build participants' self-esteem and had helped them begin to have hope.

3.7.1 Outcomes of therapy

The descriptions of 'outcomes' were, for many, powerful. Some talked about continuing difficulties, (P3: 1030) "I still have a big problem. I need to mix with the people", and (P8: 841) "I can't sleep really, or eating properly." However, for many participants therapy was a significant part of their story and they all talked positively about the therapists they saw at the primary care service.

> P3: 934: "Honestly if it's not down to therapies I had, I'm not sit down here with you, I'm dead."

> P5: 365: "I am more confident now, because before I was very low self-esteem and I have a very high self- esteem now."

Some participants appeared to hope that therapy would be able to solve all of their problems. For these participants there were aspects of therapy that were helpful but they did not feel there was a significant change:

> P6: 112: "It was helpful because maybe I could be dead if I didn't see them. I had other thoughts like ending up my life."

However, P6 hoped that all of her problems would be gone,

> P6: 137: "It will be a little bit better but not totally [my problems] didn't go."

> P2: 381: "I mean to be honest [therapy] did not fix it nothing. It did a few, let's say 10% or something like that, it gave me the idea to think about my future and not the past."

The sub-ordinate theme 'outcomes of therapy' was grouped here as participants mentioned that they had relied on therapy and its ending encouraged them to 'move on'.

3.7.2 Realising life will never be perfect

As mentioned above, some participants had hoped that therapy would solve all of their problems. However, an important part of moving on for some participants was realising that they still had difficulties and they either found a way to live with them or continued searching for solutions to them.

P1: 218: "I couldn't erase those [memories] from my head, but that is what I wanted when I went to therapy but that was impossible to do because it happened to my life, it couldn't be erased, so [the therapist] helped me see that."

P3: 1044: "[The flashbacks] won't go away [...], it's like before I had the flashback it just come I didn't know, there is some things I just to do without knowing, like sometimes I go and wash my face quickly, I didn't know that it will help me but it has been highlighted."

It seems that once participants realised that their lives would never be as they had been prior to their extreme event and exile, they found ways to cope with their current situation, which improved their quality of life.

3.7.3 Coping – finding ways to survive

Participants found their own ways to survive with their difficulties. This involved medication, controlling physical pain by keeping warm or controlling symptoms through attempting to be more aware of reality. For a number of participants coping meant being busy and not thinking about the past:

P6: 72: "The torture [...] before I came here, the rape, which I don't like to keep on repeating [...] it will bring it all out and I will be very depressed at the end of the day."

P8: 837: "After the death of [a family member] I feel like, I don't have to think about much, about anything, So that's why I tried to get friends, to get busy as much as possible."

Previous research has shown that certain cultural groups, such as Ethiopians, 'actively forget' the past (Carey-Wood et al, 1995), this is echoed here and could be thought of as participants' way of coping with difficult and painful memories.

3.7.4 Moving on

Three participants talked about being able to move on with their lives. This was a realisation that they could create new lives for themselves and move on from their difficult past.

> P8: 761: "I feel like to have counsellor is very good things in life because it changed those kind of things you couldn't imagine that can change in you and you can move on with your life."

> P1: 500: "I believe therapy is just there to help people move on from what has happened to them not keep on saying, 'Oh I have this problem I can't move on', [...] so it is there to help people move on from their problems and start new beginnings."

3.7.5 College and studying

For three participants, studying at college had been an important part of their being able to move on. They talked with pride about their achievements.

> P8: 753: "I've been chosen one of the best students of the year, who had excellent awards. [...] My tutor knows about my life and does counsellor, they say how brave and hard working I was and I tried to achieve those kind of awards."

> P7: 414: "I have been in the college [...] I was paying for myself and cycling there, all the way down, winter, summer, and try my best to be on time always at the college. [...] I was try my best to be the goodest student and do a good job [...] I tried to be useful and do something positive."

'Returning to work/being able to provide for the family' was a significant theme found by Amris and Arenas, (2004) in their interviews with survivors of torture. These ideas can also be used to understand the significance of college for participants in this study; attendance at college in this research was closely related to a wish to find employment in the future.

3.7.6 Positive and future thinking

Participants had been able to develop positive thoughts about the self or positive thoughts about their ability to do things that previously they had thought impossible:

> P6: 202: "I am not worthless, I make normal decisions [the therapist] helped me with his words."

> P8: 728: "I say why not me, if those people, this can happen to them, they think we can dream like dreams, why not me who have got the possibility to go to study to go to everything?"

Participants also had begun to develop positive thoughts about the future, where previously they had talked about, "there was no future at that time [...] before I had therapy, there was no future" (P3: 1042):

> P8: 951: "I have achieved many things, because I am always focused in the future not in the past."

> P4: 79: "[Therapy] was giving me more hopes, that the life is good, you have a future, look to the future you can make a family, they showed me how to expect all these things."

The language used by participants for this stage of their journey (e.g. not worthless, normal decisions, possibilities, achieved, focused in the future, more hopes, life is good, future, family) is markedly different from the language used by them when discussing issues related to the first super-ordinate theme and points to a significant change in their experience of life.

3.8 PERSONAL REFLEXIVITY

3.8.1 Language problems

That English was a second language for many was an issue for this research (IPA and language issues is discussed further in section 4.3.1). I did ask participants what word they might use to describe something (e.g. 'culture', 'community', 'therapy', 'counselling', etc.), which helped to clarify certain differences. Reading over the transcripts, however, I realise that there were times when I assumed I knew what participants meant but the words were ambiguous (e.g. "traumatised"; "very low self-

esteem"). These 'Western' words might be understood differently by people from non-Western contexts.

Other issues concerning language were that, at times, I found it difficult to understand what some participants were saying, which impacted on the focus of the interviews. For example, when I did not understand what someone was saying I, at times, attempted to clarify, but at other times I closed down potential conversations:

> Someone from my background, I mean any third world because my country is third world, different, Europe is not all, all, advising, these things, whatever, but you see there is not lack of trust, lack of understand as well, would, the way the people they feel, the way they talk, the way they came from, and I think that it's very important because when I done with [therapist's name] I felt more comfortable because he came with background where we was, because there is a lot of things happen or.

During the interview I found it difficult to understand what the participant was saying, reflecting on the transcript I realise he was talking about difference. Rather than attempting to understand I changed the topic completely:

> R. "So if we think about the time you spend with [therapist's name]."
>
> P3. "Yes."
>
> R. "How would you describe your experience of therapy?"

Also, some parts of some transcripts were unclear and so I was unable to interpret them. For example:

> "It took about 10 or 12 lessons [for P to begin to tell the therapist about his past], not, then I was not just telling, he was going small by small, small, small, but sometimes, honestly, when he finished the end and I said he said that's what he said, that's what he said. I was saying, no, I didn't say this, but that's what happened, I don't know because I was more comfortable with him, whatever."

3.8.2 Changing assumptions

My original assumption, that therapy could not be helpful for people from non-Western cultural backgrounds, has now changed. Although all participants said they

benefited from therapy, for some it was a life-changing experience but for others it did not have a significant impact on their lives. However, most of the stories suggested that when others show warmth and compassion, over a period of time trust can build and, in these relationships, talking and connecting to others, who give advice and support, can help individuals to heal.

CHAPTER FOUR: DISCUSSION

4.1 INTRODUCTION

This section will further discuss the super-ordinate themes presented in the analysis. Feedback from the participants will follow. The findings will then be discussed in relation to the literature.

The second section is a critical review, where the use of IPA with refugees and asylum seekers will be discussed. A discussion of issues of power and difference will follow, and criticisms made of the research. Finally, the implications of the research will be outlined, which will include implications for the NHS, clinical psychologists and for further research. A final reflexive note will end the discussion section.

4.2 SUMMARY OF DATA AND FURTHER DISCUSSION

This section will briefly summarise the findings and consider the intra-psychic, social, cultural and political levels of influence on participants' experience. The first sub-ordinate theme was 'stuck in the past'.

4.2.1 Stuck in the past

This super-ordinate category grouped together themes that were interpreted as causing participants to be 'stuck in the past'. Participants' stories suggested that their perceived difficulties generally concerned intra-psychic, social and political issues.

The extreme events that people experience in war and conflict have been well documented (e.g. Human Rights Watch, 2007; International Committee of the Red Cross, 2008; Orellana, 1989; Quiroga & Curr, 1998). A significant body of literature has developed that has looked at the outcomes of such experiences. Although much of this focuses on the intra-psychic symptoms of PTSD, others have pointed to social factors (e.g. Amris and Arenas, 2004). This research lends weight to the idea that distress associated with war and exile is experienced on an intra-psychic (e.g.

memories and flashbacks) and social level (e.g. fear, distrust, hatred, not talking to others and believing others will not understand).

On a political level, 'asylum' status was related to participants' ability to move on from their past. As Tribe (2002: pp244) points out, claiming asylum 'may be a time when psychological wellbeing is extremely fragile'. Participants feared being returned to their country of origin; they described the shame of being unable to provide for themselves and there was a sense of powerlessness in the lack of control they had over the asylum process. Kendler et al (2003) found that loss, humiliation, entrapment and danger predicted the onset of major depression and generalised anxiety. Summerfield (2001b) found that unemployment in the UK is associated with premature death, divorce, domestic violence, suicide, anxiety, depression and low-self esteem. This suggests that the asylum system, which was developed in order to help people in need, actually creates environments that have negative impacts on individuals' mental health.

The final sub-ordinate theme in this group was 'suicide'. For many participants their experience of war and torture and the difficulties that followed were so distressing that many had considered, or attempted, suicide. According to Summerfield (2001b) there is a paucity of data relating to suicide rates of asylum seekers and refugees in the UK. There were anecdotal accounts of a number of suicides by young Somali men in East London but no concerted effort by the government to collate such statistics. This appears to still be the case.

4.2.2 Searching for a solution

This section discusses the next super-ordinate theme 'searching for solutions'. Intra-psychic (e.g. anxiety); biochemical (e.g. medication); social (e.g. relationship with family and friends); and cultural factors appear to have influenced participants' behaviour. It is interesting to note that although many participants had experience extreme powerlessness in war, torture and exile, it appears that on some level they believed they could have an influence on future events. This reminds me of the ideas of 'survivors' of extreme events, rather than 'victims'.

During their search for solutions to their problems one thing that appeared to help was non-avoidance of anxiety provoking situations. It could be suggested that events such as war, torture and persecution, will cause individuals to develop a belief that the world is a dangerous place; in psychological theory, a fear of situations or things is associated with the intra-psychic symptoms of anxiety (Padesky and Greenberger, 1995). Anxiety is a Western concept; its origins are found in the 'neurosis' models developed by Freud (1966) and first appeared as a separate diagnosis in the DSM-III (APA, 1980). However, symptoms associated with the diagnosis of anxiety (e.g. heart palpitations, sweating, 'butterflies' in the stomach) have been discussed in the refugee literature (e.g. Burnett and Thompson, 2005; Ehntholt and Yule, 2006).

Medication was another aspect of participants' search for solutions. Morris and Silove (1992) have suggested that in some cultural contexts the medical model of psychiatry more closely corresponds to traditional concepts and values of healing, rather than psychotherapy. According to Morris and Silove (1992) many individuals in developing countries appear to believe that one of the only legitimate reasons to approach a physician is for medical symptoms. They suggest that in many countries such beliefs are reinforced, as physicians always respond to symptoms by giving medication. The powerful impact of cultural beliefs and experiences on individuals' health seeking behaviours can also be seen in this research as the majority of participants approached services expecting medication and subsequently tried therapy.

Culturally the idea of talking to a stranger about one's problems was an alien concept for many participants, which appeared to impact on their help seeking behaviours. These influences on participants can be understood in relation to cultural ideas of problem solving. In many cultures religion and community are used as forums for talking about problems (Giller et al., 1989); the idea of talking to a stranger about personal problems is a Western approach mainly developed from the white middle-classes (Eleftheriadou, 1997), and not found in other societies.

4.2.3 Helping me to move on

The next super-ordinate theme was named 'helping me to move on'. There appears to be different levels of influence that assisted participants at this stage of their journey. This includes: cultural (e.g. religion); social (e.g. 'connecting to others'; 'listening and

empathy'; 'passionate therapist'; 'talking'; 'confidentiality'; 'healing stories'); and intrapsychic (e.g. naming and explaining problems'; 'future and positive thoughts'; 'releasing emotions') factors.

On a cultural and individual level religion was talked about as important for many participants. Woodcock (2001, pp164) reminds us that, 'many survivors emerge from traumatic events with a sense of existential change, which for some only really makes sense within a religious or spiritual framework'. Religion was also something that gave comfort and solutions to participants' problems, which supports Peltzer (1997), who also found religion was important in offering comfort and strength to endure pain and facilitation of perceptions of abilities to cope.

Participants also talked about intra-psychic issues. It is interesting to note here the use of Western psychiatric terms, and thus the discourses that had become available to participants since their arrival in the UK. For example, P1: "those flashbacks"; P3: "what is depression, what is anxiety"; P8: "I can be traumatised"; P4: "very low self-esteem."

'Power' was also an issue in participants' lives. Refugees and asylum seekers have experienced extreme powerlessness in the event of war, torture, rape and exile (e.g. Bastick et al., 2007; Burnett & Peel, 2001; Orellana, 1989). This is further influenced by the asylum process and their lack of options to create practical change for themselves in host countries (Summerfield, 2001b).

4.2.4 Moving on

The final super-ordinate theme was 'moving on'. All participants, to some extent, had emotionally 'moved on' from their problems but, as mentioned in the introduction to the analysis section, this was a cyclical process. However, after years of searching for solutions and spending a significant amount of time working hard to overcome their problems, they were able to stop constantly focusing on the past and to think of the future. Other research has also found that refugees are able to cope well with pre-migration trauma and post migration stressors. Schweitzer and Steel (2008) discussed a piece of research where Sudanese refugees living in the community were interviewed and found that religious beliefs, social support and personal qualities helped

participants to cope well with their lives after fleeing war. It could be argued that outcome from this research also lends weight to these ideas.

4.2.5 Influences on interpretation

My interpretation of the data was influenced by cognitive theory (Beck, 1976). Cognitive theory advocates that early life experiences affect one's interpretation of later events. It could be suggested that participants' earlier life experiences caused them to negatively interpret later situations, which they might previously have interpreted as benign. Sub-ordinate themes 'fear, distrust, hatred, no-one can understand' could be explained by this. Cognitive theory (Beck, 1976) also influenced my thinking in relation to aspects of the 'helping me to move on' sub-ordinate theme (e.g. 'being mad or crazy'; 'future and positive thoughts'; 'hearing healing stories'; thinking about 'medication'). According to the cognitive model (Beck, 1976) it could be argued that participants' potentially negative interpretation of events was helped though talking to the therapist and others, where challenges to these thoughts enabled participants to build a more positive outlook.

Influences also came from the ideas of the 'therapeutic relationship', which is well documented as one of the fundamental aspects of psychotherapy (for a brief discussion see Roth & Fonagy, 1996). As one participant eloquently said, "nothing will be solved if the relationship with the therapist is not good". A good therapeutic alliance could be thought of as a trusting relationship in which the therapist is empathic and considerate of clients' needs (Roth & Fonagy, 1996). The relationship might involve therapist and client working together for a common goal. I believe these ideas influenced my interpretation of the sub-ordinate themes: 'connecting with others and building trust', 'releasing emotions and a lighter heart', and the 'therapeutic relationship'.

4.2.5.1 Using Western models to interpret data from non-Western individuals

On reflection, I am aware that I used Western theories and ideas (e.g. Cognitive and therapeutic alliance) to interpret the data provided by those of a non-Western cultural background. I realise now how powerful cultural concepts are and the difficulty of conducting research that is not influenced by it.

4.2.6 Feedback from participants

Following the completion of the analysis, participants were approached and asked to comment on it. Five participants, who had asked to see the analysis before it was shared with others outside of the research, agreed. Four participants discussed the analysis and P5 sent a message saying that she was happy for others to see it; she did not make any other comments. P3 and P8 said they could see that the report was anonymous, which made them feel comfortable with its dissemination.

Some participants thought the research findings would help others to understand. P1 thought it would help counsellors and someone who "had not gone through that" to understand and develop services. P8 said that if the report was shown to someone in authority then they will be more aware of the predicament of people who are waiting for their asylum claim. She went on to say that she liked the report because it would help people to understand that everyone is an individual, that everyone has problems but what people have in common is that they all need help, "if someone, can hear how people are suffering maybe in the future they can help."

Participants said that the research made them empathise, connect with the other participants and feel they were "not alone". P1 said she felt "bad" for the others that she was perhaps "lucky" and the counselling "helped me more." P8 said it made her feel "unhappy on one side" because "if someone has problem as me, I can see how they feel, their emotion, you can put yourself in their shoes." According to P3: "When I heard other people had the same story as me it made me feel more connected, because I didn't know there was others who have had the same experience. I feel more connected and more relaxed. If you were to say to meet with them I would still say no, but you helped me to connect to people in other ways, so thank you." P7 said that reading the analysis made him realise that there were other people who have had a similar experience to his. He said that people might think that they are the only ones who are coping with difficult experiences and they believe that they will never get over it but to read stories about others will make people realise they are not alone.

Reading the analysis made some participants realise that others who had experienced similar difficulties could also find lives that were meaningful. P7 said that when they can see that others are in a similar situation but they have got over it then it gives hope

and it might give people an incentive to find ways to cope. According to P5, "if someone can be strong, no matter what happened, it is going to help you as well, because if they are strong then why not me?" P1 said, "People were going through the same problems and they went for help and got better, or even if they didn't improve they had future thoughts".

It was suggested by P1 that the report could be used to encourage others who feared talking to a therapist, "If someone has gone through the same problem they would be scared [to see a therapist]. If people had read the report they will not be so scared."

P3 noted what he thought was an omission: "the only thing that is missing is that I lose where I am. I wake up in the morning and block the doors and think someone is going to come in."

There are two points I would like to make here. Firstly, participants said that reading the analysis was normalising and hearing others' stories was important. This supports what participants said in the analysis about the importance of hearing others' recovery stories. However, secondly, this feedback could suggest that my analysis did reflect participants' experiences or it could illustrate that participants found it difficult to disagree or criticise. Analysis did point to power as an issue for some participants, where they were unable to criticise or question professionals' decisions; that participants did not criticise the analysis could be a sign of the power differences between researcher and participants (see section 4.3.3 for further elaboration).

4.2.7 Evaluation of qualitative research

I followed the guidelines of Elliot et al (1999) for this research. They suggest firstly, 'owning one's own perspective', which involved disclosing my own assumptions and values, both before the interviews took place and as they became apparent as the interviews, analysis and write up progressed. This was done through the 'personal reflexivity' sections throughout the thesis. Secondly, 'situating the sample'. This included giving basic participant descriptive data. However, due to the wishes of some participants, this had to remain vague in the case of 'country of origin', as participants did not want me to disclose the exact country they were from due to persecution and continuing fear. Their third suggestion was, 'grounding the examples'. For this, two

specific examples of each theme were provided and an example of one transcription to show how themes were identified (see Appendix 7).

Next I provided 'credibility checks'. Initial analysis was shared with my thesis supervisor, who made comments, and five participants were shown the analysis and made comments (see section 4.2.5). 'Coherence' involved grouping together different sub-ordinate themes through the use of word boxes and arrows, which facilitated the generation of super-ordinate themes. This process was continually reflected upon throughout the analysis stage and the development of themes made explicit (see Appendix 8). The final suggestion was, 'accomplishing general vs. specific research tasks'. This research aims to develop a general understanding of asylum seekers' and refugees' experience of therapy. Eight participants were interviewed to enable the generation of multiple perspectives. However, it should be noted that participants in this sample came from different cultures and language groups, so any generalisations should be made cautiously.

4.2.8 Findings in the context of the literature

This section compares the themes to the literature on refugees and asylum seekers.

Studies have shown that many refugees and asylum seekers have experienced persecution, war and torture (United Nations High Commission for Refugees, 2006) something that was also found in this research. Fear, distrust, aggression and flashbacks have been discussed elsewhere as consequences of torture (e.g. Baker, 1990; Blackwell, 1989; Qouta et al., 1995), and was also talked about by participants.

The added distress that asylum seekers face when entering a host country has been outlined in the literature. Burnett and Thompson (2005) point to the multitude of difficulties faced by those entering a foreign country to seek asylum, such as, unfamiliar systems, cultures and language, issues of safety and multiple losses. Indeed, a significant factor in this research appeared to be the idea of talking to a stranger about one's problems, which many participants described as an alien concept and something that others persuaded them to try. Further, multiple losses and issues of safety appeared to be an issue for many participants in their discussions of loss of family and friends, fear of others, or situations, and fear of being sent to their country

of origin. This research suggests that, in addition to unfamiliar systems, culture and language, individuals might also experience alienation due to their own extreme events (e.g. 'no one will understand'), which could increase their experience of being 'different' from others.

The vast majority of the trauma research uses the diagnosis of Post Traumatic Stress Disorder as an indicator of improvements in therapy. It does seem that many of the symptoms associated with PTSD were talked about in this research. However, not all participants talked of all of the different symptom clusters and the symptoms of PTSD did not cover the scope of difficulties outlined by participants. The diagnosis of PTSD advocates that one of the indicators for a diagnosis is 'persistent avoidance responses to reminders of the event' (APA, 1994) but it seemed that some participants had actively sought out individuals to talk about their past, and for others, rather than being a symptom that had detrimental effect on their functioning, not thinking about the past was a significant part of the participants ability to move on. This is associated with the idea that the value and meaning placed on symptoms can be vastly different in different cultures (e.g. Giller et al, 1989; Woodcock, 1995; Zur, 1996).

Much of the trauma research has accorded disease status to symptoms associated with extreme events (DiSilva and Yule, 2001). Summerfield argues that by giving trauma responses 'disease' status the focus is on the individual's distress and social and cultural influence is ignored. This places blame on the individual for being unable to cope with 'their' distress (Bracken et al. 1997). I believe that this research goes some way to redressing these stigmatising views, as it shows that individuals who have experienced extreme events are able to overcome the many difficulties they have faced and are able to move on from their difficult past.

The use of psychotherapy with those from a non-Western cultural background has been criticised (e.g. Patel, 2002). However, authors have argued that there are certain needs that individuals have, which might aid recovery. For example, the need of human beings for each other (Birkett, 2006) and that in order to grieve people need to, on some level, think about their experience (Woodcock, 1995); psychotherapy might be a way for an individual to reconnect both to others and the past in a supportive and safe environment. It could be suggested that this research does lend weight to these

ideas. However, it goes beyond and suggests that once individuals have been able to reconnect to others and thought about their past they are able to move on and find a life that can be fulfilling and have meaning. Therapy seemed to be an avenue in which some were able to achieve this but therapy is not the only way in which this could be achieved. Further, as argued by Summerfield (1998b) many refugees and asylum seekers continue to be faced with the problems associated with cultural alienation, loss of status and broken social worlds, something that psychiatry and talking therapies do not have the solutions for.

4.3 CRITICAL REVIEW

In the following section I will critique the use of IPA with those of a different language group, and with refugees and asylum seekers. I will then talk about issues of power and difference as well as criticisms of this research. Implications from the research will follow, which will include implications for service developments, clinical psychologists and further research. I will end on a final reflexive note.

4.3.1 Recruitment issues

During the recruitment phase there were a number of considerations that were taken that influenced this research. Firstly, due to the nature of the asylum seeker/refugee experience (i.e. that they had fled persecution) it was important that issues of confidentiality was thought through. We decided that it was important for clinicians to both identify potential participants and to make the initial contact. However, this might have impacted on the research because, although it was made clear to clinicians that a broad range of client experience would be useful, the majority of participants described a positive experience of therapy. It could be that clinicians had not wanted to contact participants who had had a negative experience of therapy because they were concerned that it would reflect on their abilities as a clinician.

Secondly, three of the participants were still seeking asylum. Issues of asylum claim were discussed with the team and asylum seekers were included in the research because it was thought that a mixed group better reflected the population attending such services within the UK. However, again this might have impacted on the research. The asylum seekers might have agreed to take part in the research because

they believed it would look favourable in their asylum claim. They also might have believed that I could have a positive influence on their claim. Although participants did talk about their asylum claims as a difficult part of their life they did not appear to see participating in the research or myself as researcher as being able to influence it. However, if my assumptions were wrong their asylum seeking status would have impacted on what was and was not said within the research.

4.3.2 IPA and language

Familiarity with the English language was an influencing factor in this research. Four participants were fluent in English and although the other four participants did have a good command of the English language it was, at times, difficult for me to fully understand their speech. Although some interviews were affected by my ability to understand what participants said, the extensive time spent reading transcripts helped to clarify some meaning. Willig (2004) points out that IPA relies on language to capture experience. Participants' ability to describe their experience was influenced by the richness of language they had available to them. Smith (2004) argues that IPA research requires individuals to be able to reflexively articulate their experience, something that is more likely to be found in middle-class groups. These ideas indicate one of the limitations of this study.

Smith (2004) points out that interviewers need to take a stronger role in guiding participants who have difficulties with English. Extensive prompts were used when questions were not understood and a more directive approach was used for one participant to enable understanding. Also, attempts were made to use an interpreter in this research but due to the request of some participants and due to time and funding constraints, this was not possible. Although the language barrier is a limitation of the research, it was decided that it was important to carry it out and give a voice to those voices that are generally overshadowed by more dominant cultures.

Word meanings are interpreted differently with those who share a common language but this is accentuated when one is conversing with those of a different culture and language group. For example, it was interesting to note the use of Western psychiatric language by many of the participants (e.g. "flashbacks"; "depression"; "self-esteem"; and "anxiety"). Attempts were made to clarify participants meaning and long quotes

were used to give examples of the sub-ordinate themes, which gave readers a better outline of my interpretation of the data. Further, no attempt was made to analyse sections of the data if they were unclear.

4.3.3 IPA and the distrust of others

Trust issues were also an influencing factor in this research. The literature shows that distrust of others is a significant issue for those fleeing war and torture. Blackwell (1989) argues that individuals' sense of identity and safety in relation to others is fundamentally affected by torture. Most participants had fled their country of origin a number of years prior to the research, and most had been able to develop trusting relationships within this time. However, many talked about a continuing difficulty with trusting others, which also has implications for this research. I followed the recommendations of Elam and Fenton (2003) for 'researching sensitive issues and ethnicity' and time was allotted prior to the commencement of the interview to build rapport. I experienced the interviews as being open and was told by some participants that they had indeed felt able to talk openly with me:

> P8: "Sometimes I feel, why bother to talk to this person. Like we are talking now you told me this is your research you are doing on, I feel like comfortable to talk to, because the way you receive me from outside."
>
> P5: "You can see, I have that connection with the people, even you now, I have that connection with you, really, if it was me with some other person I would say like I cannot do this, so you are like one of those two."

However, it could be suggested that participants said this only because they felt powerless to do otherwise. Further, although past experiences were not part of the interview some participants talked freely about this but others were much more guarded. This could suggest that some participants felt more comfortable than others, which would have influenced what they might or might not have talked about. This is a general difficulty when researching potentially sensitive topics and for individuals whose experience has caused them to significantly distrust others, this must be pronounced.

4.3.4 Power and difference

Willig (2004) points out that the words chosen to describe an event will portray a particular version of that event. Individuals might choose to describe the event in an entirely different way depending on their audience. It could be said, therefore, that this makes it impossible to gain direct access to individuals' experiences. A story would be differently told when the audience is a friend, compared to a researcher because power dynamics between researcher and interviewee influence what will and will not be said (Smith, 1997). As mentioned above, this might be pronounced when interviewing those who have experienced extreme powerlessness through war and torture. For example, in the following quote I thought the participant was beginning to talk about her experience of therapy, which was my next question:

> P1: "I thought if you are sick with a cough you go to the GP, you expect him to give you the right medication to stop the cough. So that's what I thought, if I came to a therapist all my problems would go away. But that's not really what happens."
>
> R: OK, now the next questions are about your actual experience of therapy, so, if you knew someone was hoping to come to the same place for help how would you describe to them, what is psychological therapy?

If I were a more experienced interviewer I would have explored her ideas further. She might have been intending to criticise therapy and by ending the conversation by asking her a seemingly unrelated question this might have portrayed to her what was, and was not 'allowed' during the interview. Although some participants were able to criticise therapy, others and the asylum system, I wonder what stories they chose to share and what was not said. Differences between participants' age, class and ethnicity and my own were not discussed. Exploration of these issues might have broadened my understanding of the impact of difference on the research. Had the research been conducted by someone of a different background to my own the content of the transcripts and the analysis could have been quite different.

4.3.5 If I could do it again…

Bentall (2003) has stated that once a piece of research has been completed only then can one understand how it should have been done. If I had been more experienced in conducting research I would have taken certain things into consideration.

Firstly, I would have consulted with a refugee or asylum seeker in the development of the interview schedule and during the analysis stage. This would have made the process more collaborative and would have counterbalanced the possibility that the interview schedule and analysis was dominated by my white middle-class assumptions and biases. Consultation was considered during the research but unfortunately this was done once ethics had been submitted and due to time constraints it was not possible to take this forward.

Secondly, due to time constraints the analysis of the data began before I had finished interviewing participants. I found this influenced further interviews as I explored further what participants were saying when I thought it might be connected to developing sub-ordinate themes. I believe it would have been more beneficial to complete all of the interviews before beginning the analyses so that the later interviews were not biased by my assumptions.

4.3.6 Implications

The following section will illustrate how the analysis has positioned my current views on implications for service improvements, clinical psychologists and further research.

4.3.6.1 Implications for service improvements

This research suggests that the current cultural perceptions of refugees and asylum seekers within the health system should be changed. Generally those who have experienced war, torture and exile are viewed as individuals with highly complex and long-term difficulties. According to Kmietowicz, (2001), at a conference arranged by Amnesty International it was suggested that doctors were refusing to see refugees and asylum seekers as they feared they would be overwhelmed with demanding and time consuming patients (Kmietowicz, 2001). Dr Ann Sommerville, head of medical ethics at the BMA, said, "We have heard that some primary health practices are being overwhelmed and are being tempted to discriminate against asylum seekers. But the BMA has warned its members that to act in this way could be a violation of the Human Rights Act." (Kmietowicz, 2001: p. 653). This research has shown that people who have gone through extremes of experience show determination in their wish to find

solutions to their problems, can move on from their difficult past, and can find lives that are meaningful.

PTSD is now commonly viewed as a disease (Summerfield, 1999), which suggests negative outcomes for those diagnosed. Long-term outcomes research appears to focus on the difficulties refugees continue to face (e.g. Holbrook et al, 2002; Silove et al, 2007), rather than focusing on what has enabled them to live with these difficulties and, in some way, to recover. This culture encourages the perception that long-term outcomes are negative. This research, however, suggests that individuals have resilience and can find lives that are meaningful to them. The NHS has begun to embrace recovery ideas throughout the mental-health system. Although there are some services, such as the one in which this research was conducted, where these ideas have already been integrated, I would suggest that this should be extended to all services for refugees and asylum seekers throughout the NHS. A change of focus from disease to recovery will ultimately help individuals to recover, which will ultimately help with the limited resourses of the NHS.

4.3.6.2 Implications for therapists

This section discusses the implications of the analysis for professionals working with refugees and asylum seekers therapeutically. Analysis suggested that talking to a stranger about one's difficulties was an alien concept for individuals within this research. Participants talked of the need for others to persuade them that therapy might be useful; therapists might find the use of advocates or the voluntary sector, which generally have close links to particular refugee groups, useful when attempting to develop relationships. Further, according to participants, they had developed fear and a distrust of others and a belief that others would not understand them. Therapists should be mindful of this and work with individuals to attempt to understand the impact this will have on the therapeutic relationship.

Many participants talked of the difficulty of sharing their extreme experience, where remembering was described as making a "black heart" [...] "more heavy." Participants also talked about the difficulties of sharing stories with a therapist whom they did not trust. It is important for those working with people who have experienced extreme events to be aware of these issues. It could be suggested that this is connected to the

importance of 'client-led' sessions, where therapists should make it explicit that it will be useful for them to hear stories, so they can think with clients about formulations, but that this should be done at a pace that is comfortable.

Therapy appeared to be a fundamental part of most participants' recovery, and a good therapeutic relationship that involved listening, empathy and confidentiality, was integral to this. Some have argued that the therapeutic alliance, of which these facets are essential, is sufficient for therapeutic success (Rogers, 1951). However, participants in this study talked about the importance of the therapist taking a more active role. It was important for participants to hear advice, be offered psycho-education, and hear others' recovery stories, which enabled them to build positive thoughts about the self and future and allowed them to move on. It seemed that for one participant the reason why she ended therapy was because she wanted "action." It could be argued that therapists should be more explicit about the process of therapy: that it might begin with a more general gathering of information to enable the therapist to formulate difficulties, and then, depending on the orientation, might include therapist and client working together to overcome difficulties practically.

'Active forgetting' was a significant part of participants' ability to move on. It seems that therapists encouraged them to talk about the past, so they could challenge some negative beliefs, such as the belief that they were somehow to blame for what had happened to their family. Blaming oneself for the past would have been something affecting participants' recoveries so the benefits of challenging such assumptions can be seen. However, it seemed that once individuals had accepted the past and realised that it could not be changed some found it important to be able to 'actively forget', which enabled them to move on. 'Active' forgetting could be easily pathologised by therapists. For example, those working from a psychodynamic perspective might argue that this is a form of denial. I believe it is important for us to familiarise ourselves with the literature focused on working with those of different cultural groups, as for some cultures, forgetting about the past might be a coping strategy that is embedded within their cultural beliefs and any criticism of this might impact on the outcome of therapy.

One final thought here relates to the power dynamics that were alluded to by some participants. As healthcare professionals this research reminds us to be constantly

aware of our position of power, especially when working with those whose previous life experience might have been one of extreme powerlessness.

4.3.6.3 Implications for further research

As with all qualitative data, analysis creates further questions and so implications for further research will follow. Participants' stories suggested that their perceived difficulties were generally related to intra-psychic, social, cultural and political issues. Interpretative phenomenological analysis and a critical realist epistemology advocate that individuals are able to give accounts of their own experience (Larkin et al, 2006). However, qualitative research with refugees and asylum seekers is lacking in the literature. Studies that do exist go some way to redress the imbalance for those who have generally had their voices subjugated. Qualitative research exploring what are refugees' and asylum seekers' perceived difficulties, rather than difficulties assumed by the dominant cultures, will give a clearer understanding and help to focus services enabling them to become more client centred.

This research found that those who have experienced extreme trauma can 'recover'. Recovery stories positively influenced participants' outlook on their own future. Further research could attempt to interview those who have not presented to therapeutic services to find out what enabled them to survive and move on with their lives. These stories can then be shared with others. This will not only help individuals but will help to challenge the wider societal perception of refugees and asylum seekers as individuals with complex, entrenched long-term difficulties.

The majority of the participants in this study had completed therapy and suggested that therapy had a significant impact on their recovery. However, this could have been for a number of reasons. Firstly, clinician biases might be implicated, where clinicians only approached potential participants who had good outcomes. Further, it could be suggested that they were a self-selecting group, where only individuals who had good outcomes agreed to the research. Other research has shown that many refugees and asylum seekers have not benefited from psychotherapy (e.g. Baluchi, 1999, Mollica et al., 1990). Further research could examine the reasons why some individuals do not want to attend therapy or why some do not complete it. Further understanding about

what draws some refugees and asylum seekers to therapy and what deters others from attending, would help us to think about service development.

4.4 Final reflexive note

4.4.1 Being overwhelmed

I was told to expect to be shocked by participants' stories but I was unprepared for the extent to which it affected me. My reflexive diary states, 'I feel exhausted. Listening to their stories brings a sense of hopelessness for me. It makes me feel there is danger all around, is this transference? I need to keep reminding myself that this country is relatively safe and it is highly unlikely something will happen to me or [my son]'. I found it difficult to hear stories and felt overwhelmed by the experiences some had faced. I wondered about the effect this has on those working in the health service and to what extent this influences the label of refugees as being difficult – is it perhaps professionals' difficulties of hearing stories and feelings of being 'overwhelmed' rather than refugees per se?

4.4.2 Strength and resilience of participants

I want to end this thesis with a focus on the strength and resilience of participants, and their wish to recover, which had a profound effect on me. My reflexive journal states, 'I was moved by P8's strength and positive thinking. She had experienced extreme hardship but had managed to turn this into something positive, "what doesn't kill me makes me stronger"'. Perhaps, however, my initial reasons for wanting to interview a stigmatised and marginalised group created an unconscious wish to want to portray individuals in a favourable light, to somehow counterbalance the unjust way asylum seekers and refugees are sometimes described in the media. It did seem that once I had made a 'road to recovery' interpretation of the data I held strongly to this view. I did make some attempts to arrange themes in different ways but was perhaps influenced by my wish to make this a positive piece of research. As with all pieces of research our biases and assumptions are implicated in the interpretation of the data. However, participants did agree with my analysis so I end this research being pleased that it portrayed 'survivors' and not 'victims' of extreme events.

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APPENDICES

APPENDIX 1 – Information sheet

A STUDY EXPOLORING VIEWS OF THERAPY

INFORMATION SHEET

University of East London

Department of Clinical Psychology: Romford Road, London, E15 4LZ

Below are some answers to questions that you might have about the study to help you decide whether you wish to take part.

What is your research about? The aim of the study is to explore the ways that people who are refugees experience therapy at a primary care service. This information can then be used to influence or change future services offered to refugees.

Why am I being asked to take part in the research? I believe that it is important for us to ask people about their experience of therapy so that this information can help us to think about what has been useful, or not.

If I agree to take part in the research, what will I have to do? If you agree to be involved you will be asked to take part in an interview. It will last for approximately one hour, and will be held at a time and location that is convenient for you. I will ask you about your expectations of therapy before it began and also about your experience of therapy. For example, what was helpful and what was less helpful.

Do you have to tape record the meeting? It would be difficult for me to listen carefully to what you are saying and, at the same time, make accurate notes of our conversation, so I will need to tape record the interview. All tapes will be kept secure, and at the end of the research the tapes will be destroyed.

How will what I say be kept confidential? All the information collected in this study will be kept in a secure place. The material from the tape will be transcribed (it will be written down) and this information will remain anonymous (I will not use your name in the transcriptions and I will change any other material that may identify you). If I quote from your interview in the write-up of the research or in any published articles I will ensure that what I use will not contain any identifying information.

Will what I say be shared with any individuals involved in my care? The interview is confidential and no information will be shared without your permission, unless anything in our conversation indicates that serious harm may come to yourself or anyone else, in which case I would need to follow the procedures of the NHS. However, you will be fully informed of this. After I have written up the work it will be available for others to read, but as I mentioned before all the information will be anonymous.

What happens if I agree to take part then change my mind? If at any point you decide that you no longer wish to take part you can stop the interview (or withdraw from the study) at any time without giving a reason; this will not affect your treatment in any way.

What will I get out of taking part in the research? I will send you a written summary of my findings once the research is completed. You may also request a copy of the written version of your interview.

In addition, I believe this research will provide useful information that can be used to influence future therapeutic services for refugees.

If you are interested in participating in this study, or would like any more information, please let either your clinician or myself (Joanne Stuart) know. You can contact me on (phone numbers). I look forward to hearing from you.

APPENDIX 2 – Interview schedule

Expectations of therapy

1. Before you came to see the therapist what was your understanding of Psychological therapy?

   Prompts:
   - How did you think it might help?
   - Expectations?
   - Concerns/fears?
   - How is it similar/different to what you would do in your own culture?

Experience of therapy

2. If someone you knew was hoping to come to the same place for help, how might you describe to them what is 'psychological therapy'?

   Prompts:
   - How would you describe your experience of therapy?
   - Tell me about the role of the therapist.

3. What did you find helpful or not?
   - **Prompts:** What did you enjoy most about the meetings? What did you enjoy least? What did the therapist do that was helpful/unhelpful? What did you do that was helpful?

4. What do you think was particularly helpful about coming to see the therapist?
   - **Prompts**: relationship with therapist, how therapist made you feel, coping strategies, advice given, talking about the past, talking about emotions, talking about yourself/family members/ community members, etc.

5. How did your experience of therapy impact on your life?

   Prompts
   - Which aspect of your life?
   - Which level: symptoms, distress, hope, family, parenting, functioning in social/family roles, in the community, etc.

6. What is your understanding about why the therapy ended?

   Prompts:
   - How did you feel when therapy ended?
   - Why do you think therapy ended?

7. Having gone through therapy has your understanding of therapy changed?
   - **Prompts:** you mentioned at the beginning of the interview that your expectation of therapy was…….. is this now different? If yes – in what way?

8. In your own country/culture/community (find out the word they would use). if someone had psychological problems, who would they go to for help?

   Prompts: e.g. talk to family, go to see a religious leader or elder.

APPENDIX 3 – Updated Interview schedule

Expectations of therapy

1. Before you came to see the therapist what was your understanding of psychological therapy?

   Prompts:

   - How did you think it might help?
   - Expectations?
   - Concerns/fears?

Experience of therapy

2. If someone you knew was going to see a therapist (find out the word they would use), how might you describe to them what is 'psychological therapy'?

   Prompts:

   - How would you describe your experience of therapy?
   - Tell me about the role of the therapist.

3. What do you think was particularly helpful about coming to see the therapist?
   - **Prompts**: relationship with therapist, how therapist made you feel, coping strategies, tasks, advice/information given, talking about the past, talking about emotions, crying, talking about yourself/family members/ community members, etc.
   - What exactly did the therapist do that was helpful?

4. What part or parts of therapy did you find difficult or least helpful?
   - **Prompts:** Was building trust difficult? Was talking about the past difficult? Why? What aspect of therapy did you think was not useful to you? What did you enjoy the least about therapy? Was there anything else you would have liked the therapist to do that they did not do?

5. How has your life changed since you had therapy?

   Prompts

   - Which aspect of your life?
   - Which level: symptoms, distress, coping, hope, family, parenting, functioning in social/family roles, in the community, etc.

6. What is your understanding about why the therapy ended?

   Prompts:

   - How did you feel when therapy ended?
   - Why do you think therapy ended?

7. Tell me in your own words what going to see a therapist (use their word) was like?

8. What sort of problems do you think could be helped by a therapist?

   Prompts: e.g. anxiety, worrying, bad thoughts.

9. In your own country/culture/community (find out the word they would use), if someone had similar problems, who would they go to for help?

   Prompts: e.g. talk to family, go to see a religious leader or elder.

APPENDIX 4 - University of East London Ethical Approval

Dr Nimisha Patel
School of Psychology
Stratford

ETH/09/44

06 October 2009

Dear Dr Patel,

Application to the Research Ethics Committee: Adult refugees (J Stuart)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Administrative Officer for Research
d.dada@uel.ac.uk
02082232976

Research Ethics Committee: ETH/09/44/0

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date: .....

Please Print Name:

APPENDIX 5 - Barking and Havering Local Research Ethics Committee

Barking and Havering Local Research Ethics Committee
Room 7, 2nd Floor
Becketts House
2/14 Ilford Hill
Ilford
Essex
IG1 2QX

Telephone: 0208 9265025
Facsimile: 0208m926 5009

22 August 2008

Ms Joanne E Stuart
Trainee Clinical Psychologist
University of East London
Clinical Psychology Department,
University of East London,
Romford Road, Stratford
E15 4LZ

Dear Ms Stuart

Full title of study: **An exploration of outcomes of psychological therapy for refugees attending a primary care service.**

REC reference number: **08/H0702/53**

Thank you for your letter of the 17th August 2008 responding to the minor amendments requested by the Committee. These have been noted and filed and I am pleased to confirm that this study has been approved by the Committee.

The Committee looks forward to receiving a final report of your research findings in due course.

With best wishes

Yours sincerely

Janett Carter
B&H REC Coordinator

APPENDIX 6 – Consent form

A STUDY EXPOLORING VIEWS OF THERAPY
PARTICIPANT CONSENT FORM

Please read this form carefully, tick the boxes and sign below if you willing to take part in this research project. Researcher: Joanne Stuart, Trainee Clinical Psychologist, University of East London.

Please tick the box

I have read and understood the information sheet and have been given a copy to keep.	☐
I have had an opportunity to ask any questions and discuss the research.	☐
I understand that the interview will take approximately 1 hour and I can take a break at any time.	☐
I understand that the information given by me in the interview will remain confidential, unless there is an indication of serious risk to myself or others.	☐
I understand that information from the interview will be used in a final report and may be published in a journal, but that any extracts used will be anonymous (e.g. names and identifying details will be changed).	☐
I understand that in signing this form I am giving my consent for the interview to be audio-taped, but that the tapes will be destroyed once the research is complete.	☐
I fully and freely consent to participate in this study. Having given consent I understand that I have the right to withdraw at any time. If I do withdraw I do not have to give a reason and this will not affect my treatment in any way.	☐

Participant's name (capitals) .....

Signature: .....

APPENDIX 7 - Example of one transcript that demonstrates the development of sub-ordinate themes (due to issues of confidentiality I have chosen 2 parts of the interview (pages 4 and 5, and 9,10 and 11)

	151	be able to help you because they hadn't gone through the same	
	152	experiences as you. Did you have any kind of fears about coming to	
	153	the therapist, or other concerns about coming to the therapist?	
	154		
	155	P2. Yes, like I said earlier, my main concern was like they wouldn't	
	156	understand me or they would judge me, . that	
	157	kind of thing, that was all my concerns.	
	158		
	159	R. OK whether or not they would judge you. OK, did you have any kind	
	160	of expectations or hopes about therapy?	
	161		
	162	P2. Yes, I hoped it would solve my problems actually. Yes. I thought	
	163	that if it's like if you are sick and you're sick like maybe with a cough	
	164	you go to the GP you expect him to give you the right medication to stop	
	165	the cough. So that's what I thought I thought if I came to a therapist all	
	166	my problems would go away. But that's not really what happens. Yes.	
	167		
	168	R. Em OK now the next questions are about your actual experience of	
	169	therapy. So the next question is: If someone you knew was hoping	
	170	to come to the same place for help how would you describe to them,	
	171	what is psychological therapy.	
	172		
	173	P2. Can you repeat that question please?	
	174		
	175	R. Yes. If somebody you know was going to come to the same place,	
	176	someone from your community was going to come here to see a	
	177	therapist, how might you describe to them what it is, what	
	178	psychological therapy is.	
	179		
	180	P2. Basically I would tell them it's, a face to face communication	
	181	whereby you, you can go and cry as much as want, a therapist will	
	182	always be there for you, they will listen to your cries, if you want to go	
	183	and cry you will cry and you remove out the anger. If you have the	
	184	problem they will listen to you and give you advice on how to deal with	
	185	it because that's exactly what happened to me. Yes. So I would basically	
	186	say yes, go for it, because I was scared and I did it and I am now better.	
	187	Yes	
	188		
	189	R. Em can you tell me a bit about, how you see the role of the therapist.	
	190		
	191	P2. That is a tricky question.	
	192		
	193	R. I suppose maybe we can say what did she do that was helpful?	
	194		
	195	P2. Yes, she set me like tasks she would tell me, because I had problems	
	196	like facing up to some problems in my past and she would set me like	
	197	tasks and tell me go and try this and see how it works out. So I would go	
	198	and do it and try to do it actually. Then the next time I saw her I would	
	199	come and tell her how it went. So I think those tasks helped me so much	
	200	to overcome my problems and fears. Yes. Because I had a problem with	

[redacted]

R. So em so this question is kind of connected to it. Em, what did you find most helpful about the therapy. You said it helped you to let go, what else?

P2. It also helped me to, because I thought like I said, I thought if I did therapy all my problems would go, but it really showed me that that's impossible and that I have to live with those problems, I have to keep them at the back of my head and move on and do something new. Like. That problem would always be there, like in my situation I have those nightmares, I had flashbacks of the war and everything. I couldn't erase those things from my head, but that's what I wanted when I went to therapy. But that was impossible to do because it happened to my life, it couldn't be erased, so she helped me see that, that it's impossible to be erased and that I had to move on, because, basically, myself I was like, saying I can't move on with these flashbacks in my head every time. But she helped me to see that, no way, you can move on even if those flashbacks are there. They will always be there whatever you do, whenever you see a problem you will always remember your past. So, yes, she really showed me that you can move on even though you have problems, but you can still move on and make a better life for yourself.

R. And you said also about crying, being able to come and cry and feel like she would always be there.

P2. The first days I was like hesitant to talk to her about exactly what had happened to me in my past and she told me you can come and just cry if you want, and I was like every time I started speaking about my past I would just feel tears coming and anyway, I didn't spend the whole session crying but she told me I'm hear to help, if you want to cry for the session come and cry if it's going to make you feel better, because most people they are like saying, 'Oh I wouldn't cry over that', but if you cry sometimes it helps you a lot to release the pain, yes, so she told me you can cry as much as you want for the whole session and I wouldn't mind, you don't need to talk every time, you can decide to come and cry. Yes, so it helped me.

R. OK. What, erm, was there parts of the session that you felt maybe was not so helpful or what part of the session did you enjoy the least.

P2. (5) Erm, (4) I don't know really, because like if I hadn't stopped myself I felt like I was getting addicted to those sessions. So in the long run they helped me. So I couldn't think of, the least that I could say

401 to make friends and trust people. I can talk to them, although I don't talk
402 to them my secrets, like what happened to me in the past, but I am able
403 to talk to them, make friends with them, invite them to my house, just for
404 tea or something. Yes, I am beginning to get to trust back , to come easy
405 on people.
46
407 R. To what sorry.
408
409 P2. To come easy on people.
410
411 R. To come easy on people.
412
413 P2. Because before I couldn't it, I was like scared, anybody who came
414 to my house I couldn't trust them. Yes.
415
416 R. And what do you think it was about the therapy that allowed you to
417 be able to start to trust others again?
418
419 P2. I wouldn't say trust.
420
421 R. To be a bit, how did you describe it, be a bit easy?
422
423 P2. Yes, like, be a bit easy on people, or have more people skills maybe,
424 that kind of thing. Yes but
425
426 R. What do you think it was about the therapy that helped with that?
427
428 P2. (5) Erm Let me see, (5) I'm looking for the right words for it. (4)
429 Em I think talking to the therapist about my relationship problems, my
430 trust issues with people, especially from my country, she made me
431 realise, like not everybody is the enemy. Do you see what I mean,
432 because I believed that everyone from my country was the enemy?
433 Because I didn't know who I was speaking to I didn't know which tribe
434 person I was talking to where they [name of tribes], I didn't trust them or
435 even other people, I didn't know if they would laugh at me when I told
436 them about my problems, like my neighbours, the community where I
437 live. So I think when I talked to the therapist, she helped me see that not
438 everybody is that bad like I thought they were. OK, they might have
439 been bad in my country but not here. Yes. Because here nobody knows
440 about me really, so, I think, I don't know how I can put it but she helped
441 me to overcome my trust issues anyway.
442
443 R. How did she do that, was that by talking about it, were you able to
444 say how you were finding it difficult to talk to others and she was
445 able to say to you, but they don't know anything about you, or
446
447 P2. That kind of thing, yes, that kind of thing and she then told me to try
448 things like talking to somebody, not exactly confidential issues, but
449 talking to somebody, something which I wouldn't talk to everyone about,
450 so that kind of thing.

relying on therapy
relying
relying on the past

451		
452	R. Trying it out.	
453		
454	P2. Trying it out, so I managed to talk to a couple of people and nobody	Trying things out
455	returned that same information, so I felt like, yes, I could trust someone.	
456	Yes.	
457		
458	R. OK. Thank you. Now, so we have just got the last couple of	
459	questions. So what is your understanding about why the therapy	
460	ended?	
461		
462	P2. I didn't want it to end anyway [Laughs] but em I think she assessed	
463	me after a while and according to how I had come the first time she	
464	assessed me to that period and she saw that I had made some progress,	Outcomes
465	because every time I would come to the session I would tell her what I	
466	had done in the previous week or in that week, how I had progressed,	Outcomes
467	what I had done with myself, a difference I had made, so I think she	Outcomes
468	looked back to how I came in the first time and even though I was	
469	speaking in the sessions in those last days I was more confident to talk to	
470	her than before, because before I was like hesitant to tell her anything of	
471	my life. So I think she judged all those things and she told me maybe	
472	it's time for me to let go, but before she told me before she let me go is	letting go of therapy
473	that if I had any problems I can still come back to therapy. Yes.	
474		
475	R. And that was helpful.	
476		
477	P2. Yes, that was helpful because I thought that, Oh if I felt bad again,	
478	I'm able to go back, it is not that it is finished. Yes. But she pushed it so	
479	much so that I can try as much as possible not to rely on the therapy so	moving on
480	much and start to move on with my life. Yes.	
481		
482	R. OK Em. So having gone through therapy, now you've gone through	
483	it and you have come to the end, em, you mentioned at the beginning	
484	of the interview that your understanding of therapy was that you	
845	would em talk about your past problems and maybe it would help	
486	you to face your demons. You were kind of hoping for em that it	
487	would take all of your problems away, em, so in what way has your	
488	understanding of therapy changed now.	
489		
490	P2. Oh God. I believe therapy will help you in at least 80% of what you	
491	believe, because, (9) anyway [laughs] it can't take out everything, but it	no magic wand.
492	can help you move forward from your experiences, your problems. It	
493	can help you do that, but of course, it can't make you forget what has	moving on
494	happened to you in the past, that's what therapy can't do it's always	realization
495	going to be there, you like it not. But what therapy can do is help you	
496	move on, forget about the past just move on and start a new beginning	outcomes
497	instead of relying too much on the past because at the end of the day,	moving on
498	therapy says that, 'no don't rely on the past', otherwise nothing is going	
499	to happen to your life, you will always stay in the dark about your	
500	troubles. So I believe therapy is just there to help people move on,	

"I managed to ...

Trying things out & moving on; difference I had made; made progress; progressed; I shared my what I had done

I was more confident to talk

Keeping things in = hesitant

Time for me to let go; she let me go

Don't rely on therapy & move on with life.

Someone I can if I need them

no magic wand but can help you to move on; can't make you forget; the past will always be there

basically, move on from what has happened to them not rely on, keep on saying, 'Oh I have this problem I can't move on', that kind of thing, so it is there to help people move on from their problems and start new beginnings, really.

R. And kind of accept that things aren't going to be, you are not going to forget the past, but you can cope with life and move on.

P2. Exactly

R. And give you tasks to help you do that, and all that is done in a trusting relationship, with

P2. Yes it has to be a mutual relationship between you and your therapist otherwise if you don't have trust with your therapist if the relationship is not good nothing is going to be solved. I was lucky I met my therapist who was trustworthy and I had a very nice mutual relationship with her. She understood me, I understood her, we understood each other, like the communication was very easy for us. So I think that one as well contributed to my success, I would say, in achieving my goal after my problems.

R. And that was, and she em, I mean it sounds like that trusting relationship was the most important part of it, and then everything else could happen after that.

P2. Yes, I think so.

R. If you did not have the trusting relationship in the first place then...

P2. Nothing is going to happen no.

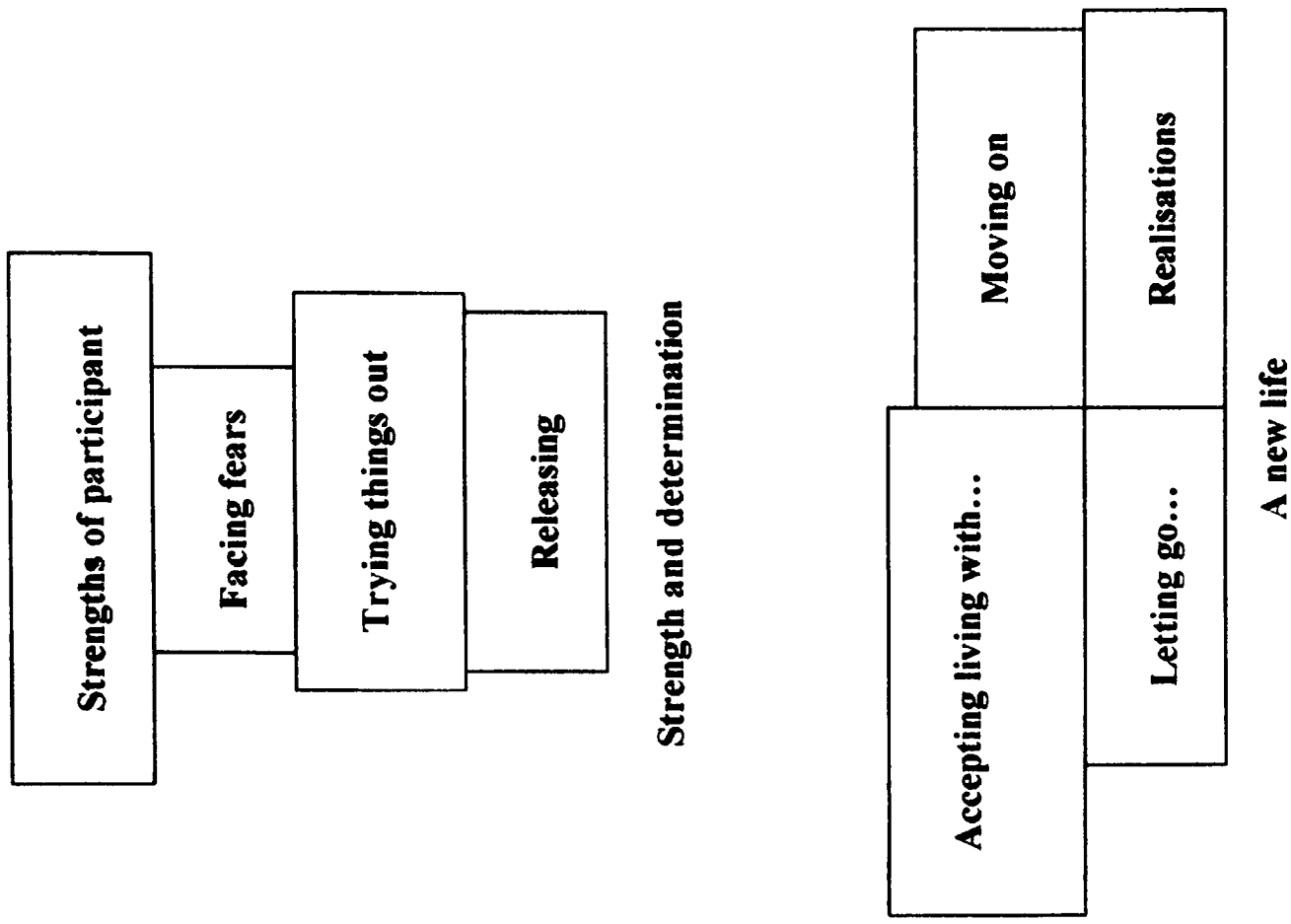
R. And that was by her talking about confidentiality? being not judgmental?

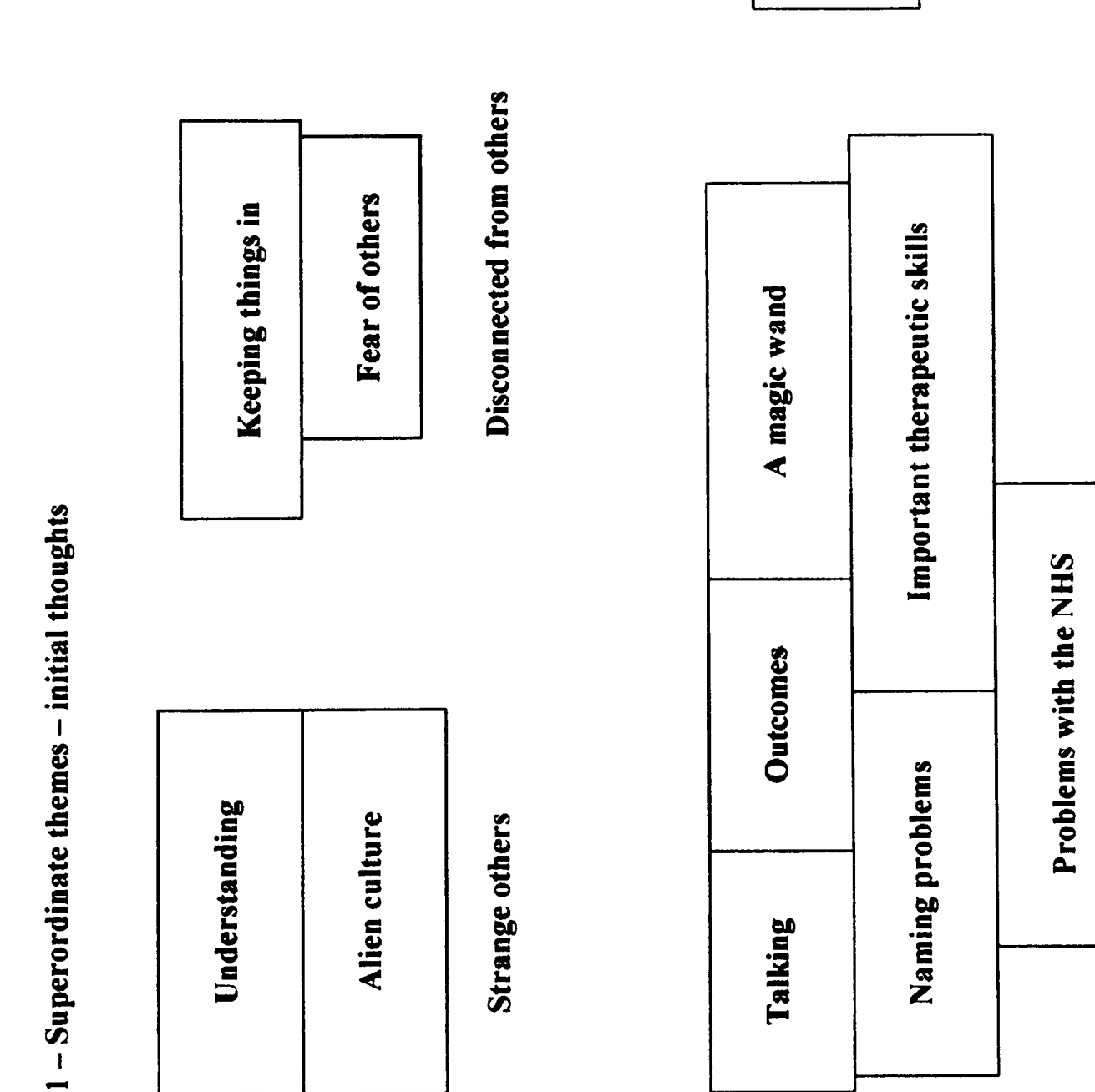
P2. And just being there for you and listening to your troubles. My therapist, personally, she listened to me sometimes I wanted her to just listen to me and not give me advice, and she did it perfectly well, because I just wanted to talk to somebody who would listen and not judge me like saying, 'Oh you wouldn't have done that, or you wouldn't have done that', that kind of thing. She just listened to me and she was like sympathetic, she never even once judged me, so that made my life so easy with communicating with her. So. Yes, I believe if you have that trust, that trust is the most important thing. Without that trust nothing is going to be solved. Yes.

R. And it sounds like for you that had an impact, the therapy had an impact on lots of different kind of levels of your life, it had an impact on, ..., it had an impact on, kind of, your relationship with yourself. Enabling you to be with yourself and not

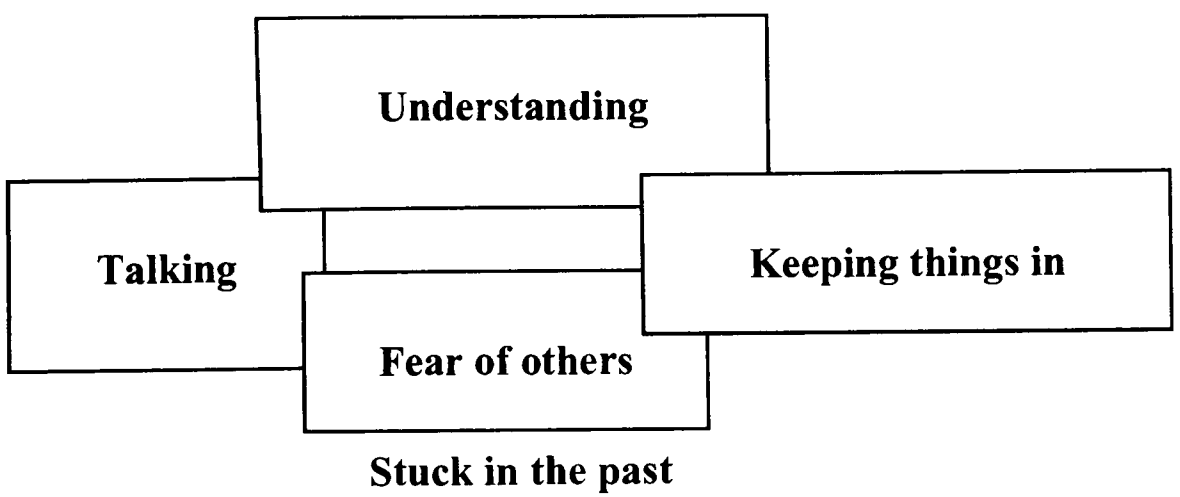
APPENDIX 8 – Development of super-ordinate themes

Please note: red indicates new themes identified and arrows indicate connections

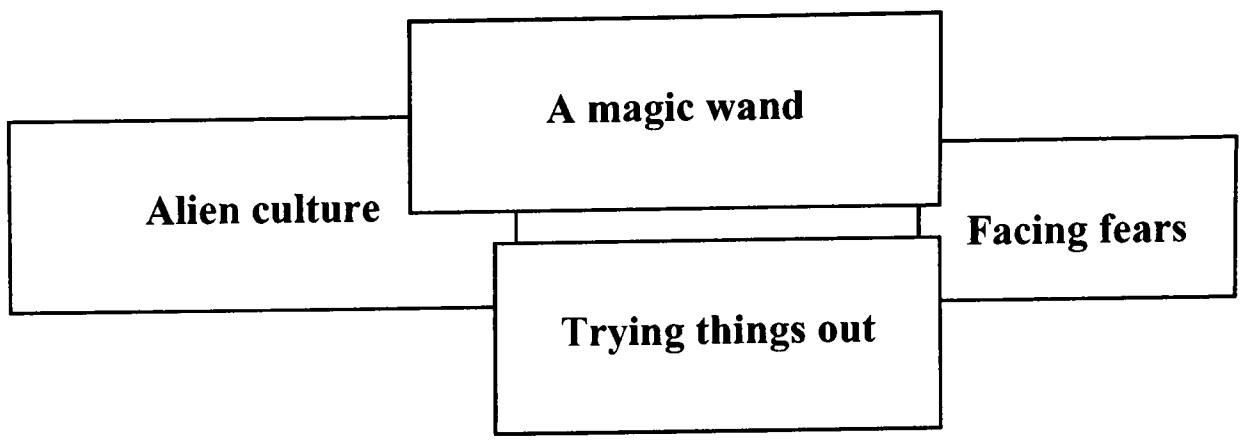




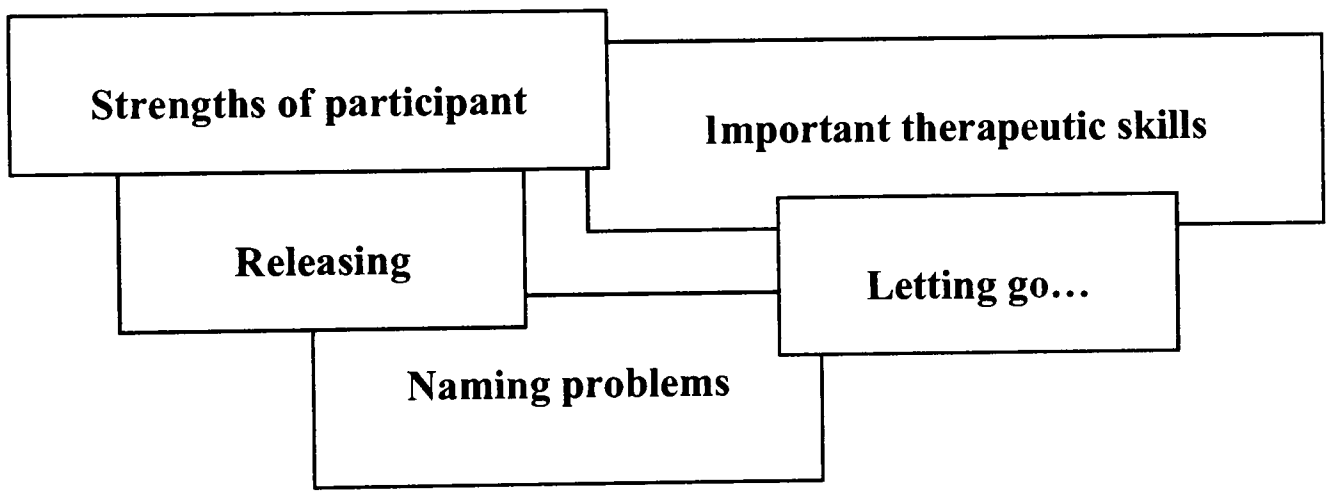
Super-ordinate themes 1 – for P1



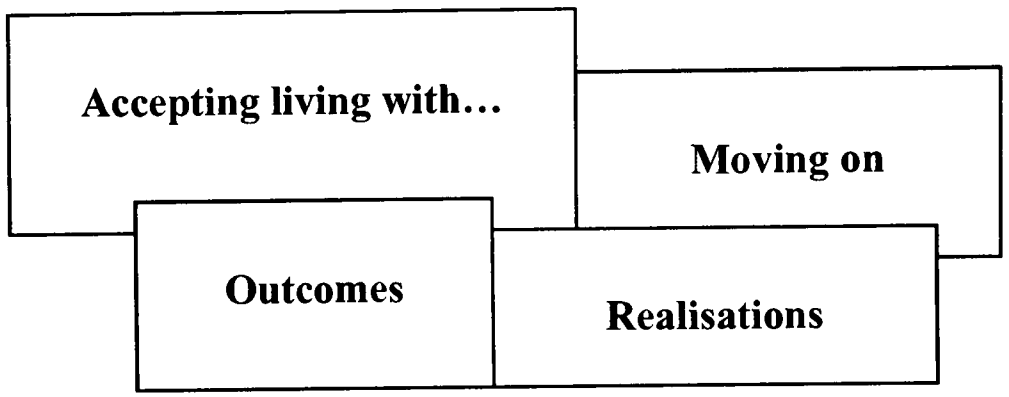
Stuck in the past



Searching for a solution



Helping me to move on….

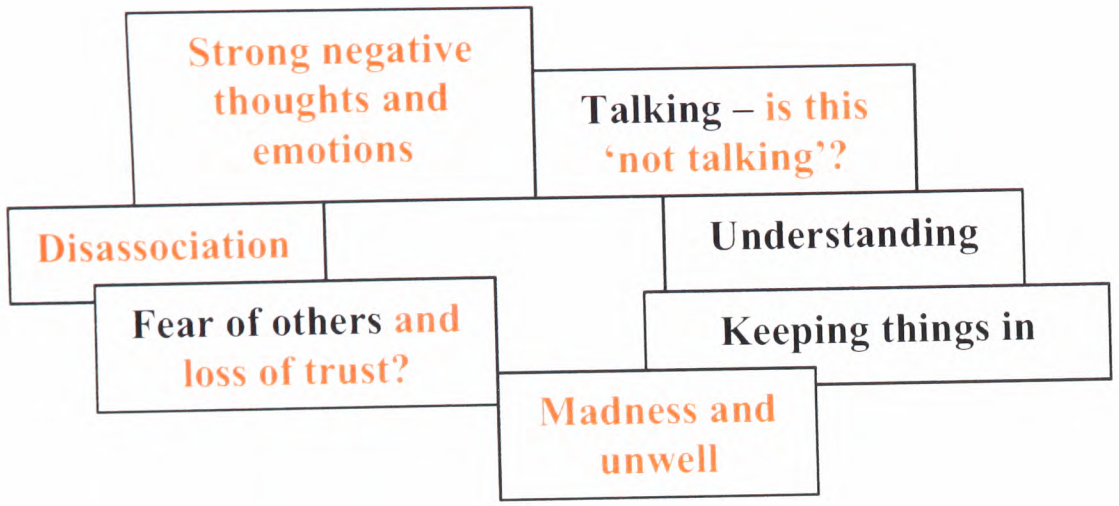


Moving on

Problems with the NHS

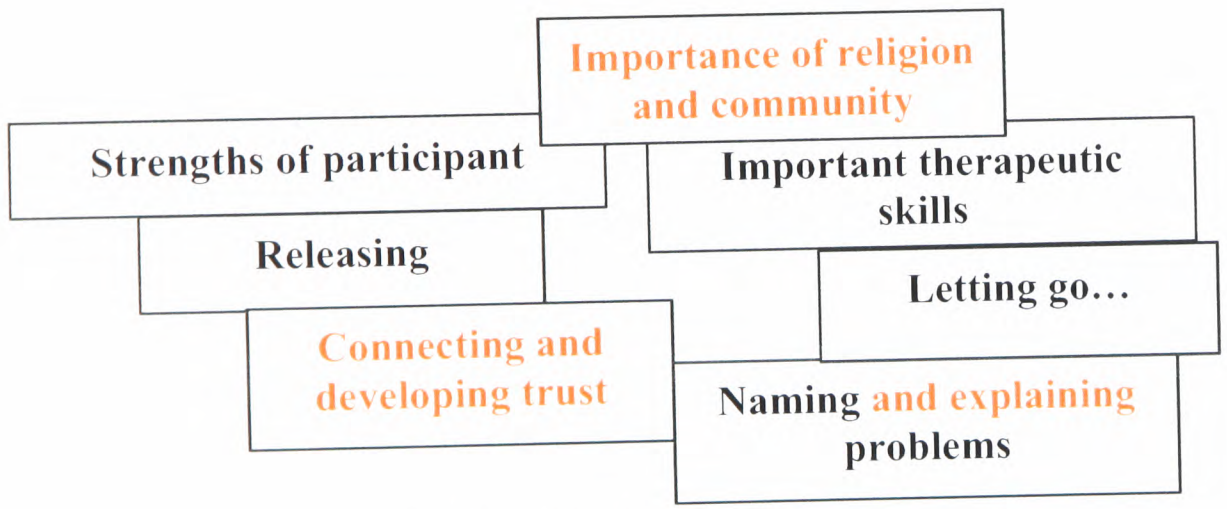
Thinking of others' needs

Super-ordinate themes 2 – for P3

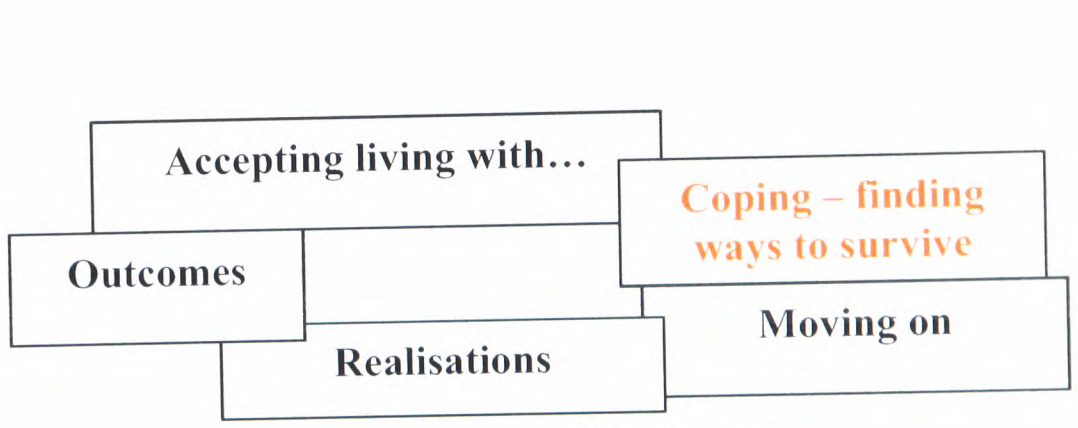


Stuck in the past

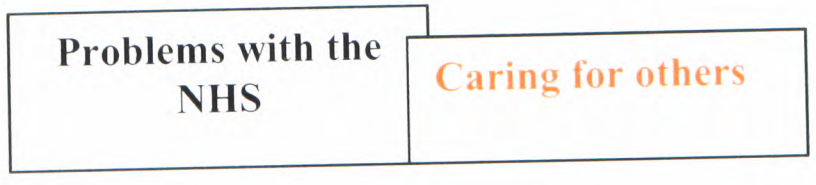
Searching for a solution



Helping me to move on….

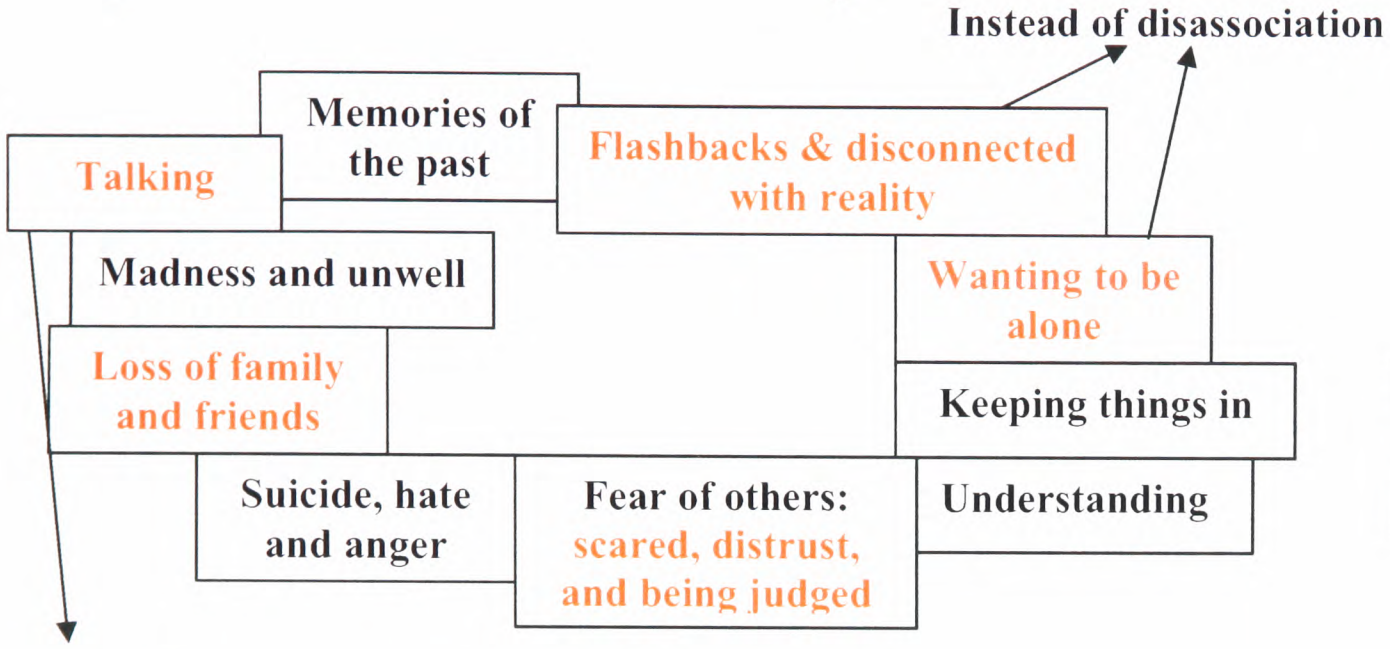


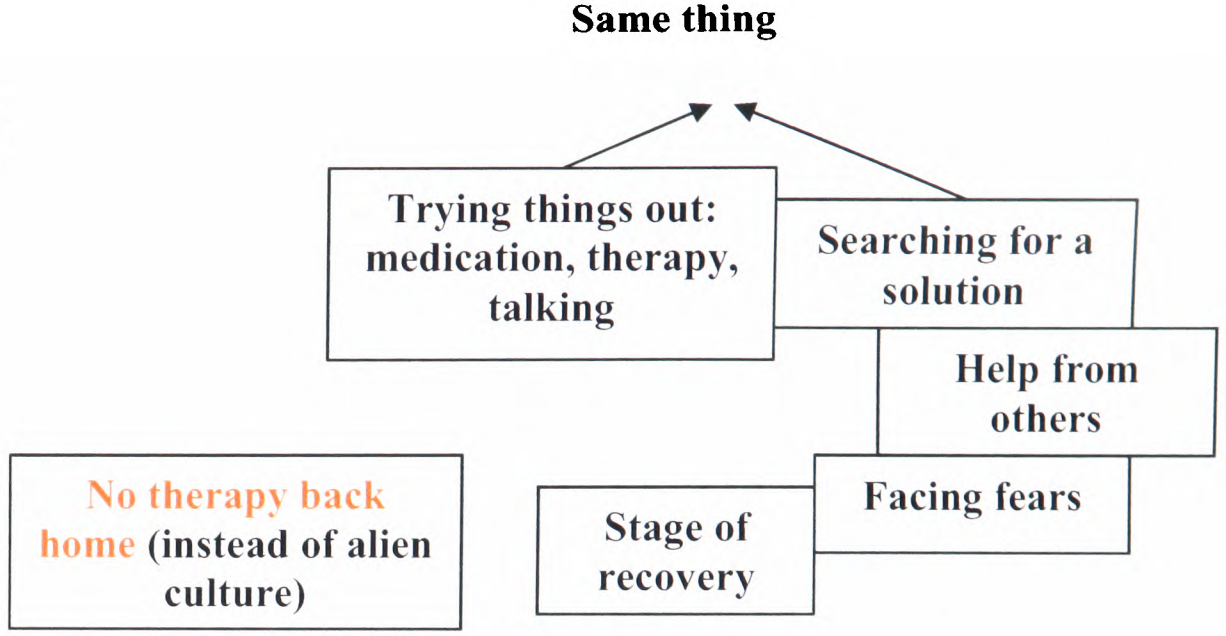
Moving on

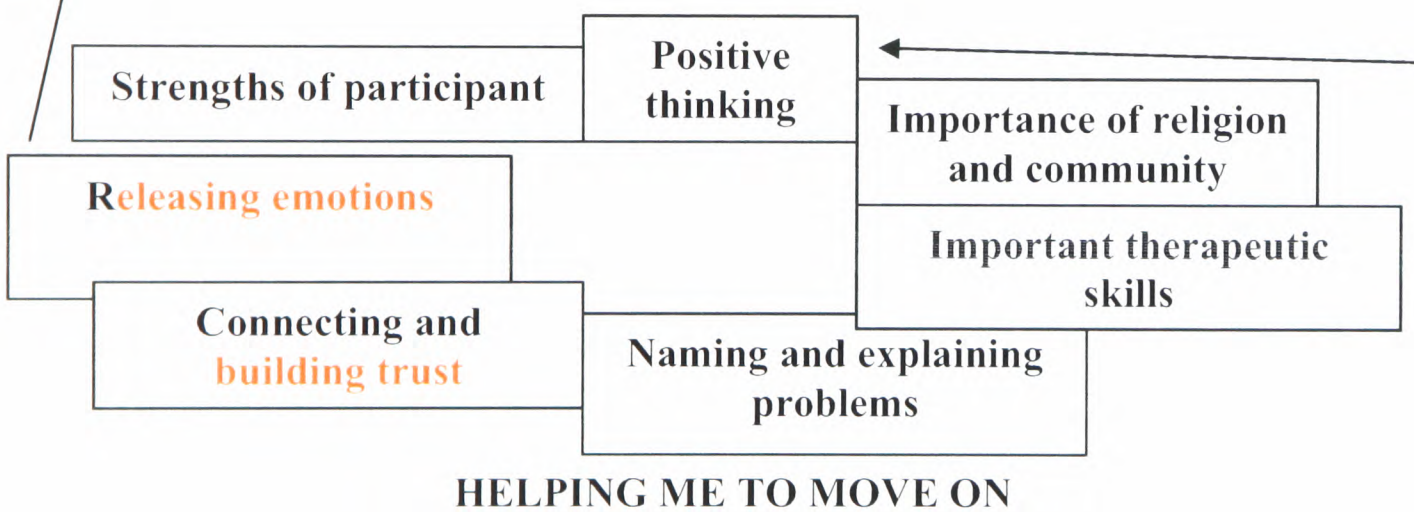


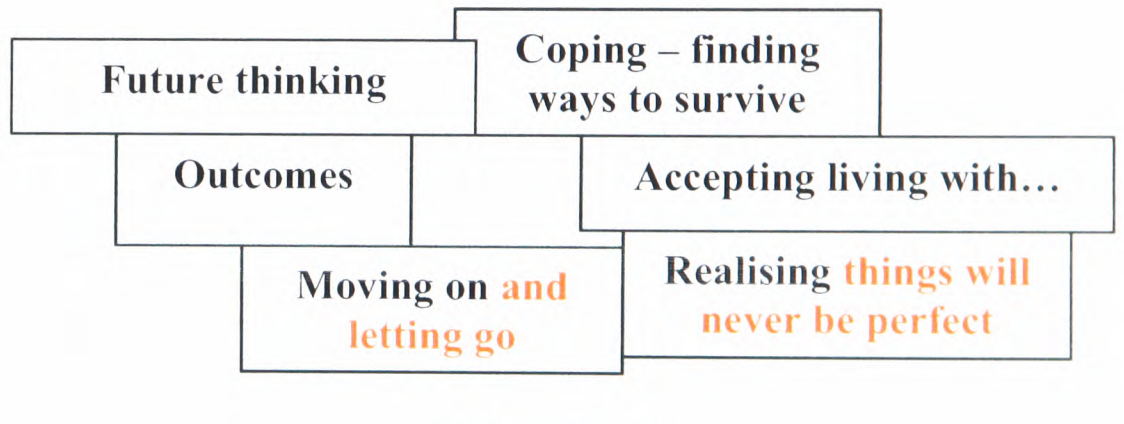
Thinking of others' needs

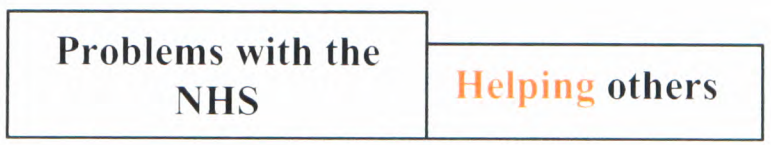
Super-ordinate themes 3 – Further thinking





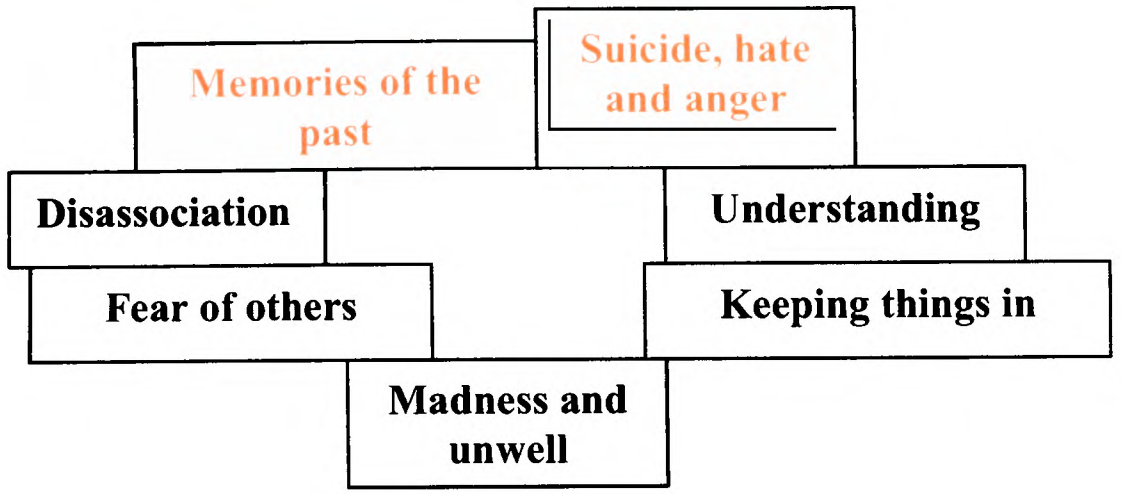




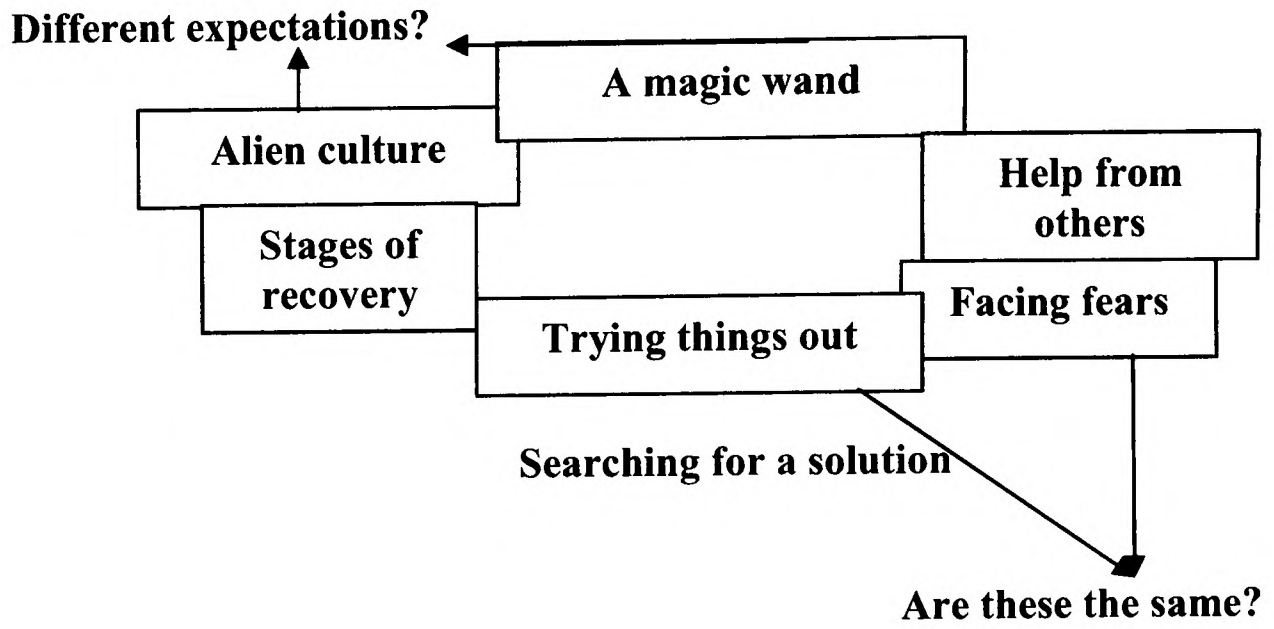


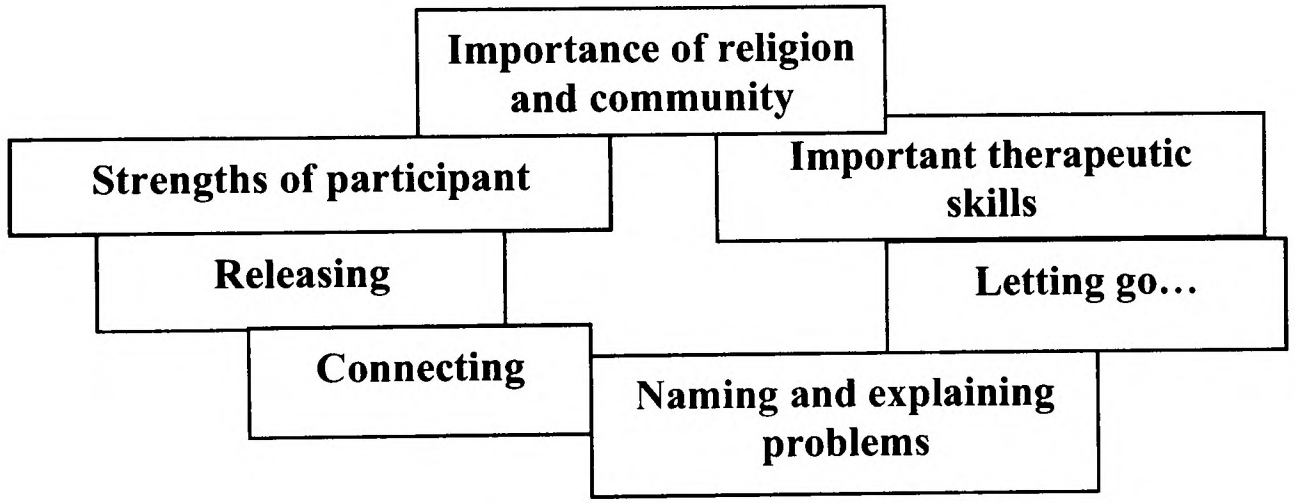
THINKING OF OTHER'S NEEDS

Super-ordinate themes 4 – P8

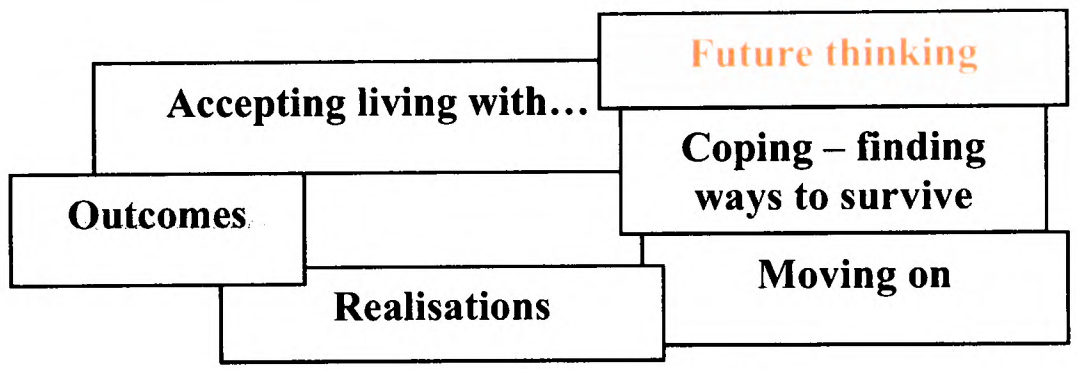


Stuck in the past

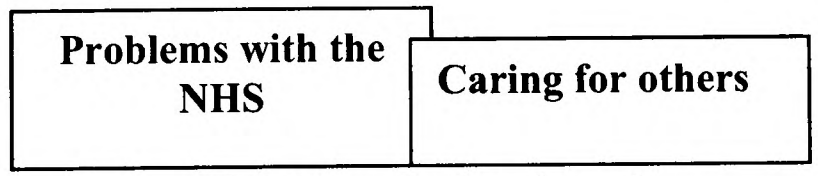




Helping me to move on….

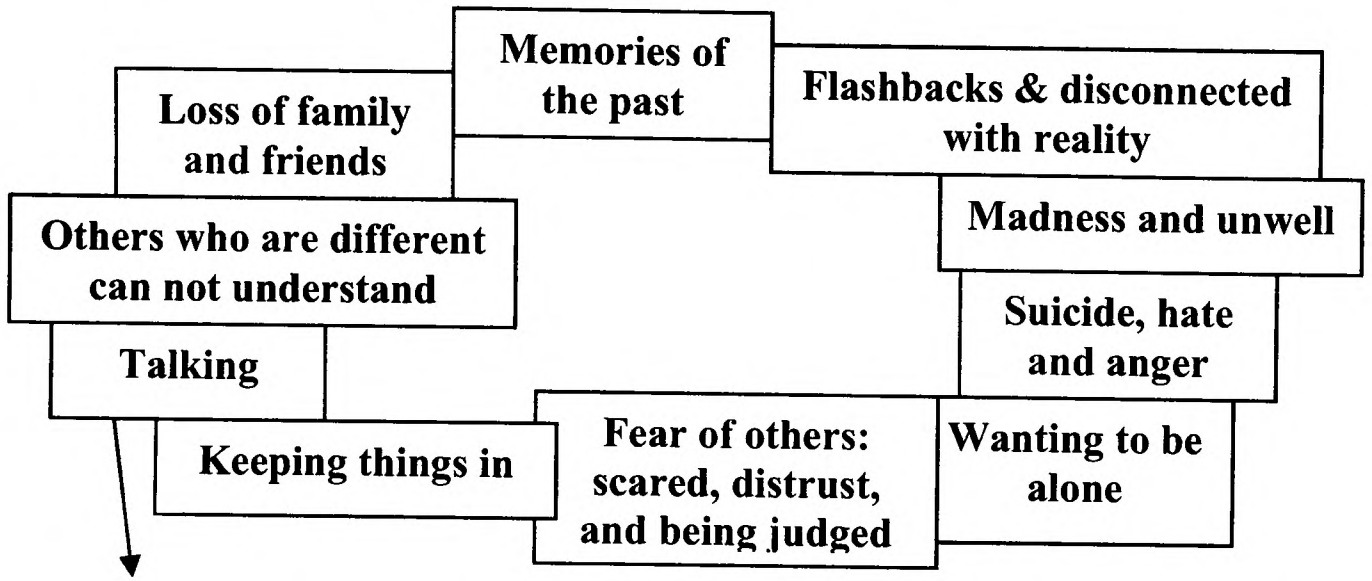


Moving on

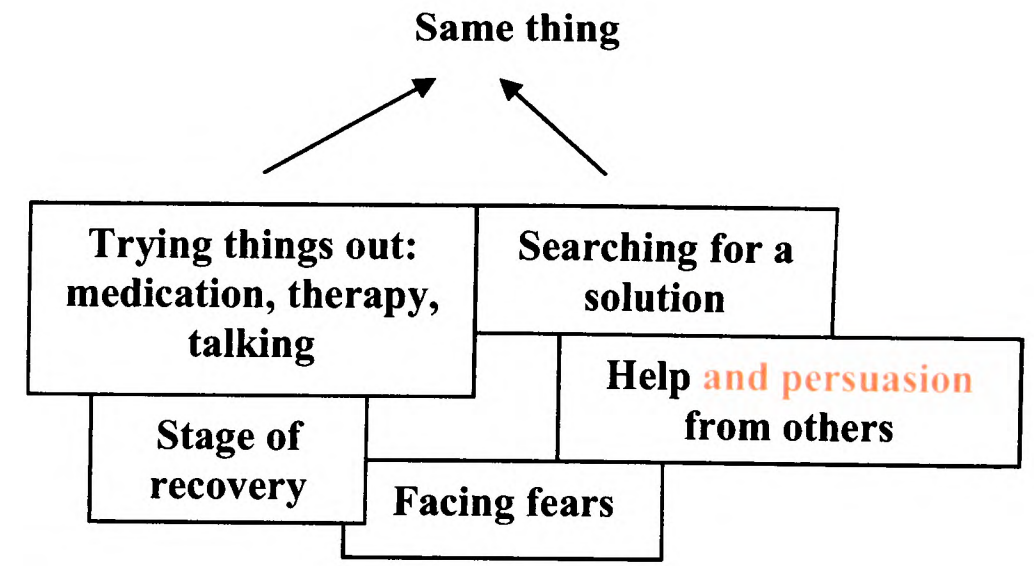


Thinking of others' needs

Super-ordinate themes 5 – P5

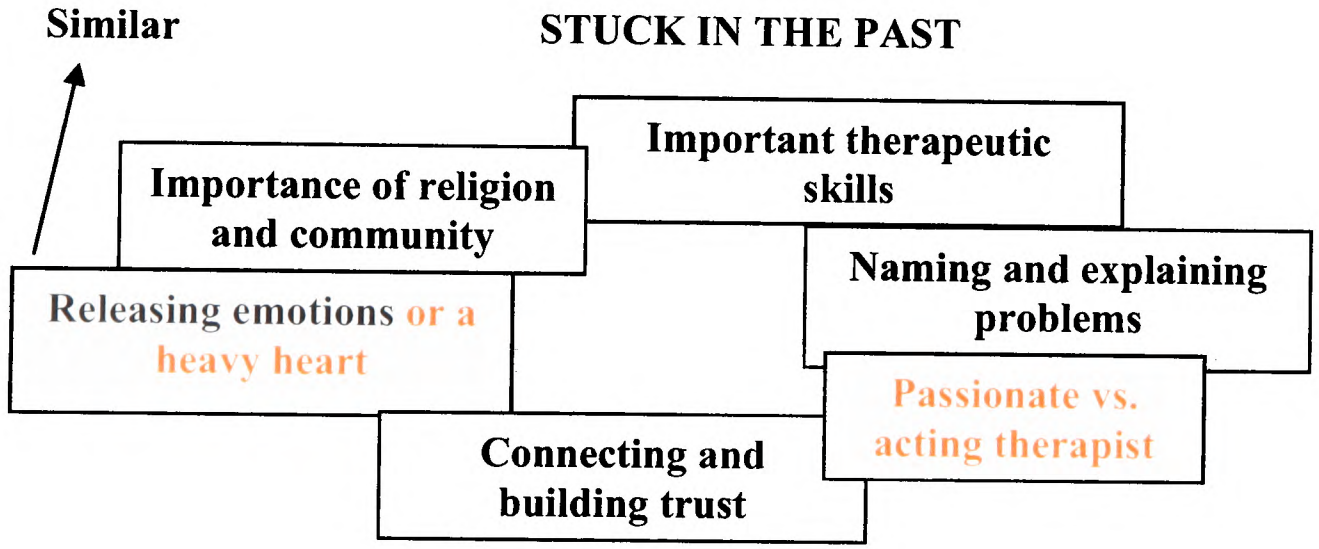


STUCK IN THE PAST

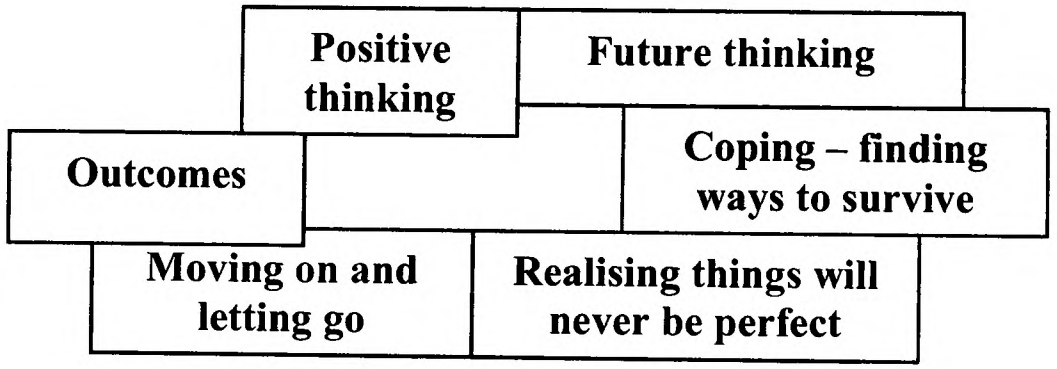


SEARCHING FOR A SOLUTION

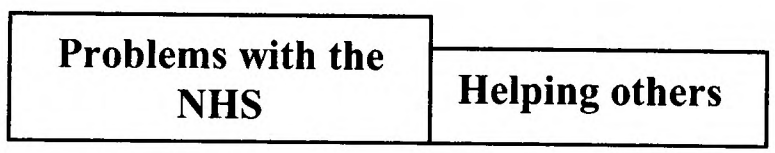
Similar



GETTING BETTER

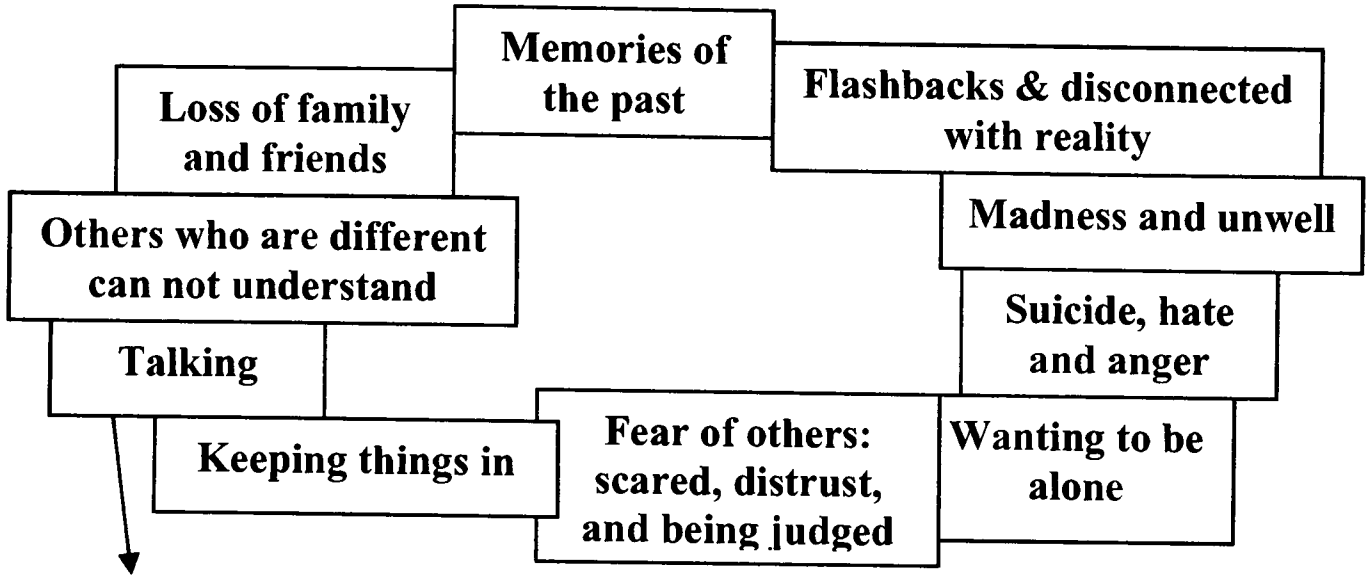


MOVING ON



THINKING OF OTHER'S NEEDS

Super-ordinate themes 6 – P7



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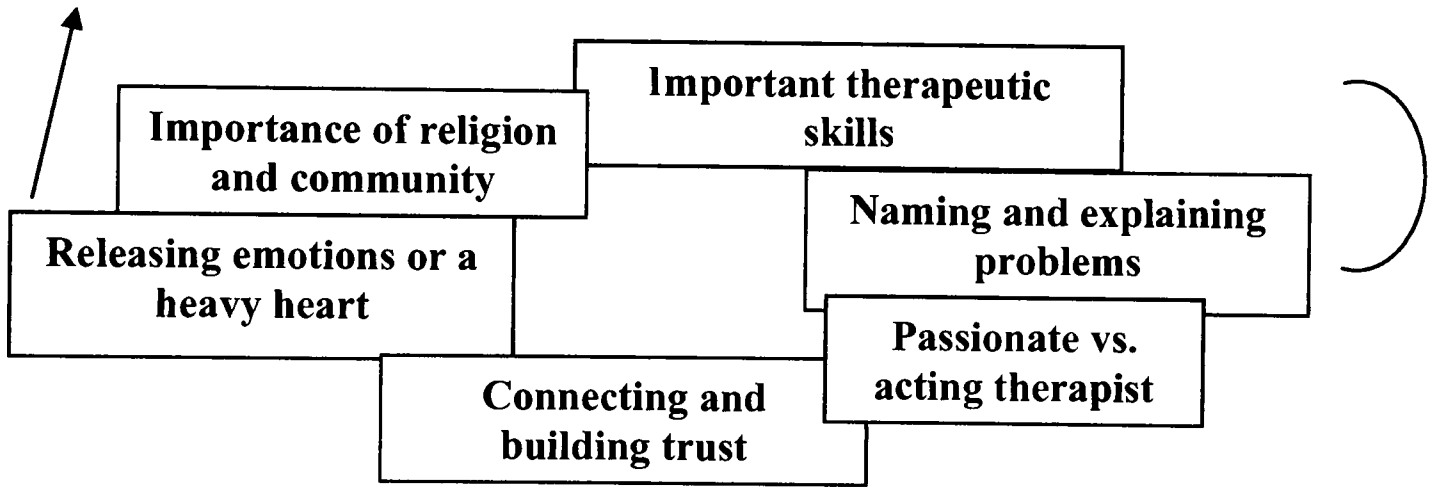
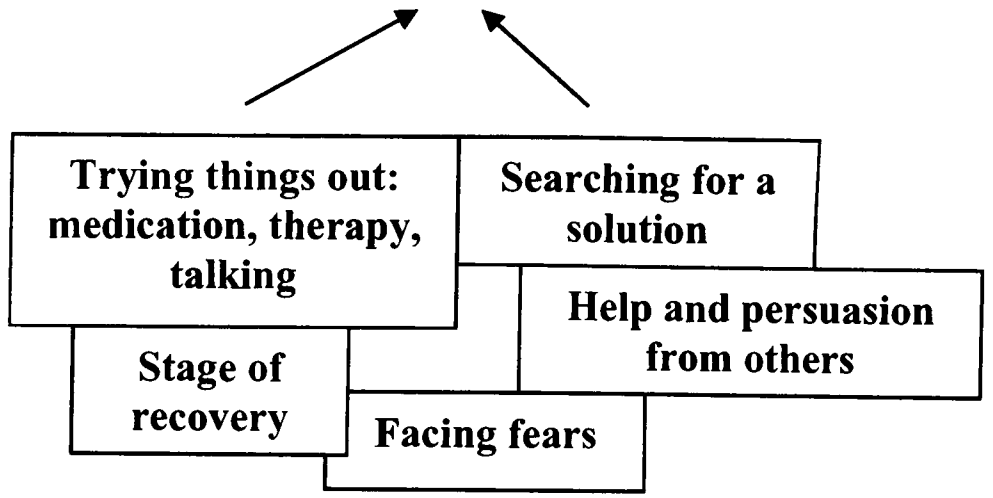
STUCK IN THE PAST

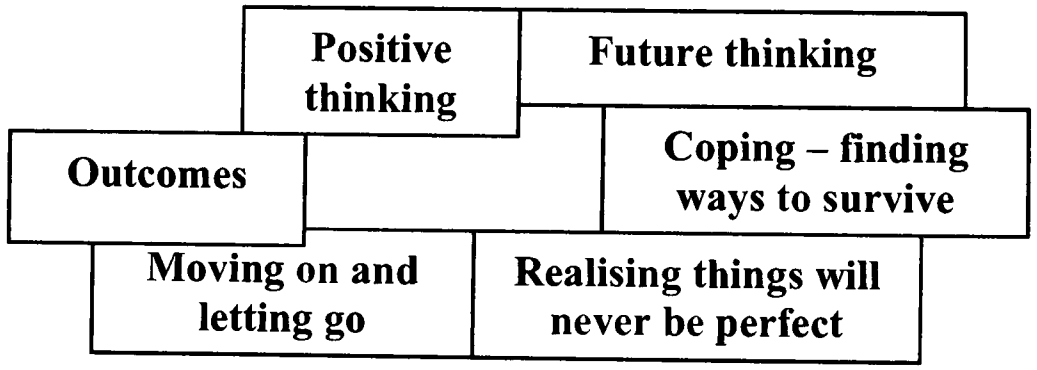


GETTING BETTER

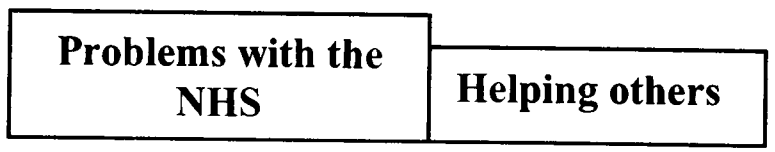
Same thing



SEARCHING FOR A SOLUTION

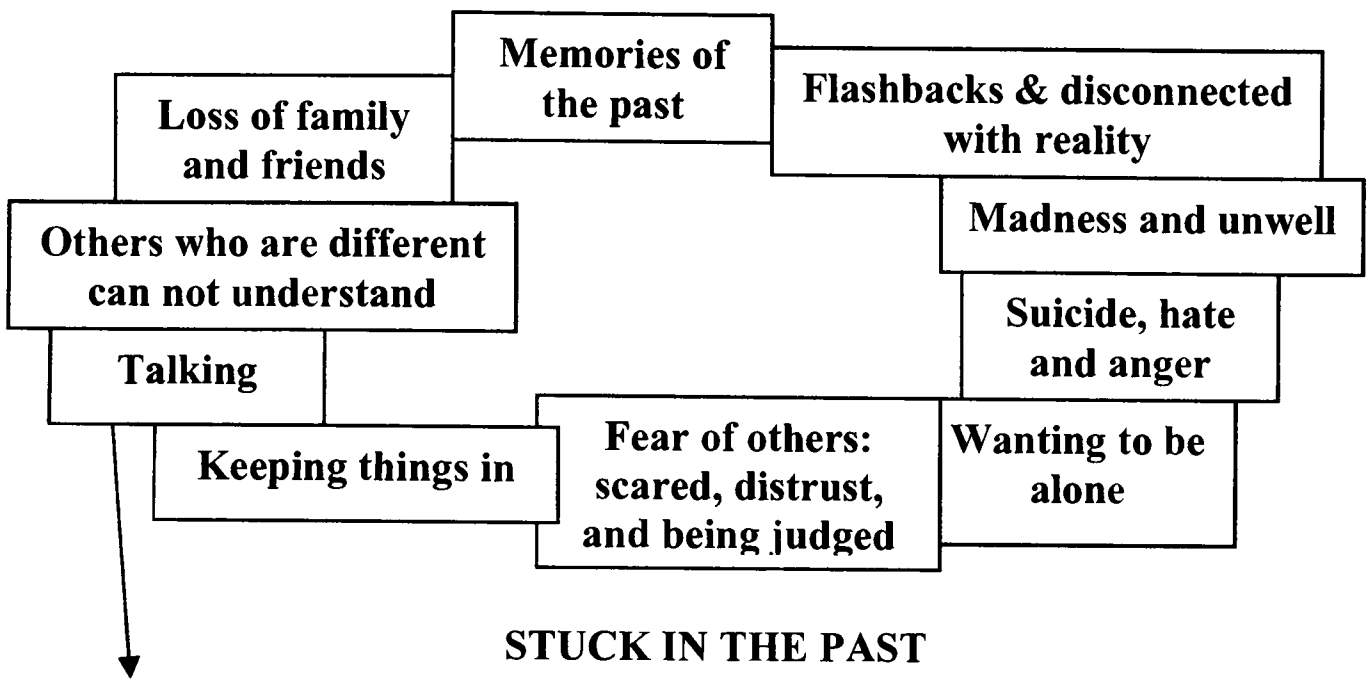


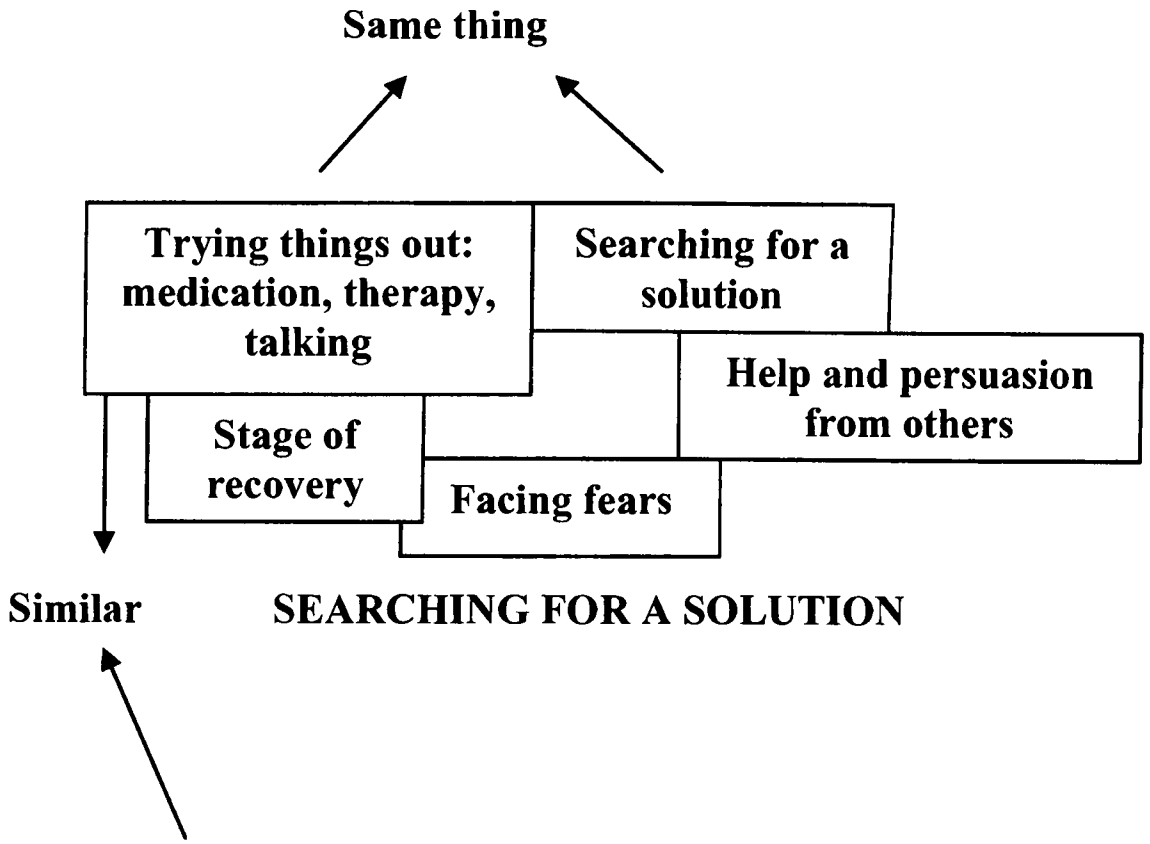
MOVING ON

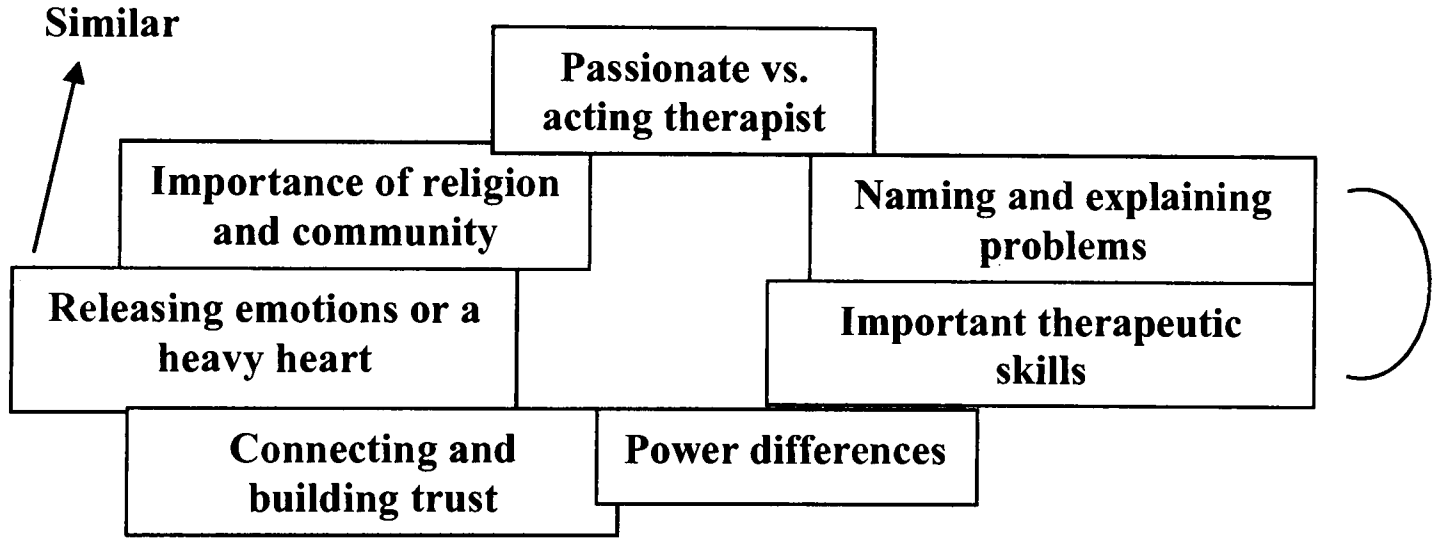


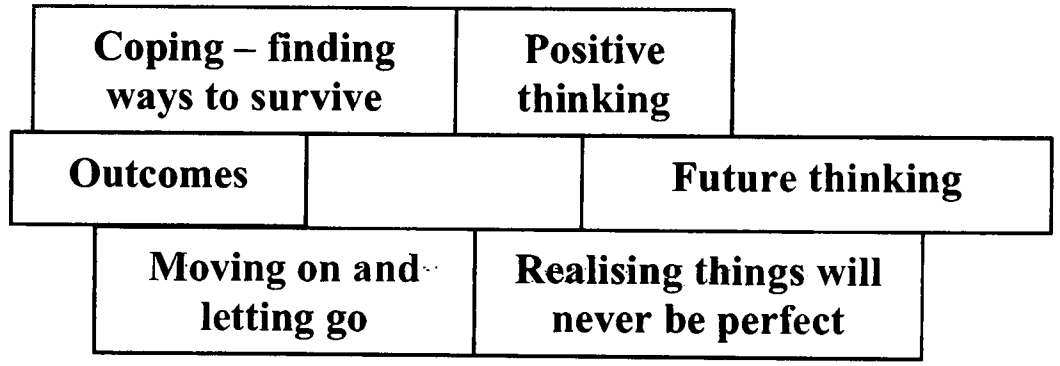
THINKING OF OTHER'S NEEDS

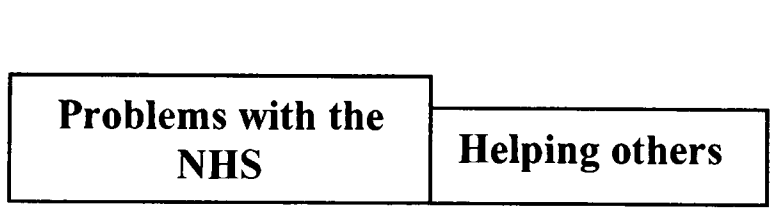
Super-ordinate themes 7 – P4





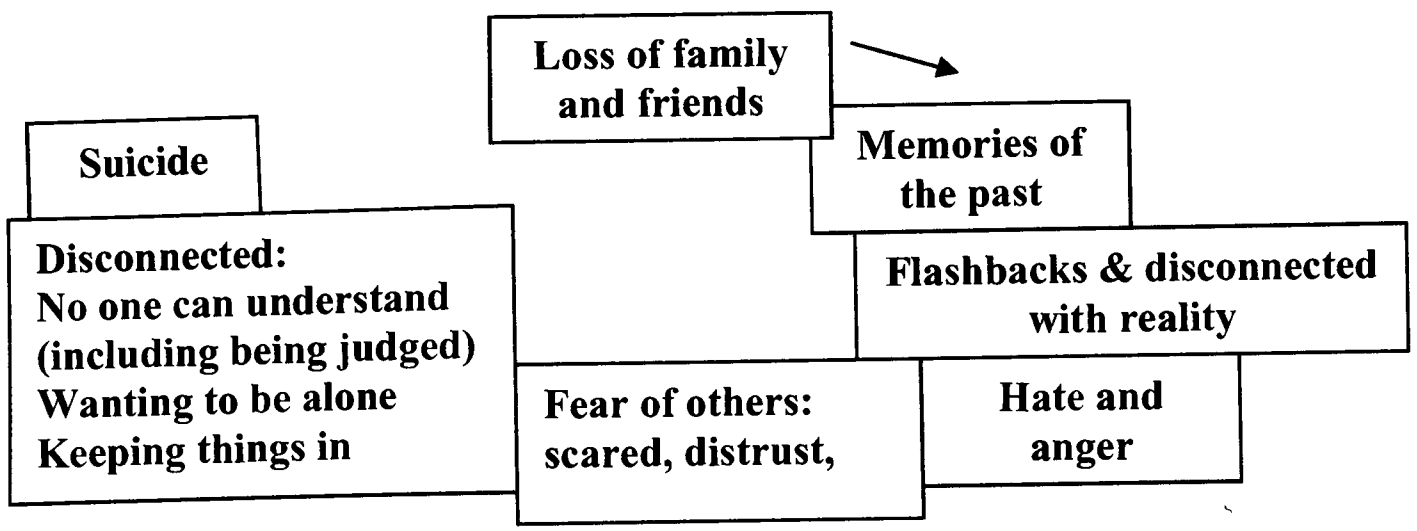




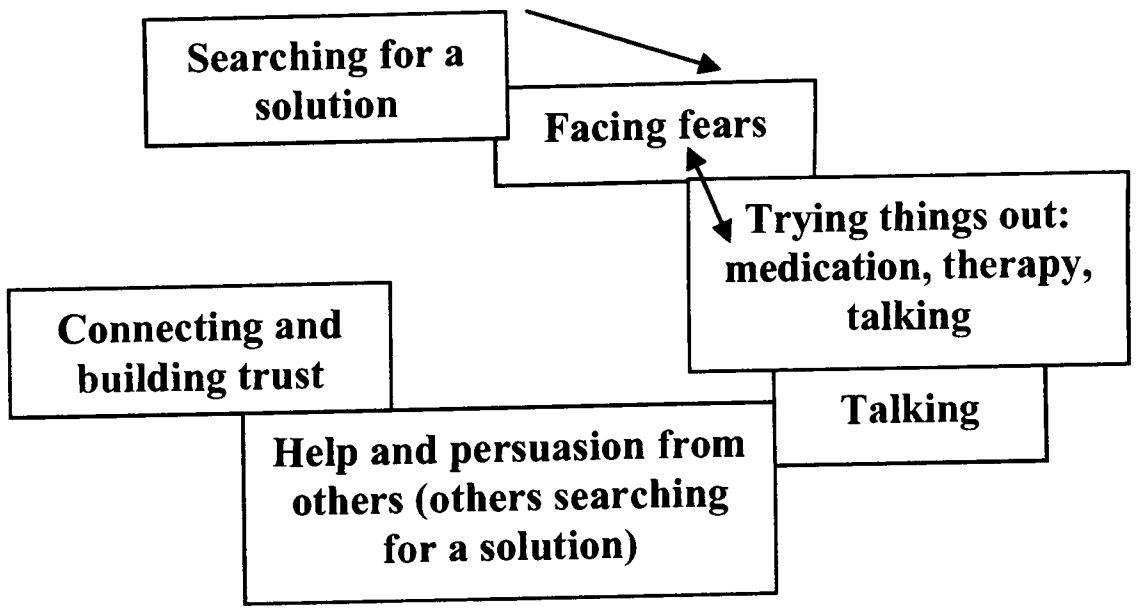


No therapy back home

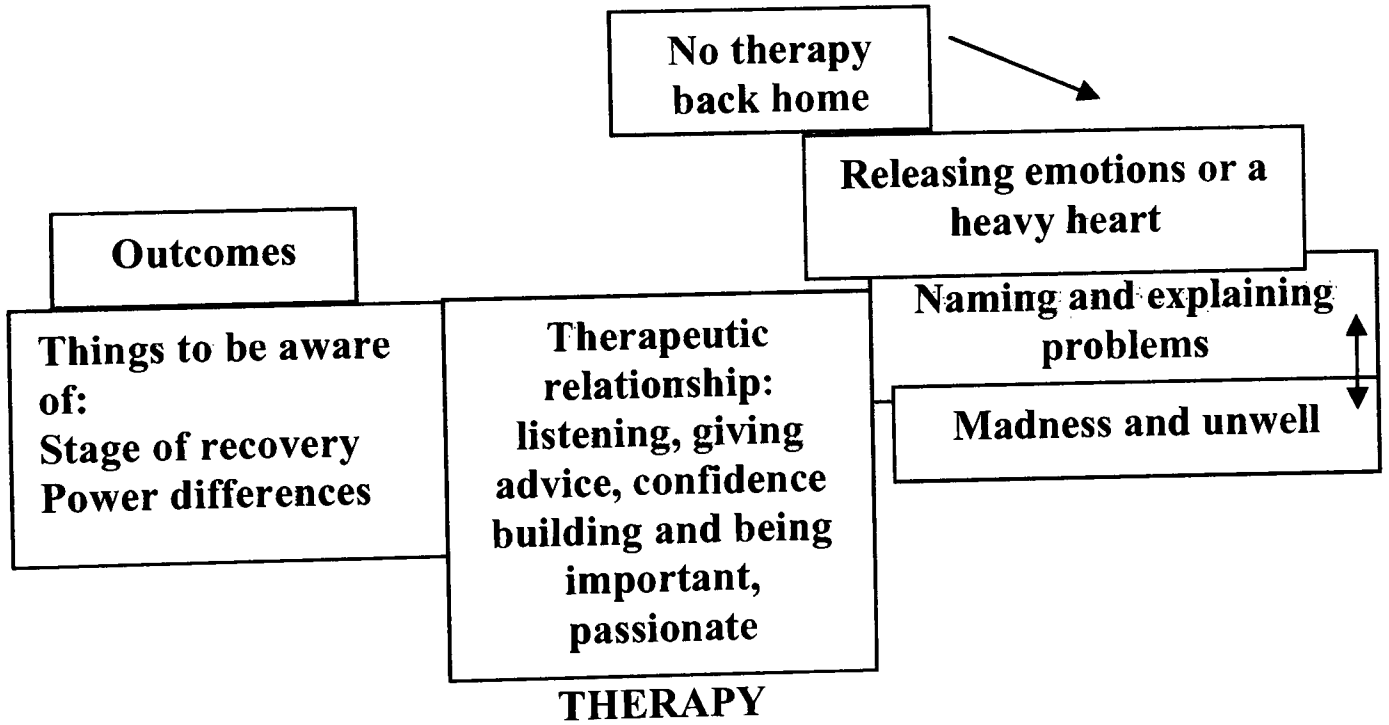
Super-ordinate themes 8 – further thinking after first analysis of all transcripts



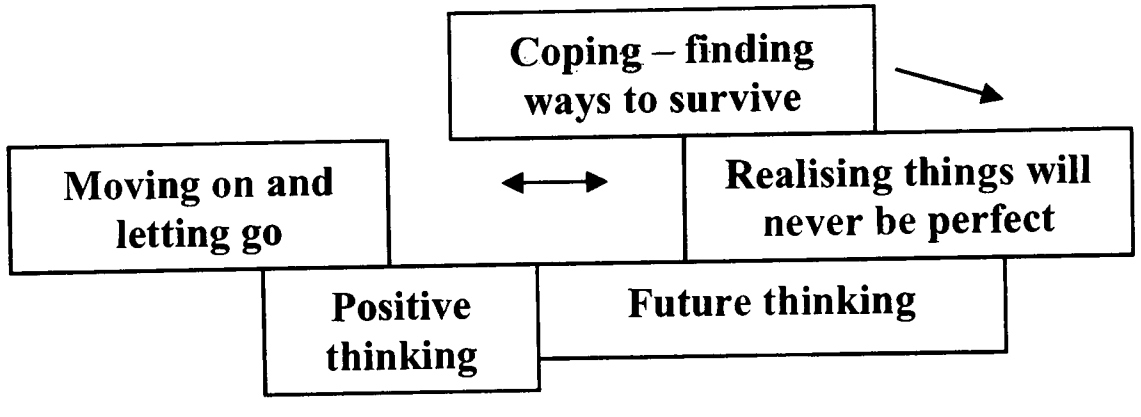
STUCK IN THE PAST



SEARCHING FOR A SOLUTION



THERAPY



MOVING ON

Helping others

Importance of religion and community

Problems with the NHS

Super-ordinate themes 9 – further thinking after checking quotes for sub-ordinate categories

Loss of family and friends

Memories of the past

Flashbacks & disconnected with reality

Suicide

Disconnected:
No one can understand
Wanting to be alone
Keeping things in

Fear of others: scared, distrust,

Hate and anger

STUCK IN THE PAST

Searching for a solution

Trying things out: medication, therapy, talking

Talking

Help and persuasion from others (others searching for a solution)

Importance of religion

SEARCHING FOR A SOLUTION

No therapy back home

Connecting and building trust

Releasing emotions or a heavy heart

Outcomes

Stage of recovery

Medication

Therapeutic relationship: listening, giving advice, confidence building, passionate, power differences, telling recovery stories

Am I crazy? Naming and explaining problems

HELPING ME TO MOVE ON

Coping – finding ways to survive

Moving on and letting go

Realising things will never be perfect

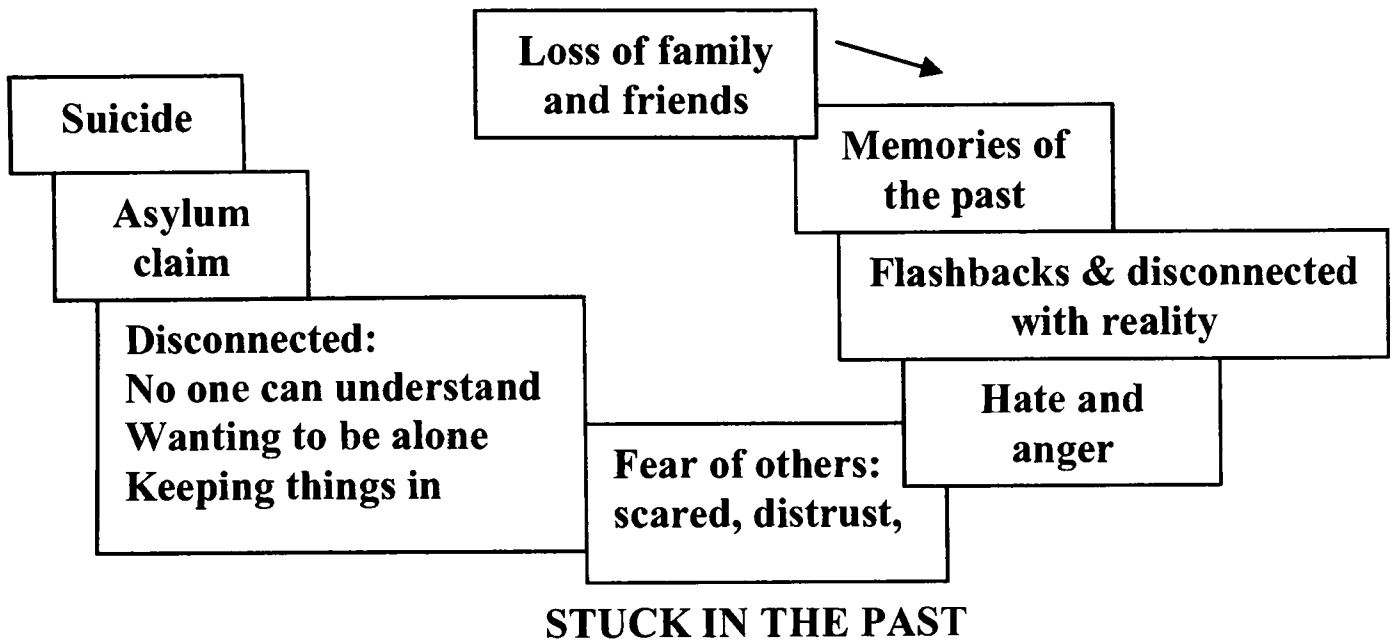
Positive thinking

Future thinking

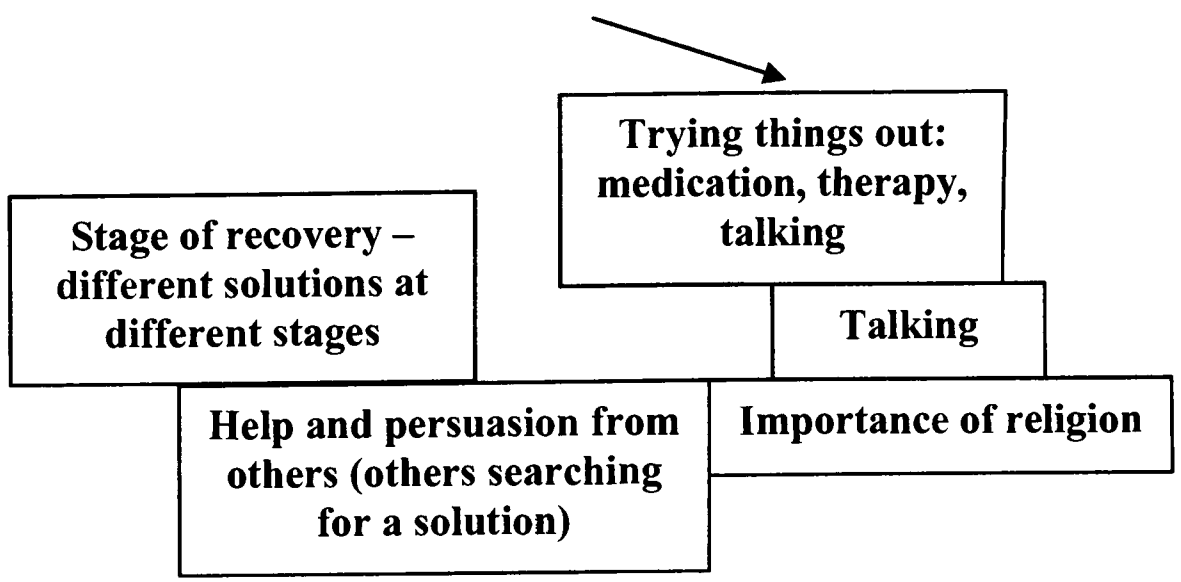
MOVING ON

Problems with the NHS

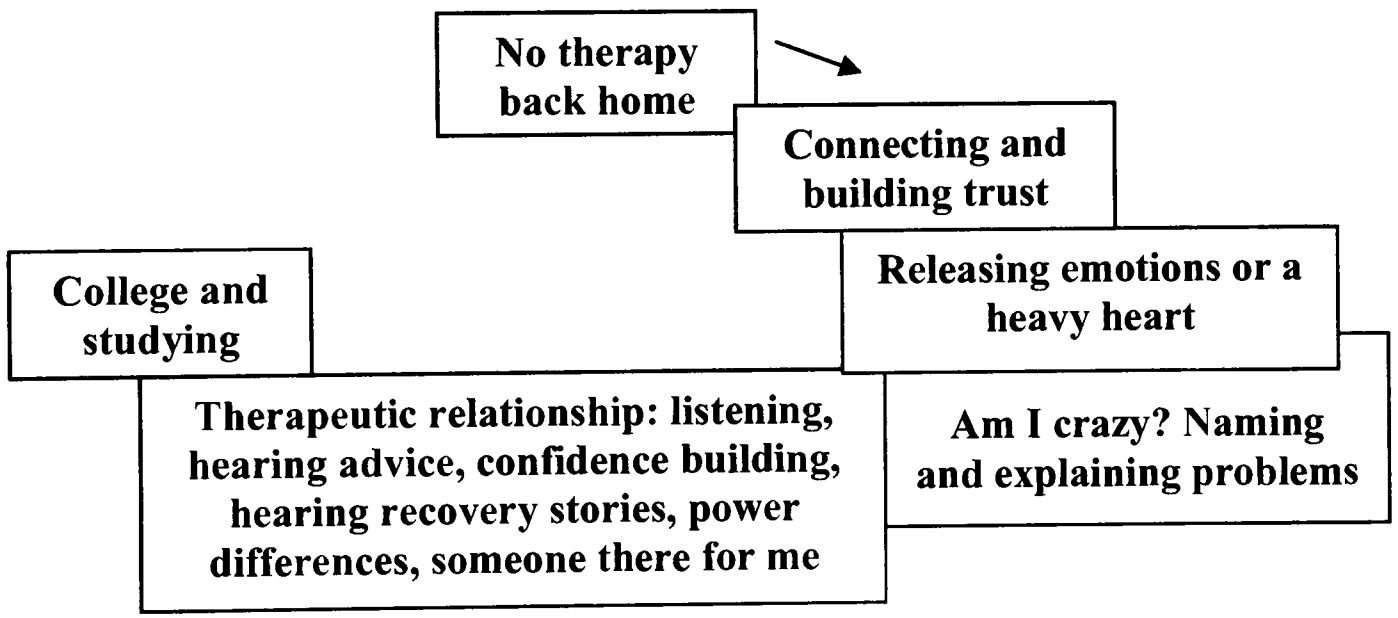
Super-ordinate themes 10 – after final reading of transcripts



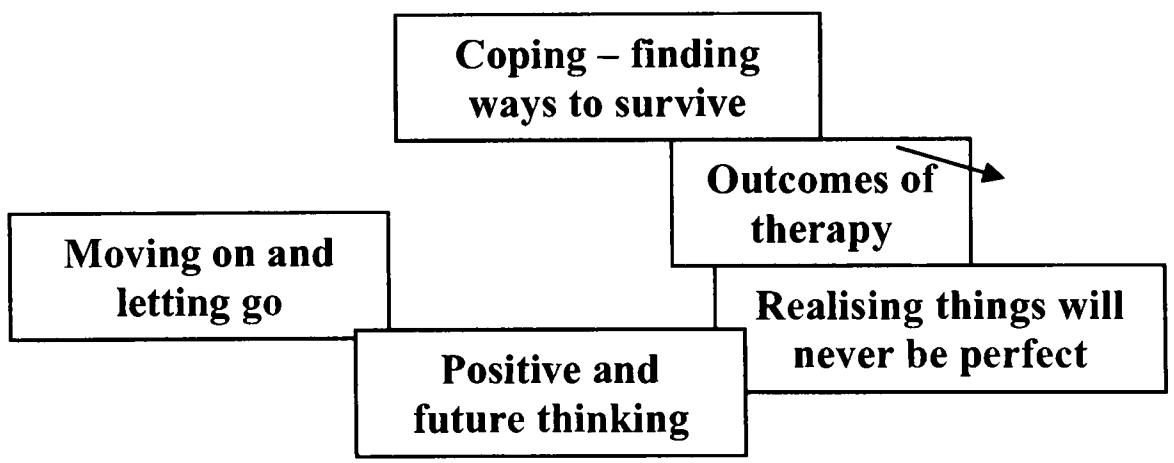
STUCK IN THE PAST



SEARCHING FOR A SOLUTION



HELPING ME TO MOVE ON



MOVING ON

Super-ordinate themes 11 – final thinking

THE ROAD TO RECOVERY

A painful past: loss and remembering

Flashbacks & disconnected with reality

Hate and anger

Fear of others: scared, distrust

Disconnected: No one can understand Keeping things in

Suicide

Asylum claim

STUCK IN THE PAST

Searching for a solution

Practically trying things out: medication, therapy, tasks

Help and persuasion from others (others searching for a solution)

SEARCHING FOR A SOLUTION

Importance of religion

Talking

Connecting and building trust

Releasing emotions and a lighter heart

Am I crazy? Naming & explaining problems

Therapeutic relationship: listening, confidential, hearing advice, confidence building, hearing recovery stories, power differences, someone there for me, my sessions

HELPING ME TO MOVE ON

Outcomes of therapy

Realising things will never be perfect

Coping – finding ways to survive

Moving on

Positive and future thinking

College and studying

MOVING ON