

**The mental health needs of refugee torture survivors:  
exploring staff understandings**

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## ABSTRACT

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This study explored the issue of access to appropriate mental health care for refugee torture survivors in the United Kingdom (UK). Despite survivors' legal entitlements, there are substantial concerns about their access to care. To date, there has been little empirical investigation of the ways in which staff who have contact with torture survivors understand and manage their mental health needs. The focus of this study was on general practitioners' (GPs') understandings of torture survivors' mental health needs and their accounts of how they respond. This is an important focus for exploration given GPs' roles as referrers, gatekeepers and future commissioners of services for this group.

This study involved individual in-depth interviews with eight GPs. Interviews were analysed using thematic analysis informed by a critical realist epistemology. Three main themes were identified.

Theme One encompassed participants' talk about the challenges of assessing and responding to torture survivors' mental health needs. Challenges related to GPs' expertise and remit, their work context and the complexities of working with a patient group with multiple needs and different cultural and experiential backgrounds. Theme Two related to conceptualisations of torture survivors' mental health needs and associated solutions. Participants were seen as drawing on competing social and medical models of distress. Suggested interventions for this patient group were tied strongly to addressing their multiple needs. The third theme related to medical practice within the asylum context and its associated social and political discourses.

Based on the analysis, implications for future research, policy and practice are considered. The research supports the position that torture survivors' mental health needs and their wider psychosocial needs cannot be separated if they are to receive the most effective and suitable care.

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This thesis, and the qualification I hope to subsequently achieve, are dedicated to my family and my partner Leo – for the loan of their arms when mine could no longer type; for accompanying (and tolerating!) me through exceptionally difficult times; and for their constancy and support in this endeavour, as in so many others. Without them, I would never have made it this far.

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# CONTENTS

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<b>1. <u>CHAPTER ONE: INTRODUCTION</u></b>	<b>8</b>
<b>1.1. Overview of the research</b>	<b>8</b>
<b>1.2. Approach to the literature review</b>	<b>9</b>
<b>1.3. Social and legal context of the research</b>	<b>10</b>
1.3.1. Refugee torture survivors in the UK and their mental health needs	10
1.3.2. Obligations of statutory healthcare services to respond to the mental health needs of refugee torture survivors	12
1.3.3. Concerns about refugee torture survivors' access to appropriate mental health services	13
<b>1.4. Factors influencing refugee torture survivors' access to appropriate mental health services in the UK</b>	<b>14</b>
1.4.1. The trajectory to mental health care	14
1.4.2. The influence of social and political discourses and associated Government policy	18
1.4.3. The influence of health care services structure	19
1.4.4. Mental health care models as a barrier to accessing appropriate care	20
1.4.5. Health service staff understandings as barriers to accessing appropriate care	22
1.4.5.1. <i>The role of GP understandings</i>	23
<b>1.5. Gaps in the current literature on the role of GP understandings in mental health access for torture survivors</b>	<b>28</b>

1.6. Rationale for the focus on GPs in the current research	29
1.7. Relevance of this study to the practice of Clinical Psychology	31
1.8. Research aims and questions	31
<b>2. <u>CHAPTER TWO: METHOD</u></b>	<b>33</b>
2.1. Philosophical underpinnings of the research	33
2.1.1. The relationship between philosophy and research methods	33
2.1.2. The epistemological position of the current research	34
2.2. Methodology	39
2.2.1. Qualitative approach	39
2.2.2. Reflexivity	39
2.3. Method	40
2.3.1. Data collection: the interviews	41
2.3.2. Data analysis	42
2.4. Procedures	45
2.4.1. Recruitment strategy	45
2.4.2. Participants recruited	46
2.4.3. Interview schedule	47
2.4.4. Interviews	48
2.4.5. Transcription	48
2.4.6. Ethical issues	49
2.4.7. Ethical Approval	50
<b>3. <u>CHAPTER THREE: ANALYSIS AND DISCUSSION</u></b>	<b>52</b>
3.1. GP participants	52

<b>3.2. Presentation and discussion of thematic material</b>	<b>53</b>
3.2.1. THEME ONE: Challenges in assessing and responding to torture survivors' mental health needs	55
3.2.1.1. <i>Patient-related challenges</i>	55
3.2.1.2. <i>GP-related challenges</i>	61
3.2.1.3. <i>Context-related challenges</i>	62
3.2.1.4. <i>Strategies developed in responses to challenges</i>	66
3.2.2. THEME TWO: Conceptualisations of torture survivors' mental health needs and solutions	68
3.2.2.1. <i>Competing models of distress</i>	68
3.2.2.2. <i>Proposed responses to distress</i>	72
3.2.3. THEME THREE: Medical practice within the asylum context	74
3.2.3.1. <i>GPs' adopted roles in relation to torture survivor patients</i>	74
3.2.3.2. <i>Visible difference within the asylum context</i>	78
<b>4. <u>CHAPTER FOUR: FURTHER DISCUSSION</u></b>	<b>80</b>
4.1. <b>Summary of findings</b>	<b>80</b>
4.2. <b>Research Questions</b>	<b>81</b>
4.2.1. How do GPs, working in settings where they may come into contact with refugee torture survivors, understand their mental health needs?	81
4.2.2. Influences on participants' accounts	82
4.3. <b>Contributions to the existing literature</b>	<b>85</b>
4.4. <b>Implications for further research</b>	<b>87</b>
4.5. <b>Implications for practice and policy</b>	<b>88</b>

<b>4.6. Limitations of the study</b>	<b>90</b>
<b>4.7. Reflexivity</b>	<b>91</b>
4.7.1. Personal Reflexivity	92
4.7.2. Epistemological reflexivity	94
4.7.3. Critical language awareness	96
<b>4.8. Quality within qualitative research</b>	<b>97</b>
<b>4.9. Conclusions</b>	<b>98</b>
<b>5. REFERENCES</b>	<b>100</b>
<b>6. APPENDICES</b>	<b>112</b>
6.1. <b>Appendix 1:</b> Definition of terms	112
6.2. <b>Appendix 2:</b> Literature search strategy	113
6.3. <b>Appendix 3:</b> Transcription notation key and coded section of transcript illustrating worked example of the analysis	117
6.4. <b>Appendix 4:</b> Initial, Developed and Revised Thematic Maps as used in the Analysis	122
6.5. <b>Appendix 5:</b> Checklist of criteria for good thematic analysis	125
6.6. <b>Appendix 6:</b> Letter of invitation to participate in the study and participant information sheet	126
6.7. <b>Appendix 7:</b> Interview schedule (as approved by NHS Ethics Committee)	130
6.8. <b>Appendix 8:</b> Consent form	132
6.9. <b>Appendix 9:</b> UEL Ethics Committee approval	133
6.10. <b>Appendix 10:</b> NHS Ethics Committee approval and correspondence	134

# CHAPTER ONE: INTRODUCTION

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In this chapter, I will describe the central aims of the research and the context in which it was conceived. I will outline the present knowledge relating to this topic, and highlight gaps in the extant literature necessitating the current research.

## **1.1 Overview of the research**

The central concern of this study is that of access to appropriate mental health care for refugee torture survivors<sup>1</sup> in the United Kingdom (UK). Torture survivors have a legal right to access rehabilitation including psychological care, yet substantial concerns are recorded about their access to appropriate mental health care. The reasons for this are complex, and it is therefore important to explore methodically the multiple factors contributing to this situation.

The particular focus of this study is on referrers' understandings of torture survivors' mental health needs and their accounts of how they then respond to these. The title of this thesis reflects its original aim to explore the understandings of staff across the range of agencies with which torture survivors come into contact following their entry to the UK. However, as a result of a dialogue with the National Health Service (NHS) Ethics Committee to which the project was referred, the decision was made to focus more specifically at the level of general practitioners (GPs), as the main gatekeepers to statutory mental health services in the UK. The study explores how GPs, working in settings where they may come into contact with refugee

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<sup>1</sup> *Refugee torture survivors* are defined here as those survivors of torture who are either seeking asylum or have been granted refugee status on the basis of having been tortured. Although this research focuses on refugee torture survivors and interview questions were framed accordingly, it was notable that participants often appeared to use the terms "torture survivor", "asylum seeker" and "refugee" interchangeably. This lack of distinction may pose problems within health services (International Rehabilitation Council for Torture Victims, 2007) and is also reflected in inadequate specificity within much of the literature. The reader is referred to Appendix 1 for further definitions of each of these terms.

torture survivors, understand the mental health needs of this group. It is important to elaborate how these understandings might influence them, primarily in their role as referrers, but also in terms of their potential future role in commissioning services for this group.

This study was a qualitative one, involving in-depth interviews with a small number of GPs. In conducting such interviews, I recognise that the data were generated within the context of a specific social process, wherein participants' accounts will have been influenced both by my questions and identity, and their own agendas and concerns. This point will be discussed further in the Method and Further Discussion sections.

## **1.2 Approach to the literature review**

Following identification of the broad topic area, a structured review of the literature was undertaken with the following aims:

- To understand the broad social, legal and policy context within which refugee torture survivors are positioned.
- To clarify what is currently known about refugee torture survivors' access to appropriate mental health care.
- To identify gaps or limitations in the existing literature, warranting further exploration.
- To define the research question.
- To examine the concepts and language commonly used in relation to this topic, to give an indication of the discursive and intellectual resources that might be available to study participants.

A search strategy was developed to allow a structured exploration of the available literature and identification of relevant material. Further details of the search strategy are included in Appendix 2.

### **1.3 Social and legal context of the research**

In this section, I present information about estimated numbers of refugee torture survivors in the UK and their mental health and social needs. I describe the obligations of statutory services to meet these needs and associated concerns that accessibility to and appropriateness of these services is limited for this group.

#### **1.3.1 Refugee torture survivors in the UK and their mental health needs**

In 2010, the UK received 17,916 asylum applications (excluding dependents), following a decline from a peak of 84,130 applications in 2002 (Blinder, 2011). It is estimated that between five and thirty percent of those seeking asylum in the UK have been tortured. The range in these figures relates to variations in the definition of torture and differences by country of origin (Burnett and Fassil, 2002, p49). The sensitivity of the issue of torture and difficulties with disclosure further contribute to the complexity in estimating its incidence amongst asylum seekers and prevalence estimates are rare and unreliable (Jaranson and Quiroga, 2011). Considering even the lowest estimates, however, it is evident that every year the UK receives, and may subsequently accommodate, significant numbers of refugee torture survivors.

Refugees and torture survivors have complex and interacting needs, including legal, social, physical and psychological needs (Montgomery and Patel, 2011; Papadopoulos, 2007). In terms of mental health needs, several authors in the field have highlighted high levels of mental distress amongst torture survivors (see for example, Jaranson and Quiroga, 2011; Kinzie, 2011); and various large-scale systematic reviews have concluded that a history of torture is strongly associated with higher rates of diagnostically-defined mental health problems such as post traumatic stress disorder (PTSD) and depression (see for example, Johnson and Thompson, 2008; Steel, Chey, Silove, Marnane, Bryant and van Ommeren, 2009). Examining refugees as a homogeneous group, Fazel, Wheeler and Danesh (2005) conducted a large-scale systematic review of the prevalence of serious mental health problems in



refugees resettled in seven Western countries. Drawing on data from 20 psychiatric surveys, relating to almost 7,000 adult refugees, they report a much higher rate of problems in refugees when compared to the age-matched general population. For example, they estimate that refugees are around ten times more likely to experience symptoms of PTSD.

As with those studies estimating prevalence of torture amongst asylum seekers, epidemiological studies of the incidence of mental distress amongst torture survivors have been plagued by methodological issues and heterogeneous results (Fazel *et al.*, 2005; Steel *et al.*, 2009). Moreover, the cross-cultural applicability of instruments used to assess refugee mental health, and the psychiatric disease categories invoked, have been critiqued (Jaranson and Quiroga, 2011; Johnson and Thompson, 2008). Whilst the contribution of focused epidemiological studies has been acknowledged, concerns are noted about their limited focus on mental health difficulties to the neglect of other interacting facets of wellbeing (Montgomery and Patel, 2011). Furthermore, several authors have highlighted that the focus on mental health difficulties may mask the immense resilience and resourcefulness of many refugees and torture survivors; who may therefore survive many atrocities with few mental health difficulties, and cope with little assistance given a facilitative environment (Burnett and Fassil, 2002, p51; Papadopoulos, 2007; Patel, 2003). Sadly, however, the environment in countries of refuge is often far from facilitative. Refugee torture survivors are required to cope not only with their pre-flight experiences (which may include severe and prolonged torture, death of friends or family members) and the immense losses of exile (for example, loss of home, homeland, role, status, family); but also with ongoing difficulties in the destination country. These will likely include hostility, isolation, socio-economic difficulties, and uncertainty about asylum status (Mahtani, 2003). It is little surprise, therefore, that torture survivors often describe their experiences in the destination country as having a greater negative impact than the torture they have previously suffered (Gorst-Unsworth and Goldenberg, 1998; Patel, 2003).

Debates about the level of distress amongst torture survivors, appropriate

ways of defining this distress, and the implications of focusing on individual pathology in isolation from social circumstances are ongoing. Notwithstanding this difference of opinion, it is clear that refugee torture survivors are a group of people who may suffer high levels of distress and may benefit from access to mental health provision. In the following two sections, I consider, first, the obligations of statutory services to respond to torture survivors' needs and, second, concerns about accessibility and appropriateness of existing mental health provision for this population.

### **1.3.2 Obligations of statutory healthcare services to respond to the mental health needs of refugee torture survivors**

Statutory healthcare services within the UK are obliged to respond to the mental health needs of refugee torture survivors<sup>2</sup> at a number of levels. First, since healthcare professionals are ethically bound to respond to the assessed health needs of every presenting patient, statutory clinical services within the NHS have an obligation to develop appropriate mental health services for refugee survivors of torture (Patel and Mahtani, 2007).

Second, by the Race Relations (Amendment) Act 2000 ("the 2000 Act"), public bodies such as the NHS have a duty to ensure that services are delivered in such a way as to promote race equality and prevent race discrimination. The Department of Health's 2005 action plan for reform, 'Delivering Race Equality in Mental Health Care', provided guidance to mental health services for implementing their duties under the 2000 Act, by reducing inequalities in Black and minority ethnic (BME) patients' access to, experience of, and outcomes from those services. This would include services for refugees, including those who have been tortured.

Third, under international human rights law, torture survivors have an absolute

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<sup>2</sup> It should be noted that changing legislation has meant that there are complex rules about what healthcare failed asylum seekers (those who have exhausted all their appeal rights) can access. The issue of changing NHS regulations about access to secondary healthcare for this group is still under debate.

right to rehabilitation. All signatory states to the United Nations Convention Against Torture (1984), of which the UK is one, are bound by Article 14, which provides that:

*“Each state shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible.”*

In this context, ‘rehabilitation’ may include provision of legal and social services, as well as medical and psychological care (Medical Foundation for the Care of Victims of Torture, 2009). States, via actors such as the NHS, have a legal obligation to identify torture survivors and provide appropriate rehabilitative services<sup>3</sup>.

### **1.3.3 Concerns about refugee torture survivors’ access to appropriate mental health services**

Despite the potentially high needs, including mental health needs, of refugee torture survivors, and the obligations of states and their actors to meet these, the International Rehabilitation Council for Torture Victims (2007) raises serious concerns about the ability of government-supported health services throughout Europe to do so. This concern is echoed by Jaranson and Quiroga (2011), who highlight that only a small proportion of torture survivors receive the rehabilitation to which they are entitled.

Such concerns regarding refugee torture survivors’ access to mental health services are consistent with a wider picture of inequalities in access to appropriate mental health care for all refugees in the UK (McColl, McKenzie and Bhui, 2008), and, more generally for people from BME groups (Williams, Turpin and Hardy, 2006). It is important to note, when considering issues of mental health provision for these groups, that concerns relate not only to whether clients are able to access services, but whether the services they do

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<sup>3</sup> The concept of ‘rehabilitation’ remains contested, both in law and by those services offering healthcare provision to refugee survivors of torture (for a fuller discussion see Patel, 2007). This lack of clarity may have significant implications in terms of services offered to torture survivors, leaving staff in involved agencies to act on their own conceptions. This concern has been raised by the International Rehabilitation Council for Torture Victims (2007), who note the lack of clear referral pathways to rehabilitation for potential torture survivors.

access are actually appropriate. And although there is some debate as to whether ‘talking therapy’ is an appropriate response to the difficulties faced by refugee torture survivors (see the following section), access to health care for this group, which could include psychological care, is a right provided by law.

#### **1.4 Factors influencing refugee torture survivors’ access to appropriate mental health services in the UK**

In the remainder of this review, I explore what the existing literature highlights about why torture survivors might not access appropriate mental health care and what role GPs may play in this process. Given that GPs are only one piece in a complex puzzle of access to health care, I start by examining the trajectory torture survivors will likely follow from entry into the UK to receipt of mental health care. In doing so, I draw attention to key social, political and service-related factors that impose themselves across this trajectory<sup>4</sup>.

##### **1.4.1 The trajectory to mental health care**

As newly arrived entrants to the UK, torture survivors have not yet established their relationship to the health care system. However, protocols are in place to ensure, in principle, that those seeking asylum, particularly individuals identified as torture survivors, have access to health services. These protocols will be implemented by a range of staff in asylum-related and healthcare settings.

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<sup>4</sup> While some of the broad social and legal contexts may apply across Europe, others will be country-specific. Health service structures and specific provisions for asylum seekers and torture survivors vary across Europe, with asylum seekers in some countries channelled directly into specialist services (Patel, 2011; personal communication). Health service funding arrangements also differ, with implications for the positioning of refugees as a patient group. For example, in Switzerland major structural changes within the healthcare system had resulted in doctors being placed under economic pressure to find new patient groups needing high levels of care. As such, asylum seekers with their complex needs requiring long-term intervention had become a highly desirable patient group (Gross, 2004). This contrasts with the situation in the UK primary care setting, where, historically, GPs have been under-funded for work with this group (Jones and Gill, 1998). This situation remains the same in the present day.

Upon entering the UK, those seeking asylum will first come into contact with staff of the UK Border Agency (UKBA). Since the full implementation of the New Asylum Model (NAM) in 2007, all asylum seekers are allocated a NAM Case Owner, who maintains responsibility for their case throughout the application process. The duties of the Case Owner include ensuring access to required health care, much of which can only be accessed following initial registration with a general practitioner (GP). Some asylum seekers will be accommodated at induction or accommodation centres, which may have on-site health care staff.

Refugee survivors of torture may also come into contact with non-governmental organisations (NGOs) such as the Refugee Council via their 'One-Stop' Services, which can provide onward referral to other agencies. They may be referred (or self-refer) to Freedom From Torture (formerly the Medical Foundation for the Care of Victims of Torture), for medico-legal assessment following claims that they have been tortured, or to access other services such as psychological care. Additionally, Refugee Community Organisations (RCOs) may offer support and onward referral, and may provide their own therapies (LeTouze and Watters, 2002).

As previously stated, each asylum seeker should be registered with a GP, and have assured access to NHS health care. In some parts of the UK, there are a small number of GP surgeries that specialise in providing care to refugees and asylum seekers (MIND, 2009). For mental health care, asylum seekers<sup>5</sup> should in theory have access to the same generic services as any other UK resident (for example, community mental health teams, outpatient psychotherapy departments and the new *Improving Access to Psychological Therapies* (IAPT) Programme), accessed via the same referral pathways (Independent Asylum Commission, 2008). Additionally, in some parts of the UK, 'specialist' services have been developed; organised around client group (usually refugees and asylum seekers, rather than torture survivors specifically) or presenting problem (in the NHS, such services are often

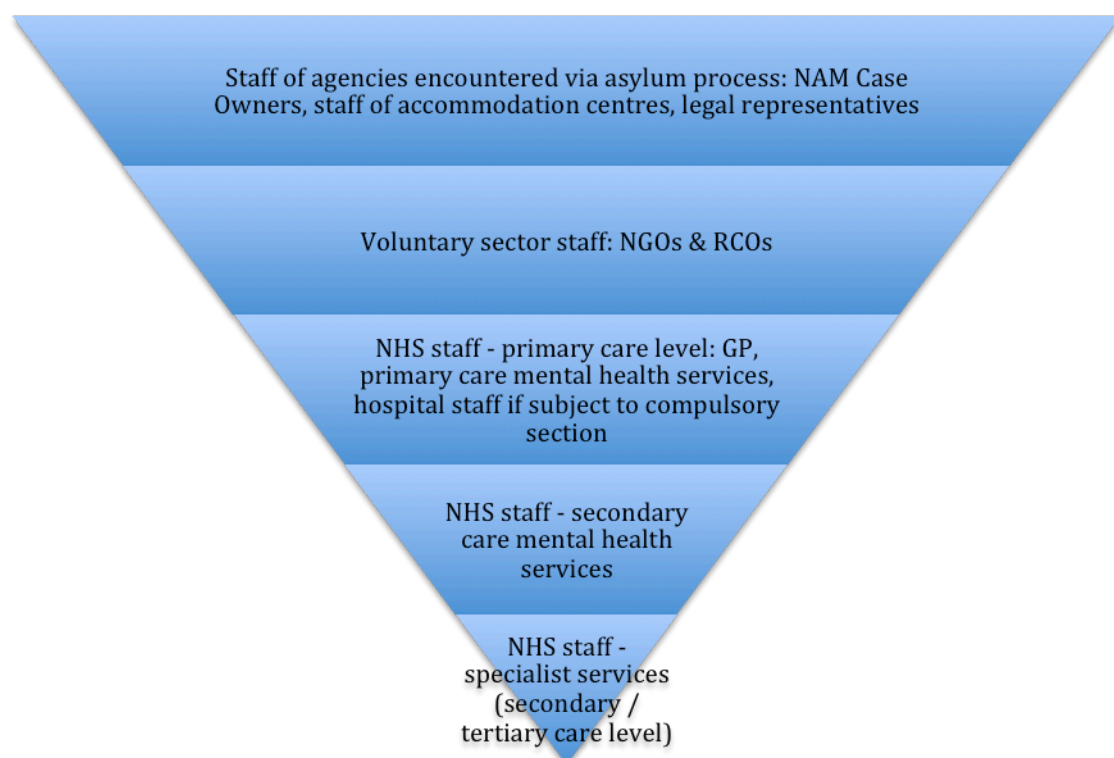
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<sup>5</sup> Other than those whose applications have failed, where access is often at the discretion of the service.

organised around diagnostic categories, for example, Post Traumatic Stress Disorder).

Figure 1 illustrates the levels of service within which torture survivors may (though not inevitably) be seen along the trajectory from initial entry to the receipt of mental health care. Experience on the ground suggests that a significant majority of refugee torture survivors who are seen by staff in the first level are not represented in healthcare services and may never receive care within the NHS, despite their entitlements (Patel, 2010, personal communication).

**Figure 1: Levels of service along torture survivors' trajectory to NHS mental health care**



The reasons for the reportedly diminishing representation across the trajectory to care, of torture survivors compared to other patient groups, are not fully understood. However, it is important to note that refugee torture survivors are a relatively powerless social group, who may experience many

difficulties, some related to torture, which prevent them from accessing care. These might include shame about what has happened to them, lack of knowledge regarding health services and their entitlements thereto, fear of negatively affecting an ongoing asylum application, and mistrust of medical professionals due to their involvement in previous torture (Home Office, undated; Eisenman, Keller and Kim, 2000; Crawley, 2010; cited in Royal College of Nursing, undated). Consequently, it is likely that decisions involving their care, including referral to mental health services, will often be made by more powerful others (including GPs). Staff at each level will potentially shape a torture survivor's trajectory to mental health care, as a result of their own understandings of torture survivors' mental health needs and their related referral decisions.

The existing literature exploring the reasons for non-referral to mental health care has tended to focus on processes at the later stages of the trajectory, that is, within the NHS, rather than at the early stages. However, there is evidence that mental health problems are often missed at initial health screening assessments occurring as part of the asylum application process (Independent Asylum Commission, 2008). Further, it is reported that Refugee Community Organisations may not refer to NHS mental health services due to concerns that they are culturally inappropriate (Kanani, Webster, Ndegwa, Murphy and Stevens, 2001; MIND, 2009).

Given that the care of torture survivors residing in the UK is both an emotive and highly-politicised arena, those making decisions about their care will potentially be influenced by a wide array of clinical and non-clinical factors. These may range from socio-political (law, government policy, social attitudes), to service-related (referral processes, funding, availability), to discipline-related (theoretical models, training of health professionals), to individual practitioner-related (expertise, personal feelings about the work); all of which may be interlinked.

#### **1.4.2 The influence of social and political discourses and associated Government policy**

The social and political environment throughout Europe is hostile to asylum seekers (Montgomery and Patel, 2011). Kraut (1994; cited in Vara, 2003) contends that refugees are perceived in changing ways in response to the changing concerns of receiving countries. Whereas refugees were welcomed to the UK following the two World Wars in a context of economic reconstruction, the economic difficulties of the 1960s brought negative changes in perceptions of refugees, and increasing social and political concern about the entry and residence of non-native people to the UK. These escalated through the following decades. Similar changes can be observed throughout Europe. Gross (2004), for example, documents the way in which immigration has become an instrumental political issue within Switzerland, with large numbers of votes gained at recent elections by the anti-immigration party, Schweizerische Volkspartei, due to their rhetoric of keeping "bogus refugees" out of the country. National discourses, as shaped both by politicians and the media, have created increasing stigma for asylum seekers (McColl, McKenzie and Bhui, 2008). Previous research has indicated that such negative discourses may infiltrate the views of refugee patients held by health professionals, who have expressed fears that these clients may somehow be manipulating the system (Century, Leavey and Payne, 2007). Further exploration is required as to how such views influence their clinical practice.

Recently, national concerns regarding immigration have been reflected in UK government policies. The Asylum and Immigration Act 1996 enforced increasingly punitive asylum conditions in order to reduce the number of people entering the UK. Recent UK legislation has also had a direct and significant impact on refugees' access to health care. Since the coming into force in 2000 of the Immigration and Asylum Act 1999, the UK government's policy has been to disperse asylum seekers to regions away from the South East. LeTouze and Watters (2002) note that asylum seekers are commonly dispersed to deprived areas where already overstretched primary care



services may actively discourage them from registering in GP surgeries, due to the higher costs of treating them. Additionally, specialist services are sparser elsewhere than in London and the South East, where they have been based historically.

### **1.4.3 The influence of health care services structure**

Health services in the UK are organised around a tiered model of primary, secondary and tertiary care, with increasingly specialist services at the higher levels and general practitioners at the primary care level acting as gatekeepers to many higher level services. While many health services are accessed via GP referral, or referral from another health professional, some services will take self-referrals. But these are inevitably dependent not only on a potential patient's awareness of the existence of services and their entitlement to use them, but also their ability and readiness to complete the self-referral process. Access to many specialist services, however, remains controlled by referrals from the GP or another health worker. A recent survey of UK trauma services identified that, of the seventeen specialist trauma services in the UK, only five took patient self-referrals, all others being accessed via referral from a GP or other health professional (Gavrilovic, d'Ardenne, Bogic, Capuzzo and Priebe, 2005).

While mainstream services should be able to provide for any client, there is currently no evidence that they are able to identify torture survivors and provide necessary rehabilitative services. In contrast, there is some evidence of effective rehabilitation within specialist services (Mollica, 2011). There are no statutory services specifically for torture survivors in the UK, although some services specifically designed for this group are offered by voluntary organisations such as Freedom From Torture, formerly the Medical Foundation for the Care of Victims of Torture (Patel and Williams, 2010). Voluntary sector services, however, are subject to funding cuts and a fight for survival internationally (Jaranson and Quiroga, 2011; Montgomery and Patel, 2011). As such, specialist services for torture survivors are severely restricted (Tribe and Patel, 2007; Patel and Mahtani, 2007; Eisenman, Keller and Kim,

2000). Because, historically, there have been more refugees and asylum seekers in London and the south east, specialist voluntary sector services have been concentrated there. Similarly, NHS services in the capital have to some extent adapted to meet the needs of refugee patients (though not specifically the needs of torture survivors). In 2005, five out of eleven London Mental Health Trusts had services specifically designed to meet the needs of refugee and asylum seeker clients, with additional services provided within specialist trauma clinics (Ward and Palmer, 2005), though there is anecdotal evidence that some of these services are also facing cuts.

Barriers linked to the structures described above include problems registering with a GP due to lack of permanent address and/or relevant documentation (Independent Asylum Commission, 2008, p74); insufficient use and variable quality of interpreting services (MIND, 2009); lack of clear referral pathways; poor provision of talking therapies and lengthy waiting lists for specialist care (Kanani, Webster, Ndegwa, Murphy and Stevens, 2001); inadequate staff training and support, leading to an inability to deal competently with this patient group (Carey Wood, Duke, Karn and Marshall, 1995; British Medical Association, 2002; Tribe and Patel, 2007); poor links between voluntary and statutory services; and scarcity of refugee community organisations and specialist services, especially outside London (Burnett and Peel, 2001; MIND, 2009; Summerfield, 2001a).

#### **1.4.4 Mental health care models as a barrier to accessing appropriate care**

Healthcare models must be understood in the wider social context in which they have been developed and applied. This is particularly pertinent to the treatment of torture survivors, where the model around which rehabilitation services specifically for torture survivors are organised embodies a fundamental tension between medicine and politics (Jaranson, 1998). Within health services offered to this group, the influence of dominant theoretical models – or ways of conceptualising their mental health needs – has been noted. Patel (2003) critiques the profound influence of Western psychiatric

diagnostic categories such as PTSD on professional understandings of torture survivors' mental health needs, and hence upon the nature of services offered. In the UK, Post Traumatic Stress Clinics developed additional services to meet the needs of refugee clients, and trauma counselling became a familiar provision (Summerfield, 2001a). This is despite the fact that torture survivors' accounts of their difficulties indicate that negative experiences in exile may have a greater impact than previous 'trauma' experiences (Gorst-Unsworth and Goldenberg, 1998). Within a context of socio-economic insecurity and an accompanying distrustful asylum system, the PTSD diagnosis has become a validating label that doctors have the power to supply (Gross, 2004). Gross (2004) identifies this dynamic as having major implications for the doctor-patient relationship and both parties within it: first, that asylum seekers may be pushed to take on this sickness role in order to have their needs and traumatic histories taken seriously; second, that doctors may make hostile assumptions about why asylum seekers are presenting particular symptoms and behaviours to them, feeling used and 'instrumentalised' (p162).

While recognition and rehabilitation may be powerful steps in a process of healing, the question arises whether the discourse of trauma contributes to this process or brings potentially negative effects. Some possibilities are as follows. First, that the focus on trauma is essentially a focus on damage, rather than capacity for survival (Patel, 2003). Second, that widely-held social beliefs may influence an individual's experience of their situation, causing them to communicate and even understand their difficulties in line with expectations placed upon them (Summerfield, 2001b). If such expectations enter the GP consultation or the therapy room, the question then arises what effect they might have on the therapeutic encounter and the opportunity for patients to have their real needs heard and met. Third, Patel (2003, p24) argues that, "the psychological discourse of trauma has skilfully averted the professional gaze from the causes – that is social inequalities, injustices and human rights violations – to the individual". Such a process will have implications both in broad ethical and immediate clinical spheres. One important clinical implication is that opportunities to promote more culturally

appropriate and empowering methods of assistance may be missed (Cavill, 2000; Patel, 2003).

It is widely held that many torture survivors will neither require nor benefit from psychological therapy; a factor that may quite rightly contribute to low referral rates. Psychological therapy is, of course, founded on a central assumption that talking is helpful; yet in some cultures “talking, particularly to an individual stranger, is tantamount to a loss of dignity and humility and can be seen as not only self-indulgent but as bringing shame onto the family or community” (Patel, 2003, p29). Further, Summerfield (2001a) warns that a focus on refugee ‘mental health problems’ and access to services may obscure the immense social difficulties faced by refugees, for which talking therapy cannot provide solutions. There is consistent evidence that, for many refugees, re-establishment of social roles (for example, through work) is of greater mental health benefit than psychological intervention (see, for example, Eastmond, 1998). In exploring this area, therefore, I make no claim that psychological therapy is the most effective form of help for all torture survivors. It is, however, a service that they are entitled to, but rarely receive, within the context of a broad programme of rehabilitation.

#### **1.4.5 Health service staff understandings as barriers to accessing appropriate care**

In addition to highlighting the impact of the broad socio-political context, health service structures and Western conceptualisations of mental health on access to care, the existing literature points to the importance of individual staff members’ understandings of torture survivors’ mental health needs. It must be noted here that professionals’ understandings and their subsequent decisions may not only serve as barriers to onward referral, but may also expedite referral to mental health services in which torture survivors’ needs may not be well-served (Summerfield, 2001a).

#### *1.4.5.1 The role of GP understandings*

As discussed above, the GP represents a critical point of contact on the trajectory to mental health care for most patients<sup>6</sup>, and their responses to mental health needs are critical in determining their patients' access to mental health care (Ross and Hardy, 1999). Due to the paucity of research into GPs' understandings and decision-making in relation to torture survivors specifically, I begin this section by considering the literature relating to their responses to the mental health needs of *any* patient. I then go on to discuss the literature relating to their responses to the needs of patients originating from minority ethnic groups. Finally, I consider evidence about their responses to refugee patients.

#### *GP referral decisions in relation to any patient with potential mental health needs*

Knight (2003) conducted structured interviews with GPs to identify factors influencing their generic mental health referral decisions. This study did not focus specifically on refugee patients or BME patients, but on all mental health patients. GPs were asked to describe treatment and referral options they would recommend for specified case scenarios. The study concluded that mental health referral decisions are complex, and influenced by a range of patient-related, service-related and doctor-related factors. Patient-related factors identified included the nature of patient needs, symptoms and diagnosis; severity, chronicity and urgency of the problem; severity of distress; and level of social support. Service-related factors included the availability and perceived quality of therapeutic services; ease and promptness of access; and availability of therapists with expertise in responding to the particular needs of the patient (e.g., abused patients). Doctor-related factors included GPs' own ability and availability to deal with the problem; the emotional drain of managing mental health patients at a primary care level; difficulties presented by particular types of patient (e.g., patients with chronic

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<sup>6</sup> As discussed elsewhere, this may not be the case for many survivors of torture who may never access primary care services.

and long-term difficulties); and hesitation about referring patients to another professional when they have already 'opened up' to the GP. GPs expressed diverse views of their role in relation to patients' mental health problems, with some GPs considering it as encompassing that of a counsellor and psychologist, and others expressing a preference for treating physical problems only. Knight concludes that there are "considerable differences between GPs in terms of preferences, inclination and confidence to treat psychological problems" (p209).

In a review of the literature, Ross and Hardy (1999) summarised factors influencing GPs' decisions to refer to adult psychological services. Prefiguring Knight (2003), they similarly listed a number of different factors that represent the interplay between the patient, the GP, and the mental health services available. These included patients' representations of mental health and illness, and their subsequent help-seeking behaviour, as well as GPs' own attitudes to patients' psychological problems and their ability to recognize patients' mental health needs. Also relevant were criteria specified by mental health services for accepting patients, and the links GPs had to those services. The authors also noted the critical influence on referral decisions of GPs' beliefs about the ability of available mental health services to meet their patients' needs. GPs expressed concern regarding long waiting lists, the inadequacy of specialist services locally, and the potential harmfulness of time-limited counselling for severely distressed patients (Burton and Ramsden, 1994; Hendryx, Doebbling and Kearns, 1994; both cited in Ross and Hardy, 1999). Ross and Hardy (1999) conclude that there is a two-way interaction between GP services and mental health services, commenting that while GP referrals depend on the quality and availability of mental health services, these are in turn shaped by GPs' referral behaviour.

#### *GP referral decisions in relation to BME patients*

Ross and Hardy (1999) cite numerous studies focusing on detection of mental illness in general practice, which highlight that up to 50% of cases may be missed; and that factors relating to poor detection include somatic

presentations of distress and cultural differences between physicians and their patients.

Concerns regarding the representation of BME patients within UK mental health services are widespread and well documented. There is substantial evidence that people from minority ethnic groups are heavily over-represented in psychiatric and crisis services, yet under-represented in services providing talking therapies (Williams, Turpin and Hardy, 2006). Williams, Turpin and Hardy reiterate the role of the GP as an important gatekeeper to mental health services. These authors highlight that the GP represents a key level at which minority ethnic groups may be excluded from talking therapies, in part as a result of stereotyped beliefs about certain ethnic groups. GPs, alongside other health professionals, may misunderstand and misinterpret the behaviour and mental health needs of certain ethnic groups. Furthermore, these authors highlight the dominance of Eurocentric conceptualisations of mental distress, which have implications both in terms of GPs' detection of distress, and the structure of and access to mental health services<sup>7</sup>.

This point is reinforced by a study conducted in Sweden by Lehti, Hammarström, and Mattsson (2009). These authors used qualitative content analysis of material from focus groups and interviews to explore GPs' thinking in relation to the identification and treatment of possibly depressed patients from foreign countries. They identified that in attempting to assess and initiate conversations about mental wellbeing, GPs struggled with the limitations of available Western diagnostic concepts. They experienced these concepts, and the resultant clinical guidelines for diagnosis and treatment, as generally of little or no relevance for work with this patient group. Due to this conceptual gap, and the additional cultural and linguistic barriers, they described struggling to comprehend the meaning of patients' symptoms. GPs raised concerns about understanding too little about their patients' cultural backgrounds, including specific cultural conceptualisations of health. In this

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<sup>7</sup> In drawing attention to GPs' reliance on and use of Eurocentric conceptualisations and associated management approaches, I do not assume that all GPs working in the UK are of European origin. They do, however, work within a Western medical system and are, as such, likely to draw heavily on a Western medical framework.

context, they pointed to the difficulties of interpreting non-verbal cues and behaviour, and of determining whether non-verbal behaviours were indicative of depression or simply culturally normative behaviour. They hypothesised that many patients had experienced traumatic life events, including sexual violence and torture; however, they often lacked the means to establish exactly what their patients had been through, which then compounded their difficulties in making a diagnosis. The doctors struggled in the knowledge that these patients' problems were as much social and existential as medical, and therefore not necessarily solvable within a medical framework. Consequently, they felt very powerless to manage these patients effectively. In an attempt to respond to the difficulties of these patients, GPs described drawing heavily on their experience and intuition rather than on clinical protocols.

### *GP management of refugees' including torture survivors' mental health needs*

In this section, I reference the literature relating to GP management of refugees' and asylum seekers' mental health, which includes some reference to torture survivors. However, as highlighted by Jones and Gill (1998), literature relating to GPs' perceptions of refugees' health needs is limited, a fact arguably symptomatic of the marginalized position these patients occupy in national health agendas. An additional difficulty is that the existing literature generally treats refugees, asylum seekers and torture survivors as a homogeneous group, with inadequate reference to the specific and additional needs of torture survivors (Patel, 2010; personal communication). This mirrors concerns raised by the International Rehabilitation Council for Torture Victims that staff working with torture survivors may fail to recognise and respond adequately to their distinct needs (IRCT, 2007). This may, in part, be due to failures in identifying individuals seeking asylum as torture survivors. Despite policy directives<sup>8</sup> relating to the importance of early identification (Patel and Granville-Chapman, 2010), research demonstrates that survivors' history of

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<sup>8</sup> The EU Council Directive on minimum standards for the reception of asylum seekers, provides for the evaluation and identification of persons with special needs: "Member states shall take into account the specific situation of vulnerable persons such as....persons who have been subjected to torture, rape or other serious forms of psychological, physical or sexual violence." EU Council Directive 2004/83/EC, 29 April 2004.



torture may often be missed in primary care settings (Eisenman, Keller and Kim, 2000; Mollica, 2011).

Existing literature indicates that GPs are often unsure about how to respond to asylum seekers' mental health needs, including in relation to making onward referrals (Feldman, 2006). In the context of torture survivors specifically, GPs' uncertainty may also reflect concerns about the possibility of re-traumatising their patients. There is evidence that refugees are frequently not referred on for therapy by GPs who fail to detect their mental health needs, do not think therapy is useful for this client group, or do not understand their health care entitlements (Independent Asylum Commission, 2008; MIND, 2009). The lack of clarity regarding the specific rights of torture survivors to rehabilitation is likely to compound this problem (Patel, 2007).

GPs, like other health professionals, run the risk of applying Western psychological frameworks to groups for which they were not devised, and of universalizing human reactions to distress (Summerfield, 1999). A recent study in Australia explored the implications of this, by comparing interview accounts about the nature of distress offered by refugee patients and the GPs attempting to treat them (Kokanovic, May, Dowrick, Furler, Newton and Gunn, 2010). Patients' accounts of their distress were firmly embedded in shattered social worlds and a consequent sense of normlessness. Their GPs were left struggling to reconcile these communally-based accounts of distress with the individualised concepts of depression and associated treatment options available to them. Kokanovic *et al.* (p524) concluded that both refugees and GPs faced a central dilemma about, "how to integrate experiences grounded in one social context into the matrices provided by another." They noted that one of the mechanisms adopted by GPs to resolve this dilemma was to problematize cultural difference, rather than letting go of their own culturally based ways of understanding. In a similar vein, Summerfield (2001a) contends that GPs' continuing reliance on Western biomedical models of distress may result in inappropriate referrals. He suggests that referrers may unthinkingly equate a history of torture to a diagnosis of post-traumatic stress disorder, with the immediate assumption that psychological therapy is

required. The extent to which his ideas are supported by primary research finding is however unclear, suggesting a need for further in-depth exploration.

Though not the focus of this thesis, the implications in practice of GPs' understandings of and approaches to managing refugee mental health are demonstrated in a small literature which examines directly the experiences of refugees in UK general practice. In a study by Bhatia and Wallace (2007) focusing on both physical and mental health problems, refugee patients described their difficulties in both accessing primary care and in eliciting helpful and appropriate responses from their GPs. They expressed concerns such as not being taken seriously by the GP, voicing a preference for GPs who listened and advised as opposed to prescribing medication. A second study, which explored the views of representatives of asylum seeker communities, highlighted that mental health needs of asylum seekers were seen to be inadequately met due to language and cultural barriers throughout health and social care, including at the primary care level (Misra, Connolly and Majeed, 2006). In reviewing the literature, I was unable to identify any studies relating specifically to torture survivors' experiences of primary care; this remains an area of important future study.

### **1.5 Gaps in the current literature on the role of GP understandings in mental health access for torture survivors**

There is an informative body of general literature about GP decision-making in relation to mental health referrals. While there has been some exploration of additional influences on GP referrals of BME and refugee patients, and some theorising about GPs' responses to torture survivors, there appears to have been no empirical exploration of GPs' understandings of torture survivors' mental health needs or of their referral decision-making in the context of this group. Supporting my own experience of reviewing the literature, Jaranson (1998) argues that there has been less empirical study in the torture rehabilitation field as a whole than in other related fields, a phenomenon he attributes both to research methodological challenges and wider political agendas.

Another limitation of much of the existing literature is that it focuses on refugees, asylum seekers and torture survivors as a homogenous group. In considering mental health care provision for torture survivors, it is of course important to consider not only issues relating directly to experiences of torture, but also those relating to the process of seeking asylum in the UK and living as a refugee outside one's country of origin. However, in work with survivors of torture, there will be additional issues to consider including, but not limited to, the additional legal entitlements afforded to torture survivors; the different theoretical frameworks utilised in understanding effects of torture; the additional difficulties torture survivors may experience in building a trusting relationship with a health professional; and the specific emotional responses of staff working with this group. For this reason, a further exploration of staff understandings of the specific mental health needs of torture survivors is required.

### **1.6 Rationale for the focus on GPs in the current research**

As described, the issue of access to appropriate mental health services for refugee torture survivors is a complex one. As newcomers to the UK, occupying a relatively powerless social position and possessing little knowledge of health care services, torture survivors may encounter a wide range of medical and non-medical staff (UK Border Agency staff, legal representatives, staff of Refugee Community Organisations and Non-Governmental Organisations, GPs and mental health practitioners), all of whom have a potential role in detecting their mental health needs and directing them towards help. Since many torture survivors are never registered with a GP, it is clearly necessary to look beyond standard NHS referral structures to understand why access to appropriate mental health care is so poor.

Accordingly, the original design for this project involved examining the views of the wide range of staff across the trajectory to mental health care. Understanding the interplay between the views of these different staff groups

will be an important area for future study. However, following negotiations with the NHS Ethics Committee, it was decided that the current study should focus on a narrower group of participants, GPs only<sup>9</sup>. While this elucidates only a specific area within a broad and complex picture, it has enabled a more in-depth and focused exploration. The rationale for selecting this participant group was as follows:

- (i) The role of GPs as gatekeepers to NHS mental health services: As highlighted above, within existing referral structures GPs act as the main referrers to many NHS mental health services (Ross and Hardy, 1999). As such, even where staff in non-NHS settings identify a torture survivor as having mental health needs, a referral to statutory mental health services would likely still require channelling through an NHS GP.
- (ii) The role of GPs in assessing health needs in various settings: Although some refugee torture survivors are not registered with a GP practice, they may come into contact with GPs working in refugee community organisations and non-governmental organisations, and in other settings connected to the asylum process (for example, during health screening assessments at Initial Accommodation Centres, or during the asylum determination process). In each of these settings, GPs amongst other health professionals will be responsible for assessing the health needs of refugee torture survivors. It is therefore important to understand how GPs in various settings assess and respond to the mental health needs of this group.
- (iii) The role of GPs in commissioning health services: Under the coalition government's plans for NHS reform, GP consortia will take on responsibility for commissioning most NHS-funded services, including mental health services (at the time of writing, the Health and Social Care Bill, which provides for GP-led commissioning, is undergoing

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<sup>9</sup> The experience and impact of the NHS ethics process will be explored in more detail in the Further Discussion section.

legislative scrutiny in the House of Lords). It is therefore increasingly important to explore GPs' understandings of torture survivors' mental health needs, not only for the purposes of identification and referral, but also in commissioning appropriate services for this group.

### **1.7 Relevance of this study to the practice of Clinical Psychology**

Under international law, refugee torture survivors are entitled to rehabilitation, which may include psychological care. This is a group with potentially many complex psychological health needs, but few reach mental health services, and even fewer reach the scarce specialist psychological services available. The literature reviewed above demonstrates that GP referrals to mental health services are determined in part by GPs' understandings of their patients' needs and the adequacy of available mental health services to meet these needs. As health professionals, psychologists have an ethical obligation to respond to clinical need in developing appropriate and accessible services for all. A greater understanding of barriers to accessing services for this particular client group is therefore of the utmost importance.

### **1.8 Research aims and questions**

The broad policy question underlying this research is concerned with the ways in which current health (and other social and immigration) practices and policies might hinder torture survivors from being identified and accessing the means to rehabilitation in the form of appropriate health care.

In light of this, my review of the literature led me to develop the following broad research question: **How do GPs, working in settings where they may come into contact with refugee torture survivors, understand their mental health needs?** My particular interest was in examining the influences on GPs' understandings, and the potential implications of these for torture survivors' access to appropriate mental health care.

While there are no existing studies exploring GPs' understandings of torture survivors' mental health needs, the broader literature relating to GP mental health referrals has highlighted the importance of examining GPs' understandings; and hence sets a precedent for doing so in relation to this specific patient group.

**REFLEXIVE SECTION – The impact of the researcher on the construction of the research rationale and questions:**

For me, the starting point for the research was my personal interest in the provision of psychological therapies to those groups marginalized by traditionally-structured services; coupled with a desire to learn not only how to research a topic, but how to undertake a piece of research that might have practical policy applications. In collaboration with my supervisor, whose work entails advocacy for refugee torture survivors, I decided to focus on the topic of access to appropriate mental health care for this group. From this position, I attempted to examine the existing literature in a thorough and methodical manner. It serves to consider here, however, that researchers will bring their own interpretations and bias to their reading of the literature and decisions about which literature is relevant. Another researcher working in another context might have interpreted the available social and academic material in a different light; thus reaching different conclusions about what to research. I came to the research with particular hopes, values, and political and theoretical alignments (for example, an interest in critical psychology approaches and a human rights perspective). These doubtless influenced not only my choice of broad topic area, but also my subsequent reading of the literature.

## CHAPTER TWO: METHOD

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In this chapter, I describe my approach to the research. I start by explaining the philosophical underpinnings and objectives of the research, and how these relate to both the broad methodology and the specific methods employed. I go on to describe the procedures involved in undertaking the research, and include reflexive sections on personal and contextual factors shaping the research process.<sup>10</sup>

### **2.1 Philosophical underpinnings of the research**

#### **2.1.1 The relationship between philosophy and research methods**

Two areas of philosophy are relevant to the determination of research aims and methods. The first, *ontology*, relates to fundamental questions about the nature of the world (or 'reality'). The second, *epistemology*, is concerned with the nature of knowledge, and pertains to questions such as how and what we can know about whatever 'reality' exists; what weight we can confer upon our knowledge claims; and where the confines of our knowledge lie (see, for example, Nightingale and Cromby, 1999, p226-7; Willig, 2008, p2; Yardley and Marks, 2004, p2). Consensus in the literature is that, whilst epistemology and research methods are not rigidly correlated, there should be overall coherence between epistemology, methodology (the broad approach to the research) and method (the particular techniques employed) (see, for example, Willig, 2008, p7; Braun and Clarke, 2006, p80).

In designing the current study, therefore, I have been guided by my emerging ideas about what knowledge I believe it is possible to gain through research (my epistemological position). In line with Braun and Clarke (2006), I recognize that I, as a researcher, have made active decisions about how to

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<sup>10</sup> A note on writing style: In line with the chosen epistemological position and qualitative methodology, I have taken a 'reflexive' approach to the research and, as such, have opted to present it in a way which acknowledges my active role in shaping the entire research process. Where appropriate, this report is therefore written in the first person.

approach the research topic and respond to the data generated, and that these decisions have implications for the 'knowledge' produced.

### **2.1.2 The epistemological position of the current research**

For the current research, I have adopted a *critical realist* version of a social constructionist epistemology (as described by Nightingale and Cromby, 1999). I discuss some key philosophical ideas below, to clarify the meaning of these terms.

In adopting an epistemological position, one assumes a point along a philosophical continuum ranging from naïve realism (or positivism), to extreme relativism (associated with 'strong' social constructionism) (see, for example, Sullivan, 2010; Willig, 2008, p3). *Ontological realism* is the conviction that an external world ('reality') exists independent of our experience of it (Nightingale and Cromby, 1999, p228). Ontological realism need not dictate *epistemological realism*: it is possible to believe that an external world exists without believing that one can have objective knowledge of it. However, a researcher taking an epistemologically realist (or *positivist*) position would postulate an uncomplicated relationship between the external world and our representations of it. The positivist argument follows that, by adhering to rigorous scientific procedures, it is possible to create 'objective' and universal knowledge of the world, unmediated by either the researcher's perspective and agenda, or by the social, political and historical context (Sullivan, 2010; Willig, 2008, p2). The doctrine and methods of positivism remain dominant in psychological research (Sullivan 2010). The approach, however, has been strongly criticised (Willig, 2008, p3).

Some major challenges to positivism come from researchers employing a *social constructionist* perspective. Cromby and Nightingale (1999) describe social constructionism as a diverse group of approaches, united by fundamental assumptions about human experience and scientific knowledge. The first of these is that human experience and perception are centrally shaped by social, historical and cultural processes, operating primarily



through language. The study of language is central, with a focus on the way in which it may not only describe 'reality', but also reflexively shape its form and impact. Consequently, social constructionist research often seeks to deconstruct the reified concepts upon which much positivist psychological research is based, and consider the ways in which particular ways of talking contribute to maintaining societal power relations (Cromby and Nightingale, 1999; Sullivan, 2010; Willig, 2008, p7; Willig and Stainton-Rogers, 2008, p7). Second, counter to the positivist claim that objective knowledge of 'reality' can be attained through a process of neutral observation, the social constructionist stance holds that human knowledge is neither objective nor neutral. Instead, there is recognition that our knowledge is determined by both the aspects of the world that we choose to explore, and the methods and purposes of our exploration. Choosing different objects and methods of study, therefore, might produce different knowledge(s) or 'truths', each with different implications. The aim of social constructionist research, therefore, is not to discover whether things are 'true', but to examine the different constructions of reality available to people, and consider the implications of these. As such, social constructionist research always adopts a critical stance (Cromby and Nightingale, 1999; Sullivan, 2010).

While all social constructionist approaches cohere around these key principles, Cromby and Nightingale (1999) describe an impasse between social constructionists grounded in a more realist ontological position and those occupying an extreme *relativist* position. Relativism is the conviction that there is no basis for presuming or exploring an external reality independent of our experience of it. Extreme relativist (or 'strong') varieties of social constructionism hold that the only 'reality' to which we have unproblematic access is that of discourse. In this line of thinking, we can neither access nor theorize an 'extra-discursive' reality: we can study only our linguistic representations and their constitutive effects (that is, their role in shaping the world and those individuals within it). There is no fundamental truth, hence no basis upon which to weigh the validity of different truth claims (Nightingale and Cromby, 1999, p228; Sullivan, 2010).

Various authors, however, have critiqued the extreme relativist position (see for example, Nightingale and Cromby, 1999; Pilgrim and Bentall, 1999; Willig 1999). The first major area of critique relates to relativism's failure to theorize extra-discursive influences on human experience. Cromby and Nightingale (1999) contend that the strong focus on the constitutive effects of language has resulted in the neglect of other significant influences, as follows:

*Embodiment:* The impact of biological factors (such as severe physical injury or skin colour) and personal-social histories (such as torture).

*Materiality:* The fundamental physical nature of the world (for example, the heat of a cigarette on the skin), which both enables and constrains our options for discursive constructions of that world.

*Power:* The effect of structural inequalities and the power of institutions.

A second area of critique relates to relativism's failure to adopt a political position. Relativist approaches are frequently engaged in theoretical critique of the potentially oppressive and divisive concepts on which positivist research is founded (for example, mental illness) (Cromby and Nightingale, 1999; Willig, 1999). It has been argued, however, the endeavour fails if not grounded in a political critique of the material structures and power relationships that create and sustain those concepts.

For the reasons outlined above, various authors have reached a preference for a *critical realist* version of social constructionist work (see Nightingale and Cromby, 1999; Nightingale and Cromby 2002; Pilgrim and Bentall, 1999; Willig 1999). This approach embraces the core principles of a social constructionist epistemology, but is grounded in a realist ontology. As such it accepts the existence of, and attempts to theorize, both discursive and extra-discursive facets of existence. While attempting to understand a reality outside discourse, however, there is recognition of the partial, subjective and culturally mediated status of this knowledge. Language is still seen as important, both in reflecting and shaping aspects of our existence, and in justifying certain courses of action; but there is an additional attention to underlying material and power structures (Nightingale and Cromby, 2002; Sullivan, 2010; Willig, 2008, p13). Willig (1999, p45) defines critical realism as

maintaining, “ontological realism by proposing that events (observable and experientable phenomena) are generated by underlying, relatively enduring structures such as biochemical, economic or social structures”. For Nightingale and Cromby (2002, p702) this approach is “more credible, has greater utility and is closer to a ‘truth’ than the alternatives”.

A critical realist approach provided both the best fit with my own developing ideas about reality and knowledge-production, and the most appropriate means for investigating my chosen topic. It enabled me to critically consider the implications of participants’ accounts, whilst also theorizing the broader context in which these accounts arose and operate. As Nightingale and Cromby (2002, p706) contend, “people construct their own subjectivities but not in conditions of their own choosing”: a statement applicable both to torture survivors and the GPs seeing them. Whilst GPs hold a powerful social position relative to torture survivors, they nonetheless operate within conditions that may often lie beyond their individual control (following Willig’s (1999) analysis, the enduring economic and social structures relevant to GPs’ work with torture survivors might include the NHS, with its associated care structures and funding restraints, and the UK Border Agency). Furthermore, in work with torture survivors, I would also argue the central importance of theorizing extra-discursive factors such as material structures and the power of institutions.

**REFLEXIVE SECTION – The impact of the research process on the epistemological position:**

Braun and Clarke (2006, p85) explain that: *“the question of epistemology is usually determined when a research project is being conceptualized, although epistemology may also raise its head during analysis, when the research focus may shift to an interest in different aspects of the data.”* This description of a ‘shifting’ epistemology applied to the current research. While no major changes were made from the time of conceptualisation, refinements occurred during the process of write-up, interviews and analysis. This was, first, due to my increasing understanding of epistemology, which allowed me to make

theoretically-informed decisions (for example, the development of a fine-grained appreciation of the differences between various versions of social constructionist thinking allowed me to select as most appropriate a critical realist perspective). Secondly, these refinements were shaped by further thinking about the aims of the research and the broader social and political context. I considered that, in conducting policy-oriented research, it would be important to examine not only GPs' understandings, but how these related to the material structures they must interact with. Finally, these considerations were reinforced during the interviews themselves, when I became increasingly concerned about focusing exclusively on language, when GPs were consistently describing to me the material structures they were required to negotiate in their work. There is perhaps a question about whether I allowed my participants' accounts to influence my epistemological position. The following extract from my research journal illustrates how I may have been susceptible to being influenced by the viewpoints put forward by my participants, due to my own position, identity and experiences:

*"After the delays with this thesis and the worries that I might not recruit anyone, I feel so grateful to my participants for offering to participate, and worried about being 'critical' of what they say. I feel very aware of the difficulties they are faced with in their work, and how difficult and complex I myself have found work with refugees."*

(Extract from research journal, at time of recruiting for interviews)

Of course, as a researcher, one must be mindful about the ways in which emotions evoked (such as gratitude, fear and empathy) affect the research process. The risk here was that these emotions, and my own experiences of working with refugees, might push me towards an excessively realist interpretation of GPs accounts and blind me to the potential role of GPs in keeping torture survivors out of mental health services. I found it very difficult that my participants were not the group I was ultimately advocating for, but conceived potentially as a 'part of the problem'. I feel that this concern – coupled with my own experiences of working with refugees and of the seemingly immovable social structures with which one must engage –

reinforced my choice of a critical realist (rather than an extreme relativist) perspective. In my analysis, therefore, I worked hard to remain aware of these influences, and strike a balance between describing the extra-discursive factors identified by GPs and interpreting the effect of their understandings on torture survivors' access to services.

## **2.2 Methodology**

### **2.2.1 Qualitative approach**

This study employs a qualitative methodology. The choice of methodology must derive from the nature of the research question, and consideration of how that question can best be answered (Marshall, 1996). Qualitative methodologies lend themselves to work across a range of epistemological positions (Willig, 2008, p8), the aim being, "to provide illumination and understanding of complex psychosocial issues and are most useful for answering humanistic 'why?' and 'how?' questions" (Marshall, 1996, p522). In relation to the current research topic, there is an absence of literature exploring in-depth *why* and *how* health professionals make sense of torture survivors' needs, questions suited to a qualitative approach.

### **2.2.2 Reflexivity**

The term 'reflexivity' relates to the researcher's consideration of their influence on the research process and knowledge produced (Nightingale and Cromby, 1999, p228; Willig, 2008, p10). As discussed in Section 2.1, any researcher stepping outside a rigid positivist framework must recognize that they have an impact on the research process.

Willig (2008, p10) describes two types of reflexivity: (i) *Personal reflexivity*: which requires the researcher to consider the impact of their identity, experiences, principles, political alignments, and life aims on the research; and (ii) *Epistemological reflexivity*: which is concerned with the ways in which

the research question and study design have influenced what can be found. She further describes an additional component of reflexivity, *critical language awareness*, which requires consideration of the ways in which the researcher's language may affect participants' responses, and the degree to which language is theorised as reflecting versus shaping 'reality'. While reflexivity is strongly associated with qualitative research, different qualitative methodologies theorise to different degrees the influence of the researcher and the role of language. Willig (2008, p11) describes the diverse ways in which the researcher's influence is theorised in more relativist methodologies (researcher as 'constructor' of findings) versus more realist methodologies (researcher as 'skilful excavator' of findings).

The current research employs a critical realist version of a social constructionist epistemology, wherein personal, epistemological and linguistic reflexivity are central to the research process. Within a critical realist perspective, the researcher's influence is theorised as lying between the two extreme ends of the spectrum described above: the realist aspect of critical realism theorises the existence of certain material structures which can be observed and analysed, while the critical (or constructionist) aspect acknowledges that our understanding of these structures is at best subjective and culturally mediated. Similarly, critical realism's approach to language lies between the two poles: language is seen as shaping experience and knowledge, while also reflecting underlying material structures. I have therefore engaged in both personal and epistemological reflexivity throughout, by keeping a research journal and considering key reflexive questions at various stages of the research (reflexive sections are included throughout the write-up).

### **2.3 Method**

As with broad methodologies, specific methods must be selected on the basis of their potential to answer the research question. This study involved a series of individual in-depth interviews with GPs in two areas of the UK. The

interviews were tape-recorded and transcribed for analysis. Analysis involved a thematic approach (see Section 2.3.2).

### **2.3.1 Data collection: the interviews**

The current research sought to illuminate the ways in which GPs understand torture survivors' mental health needs, examine the resources they draw on and explore their rationale for certain described courses of action. Interviews were chosen as the means of data collection because they offer the most fruitful opportunities to explore the ways in which people understand the world and are appropriate where potentially sensitive topics may be explored (Kvale and Brinkmann, 2009; cited in Hugh-Jones, 2010; Ward and Palmer, 2005). Further, they allow exploration of "the real contradictions and complexities" inherent in participants' experiences, and in the operation of health services (Banister, Burman, Parker, Taylor and Tindall, 1994, p50).

Interviews, however, are not a faultless research tool. Potter and Hepburn (2005; cited in Gibson and Riley, 2010) contend that the contrived nature of the research interview, and the conversational involvement of the researcher, gives us information only about how participants talk in these highly specific circumstances. For this reason, some authors favour the use of more naturalistic data (for example, analysis of medical records or recorded doctor-patient interactions)<sup>11</sup>.

Interviews may be 'structured' (essentially a verbally-conducted questionnaire with a pre-determined range of responses); 'unstructured' (an exploratory and sometimes spontaneous interaction between researcher and participant, supposedly free of imposed categories of enquiry); or 'semi-structured' (a formalised interview structured by a theoretically-derived interview guide, but providing flexibility for the researcher to follow up unexpected issues raised by

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<sup>11</sup> For the current research, analysis of taped doctor-patient interactions might have provided valuable and more naturalistic information about the ways in which general practitioners respond to torture survivors' expressed needs, and the dynamics influencing that process. It would, however, have been a more complex study to implement, and would have afforded no opportunities to explore with GPs their rationale for responding in certain ways.

the participant). For Banister *et al.* (1994, p50), structured interviews offer insufficient exploratory opportunities, while unstructured approaches adhere to a precarious pretence of being uninformed by prior assumptions. They argue that: “assumptions structure all research, and the least we can do is to recognize this and theorize the impact of these assumptions”. For these reasons, semi-structured interviews were chosen for their balance of focus and flexibility; and the impact of the interview format on data collection – and of the researcher on data analysis – has been considered throughout the research process.

#### **REFLEXIVE SECTION – Learning the art of interviewing:**

I found it a hard process learning to undertake research interviews, and my early interviews were more in the style of structured interviews, in that I was less confident in following up novel issues raised by participants. In my later interviews, I consider that I became more successful in reducing the extent of my influence, and eliciting long passages of uninterrupted talk. I reflected during the process, however, on the ways in which my own assumptions as an interviewer impacted on the material generated. For example, in following up on unforeseen issues introduced by participants, I suspect that I – like any interviewer – probed further into those ‘novel’ topics that resonated with some aspect of my prior theoretical knowledge. I was also aware of being a very responsive interviewer (giving brief verbal encouragements regularly). Re-reading the transcripts, I was aware at some points of having given more feedback when I agreed with participants’ comments, thus neglecting to challenge or question talk that was more consistent with my own perspective. I will consider these issues in more depth in Chapter 4 (Further Discussion).

#### **2.3.2 Data analysis**

Data was analysed using *thematic analysis*, informed by the epistemological position and objectives of the research.



Willig (2008, p9) highlights the central role of theory in data analysis; explaining that, before analysing a transcript, the researcher must decide what that transcript signifies. Researchers employing diverse theoretical frameworks (and bringing diverse personal experiences) may interpret the same accounts in varied and numerous ways. From a critical realist position, I theorised the potential implications of GPs' talk, while also acknowledging that such talk will be underpinned by the structures within which GPs were operating and the resultant range of paradigms available to them that enabled such talk.

While some analytic approaches are tied to a particular epistemological framework, thematic analysis can be adapted to a range of theoretical and epistemological positions (Braun and Clarke, 2006). This flexibility is considered a great strength, and has obliged me as a researcher to consider carefully the philosophical and ethical debates surrounding different ways of responding to participants' accounts, rather than accepting a pre-determined analytic method and its inherent assumptions. I have, of course, imposed an epistemological framework upon participants' accounts (as described in section 2.1), within which my analytic claims will be grounded. My hope, however, is that the additional thought given to this framework has assisted in ensuring a reflexive analysis.

The core skills employed in thematic analysis underlie all qualitative analytic methods. For this reason, various authors have characterised thematic analysis as a technique used within other analytic methods, rather than a method in its own right (see, for example, Boyatzis, 1998; Ryan and Bernard 2000; both cited in Braun and Clarke, 2006). It has been argued, however, that it should be conceptualised as a distinct method, offering many benefits such as accessibility and usefulness in policy-oriented research (Braun and Clarke, 2006; Ritchie and Spencer, 1994). As with any analytic method, the authors contend that, for thematic analysis to be used successfully, it must be clearly defined and the researcher's assumptions clarified. I therefore detail the procedures followed below.

Analysis followed the six-phase approach defined by Braun and Clarke (2006):

- (i) Familiarisation with the data – I first listened to the interview recordings to gain a general sense of the atmosphere of the interview and what had been discussed. I then transcribed the interviews myself (see Section 2.4.5). Finally I read through the transcripts and made notes about my initial ideas and possible themes.
- (ii) Generating initial codes – I worked systematically through all transcripts, highlighting segments of text containing features of interest in the context of this enquiry. My analysis was data-driven (inductive), meaning that my coding categories were closely linked to the content of the text. As Braun and Clarke (2006) describe, thematic analysis can focus at either the semantic level (that is, looking at what is explicitly stated in the text) or the interpretative level (that is, looking beyond what is explicitly stated, for example looking at underlying assumptions). I opted to code at both levels, to retain different but equally important types of information. This ‘binocularity’ is advocated by Frosh and Young (2008). An anonymised section of transcript illustrating a worked example of the analysis is included in Appendix 3.
- (iii) Searching for themes – I considered all the coding categories generated and organised them into potential themes both within and across the transcripts. This was done using detailed mind maps and referencing back to the original coded data extracts to ensure the codes were representative of what was said. I then generated an initial thematic map (Appendix 4A), using colour coding to represent individual informants’ talk. This allowed me see at a glance the distribution of themes across participants’ accounts and further develop my thematic map (Appendix 4B). There are debates in qualitative analysis about what constitutes a theme: for example, to what extent an issue must be recurrent across all accounts and is predominant within individual accounts. Addressing this issue, Braun and Clarke (2006) comment that it is not possible to be prescriptive and that individual researchers must make their own judgements about this. In my write-up of the analysis, while avoiding quantification, I have tried to

be transparent about the distribution and weight of themes across the interviews.

- (iv) Reviewing themes – I reviewed my candidate themes, regrouping them to decrease repetition and increase distinctness of the final themes. This led me to develop a final thematic map (Appendix 4C).
- (v) Defining and naming themes – at this stage I worked to organise my themes so as to develop a coherent narrative around the data and points of interest identified within it. This involved defining and naming overarching themes and sub-themes within them.
- (vi) Producing a report – in undertaking the analysis and producing this report, I have sought to ensure quality throughout by following Braun and Clarke's checklist for a good thematic analysis (included in Appendix 5).

## **2.4 Procedures**

### **2.4.1 Recruitment strategy**

Qualitative research does not aim to produce generalisable results, but rather, to understand complex phenomena (Willig, 2008, p9). Qualitative researchers therefore aim to recruit participants who, by virtue of their experiences and context, may offer rich insights into the research questions (Marshall, 1996). In the current study the recruitment approach was informed by general principles of qualitative sampling, and developed with the aim of accessing participants who might provide a rich and diverse range of accounts. While the content of accounts cannot be predicted, various factors that might contribute to such diversity were considered and incorporated in the recruitment approach as follows:

- (i) Range of work settings: As highlighted in section 1.6, GPs may encounter patients who are torture survivors in a range of settings including standard primary care GP practices, specialist services for refugees and torture survivors, and settings connected to the asylum process. This project consequently sought to recruit GPs working in a range of settings where they may come into contact with refugee survivors of torture.

(ii) Levels of experience: Similarly, the recruitment approach sought to access GPs with varied levels of expertise in working with torture survivors. Recruitment material clarified that participants with little or no experience were welcome to participate, provided they were working in settings where they might encounter refugee torture survivors.

(iii) Geographical location: Although the researcher was based in London, it was not felt appropriate to restrict recruitment to the London region, due to the large numbers of asylum seekers dispersed outside London since 2000. Additionally, service availability and structure varies within and outside the capital, and therefore may affect the experiences and perspectives of GPs. For these reason, attempts were made to recruit participants from both London and Liverpool, the two main asylum processing centres in the UK.

The exact method of recruitment depended on local Research and Development (R&D) approval processes. In all cases, potential participants were contacted via email. Emails contained a letter of invitation to participate, plus a written information leaflet (see Appendix 6). Potential participants were invited to contact the researcher with any questions or if interested in participating. They were also invited to pass on study information to other eligible staff in order to enable the participation of other key parties not initially identified.

Within Liverpool, study information was circulated around a Liverpool-wide GP research network. In London, recruitment was via existing professional networks of the researcher and researcher's supervisor. Some relevant specialist organisations were also contacted directly.

#### **2.4.2. Participants recruited**

Eight GPs were recruited and interviewed for the research. The sample size, was based on both theoretical and pragmatic considerations: the aim was to capture a number sufficient to generate a range of accounts, while enabling a thorough analysis of each within the time restrictions imposed by conducting a piece of research in the context of the Clinical Doctorate. There is some

debate about sample sizes in qualitative research, with some researchers arguing that interviewing should continue until the point of theoretical saturation, and others arguing for a more pragmatic approach of between five and twenty-five participants, depending on resources (Lyons and Coyle, 2007; cited in Hugh-Jones, 2010).

The sample consisted of six GPs from the Liverpool region, and two GPs from the London region. It had been hoped that the sample would be more evenly distributed between the two recruitment regions, and additional efforts were initiated to recruit more GPs in London, but recruitment there was slow, and recruitment rates in Liverpool ultimately proved sufficient to ensure the required number of participants.

### **2.4.3 Interview schedule**

A first draft of the interview schedule was constructed following an initial review of the literature and discussion of key issues with my supervisor, an expert in the area. The interview schedule was designed to focus on how GPs aim to identify mental health needs, what challenges they experience, and how they determine an appropriate response. These questions were based around the core tasks that GPs in various settings might undertake in work with this client group (identification of torture history, assessment/identification of health need and onward referral). In view of government proposals regarding GP commissioning, a question was also included which aimed to elicit GPs' views on which services should be commissioned for this client group.

The interview schedule was piloted with one GP whose feedback on the process was combined with feedback on the interview transcript from my supervisors. The final version of the interview schedule, as approved by NHS Ethics, and used to guide research interviews, is included in Appendix 7. It must be noted, however, that development of the interview schedule is an iterative process, and therefore minor refinements were made during the course of fieldwork in light of issues raised by individual participants.

#### **2.4.4 Interviews**

Arrangements were made for interviews to be held at a time and venue convenient for the participant. Subject to site-specific approvals, interviews were held either at the participant's workplace, their home, or at university premises. At all venues, interviews were held in a quiet and private place.

At the start of the interview, study information sheets were reviewed with participants, and they were given the opportunity to ask questions. They were reminded that they had the right to withdraw at any time, and were then asked to sign a consent form (see Appendix 8). Participants were also offered a summary of study results when complete.

At the end of the interview, the researcher debriefed with participants to ensure they felt comfortable with the interview process and that they were happy for all parts of the interview to be included in analysis.

#### **2.4.5 Transcription**

Interviews were recorded using a digital voice recorder and then transcribed by the researcher. Transcription entails the conversion of spoken material into written material and, as such, constitutes an interpretative process in itself (Banister *et al*, 1994, p57; Willig, 2008, p27). Various transcription conventions have been developed to meet the requirements of different analytic approaches. Since thematic analysis can be employed in diverse ways, however, Braun and Clarke (2006, p88) explain that there is no set transcription convention. They do, however, specify a set of minimum requirements: (i) that the transcript retains the information needed for analysis (a verbatim account of all verbal material and, where relevant, non-verbal material); (ii) that this is in a form that accurately represents the original account. They highlight, for example, the way in which added punctuation may alter the meaning of a sentence (Poland, 2002, p632; cited in Braun and Clarke, 2006).

As the researcher, it was therefore necessary to make certain decisions about how to transcribe the data. As required, I transcribed all verbal material and noticeable non-verbal material (such as laughter, pauses) that I felt contributed significantly to the tone of the interview. Despite cautions about punctuation, I made a decision to punctuate the transcripts for readability, and to try to retain the original meaning of participants' talk as I heard it. For example, where participants were clearly listing items during interview, I added commas to ensure this was not lost in the written transcript. A transcription key is included at the start of Appendix 3.

Once transcription was completed, all transcripts were checked against the recordings to ensure accuracy and to check that the transcription matched the tone of the recording as closely as possible in the researcher's opinion.

Analysis of data was then started, as described in Section 2.3.2.

#### **2.4.6 Ethical issues**

Non-coercion and informed consent: As described in Section 2.4.1, participants were recruited to the study on an opt-in basis (that is, they had the option to respond to study information circulated to them if interested). Potential participants were provided detailed information about the purposes and process of the research, and given opportunities to ask questions, to ensure informed consent.

Confidentiality: In order to protect confidentiality, data relating to each participant was given a code number. Consent forms and details of these codes were kept in a locked filing cabinet, separate from digital records, interview transcripts and demographic details. All identifying details were removed when digital records were transcribed. Digital records were kept securely and will be erased after examination of the research is complete. Transcriptions were securely password-protected on a computer, and will be kept for five years, after which time they will be erased. Only the researcher,

the internal supervisors and the examiners have access to the transcribed material.

Support in the event of distress: It was considered unlikely that participants would become distressed during or after an interview. However, at the end of each interview, the researcher debriefed participants to explore whether they found anything in the interview difficult, and they were given information about how to contact the researcher or researcher's supervisor following the interviews if needed.

Payment for participation: Participants were offered reimbursement of travel expenses if applicable but were not paid for their time.

#### **2.4.7 Ethical Approval**

Ethical approval was sought via the UEL Ethics Committee and an NHS Ethics Committee. While the UEL Ethics Committee granted approval immediately, the NHS Ethics Committee requested major changes to the initial proposal as described in Section 1.6. Further to these changes, ethical approval was granted by the NHS Ethics Committee and the UEL Committee was informed and accepted these changes. Letters of approval from the UEL and NHS Ethics Committees are included in Appendices 9 and 10.

#### **REFLEXIVE SECTION – The impact of the ethics approval process on the research and the knowledge produced:**

The process of applying for NHS ethical approval provided an informative illustration of how the context in which research must be undertaken, and the associated bureaucracies, influence the knowledge produced:

1) Resource availability: In completing the NHS ethics form, I was struck by the mystifying and time-consuming nature of the process. Arguably, the push towards evidence-based practice in the NHS is hindered by the complexity of this process. While completing the application, I wondered how many NHS



clinicians would have time to engage in research requiring so lengthy an approval process.

2) Timing: At the time of planning this research, all studies involving NHS staff required ethics approval. The major changes requested by the Committee resulted in an entirely different project from that initially conceived, thus the production of different knowledge. If this project had been undertaken a year later, changing requirements would have meant that NHS ethical approval was no longer required, and so the project would have proceeded as originally planned.

3) Power and remit of NHS Ethics Committee: the process of gaining NHS Ethical Committee approval proved to be extremely challenging. Quite rightly, NHS Ethical Committees act as gatekeepers to the portfolio of research taking place within the NHS context and have the power to refuse approval for research they deem unethical. In the case of my study, however, their concerns related to methodological issues already approved by UEL academic reviewers. Due to the pressure to move ahead with my research, I accepted the methodological changes demanded by the Ethics Committee. While I appreciate that methodologically unsound research is, *de facto*, unethical, I subsequently understood that the changes requested were beyond the remit of the Committee. Clearly, this had enormous implications for the knowledge I have produced.

4) Respected forms of enquiry: Sullivan (2010) observes that quantitative research is widely viewed as superior to qualitative research. The Ethics Committee I attended was made up of members who, by virtue of their professional backgrounds, seemed likely to have little knowledge of qualitative research methods and their epistemological underpinnings. Though the value of qualitative research enquiry has gained increasing recognition within the biomedical arena (Pope and Mays, 1995), its status within a research framework where a quantitative paradigm remains dominant is uncertain.

## CHAPTER THREE: ANALYSIS AND DISCUSSION

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In this chapter I present my analysis of the interview data. As described in Chapter Two, I analysed data at both a semantic and an interpretive level. Therefore, I present the main themes I derived from my participants' accounts and integrate my interpretations about these accounts, for example, the contexts and paradigms influencing them and the potential implications for practice. I begin this chapter by introducing the reader to my participants. I then summarise the themes derived and go on to describe these in more detail.

I draw the reader's attention here to my use of the terms 'patient' and 'patient group' throughout. This reflects the way those individuals seeking help from a GP are commonly labelled and the terminology adopted by my participants, but does not imply my alignment to a medicalised model of distress and the effects of torture.

### **3.1 GP participants**

In Table 1 below I have summarised some of the key characteristics of my eight participants. As described previously, my recruitment approach was aimed at accessing GPs with various levels of experience in working with torture survivors, across a range of settings in which they might encounter them. As previously stated, the purpose of this approach was to generate a diverse range of accounts; and while I have made some reference in my analysis to perceived differences in the accounts of participants with greater or lesser experience of working with this group, I have not made formal comparisons, as to do so was not the focus of the study. I also recruited GPs from two geographical areas (London and Liverpool). Although in my analysis I refer to aspects of local working context such as resource availability, I have chosen not to identify participants' geographical location in order to offer greater anonymity and enable reference to other aspects of their identities that I considered more relevant. Whilst geographical location might have been

a relevant influencing context in GP's accounts, for the purposes of this research I have not referred to it.

**Table 1: Background and work context of participant GPs**

<b>Participant:</b>	<b>Summary of features of interest for the analysis</b>
Participant One (P1)	GP in NHS primary care Also working in charitable refugee organisation Extensive experience of refugee work
Participant Two (P2)	GP locum working across several practices Some clinical experience with this patient group
Participant Three (P3)	GP in NHS primary care Very little clinical experience with this patient group Voluntary experience with a refugee organization
Participant Four (P4)	GP in NHS primary care Some clinical experience with this patient group
Participant Five (P5)	GP in NHS primary care Extensive experience of refugee work
Participant Six (P6)	GP formerly in NHS primary care Currently working for charitable refugee organisation Also in private practice conducting medico-legal assessments in relation to asylum applications Extensive experience of refugee work
Participant Seven (P7)	GP in NHS primary care Some clinical experience with this patient group
Participant Eight (P8)	GP in NHS primary care Some clinical experience in specialist care setting for asylum seekers

### **3.2 Presentation and discussion of thematic material**

Three main themes were identified. These were: Challenges in assessing and responding to torture survivors' mental health needs; Conceptualisations of torture survivors' mental health needs and solutions; and Medical practice within the asylum context. A number of sub-themes were identified within each main theme and are outlined in Table 2 below.

**Table 2: Summary of the themes and sub-themes**

Themes:	Sub-themes:
Challenges in assessing and responding to torture survivors' mental health needs	<p>Patient-related challenges</p> <ul style="list-style-type: none"> <li>A. Issues of trust</li> <li>B. Reluctance to talk and dangers of talking</li> <li>C. Issues of difference</li> </ul> <p>GP-related challenges</p> <ul style="list-style-type: none"> <li>A. Survivors' needs go beyond GP domain and expertise</li> <li>B. Work evokes pain and angst</li> </ul> <p>Context-related challenges</p> <ul style="list-style-type: none"> <li>A. Lack of GP time</li> <li>B. Problems with interpreters</li> <li>C. Available MH services inadequate and potentially damaging</li> <li>D. Government dispersal policy</li> </ul> <p>Strategies developed in responses to challenges</p>
Conceptualisations of torture survivors' mental health needs and solutions	<p>Competing models of distress</p> <ul style="list-style-type: none"> <li>A. Mental health needs in a social framework</li> <li>B. Mental health needs in a Western medical framework</li> </ul> <p>Proposed responses to distress</p> <ul style="list-style-type: none"> <li>A. Intervention should address both psychological and practical problems</li> <li>B. Interventions should be at the specialist level</li> </ul>
Medical practice within the asylum context	<p>GPs' adopted roles in relation to torture survivor patients</p> <ul style="list-style-type: none"> <li>A. GP as judge and detective</li> <li>B. GP as defender</li> </ul> <p>Visible difference within the asylum context</p>

### **3.2.1 THEME ONE: Challenges in assessing and responding to torture survivors' mental health needs**

Participants talked extensively about the challenges of meeting torture survivors' mental health needs, describing a range of challenges that I have conceptualized as falling into three broad areas: patient-related, GP-related and context-related. Although I have separated these out for the sake of reporting the data, they are inevitably interlinked. So, for example, one of the context-related challenges identified was that of short GP consultations (an issue related to structure of NHS services and rationing of care). This contextual factor became a particular challenge, however, in the light of factors seen as specific to this patient group (complexity of patient needs, patient's reluctance to talk). In response to the challenges identified, it appeared participants had developed a number of strategies to assist them in assessing and responding to survivor patients.

#### **3.2.1.1 Patient-related challenges**

##### A. Issues of trust

A number of participants commented that survivors of torture were, as a group, generally distrustful, especially of authority figures, including doctors. For this reason, they felt it took time to build up trust to enable a confiding relationship:

*P1: So what we're really talking about is officially one hour of medical time and one hour of practice nurse time, but it's probably equivalent with writing reports and everything to about three hours of doctor time and two hours of nurse time, just for an initial assessment of this group. Because, the reason it's spread over three weeks is you have to develop trust in the clients, they're very distrustful of people in authority, very distrustful, and you need to break down that mistrust that has been, er, built up. (259-268)<sup>12</sup>*

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<sup>12</sup> Please note that while brief interjections I made during the course of the interviews were initially transcribed, they have not been analysed in detail and so for clarity have been omitted from data extracts presented here.

### B. Reluctance to talk and dangers of talking

I noted a widespread perception amongst participants that torture survivors often would not or could not talk about their torture experiences and mental health:

*P8: They don't come out and say 'Here's what's happened, Doctor, I feel really really bad because this thing happened.' (621-623)*

*P5: I find that speaking to some of the refugees you know they are numbed and they don't know how to, to bring it out, the feelings. (272-274)*

It was described that some torture survivors were deeply avoidant of talking, either because they were not ready to talk at all about their experiences or because they were not willing to talk to someone new, having already told their story to their GP. In neither case was it seen as relevant or helpful to make a referral to talking therapy:

*P6: Well there are some people who just can't talk about what happened, you know, they just say they can't talk about it and if you try, they are really not at a verbal point about that, they will do anything to avoid talking about it and clearly then it's [talking therapy referral] not going to be the most helpful thing for them. (414-418)*

Participant Six further raised the issue that cultural differences in the stigma attaching to mental ill health might reduce torture survivors' willingness to disclose their mental health problems.

In several participants' accounts, I noted that they themselves were concerned about the potential dangers of encouraging torture survivors to talk, which had implications both in the context of assessing survivors' mental health needs and deciding whether to refer for talking therapies. They

highlighted the risks of either losing or re-traumatising survivors, if asked to recount their torture experiences:

*P3: Some things you just can't push cos you'll just make things worse.*

*Kate: Mmm. What do you think would happen if you did push and made things worse, can you tell a bit more about that?*

*P3: I think the, the worst thing would be that um they wouldn't come back, you just wouldn't see them again. (124-130)*

*P4: Often it's hard to know how much you should talk about what previously happened, um, with post-traumatic stress it's hard to know whether you should go over those, go over those issues again or whether that's just going to bring it all out and worsen the problem, so it's hard to get a balance. (145-151)*

There is reference in the existing literature that torture survivors may find talking to a stranger deeply shameful, suggesting these concerns about re-traumatising survivors or pushing them to talk demonstrate an appropriate sensitivity. However, the strength of this theme within participants' accounts led me to question whether they might be over-cautious in their management of such patients, therefore miss opportunities to detect mental health needs and direct patients accordingly.

### C. Issues of difference

A subtle but pervasive theme threaded through participants' accounts was of the difficulties of responding to patients whose experiential, cultural and psychological lives were perceived as so different from their own and from those of other patients. Participant Three, for example, described that while every patient's life experiences differ from one's own, torture was a particularly extreme and incomprehensible experience:

*P3: But, there's something about torture which is um, you know particularly horrific and um difficult to understand because it's the sort of thing where*

*you don't really want to put yourself in someone else's shoes because it's so awful. (734-738)*

Difficulties in understanding and identifying the real issues for patients were also related to cultural and linguistic differences. Participant Two talked about how difficult he found it to assess the mental health status of patients who did not speak English. He described trying to read these patients' body language, but being conscious of the risk of misreading things. His language during the interview indicated a real feeling of uncertainty on his part. Likewise, Participant Seven articulated the difficulties of understanding what was 'really' going on for any patient, but emphasised the complexities inherent in a consultation in which shared cultural understandings were absent:

*P7: I think when you're working with people who speak the same language as you, come from roughly the same, well you, different people will come from different parts of the society and you know more or less about how that operates, but there's a way in which you come to a, you feel more comfortable that you, that there's a certain, I mean truth is such a variable thing isn't it but that, that you have an understanding between you of what is and isn't being said or, and I think it's that, it's as much the uncertainty of that, when somebody is from somewhere else, their first language isn't English, you don't understand the ins and outs of their culture particularly well. (301-312)*

Though few GPs appeared to be thinking at this nuanced level, those with extensive experience in the area were able to reflect on the potential impact of subtle cultural differences in ways of thinking about the self and mental wellbeing. It was noted by Participant Six, for example, that torture survivors' conceptualizations of mental health may differ from Western biomedical ones, for example that in some cultures individuals may not be socialized to reflect on their internal world and therefore questions about individual well-being may have little meaning for them:



*P6: Sometimes people come from a culture where individual needs and problems are simply not really considered or expressed and so they've never really had those internal conversations with themselves about how their life's going and whether they're happy about it, so they can find it quite difficult to understand the sorts of questions that we're asking. (214-220)*

Another GP, Participant One, commented that when assessing behavioural indicators of mental distress, it was important to be mindful of cross-cultural differences in behavioural norms – for example, that behaviours such as avoiding eye contact, which might be interpreted in Western cultures as symptomatic of depression may, in other cultures, represent a respectful attitude. Nonetheless, both GPs described adhering to a standard (Western) mental health assessment framework, although adapted based on their clinical experience.

Participants also discussed their perceptions that refugee patients might not only conceptualise mental health differently, but might also engage in very different help-seeking behaviours from the native UK population. Participant Two, when asked why torture survivors with mental health needs might not access mental health care, responded that they simply might not see their problems as medical. While this may be true, such a response runs the risk of placing responsibility for failure to access care with the patient, rather than the professional. A similar sentiment was expressed by Participant Four, who commented about this patient group that, *'they are very different to the English population so they cope with things very differently'* (199-200). When I probed this issue further with her, she described having noticed major differences between groups of patients from different parts of the world. The example she picked on was that of *'African people'*, who she felt were keen to cope on their own despite extreme experiences:

*P4: I did find there was very much a cultural difference between groups of patients from different parts of the world. Erm, African people have gone through sometimes the most extreme circumstances, with sexual abuse, family members killed in front of them, um multiple rapes possibly. Um, but*

*they were not forthcoming, they just, they didn't deal with our services on a regular basis like other people did. (206-213)*

Reflecting on this participant's comments, it appeared to me that she was attempting to develop knowledge she could apply to what she termed '*multi-cultural patients*'. I was struck, however, by the danger of cultural generalisation. Her expressed belief that refugees were very different to the native UK population served to create an 'us and them' distinction, wherein White-British people were viewed as the norm against which others should be compared. Her reference to '*African people*' as a homogeneous group neglected the differences inevitably existing between the vast number of different African cultures and countries, let alone those individuals within them.

I encountered similar generalisations in other participant accounts. Participant One, for example, expressed the view that counselling was an entirely alien concept for refugees and not useful for them. While this view may be an accurate one for some refugees, its application to a hugely heterogeneous population risks denying access to talking therapies to many who are entitled and may benefit.

Finally, one participant also made reference to the possible impact of the culturally defined meanings of mental illness, the potential of these meanings for social stigma and discrimination, and their consequent role in discouraging survivors from accessing any service with a mental health label attached to it:

*P6: Then there are the cultural stigmas, you know some people getting a letter that says 'mental health' on the top of it, they get very anxious and they think 'well I'm not going there'. (500-503)*

### **3.2.1.2 GP-related challenges**

#### A. Survivors' needs go beyond GP domain and expertise

Participants talked extensively about the non-medical needs of refugee torture survivors and the necessity of addressing these to promote wellbeing (see Theme Two). Whilst many participants described willingly and even passionately taking on this wider role, it was also described as a difficult role, as the issues to be addressed were often outside the GP's domain of expertise and role remit, leaving them feeling helpless:

*P2: Well it's just um, it can be very difficult. But I, I just, most of the time I just write letters of support for being rehoused and um, I do the best I can to listen to them and to help them, I'll see what I can do it's just, um, it's a bit like playing cards with a very poor hand you sort of, you do the best you can but it's very difficult. (603-608)*

*P4: It's more from a social point of view as well, so there's lots of social issues to talk about and often there's issues, finances, housing which I don't always have the answers for that, er, because that is somebody else's domain. (311-316)*

Participant Four also described having been told by her employing health trust not to get involved in legal and asylum issues, due to the time involved and the implications of any written statements.

#### B. Work evokes pain and angst

Due to the inescapable complexities participants felt they faced in this context, and the inadequacy of the resources they reported as available to make a meaningful response, GPs expressed how painful and difficult it was to work with this patient group; with one expressing the desire to withdraw altogether. Participants' accounts indicated that work with torture survivors evoked angst not only in relation to their professional role and the positions they felt placed in as a result of the asylum context (see Theme Three), but also a deeper personal angst related to facing the atrocities of torture. Participant Eight

mentioned repeatedly the horrific nature of torture stories he had heard from his patients and expressed concern about protecting me, the interviewer, from their awfulness:

*P8: I mean um, how much detail, how much detail of the individual things that happen do you want, because some of this, some of it is very very nasty, some of it's very very bad, right, but obviously we are both adults here, but I don't want to be gratuitous unless it's of any use. (239-243)*

He also talked for some time about different forms of torture and why these might be perpetrated, as if the interview had challenged him to face and comprehend these issues afresh.

### **3.2.1.3 Context-related challenges**

#### A. Lack of GP time

All participants made reference to time as a major issue for them in dealing with the potential mental health needs of refugees who may have been tortured. They consistently described the length of a standard GP consultation (normally 10 minutes, or extended in some practices to 20 minutes with an interpreter present) as inadequate to assess and respond to the needs of this client group. They described how this had an impact on their ability to explore and respond to the perceived complex and extreme needs of this patient group, and their ability to develop a relationship of trust (see Section 3.2.1.1, sub-section A):

*P4: My strong feeling is that these groups of patients need extra time. Um, I spent 40 minutes, an hour with some of these patients, they're booked in for a ten-minute appointment, with an interpreter often, um, so, which obviously is never possible to deal with their multiple health problems in, within that time. (116-121)*

*P5: You need a very therapeutic setting. Now our setting is not very conducive to that.*

*Kate: Well, what makes a therapeutic setting where that sort of conversation can happen?*

*P5: Because we work in, over 20 patients or 13, 18 patients booked for us and we are in a rush as well, and whether we will be giving that erm chance of that, I think our, our you know, like any other quick consultation sort of thing, doesn't lend itself, lend itself to deal with these people. (732-741)*

### B. Problems with interpreters

Some participants expressed the view that it was harder to build a relationship with their patients and assess their mental health needs through a third party. They also described problems with interpreting services arrangements, such as interpreters failing to show up at the arranged time, the non-availability of face-to face interpreter services due to practice funding restrictions and the complexities of interpreter-patient relationship, such as ethnic clashes between them. One participant (P4) also reported having heard that interpreters from the same cultural background could become too involved and start to introduce their own ideas into the consultation:

*P4: Having an interpreter er can be difficult sometimes and not always sure if what's being quoted is word for word at times, er, and I've heard stories that, thankfully I've not experienced it myself, when the interpreters have become too involved and said something that, from their back which was not appropriate to the patient and actually didn't help the situation because they were often from the same cultural backgrounds and can have their own views, which would be different to ours. (280-288)*

This raises questions about power and the hierarchy imposed on different healing ideas.

### C. Available mental health services as inadequate and potentially damaging

One of the predominant themes (discussed by all participants) was the complete inadequacy of existing mental health services to meet the needs of this group. Reasons commonly cited were the lack of expertise in working with

this group, lack of interpreting services, the inadequacy of restricted numbers of sessions for addressing torture-related distress, the length of waiting lists and the disconnection with primary care services:

*P7: But you know what we've got in [in this area] is um now is a, is a sort of counselling psychotherapy service that you refer someone in with a piece of paper and then they get assessed by a phone call and then if they pass their assessment they, they get put on a waiting list for three or four months for something which is only going to last 6 to 8 to 10 sessions anyway, and you know that's not going to, not going to help any of these, any of the, you know that's not gonna be what's needed for somebody who's been as traumatized as the people I'm describing really, do you know what I mean, it's just not gonna it's like, you know it's not even a sticking plaster. (481-493)*

Several participants talked about the problem of waiting lists for existing therapy services. When asked if this would be a particular problem for this patient group, and if so why, participants raised concerns about torture survivors disengaging from the idea of talking therapy, if not seen rapidly. Because of the limitations identified, several GPs explicitly stated that they either did not refer torture survivors to mental health services or that they made referrals but had little hope for these and so made little effort to engage the patient in the idea of such a referral being valuable. One participant even went so far as to say that in their opinion mental health services in their current state were so inappropriate to the needs of this group that their only function was a strategic one within the asylum process, because torture survivors' engagement with them might delay the risk of sudden deportation:

*Kate: So, if you had somebody who you thought had particular mental health needs, what might inform you in deciding whether to refer them through to mental health services?*

*P1: Uh whether they've been granted asylum or not. So if they've not been granted asylum the most important thing they need is a letter to indicate that they need assessment uh to, by a psychiatrist or by the specialist*

*service, and that will delay the chances of them being forcibly um, have a dawn raid and being handcuffed and removed back to their country. So that's the issue. I know that in practice the assessment by the psychiatrist in itself is unlikely to be of major benefit to the patient from a therapeutic medical point of view but the most important in this person's recovery is that they get refugee er status in this country, permanent leave to remain and if that helps towards that goal then it's very good. So what you're doing really is, it's a strange thing, is you're using a medical service not for it's inherent benefit but with a view to addressing a structural injustice within society. (700-719)*

Another theme identified describes a position in which mental health services were viewed not only as inadequate but moreover actively rejecting of torture survivors as patients. Participants suggested that this was due to torture survivors being 'messy' clients who may be difficult to engage and who – due to their multiple difficulties – do not fit standard diagnostic categories and therapeutic approaches. The view was expressed that in the quest to fit patients into diagnostic pigeon holes, mental health services not only excluded this client group but also lost sight of their humanity; and as such contributed to reproducing and reinforcing trauma experiences:

*P7: Maybe this is just me being cy, cy, being cynical now but it feels like the, the sort of pathways, you know, you have to have CBT or you have to have this or you have to have that it's, you know, psychology's got into pigeonholing people in the same way as psychiatry has, do you know what I mean, you need this or you need that, whereas the sort of idea that somewhere there's a person underneath all of that that's needs a little bit of this and a little bit of that and a, yeah which is probably more what some of these people need rather than a very definitive, you know we'll do it this way. (782-793)*

Additionally, it was felt that desire to keep such clients out was seen as linked to a lack of resources, particularly for refugee clients - for example, one

participant (P5) talked about the local counselling service refusing refugee clients on the grounds of having no interpreting service.

#### D. Government dispersal policy

Some participants noted that assessment and successful onward referral was complicated by the Government policy of dispersing refugees around the country. This was seen as interfering with continuity of care and positive outcomes of any referral and intervention:

*P8: By the time that patient has opened up to you and you've referred on to psychiatry and they've got an appointment waiting for them and you've started them on medication, they're gone, they've moved somewhere else and they have to go through the whole rigmarole again and then they'll be there for a month and then they're gone, and it's very very frustrating. (736-743)*

#### **3.2.1.4 Strategies developed in responses to challenges**

In response to the complexity of torture survivors' needs and the limited length of standard GP consultations, participants described adapting their standard practice to accommodate this group. This involved giving more time to patients who might be torture survivors, either by bringing them back over several consultations or by offering extended consultations at the end of clinic hours. This meant that participants were either offering what was, effectively, a charitable service (since they were using their own time) or they were offering a higher than usual number of consultations to these patients. Participants highlighted the importance of a flexible and supportive working environment, due to the potential for their efforts to better serve this group to become a source of tension between themselves and other practice colleagues:

*P1: It's very hard work in relation to, my partners in the practice are hard-pressed, they're very good doctors uh sometimes I can sense that they feel that I'm being a bleeding-heart liberal, but um I I'd say that I'm just*



*addressing the needs of the clients in the practice, um but there is that dynamic so not only does it cause stress in in personally, it also causes stress, the workload, these sort of issues do cause stress within in the the partnership within the practice, with the best will in the world. (185-194)*

In contrast, one participant working almost exclusively with refugees talked about the importance of putting strict time boundaries around what could otherwise become a limitless commitment:

*P6: You develop ways of dealing with that or pacing yourself and just not taking on too much work. And I think that's something that people find really difficult, because you have a sense of this enormous unmet need out there, there's always more people than you can, than you've got time to see and people don't want to leave if you do develop a relationship with them, they wanna keep on seeing you because their problems don't go away quickly. (107-115)*

In response to their perception that torture survivors may be reluctant to talk about their experiences, participants described drawing on a range of strategies to help them understand their patients' experiences and mental health problems. These included:

- relying on previous assessments/notes
- asking the patient directly about whether they have been tortured
- probing gently about previous experiences and current mental health (see P4 below)
- creating an environment where torture survivors feel able to talk
- relying on intuition and transference
- reading non-verbal cues, body language and facial expression (see P8 below)
- relying on general knowledge of the countries of origin of torture survivors, in order to guide questioning about what patients may have been through.

*P4: They wouldn't tell you immediately um, why, why they were upset, er you'd have to probe and ask, you know 'what, what event's happened to make you like this?' um, so they wouldn't, wouldn't be forthcoming unless you, you asked, if you didn't ask the, the, I'd, I'd have thought they probably wouldn't tell you. (172-177)*

*P8: You've got to pick up on, on I suppose, I suppose a face that is always sort of um constantly expecting something horrible to happen. That's the nearest you can get to it, it's not very good though, it's not a very good description. (513-516)*

### **3.2.2 THEME TWO: Conceptualisations of torture survivors' mental health needs and solutions**

The central aim of the research and a substantial focus of the interviews was to explore participants' understandings of the mental health needs of refugee torture survivors. This theme therefore describes my analysis of the conceptualisations of torture survivors' distress that they drew upon and their associated ideas about how best to respond.

#### **3.2.2.1 Competing models of distress**

Participants' accounts indicated that they were drawing on two competing models of distress: a social model and a Western biomedical model.

##### **A. Mental health needs in a social framework**

A major theme I identified across the interviews concerned the link between refugee torture survivors' mental health problems and the social problems they faced, which included uncertainty about their asylum status, negative public attitudes and racism, housing problems and separation from family:

*P1: The single most important thing that will improve their health is to get refugee status or, uh, extensive leave to remain in this country. That is the single most, much more important than anything else. (173-176)*

*P4: Often it can be simple things like that [social issues] which are are most worrying for, you know, things that they're most worried about. (319-320)*

In light of this, all participants talked extensively about the need to respond to *both* psychological and social issues. As highlighted in Section 3.2.1.2, subsection A, however, participants reported finding this difficult, due to limitations in their own expertise and the resources available to them.

#### B. Mental health needs in a Western medical framework

I was interested to note that having talked about survivors' problems in social context terms, participants nonetheless drew heavily on a medical model of mental health. For example, several referred to looking for psychiatric symptomatology and anticipating certain psychiatric diagnoses within this group, such as PTSD and depression.

*P8: What's important for us is to, is to pick up, to first of all to bear in mind that anyone who is seeking asylum could quite possibly be the victim of torture and therefore have the, you know have problems psychologically, and also to think about what those problems are likely to be psychologically. And those problems are likely to be somewhere, it's, somewhere around a post-traumatic stress disorder picture. (299-306)*

In looking for psychiatric symptomatology, participants described drawing on generic medical training and experience with non-refugee mental health patients, and using standard (Western-based) mental health assessment frameworks:

*P7: I think that, that sort of assessment probably follows the same lines that it would for, for somebody who was you know born and bred in [local*

*area] and came in with something, so in that respect I think it's similar (372-375)*

Given their professional background, and my knowledge of health service structures, I was unsurprised to encounter participants drawing on readily available medical frameworks. In the course of our discussions, they provided a clear rationale for doing so, suggesting that diagnosis is critical for evidence-based treatment, determining the most appropriate response to a patient's needs and accessing mental health services:

*P7: So if I want to access mental health services I need, I need to give a coherent story which involves giving, putting a label on it to get the service I want, does that make sense? So, so if I'm the gatekeeper to the services beyond um then, then one of my jobs as the gatekeeper is to put a label on to say well 'you need to look after this person because they are this label'. (649-655)*

In addition to participants' explicit talk about the functions of diagnosis within medical care structures, I theorised about the function of this talk for participants' own peace of mind and within the interview itself. One participant who appeared quite anxious about the interview talked at length about evidence-based treatments and recommended prescriptions for subtly different forms of depression. Since the interview explored an area of practice that seemed challenging and mystifying, my interpretation was that this participant had retreated into more comfortable and familiar territory where he could demonstrate his expertise and where routes to action seemed clearer.

In work with this patient group, however, the Western medical framework and its associated diagnostic categories did not come without problems. Making a firm mental health diagnosis was viewed as additionally complex in this group, firstly because they were not seen as fitting neatly into Western diagnostic categories:

*P7: It is an element of the distress they are in, but it doesn't fit neatly into the, the pigeon holes that we need, and the people who don't fit the psychotic and are probably more just traumatized don't, don't sort of hit the hurdle. (125-128)*

A further difficulty in applying a Western medical model related to its tendency to separate mind from body and the social world that body has inhabited. Participants Seven and Eight, for example, talked about the importance of understanding a patient's life history in order to distinguish between 'real' (endogenous) and experientially related (reactive) mental health problems – but this attempt to distinguish appeared to become a source of confusion at times. Similarly, some participants talked about torture survivors commonly presenting with psychosomatic complaints. The determination to see problems as either mental or physical left participants struggling to determine an appropriate response and concerned about losing their patients:

*P4: The few patients that come in with physical health problems, just headache, something like that, so you've always got to be aware of the physical health problems that actually, it's down to their emotional issues, cos you can get, if you're not careful then you could go too much into detail about their physical health problem, possibly a referral, which is, wouldn't be helpful and may cause the patient more frustration, more anxiety and that worsens the mental health and can destroy the relationship between you and the patient as well. (579-589)*

In summary, then, while both the social and medical models appeared to provide participants with useful conceptual resources, neither came without its problems and participants appeared to struggle in their attempts to synthesise these competing models of distress with such different solutions. Rather than choosing between these two models, however, participants drew on both. Participant One, for example, who was heavily engaged with a social and human rights framework, also seemed strongly wedded to the importance of torture survivors being given a medical diagnosis and critical of counselling agencies' attempts to de-medicalise distress.

### **3.2.2.2 Proposed responses to distress**

#### A. Intervention should address both psychological and practical problems

Almost all participants talked about making attempts to address their patients' asylum-related and social problems, for example by writing supporting reports, referring to legal services and ensuring that interventions addressed both mental health and practical problems. Participants were asked a question about what services they would choose to commission for refugee torture survivors. Despite the interview context (an exploration of mental health needs), there was only limited reference to services that would traditionally be defined as mental health services. Rather, proposals were for combined services that could address the multiple needs of this group (therapeutic, legal and social):

*P5: I think that, not necessarily a priority, but one thing I would say is that kind of a um, I would say good counselling service for them supported by language workers and a social worker. You don't need high-powered thing but simply these three things of er, and supporting them enough in the initial phase of things. (957-966)*

Participant Six commented that, in her experience, interventions aimed at addressing the multiple including practical needs of this group would not only be more appropriate, but would have far greater likelihood of engaging the patient, as compared to a focused mental health intervention neglecting their wider circumstances:

*P6: I think that flexibility is actually key in a way often to helping this group because they want to feel that someone is really going to help them with all these things, having found someone who's interested and cares about them, and, and what can be very difficult is somebody who only wants to work about the nightmares, but shows no interest in their accommodation difficulties and says 'don't tell me about that because it's not my problem' and they can experience that as really rejecting. (438-448)*

In thinking about torture survivors' needs holistically, some participants argued that what torture survivors needed most were community, human connection and continuous support. Mental health services as currently configured were seen as failing to meet these more fundamental needs:

*P7: So I think all the sort of more sort of higher-level services that we think of in terms of mental health is probably, um it's probably icing on the cake, it's actually a more fundamental thing that's required and I think that's probably why I think some of the Church groups actually do the best, the best work around because they, because they are actually saying 'I'm a human being, you're a human being, I want to help you' (859-865)*

#### B. Interventions should be at the specialist level

A common idea expressed among participants was that torture survivors required specialist help even at the level of GPs themselves. One, Participant Eight, suggested the possibility of specialist GP consortia as a way forward. This was linked to a sense of enormous, even excessive, responsibility to manage torture survivors within the confines of standard GP practice. Participants' accounts suggested to me a feeling that this would not only provide a better service for torture survivor patients but might also let GPs themselves off the hook. Several participants seemed uncertain about how to respond to these patients. Participant Three, for example, suggested that he might seek advice from specialist charitable agencies about how to '*approach the patient*': I wondered whether he would have felt the same need for specialist advice with other patient groups and his comment here seemed to resonate with participants' expressed worries about the dangers of getting torture survivors to talk (see Section 3.2.1.1, sub-section B). At the level of mental health interventions, participants also expressed the need for specialist help, which would be fast-tracked, easily accessible and where health professionals would have expertise regarding patients' countries of origin. There was also a suggestion that such help might best come from others who had shared similar experiences, rather than from healthcare

professionals who had no experience of comprehending the nature and legacy of the torture experience:

*P3: I'd find it impossible really to to understand someone who's been through, through torture it's not, it's not something, unless you've been through it yourself or been in that that country, or that situation at the time, you can't really imagine what it would be like and I think to, just simply for someone who's been there and done that, gone through all the, jumped through all the hoops, um it would just mean a, a huge amount more, they would they would just intuit, intuitively know what's, what things matter to refugees which I would probably just miss or overlook. (706-716)*

### **3.2.3 THEME THREE: Medical practice within the asylum context**

Although not asked about it directly, the single most pervasive theme in participants' accounts was around the complexities of working in a medical context that they saw as being infiltrated by the wider asylum context and associated social and political discourses. Most participants talked explicitly about their involvement in writing supporting reports for asylum-seeking patients. Several discussed that a proven history of torture and the associated mental health difficulties would be supporting evidence or '*a bargaining point*' (P2) in an application for asylum.

#### **3.2.3.1 GPs' adopted roles in relation to torture survivor patients**

##### **A. GP as judge and detective**

It quickly became apparent from their accounts that several of the participants felt that within their role as doctors it was necessary for them to assess the genuineness of patients' claims. One participant (P5) talked passionately about the fact that doctors should always assume the genuineness of their patients' stories, yet went on to say that they were expected to interrogate patients' claims and judge them. A high level of ambivalence was apparent across accounts, with participants talking explicitly about resisting the role of



judge or 'Border Agency guard' (P1) while at the same time describing actions demonstrating how they slipped into or actively adopted this role. For example, the participant who talked about doctors resisting the role of border guard also described producing a supporting report for every asylum-seeking patient, thus seeming to act in the role of country gatekeeper, albeit on the side of the asylum seeker. The way participants talked about the issue of genuineness suggested that discourses about the possibility of asylum seekers not being genuine are so pervasive and readily available that even GPs trying to avoid doing so are influenced by them. One participant, while arguing that non-genuineness among asylum seekers was so rare that he did not want to talk about it at any length, nonetheless repeatedly returned to the topic throughout the interview:

*P8: I think it's probably important at this stage to get this little bit out of the way, some patients erm I have suspected, and I'm a very you know I'm about as averagely cynical as, as most GPs are, some patients er or some people who are seeking asylum in general, I think have said that, have said things about their experience in their own country which quite possibly may not have been true. (116-122)*

A second (P5), when asked about difficulties identifying survivors of torture, assumed he was being asked about the difficulties of establishing genuineness.

Doctors' accounts indicated that they had not only implicitly taken on the role of judge, but also that of detective, developing strategies for determining 'truth' or genuineness which were linked to mental health symptoms or behaviours. Two main strategies were identified in the accounts: first, mental health problems were seen as a potential indicator of torture history; second, a patient's inability to talk about their history was taken as an indicator of having experienced severe trauma:

*P7: I've seen some women who I think have probably been hugely traumatized and had, and raped, and if you finally get them to start, if you*

*finally open up the question and they're finally beginning to, they can't, they can't talk about it, they just literally go silent. Whereas there are some people who seem to be so chatty about it that you, that you end up thinking, they just know they have to tell this story to get in. (76-83)*

Reflecting on Participant Seven's account I interpreted it as infused with guesswork and possible prejudice. While several participants spoke of applying the same rules for assessing genuineness, it was unclear what their foundation was. The analysis also raised a question as to how GPs' judgments about a patient's genuineness might influence their decisions about onward mental health referrals.

The language of 'genuineness' and 'non-genuineness' was similarly echoed in participants' distinctions between 'real' and 'unreal' mental health problems. Participants' accounts indicated that mental health diagnosis in itself could be a complex task, a complexity augmented within an asylum context in which applicants might have, "*learnt somewhere that they need to behave in a mad way for something to kick in so that they don't get deported*" (P7, 119-121). It was clearly evident in this participant's account that the asylum context introduced doubt into the mental health assessments she made:

*P7: Part of me thought he [refugee patient] could really be at real risk and he could, his paranoia could actually be completely real and the only safe place for him is in the psychiatric hospital, which is what he was getting both myself and the psychiatrist at the time to do, and then the sort of Home Office asylum people were basically saying 'you know it's all made up, we're going to send him back to [country of origin]'. And you have no idea. (202-209)*

This appeared to be a painful area of practice for several participants, who struggled with the role they felt bound to take on. They expressed a desire to be on their patient's side and an understanding of why patients might lie to them, while at the same time rehearsing concerns about that possibility.

### B. GP as defender

Some participants highlighted that the negative social and political discourses about asylum seekers were evident in the attitudes of other practice staff. Participants expressing a particular commitment to working with refugee patients described how this led to tensions between themselves and practice receptionists, who they felt acted like Border Agency staff in judging refugees and trying to prevent their access to the practice. Faced with other people's negative attitudes and the pressure they themselves felt to take on a judgmental role, several participants spent considerable time during the interviews refuting negative discourses about refugees and distancing themselves from any association with such discourse. Participants who had previously voiced doubts about the genuineness of some patients' stories appeared particularly anxious to demonstrate to me as the interviewer that they did not buy into this widespread negative discourse, for example, describing how they challenged prejudice on the part of others:

*P8: You get a lot a prejudice against this group of people and you see it, I see it and hear it with some other patients talking to me and I just say 'look you know I, don't say that, don't talk like that'. (813-816)*

Some participants who actively identified themselves as advocates for this group drew on evidence and ethical principles to debunk negative talk and defend their rights to equal healthcare access. One participant in particular seemed almost overly keen, given the focus of the interview, to set out the moral, humanitarian and economic arguments for torture survivors to access healthcare services. In the face of widespread negative public attitudes, a punitive asylum system and accusations of '*bleeding heart liberalism*' (P1) directed at him personally, it appeared that this participant had taken on the role of constantly fighting for this group and their rights. He and others seemed to feel the isolation of their position:

*P5: I was working with the PCT, we were trying to set up a refugee you know something for the refugee health and one of the senior person in the*

*primary care trust and so on, but nothing came out of that in. Um so what I'm trying to say is no one takes special interest in this. (913-918)*

For some participants, their unwillingness to accept socially held prejudices uncritically and their adopted role of 'defender' was linked to their own cultural identity and moral values:

*P8: I've never really got myself interested in the actual political aspects of immigration or, or asylum, I could never really get myself worked up by some people saying 'yes but these people are economic, economic immigrants instead of like' you know, I was thinking, well yeah so what, my parents were economic immigrants you know they came over here that that because they could find work here, so it didn't really, that differentiation doesn't really bother me that much. (796-804)*

*P7: I suppose in my value system we have been in part responsible for why they've [refugees] ended up having to flee where they're going, where they are coming from, but we're not, we're not into that, you know our society, our society in general, into taking that picture of it. (165-169)*

### **3.2.3.2 Visible difference within the asylum context**

One participant (P5) described himself as being from a disadvantaged minority ethnic group from a war-torn country. He described additional difficulties in serving refugee patients in relation to his own visible difference from the majority White-British population. For example, he described feeling subconsciously aware, if spending extra time with a (visibly different) refugee patient, that other practice staff and patients might judge him as partisan in his behavior. Furthermore, he described feeling placed in a conflicted position with regard to his expertise – on the one hand, his comments regarding race issues being taken less seriously due to his own ethnic status, on the other that status leading others to assume his expertise in dealing with refugee patients. In the course of the interview, he countered that assumption by arguing that, by virtue of his social class and Western medically indoctrinated

(in his words, 'colonised') mindset, he had little in common with the new wave of poorer refugees from his country of origin seeking asylum in the UK:

*P5: Well you know because, because I'm, I'm brown and from [country] it doesn't mean um I understand the working class of my people, you know what I mean? There is the assumption that 'because he's brown and that patient's also from you know therefore', what I'm trying to say in the story is that, you know, it's got nothing to do with the colour. (703-710)*

Having raised concerns about his own ethnic status impacting on how seriously others received his opinions, I was struck that this participant went on to illustrate his point by drawing on the example of a White-British middle class doctor, who had presented a parallel difficulty in understanding White working class patients.

## CHAPTER FOUR: FURTHER DISCUSSION

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In this chapter, I summarise the main findings of the study and consider to what degree they answer my research question. I further theorise influences on participants' accounts and consider the contribution of my research to the existing literature and its implications for future research, practice and policy. Finally, I consider limitations of the research and issues around its quality, including my reflexive thinking about the study.

### **4.1 Summary of findings**

Three main themes were identified during data analysis. The first theme encompassed participants' talk about the challenges of assessing and responding to torture survivors' mental health needs. These challenges fell into three broad categories: patient-related, GP-related and context-related. Challenges relating to patients included difficulties in building trust with the GP, reluctance to talk about torture experiences and mental health, and experiential and cultural differences that impinged upon the interaction between them and the GP. Challenges relating to the GPs included the sense that they lacked expertise to deal with torture survivors' needs, and that this work evoked pain and angst for them. Finally, context-related challenges included lack of time within the set-up of GP consultations, problems with interpreters, inadequacy of available mental health services and the impact of the Government's policy of dispersing refugees. In response to these challenges, participants described a number of strategies they had developed to try and meet the needs of this group.

Theme Two related to participants' conceptualisations of torture survivors' mental health needs and associated solutions. Participants were seen as drawing on two competing models of distress: a social model which situated survivors' needs in the context of attempting to establish their lives in the UK; and a Western medical model which served clear functions within health service structures but which was problematic. Suggested interventions for this

patient group were tied strongly to addressing their multiple and interacting needs; it was also felt that specialist intervention was needed, even at the GP level.

The third theme, which seemed to exercise and trouble participants, related to medical practice within the asylum context and its associated social and political discourses. In response to the conflicted feelings evoked by this work, participants appeared to take up conflicting roles as 'judge and detective' or 'defender'. One participant, the only GP from a minority ethnic group, highlighted the impact for him personally of being visibly different, in terms of undertaking work with this patient group.

## **4.2 Research Questions**

### **4.2.1 How do GPs, working in settings where they may come into contact with refugee torture survivors, understand their mental health needs?**

My core research question was aimed at exploring GPs' understandings of torture survivors' mental health needs, in relation to the broader issue of access to healthcare services for this group. While GPs often drew on individualised models of mental health, they also recognised survivors' needs as fundamentally embedded in their social and political context. They saw torture survivors as a patient group with huge unmet needs that reached far beyond isolated mental health issues. They appeared keen to meet all these needs but highly exercised in doing so due to the interplay between torture survivors' particular difficulties, their own limitations in understanding and the severe lack of resources in general practice and available mental health services.

In seeking to understand the role GPs themselves might play in the complex puzzle of torture survivors' lack of representation in mental health services, I was struck by participants' apparent commitment to meeting the needs of this group appropriately, but their strong conviction that available mental health

services were inadequate and potentially damaging. Participants seemed acutely aware that torture survivors might have particular clinical needs related to their history of torture and appeared anxious to protect them from further traumatisation. GPs' questioning of the appropriateness of UK mental health services reflects widespread concerns in the literature (see, for example, IRCT, 2007; Jaranson and Quiroga, 2011). Nonetheless, my analysis suggests that GPs' sensitivity to the needs of this group might have led them to draw on a potentially problematic discourse of vulnerability; and thereby to behave in an over-protective and over-generalising manner, failing to refer those who would, in fact, benefit from onward referral.

In light of the conflation in the literature between refugees, asylum seekers and torture survivors, my research question sought to focus specifically on GPs' understandings of *torture survivors'* mental health needs. One of the problems I encountered in attempting to answer this question was an ongoing conflation in participants' accounts. Whilst participants certainly focused at times on torture survivors, they regularly returned to more general talk about asylum seekers and refugees. As stated elsewhere, such confusion may be due to problems identifying torture survivors, and it should be noted that potential identification difficulties were implicit in the phrasing of my questions.

#### **4.2.2 Influences on participants' accounts**

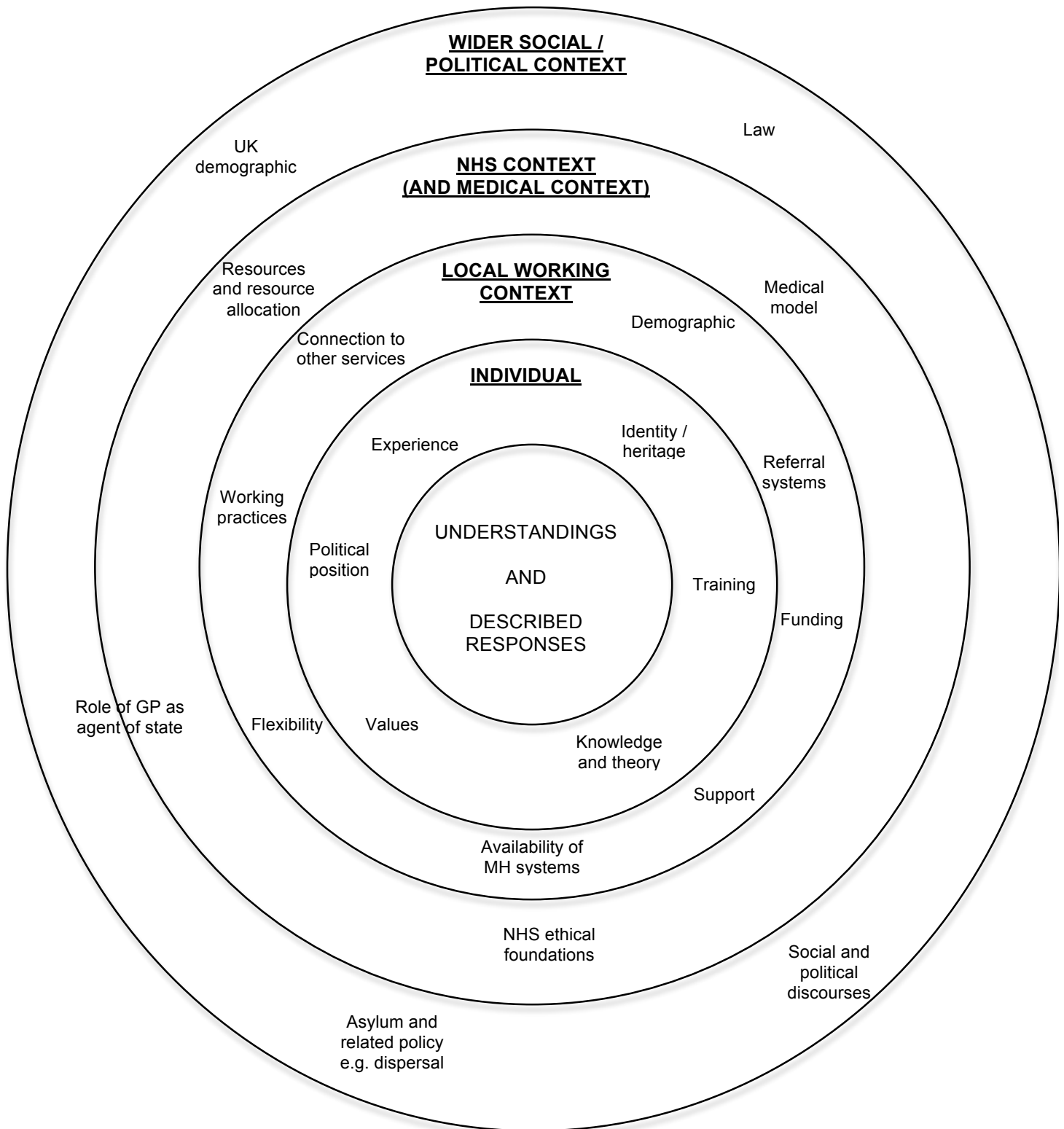
While not a direct research question, I sought, in the course of my analysis, to theorise influences on GPs' understandings of torture survivors and their needs. The pervasiveness of the asylum context and associated social discourses in participants' accounts was striking. The analysis indicated the huge impact of this context on the doctor-patient encounter and the way GPs might respond to the needs of this group. For example, though only articulated by some participants, doubts about the genuineness of survivors' mental health presentations might be reflected in ambivalence over referring them to therapy services.



Based on my analysis, I further theorised the roles I experienced GPs as adopting (judge/detective versus defender) as reflecting the conflicted position they occupy as members of a caring profession, members of the general public and members of a system of social control. As members of a caring profession they drew upon medical ethical frameworks to serve their patients. As members of the public, they were inevitably susceptible to the negative social discourses that surround the categories of asylum seeker, refugee and torture survivor (Century *et al*, 2007). As GPs, they can be seen as occupying a position that has long been imbued with authority to determine the genuineness of patients' sickness or wellbeing (Parsons, 1951; cited in Gabe, Bury and Elston, 2004). It may be the case that, in reality, GPs' role in influencing the asylum determination process is more limited than these participants' accounts suggest (Patel, 2012; personal communication). This indicates how powerful these discourses are. My interpretation was of participants struggling to reconcile the different positions they occupied and resolve the dissonance this created.

My analysis suggested that an array of structures, paradigms and discourses – operating at different levels – might influence GPs' understandings of torture survivors' needs and their described responses (see Figure 2). At the widest social and political level, the influence of asylum-related structures, policies and discourses was evident, as was the impact of the predominantly White British demographic and the accompanying 'us/them' way of thinking. At the level of the health care system, GPs were influenced by dominant medical models and structural constraints such as the 10-minute GP consultation time. At the level of their local working context, GPs referred to the importance of flexibility and support from colleagues and availability and connection to mental health services. At the level of the individual GP, participants appeared to draw heavily on their clinical experience and preferred knowledge base; they also described the impact of their personal identity and value system. As such, participants' understanding appeared situated within concentric circles of influence that were all at interplay with one another.

**Figure 2: Levels of context influencing participants' accounts**



These circles of influence provided participants with both constraining and enabling factors in attempting to pursue an agenda of work with torture survivors. This was cogently illustrated in my interview with Participant Seven, who rehearsed the unwelcome but tangible impact of negative asylum-related discourses on her thinking and practice. She described the ways in which her personal feelings, identification with the patient and knowledge mediated her reactions to such discourses:

*P7: There are some people who, whom I feel more empathy with than others and who I just think well you know, 'there but for the grace of God go I', do you know what I mean? And then there are the other people who maybe irritate you more or what they've chosen to do feels more destructive or more difficult to deal with and, and then, maybe some of that societal judgment starts kicking in, does that make sense? It's, it's, it's interesting. And I guess people who, like, I suspect I'm that much more tolerant of women than men probably, um and um, yes and societies that I know a little bit more about, I'm probably more, I've got more of an understanding of why, what might have gone on before and why they might feel they might, if I've got, the more, the more I know about what might be the background I think I probably might be more empathetic about it. (185-199)*

### **4.3 Contributions to the existing literature**

Since no previous empirical studies of GPs' understandings of torture survivors' mental health needs have been identified, this study fills an important gap. It contributes to an existing body of literature that explores factors influencing GPs' mental health referrals for *any* patient or for BME or refugee patients more broadly. It echoes the findings of authors, including the review by Ross and Hardy (1999) and primary research by Knight (2003), by suggesting that GPs take many of the same factors into account in considering mental health referrals for torture survivors as for any other mental health patient. These include patient-related factors such as the nature of patient needs and their help-seeking behaviour; doctor-related factors such

as their own ability to recognise and respond to patients' needs; and context-related factors such as availability and perceived quality of mental health services and their potential to do harm. It supports the findings of Lehti, Hammarström and Mattson (2009) who reported that GPs struggled in the knowledge that patients' problems were social rather than medical, and therefore not remediable with the medical framework, leaving some feeling powerless to assist. This study reflected similar themes to those identified by Kokanovic *et al.* (2010), namely, that GPs relying on a Western medical model faced difficulties in the context of socially embedded causes, and that one way of managing these difficulties was to problematise cultural difference.

The present study also extends current knowledge by highlighting GPs' understanding of the particular challenges and needs of torture survivors as a specific group. In particular, it draws attention to GPs' concerns about torture survivors' inability to talk to or trust them; the inadequacy of standard GP care structures and the associated lack of consultation time. It highlights their views about required service provision for this group, which is striking in its focus on a holistic rather than a pathology-oriented paradigm; and their suggestion that torture survivors require specialist help even at the GP level. It also raises issues about working in the asylum context, in particular, the conflicting roles GPs adopted in response to asylum-related structures and discourses; and their experiences of dispersal policies interfering with health care.

While my participants made frequent reference to standard diagnostic categories in thinking about torture survivors' mental health needs, they nonetheless kept these connected to survivors' real social problems. Rather than this presenting them with a clear course to therapy, GPs were often left floundering in the face of services they understood to be structured around disembodied, diagnostic categories (see Patel 2003). In contrast to Summerfield's (2001a) contention that GPs' reliance on Western biomedical models may lead them to assume a need for psychological therapies in this patient group, my study suggests that they took a more nuanced approach. This difference between my analysis and Summerfield's contention may

reflect that the sample of GPs who chose to participate in my study were individuals who were particularly interested in thinking about the complexity of mental health needs assessment with this group. In addition, they were practising a decade after Summerfield's observation was made, since which time changing service models and structures may have provided other options for thinking about and responding to the needs of this population.

#### **4.4 Implications for further research**

The results of this study, and my experience in carrying it out, have identified a number of possible areas for future study, as follows:

1. As highlighted in the Introduction (Section 1.4.1), GPs represent one piece in a complex puzzle of access to mental health care for torture survivors, many of whom are never even registered with a GP. It is therefore of critical importance to look beyond health service structures to understand why so few access statutory mental health services. This rationale underpinned the original project proposal to explore understandings of medical and non-medical staff across a torture survivor's trajectory to mental health care. Although the trajectory study was on this occasion refused NHS Ethical Approval, it remains a crucial area for future study. Indeed, given recent changes to NHS ethics policy, such a study could now proceed without the need for approval.
2. My study focused on GPs' *accounts*, gathered in a specific interview context (Potter and Hepburn, 2005). Within a critical realist perspective, it is acknowledged that such accounts are only partial representations of the ways they may think and act outside this context. Observations or recordings of GP consultations with torture survivor patients would allow triangulation of data to build a fuller picture.
3. Research into torture survivors' own perspectives of their mental health needs would provide another opportunity for data triangulation and represents, for me, the most fundamental missing piece in the jigsaw of understanding. Such research could also address questions about what would be the most effective and appropriate mental health care

from a service user perspective. There are obvious difficulties and ethical considerations of conducting research with marginalised groups, which demands investment of time and resources.

Nonetheless, I would argue that we have a duty to do so and such research could lead to better and more accessible services.

4. Finally, the preliminary model of influences on GPs' understandings I propose in Figure 2 warrants further investigation, to explore how the elements interact and where interventions may need to be targeted to help staff across the various relevant settings understand and respond meaningfully to torture survivors' currently unmet needs. Although the model was developed in relation to GPs specifically for this study, it may have applicability and relevance for any involved professional.

#### **4.5 Implications for practice and policy**

The broad policy question underlying this research related to the ways in which current health (and other social and immigration) practices and policies might hinder torture survivors from being identified and accessing the means to rehabilitation in the form of appropriate health care.

A number of core areas for practice and policy change are indicated:

1. GP service structures were presented as highly problematic. Such structural problems were compounded by lack of other resources, for example, interpreters. Given that GP service structures are strongly established, even if not immutable, this raises the question whether UK general practice is the appropriate forum for 'gatekeeping' these patients. Several participants saw the need for specialist services at both the GP and mental health services level. This proposal is supported by emerging evidence of successful rehabilitation in specialist clinics and a lack of evidence that torture survivors are being identified or their needs well met by current mainstream services (Mollica, 2011). Currently however such specialist services as are available in the UK and elsewhere are being provided outside the framework of statutory health services (Montgomery and Patel, 2011),

raising ethical implications in the light of the obligation upon the NHS to respond to the assessed health needs of any patient (Patel and Mahtani, 2007). Further consideration needs to be given as to how specialist services can be provided within a statutory framework.

2. GPs' accounts positioned existing mental health provision as inaccessible both to themselves and patients, and completely inappropriate to meet the needs of this group, resulting in low referral rates. This has two major implications for practice and policy, the first of these being the importance of strong relationships and communication between GPs, mental health services and service users. Ross and Hardy (1999) note the two-way interaction between GPs and mental health services and its effect upon the degree to which patients are referred. Similarly, my analysis suggests that mental health services need to develop closer relationships with referrers and service users, to develop better understandings of the (perceived) needs of this group. This will become increasingly important in the light of proposals for GP-led service commissioning.

The second implication is that existing mental health provision may be structured too tightly around medical diagnostic categories, thus taking insufficient account of the wider psychosocial needs of refugee torture survivors and maintaining an unhelpful dichotomy between medical and social models of mental health. In this respect, participants' accounts supported critiques highlighted in the Chapter One (Patel, 2003; Summerfield, 2001a). As an alternative, Silove and colleagues (Silove, 1999; Silove, Steele and Psychol, 2006) suggest an integrated service structure which aims to address mental health needs via the restitution of five fundamental psychosocial dimensions: safety, attachment, justice, identity-role and existential meaning. They argue that recognition of the importance to mental wellbeing of these wider psychosocial factors will allow for development of more appropriately framed clinical interventions, which address mental health needs, but not in isolation from the wider social framework in which they rest.

3. Finally, the difficulties that GP participants experienced in responding to patients from 'different' cultural and linguistic backgrounds highlights

the dangerous identification of 'the other' that takes place within health services as in wider society. This leads to problems being identified as resulting from those perceived as different, rather than as failures of the UK health and asylum systems. There is a need for education to address the dangers of discrimination among health care professionals, as well as the general public.

#### **4.6 Limitations of the study**

There were a number of limitations to this study to which I now direct the reader. These were:

- Sampling strategy: My sampling strategy was aimed at accessing participants who might provide a rich and diverse range of accounts. Attempts were made to recruit participants with various levels of experience, working in a range of clinical practice settings and across two geographical locations. I successfully recruited with varied levels of experience. In the event, although I did recruit across a range of clinical settings, it did not prove possible to reach as many participants in settings directly related to the asylum process as hoped; similarly, the geographical spread of my participants was more heavily weighted towards Liverpool than I had hoped. Despite this difficulty, I was able to recruit participants with a range of experiences and contexts, who therefore offered rich insights into the research question (Marshall, 1996).
- Generalizability: Qualitative research is not concerned with making generalized claims, but with understanding complex phenomena (Willig, 2008, p9). Nevertheless, it serves to acknowledge that the findings are particular to those who offered them. In this study, participants' accounts clearly differed in relation to their experiences, identities and local working context. However, there were also clear commonalities, which could be used to inform policy and explored further in future research.



The question arises, why did my participants agree to take part in a project with no obvious benefit to them? Based on our interactions, I theorised a range of reasons, including: that participants were committed to refugee health care and wanted to contribute to the research; that these same participants saw my research as critical of GPs and wanted the opportunity to defend themselves; that participants working for the refugee cause hoped to spread their message and potentially recruit me to their agenda; and, that participants struggling in this work simply welcomed an opportunity to 'think things through'. The ways in which these motivations coloured their accounts was evident: for example, Participant One, who positioned himself as a political activist, spent much of the interview offering messages for me to disseminate and trying to steer my research in particular directions.

- Scale of project: The resources available to me, and the timeframe in which I was expected to complete this research, imposed limits on its scale. Although some important themes were identified across participants' accounts, the analysis could not be ascertained as reaching theoretical saturation (Hugh-Jones, 2010). A further limitation of the scale of the research was that it involved interviewing only GPs. There is a need for further properly resourced and triangulated research in this area.
- Chosen method of analysis: In undertaking thematic analysis, I was very aware that the need to reduce a large quantity of data to a manageable summary inevitably involved a loss of detail and subtlety. Similarly, in thematising across accounts, the conversational context in which participants' meanings were shaped and the stories they were trying to tell were clouded. This reduced my ability to theorise context, which is an important tenet of my philosophical position.

#### **4.7 Reflexivity**

As discussed in Chapter 2 (Method), any researcher stepping outside a rigid positivist framework is required to acknowledge and theorise their impact on

the research process and outcomes. Darlaston-Jones (2007, p23) highlights that reflexive thinking about the researcher's motives and actions is central to ethical practice. In this section, I will therefore consider three core aspects of reflexive practice: personal reflexivity, epistemological reflexivity and critical language awareness (for definitions of these terms, see Section 2.2.2).

#### **4.7.1 Personal Reflexivity**

Many aspects of my identity may have been relevant to why I undertook this research and how I influenced its form and outcomes. Here I explore those that I consider to have been of particular relevance:

- *My identity as a researcher:* In interviewing GPs, my identity as a researcher positioned me as an 'outsider' and possible 'judge and detective', critically examining and revealing their thinking and practice. As such, it is highly likely that my participants told their stories and presented themselves in a particular light. The way in which they presented their stories may have reflected their own agendas for participating in the research.
- *My identity as a psychologist:* My identity as a psychologist further positioned me as an outsider, not only as interviewer, but also as a member of a different professional group with different training and theoretical models. A GP acquaintance, on learning that I was a psychologist, commented, 'you must be anti-psychiatry, then.' Whilst said in jest, I am well aware that my identity as a psychologist, and, in particular, a UEL-trained psychologist, positions me as critical of, and alert to, the potential limitations of Western biomedical conceptualisations of distress. As stated in the Analysis section, it is possible therefore that I took a greater interest in participants' talk about diagnosis than another interviewer or analyst might. In the context of undertaking research in an area where difference is often constructed as problematic, I was interested to encounter, particularly in my earlier interviews, what I experienced as a 'cultural clash' between my theoretically informed ways of thinking and the more

pragmatic and experiential ways of thinking expressed by several of my GP participants.

- *My identity as a young, female clinical psychologist:* Although as the interviewer I was in a powerful position to interpret participants' accounts, I experienced certain visible aspects of my identity as placing me in a less powerful position. Whilst I am passionate and increasingly knowledgeable about the subject of refugee health care, I have often felt concerned that others may perceive me as a 'tourist' in this domain (Fox and Priest, 2004). While this may be an unjustifiable claim, I wondered if the negative outcome of my NHS Ethics Committee interview would have been altered had I been older and able to present more authoritatively. Likewise, in terms of the interviews, I was aware that I had initially submitted to an established hierarchical healthcare model, illustrated, for example, by my addressing participants formally even after they had adopted an informal tone with me. Feedback from participants interviewed later in the research process indicated that they experienced the interviews as searching and thought-provoking. However, in my early interviews, I felt that I may not have challenged participants as much as I could have done.
- *My identity as a White-British person:* In early discussions with my supervisor, she referred to the possibility that by unquestionably imposing Eurocentric theories of distress and wellbeing, professionals are at risk of what can amount to racism. Despite understanding the point, I remember feeling anxious, at the time, that through my analysis I might have to 'accuse' participants of racism; and in turn implicate myself as a person whose thinking is inevitably grounded in the thinking of the White-British culture in which I have been educated. In my own clinical practice with refugee people I have had many of the same thoughts as those described by the participants about the complexity of the work due to clients being 'different'. In constructing the story of my analysis, therefore, might I have failed to question shared assumptions? My interview with Participant Five, the only non White-British participant, highlighted to me the impact of visible ethnic difference, and the discomfort that I as a White-British person

experienced in talking about it. During the interview, Participant Five talked about how he felt that his ethnicity influenced others' reactions to him in the context of refugee work (for example, his concern that others might assume him to have greater expertise, while also undermining his opinions on the basis of his ethnicity). He talked knowledgeably and authoritatively about the topic of refugee health care, referring often to his extensive experience with this group; and I was aware of considering him as a participant with great expertise. While I also afforded similar status to two other (White-British) participants due to their employment within refugee charities, I wonder whether I questioned aspects of his account less than I would have done had he been White. Due to Participant Five's extensive talk about the impact of visible ethnic difference in refugee work, I asked him if he would be happy for me to refer to this aspect of his identity in my write-up. We discussed the dangers of readers subsequently imbuing his account with greater or lesser authority, but he gave consent for me to refer to this as necessary. After discussion with my supervisor, I made the decision to reference this aspect of his identity on the grounds that issues of racism are so central to the topic of my research. My discomfort about this issue highlights the difficulties many White professionals may feel in knowing how to talk about issues of race and ethnicity in their work with clients and that these may therefore remain unchallenged.

#### **4.7.2 Epistemological reflexivity**

Having conducted this research it is important to reflect on the limits of the knowledge I have created. My adoption of a critical realist position (as described in Section 2.1.2) resulted in attempting to theorise both discursive and extra-discursive facets of existence. This resulted in taking GPs' talk to represent their adoption and elaboration of certain discourses made available by underlying social and material structures. While some of the structures theorised have themselves been socially constructed, and while GPs' ways of thinking may indeed uphold, I considered these to be fairly enduring and

beyond individual GP's control; and therefore providing a relatively 'fixed' framework within which they could talk and think about the issues discussed. I do not claim to fully 'know' or understand the structures and contexts considered here, since I have theorised them through the lens of GPs' accounts of their impact.

In choosing to theorise GPs' talk in relation to underlying social structures, I have inevitably made a decision about which aspects of their accounts I consider at a linguistic level only and which at a structural level. Cromby and Nightingale (1999, p8) argue that, "writers ground their critiques in aspects of the world they wish to make or remain real and, from this grounding, relativise aspects of it that they want to question or deny... which aspects of the world are to be relativised and which real-ized is a choice typically shaped by moral, political or pragmatical precepts, not epistemology or ontology". My personal identity and experience as a health professional in the NHS, as described above, have undoubtedly contributed to my moral and political position, both in deciding to pursue this research topic and in the ways in which I then choose to realize and relativise particular aspects of the data.

Another implication of selecting a critical realist framework is that participants' accounts are not taken at face value. As an analyst employing this framework, I sought to scrutinise participants' accounts at both a semantic and interpretative level. Interpretative work is based on the premise that research participants may not be aware of all the factors influencing their accounts (Willig and Stainton-Rogers, 2008, p9). This seemed highly pertinent to the current research, where participants seemed to struggle to answer questions of *why* they did and thought certain things. This may have been due, in part, to the fact that GPs, dealing with a huge range of patients, are required to draw on experience and intuition rather than specific theoretical frameworks (Lethi *et al*, 2009). Nonetheless, I subsequently theorised not only influences that were explicit in participants' accounts, but also those that were implicit or attributed by me from my own perspective. This process of interpretation, which is a valid research task, raises questions about ownership and power over the data. Aware that my participants had their own reasons for

volunteering to take part in my study, I worried that they would have expected me to analyse their accounts from a naïve realist perspective and so felt uncomfortable about imposing a more critical framework, looking for deeper meanings that they had not intended. I had made the decision not to engage in participant validation, but had offered to forward a summary of results on completion of the research. My participant information sheet made clear that I was examining GPs' understandings as part of an exploration of potential barriers to mental health care for torture survivors. Unsurprisingly, several of the GPs who volunteered were themselves deeply committed to improving access for this group. While they were aware of the nature of my project, I conceived that in taking a critical approach I might construct GPs as part of this problem; and that these committed, passionate GPs might feel betrayed when they read the summaries.

#### **4.7.3 Critical language awareness**

This aspect of reflexivity requires consideration of the ways in which the researcher's language may affect participants' responses. I have therefore tried to consider the impact of my own linguistic constructions in shaping my participants' responses. I am aware, for example, that in focusing on torture survivors as a distinct group I may have contributed to a homogenisation of torture survivors, with both positive and negative implications. Similarly, in choosing to study access to mental health services for this group, I may have contributed to a potentially unhelpful distinction between mental health needs and broader social needs.

Critical language awareness also addresses the degree to which language is theorised as reflecting or shaping 'reality'. I have described above the ways in which participants' accounts may have reflected underlying structures, and also helped to shape or reinforce them. Similarly, my interpretation and subsequent presentation of their accounts to the reader may have done the same. In this sense, I have acted as both the 'skilful excavator' and 'constructor' of findings (Willig, 2008).

#### **4.8 Quality within qualitative research**

Assessment of quality in qualitative research is a highly contested area, reflecting debate about the extent to which the dimensions and methods applied to quantitative research can be extended to qualitative research (Ritchie and Lewis, 2003, p270). It is widely acknowledged that the value of qualitative research is not determined by its objective status (Willig, 2008, p148-150); rather, Willig argues that evaluation criteria should be coherent with the epistemological framework. Accordingly, Madill, Jordon and Shirley, 2000; cited in Willig, 2008, p154) have developed evaluation criteria specifically relating to different epistemological positions. They contend that in contextual constructionist approaches (akin to critical realist), quality is primarily determined by the researcher's success in grounding their analyses within the contexts creating them (their 'reflexivity'). For this reason, I have attempted to ground both participants' accounts and my interpretations firmly within the contexts where they were generated.

In this research, I chose to pursue a thematic analysis of my data (at both semantic and interpretative levels). However, since thematic analysis is not commonly respected as a method in its own right and because it can be adapted across a range of epistemological positions, there is no readily prescribed approach to assessing its quality. In response to these concerns, Braun and Clarke (2006) have developed clear guidelines for conducting thematic analysis, which cover quality issues. While there is no simplistic formula, it is nonetheless possible to follow their guidelines rigorously and systematically. As I have already described, this does not mean that another researcher would make the same interpretations or come to the same conclusions. I hope, however, that I have been transparent in my descriptions and interpretations.

More generally, Elliott, Fisher and Rennie (1999) have developed guidelines for reviewers judging quality of qualitative research in psychology submitted for publication, which provides a useful framework in the present discussion.

They propose that research should be assessed according to the following dimensions: owning one's perspective; situating the sample; grounding in examples; providing credibility checks; coherence of the data presented; accomplishing general or specific research tasks as intended; and resonating with the reader. I hope that I have presented enough evidence in this report of having broadly addressed each of these dimensions. I recognise that (due to resource limitations) I have addressed only one aspect proposed by Elliott *et al.* for credibility checking – namely, verification by my own review of the data, rather than by external others. However, I would argue that within the epistemological framework I adhere to, where no one account is given greater authority than another, the value of such external verification is limited.

#### **4.9 Conclusions**

This research sought to explore GPs' understanding of the mental health needs of refugee torture survivors, in view of their important roles in gatekeeping and potentially in commissioning services for this group. GPs described this as an area of work beset by challenges related to their own expertise and remit, the context they work in and the complexities of working with a patient group with multiple needs and different cultural and experiential backgrounds. Although the research focused on mental health needs, participants characterised torture survivors as having needs that extended into the social realm, for which adequate service provision did not exist. My interpretation highlighted the influence of context on their accounts, most notably the asylum context and associated discourses.

A number of limitations of the work have been identified above. Nonetheless, this research contributes to the existing literature by focusing specifically on torture survivors rather than the broader group of refugees and asylum seekers. It also supports findings from research examining GP referral decisions for broader groups of patients with mental health needs. Even as the researcher, I experienced a conflict inherent in my chosen topic, namely, that focusing on access to mental health services may detract from the broader social needs of this group. In the final analysis, however, participants



themselves appeared to share the same view that torture survivors' mental health needs and their wider psychosocial needs cannot be separated if they are to receive the most effective and suitable care.

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## APPENDICES

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### **APPENDIX 1: Definition of terms**

For the purposes of clarity, the following definitions are provided to the reader. It should be noted, however, that specific definitions were not offered to participants as a matter of course, as the purpose of interviews was to explore participants' understandings.

The term "torture" means 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. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions. (United Nations Convention Against Torture, Article 1; UN, 1984).

The term "refugee" is defined as a 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 nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country or return there because there is a fear of persecution..." (United Nations Convention Relating to the Status of Refugees (the Refugee Convention); UN, 1951).

The term "asylum seeker" refers to someone who, having fled from their country of origin, has lodged an application in another country for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights (Refugee Council, undated).

## **APPENDIX 2: Literature search strategy**

### **A. LITERATURE SOURCES:**

To understand the area of access to appropriate mental health care for refugee torture survivors, it is necessary to look beyond the literature on psychological theory and practice, to understand the legal and health service context. For this reason, a multi-pronged search strategy was employed as follows:

1. Searches of the 'grey literature', using Google, to identify relevant policy and campaign documents.
2. Searches of the academic literature relating to this topic, using the following databases: Google Scholar (to access literature from multiple relevant disciplines), Medline (to access medical literature, in keeping with the study's focus on general practitioners), PsychInfo (to clarify psychological perspectives and contributions to understanding this topic).
3. A hand-search of the journal 'Torture'.
4. Searches through the reference lists of key documents, to identify any further relevant articles in this body of literature.
5. The researchers' academic supervisors, both researchers with particular expertise in this field, also recommended additional literature.

Please note: While searches of the academic literature offer access to peer-reviewed articles, searches of the grey literature may offer access to literature of unknown quality. For this reason, I have attempted to refer only to documents from known sources that I understand to be reputable. It must be borne in mind, however, that those government, charitable and academic organizations producing such documents will be pursuing their own agendas, which may be reflected in the tone of the documents.

### **B. PROCESS OF LITERATURE REVIEW:**

Initially, my literature search strategy was very broad and aimed at understanding the overall context of access to appropriate mental health care for refugee torture survivors in the UK. There is little existing literature specifically focused on survivors of torture, so it was necessary also to examine literature relating to the broader group of refugees and asylum seekers. Broad literature searches were undertaken using Google and Google scholar in June and July 2010, and again in September 2011. In order to access a wide range of relevant literature, including literature from outside the UK, a list of possible search terms was generated (see items 1 and 2 on following list)<sup>13</sup>.

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<sup>13</sup> Please note: This was a structured literature review rather than a systematic review; therefore the literature search strategy was thorough but not exhaustive. Due to time constraints and the configuration of different search engines, it was not always possible or practical to search under all possible search terms. However for each topic area, searching was continued using combinations of the various possible search terms until the point at which few novel relevant papers were being generated.

These broad literature searches enabled me to understand the complexity of this issue and the multiple influences on access to mental health care for this group. From this position I was able to start defining the more specific area that I would examine for the purposes of this research. Having decided that it would be useful to focus on general practitioners, I undertook literature searches focused at the primary care level (see items 3-6 on following list). Again, since there is little existing literature relating to torture survivors, I looked at broader literature of the relevance to the topic (for example, literature related to how GPs make decisions to refer *any* patient to mental health services). These focused literature searches were undertaken during July and September 2011, using Google Scholar plus a specific search of Medline and PsycINFO databases, plus a hand-search of 'Torture' journal.

### **1. General – mental health care for refugee torture survivors**

**Possible search terms:** ("Mental health" OR "mental health care" OR "mental healthcare" OR "mental health services" OR psychologist\* OR wellbeing OR therap\* OR psychotherap\* OR psychiatr\* OR rehabilitation OR counselling OR treatment) **AND** ("Torture survivor\*" OR "Torture victim\*" OR Refugee\* OR "Asylum seeker\*")

### **2. General – access to mental health care for refugee torture survivors**

**Possible search terms:** ("Mental health" OR "mental health care" OR "mental healthcare" OR "mental health services" OR psychologist\* OR wellbeing OR therap\* OR psychotherap\* OR psychiatr\* OR rehabilitation OR counselling OR treatment) **AND** ("Torture survivor\*" OR "Torture victim\*" OR Refugee\* OR "Asylum seeker\*") **AND** (access OR barrier\* OR appropriate\* OR referr\*)

### **3. Focus in – what is happening at primary care level?**

**Possible search terms:** ("Mental health" OR "mental health care" OR "mental healthcare" OR "mental health services" OR psychologist\* OR wellbeing OR therap\* OR psychotherap\* OR psychiatr\* OR rehabilitation OR counselling OR treatment) **AND** ("Torture survivor\*" OR "Torture victim\*" OR Refugee\* OR "Asylum seeker\*") **AND** (GP OR "General practi\*" OR "general physician\*" OR "family practi\*" OR "family physician\*" OR "primary care" OR "primary practice" OR doctor\* OR "family doctor\*")

### **4. Broad view – Why do GPs refer or not refer people to mental health care?**

**Possible search terms:** ("Mental health" OR "mental health care" OR "mental healthcare" OR "mental health services" OR psychologist\* OR wellbeing OR therap\* OR psychotherap\* OR psychiatr\* OR rehabilitation OR counselling OR treatment) **AND** (GP OR "General practi\*" OR "general physician\*" OR "family practi\*" OR "family physician\*" OR "primary care" OR "primary practice" OR doctor\* OR "family doctor\*")

May want to add in: **AND** (access OR barrier\* OR appropriate\* OR referr\*)



### **5. Focus in – Why do GPs refer or not refer people from minority ethnic groups to mental health care?**

**Possible search terms:** ("Mental health" OR "mental health care" OR "mental healthcare" OR "mental health services" OR psychologist\* OR wellbeing OR therap\* OR psychotherap\* OR psychiatrist\* OR rehabilitation OR counselling OR treatment) **AND** (GP OR "General practi\*" OR "general physician\*" OR "family practi\*" OR "family physician\*" OR "primary care" OR "primary practice" OR doctor\* OR "family doctor\*") **AND** (Refugee\* OR "Asylum seeker\*" OR BME OR "minority ethnic" OR "ethnic minorit\*")

May want to add in: **AND** (access OR barrier\* OR appropriate\* OR referr\*)

### **6. Focus in – GPs' understandings of/attitudes towards torture survivors (mental health needs)**

**Possible search terms:** ("Torture survivor\*" OR "Torture victim\*" OR Refugee\* OR "Asylum seeker\*") **AND** (GP OR "General practi\*" OR "general physician\*" OR "family practi\*" OR "family physician\*" OR "primary care" OR "primary practice" OR doctor\* OR "family doctor\*") **AND** (attitude\* OR knowledge OR understanding\* OR insight OR awareness OR comprehension OR perception\*)

### **FOCUSED MEDLINE SEARCH:**

Database: Ovid MEDLINE(R) and Ovid OLDMEDLINE(R) 1946 to Present with Daily Update.

Search terms defined in relation to database categories.

Search Strategy:

- 1 exp Torture/ (1651)
- 2 exp Refugees/ (5874)
- 3 1 or 2 (7251)
- 4 exp War Crimes/ (1583)
- 5 3 or 4 (8749)
- 6 exp Human Rights Abuses/ (406)
- 7 5 or 6 (9004)
- 8 exp "Transients and Migrants"/ (7296)
- 9 7 or 8 (15731)
- 10 exp Homeless Persons/ (5414)
- 11 9 or 10 (21047)
- 12 exp Vulnerable Populations/ (4066)
- 13 11 or 12 (24874)
- 14 asylum seekers.mp. (554)
- 15 13 or 14 (24961)
- 16 exp General Practitioners/ (340)
- 17 exp Family Practice/ (57788)
- 18 16 or 17 (58114)
- 19 exp Physicians, Family/ (14027)
- 20 18 or 19 (69545)
- 21 exp Health Personnel/ (325263)

- 22 20 or 21 (376293)
- 23 exp Primary Health Care/ (64354)
- 24 22 or 23 (424501)
- 25 15 and 24 (2061)
- 26 exp Mental Health Services/ or exp Community Mental Health Services/ (65772)
- 27 exp Depressive Disorder, Major/ or exp Behavior Therapy/ or exp Stress Disorders, Post-Traumatic/ or exp Psychotherapy/ or exp Cognitive Therapy/ or exp Stress, Psychological/ (231368)
- 28 25 and 26 (80)
- 29 25 and 27 (110)
- 30 28 or 29 (176)
- 31 1 and 24 and 30 (22)
- 32 limit 31 to english language (21)
- 33 limit 30 to english language (168)
- 34 exp Substance-Related Disorders/ (329061)
- 35 33 not 34 (157)
- 36 exp Domestic Violence/ (30732)
- 37 35 not 36 (153)
- 38 limit 37 to last 20 years (135)

#### **FOCUSED PSYCINFO SEARCH:**

Search terms: (Torture victims OR asylum seeker OR refugee OR torture survivor ) **AND** ( G.P. OR doctor OR general practitioner OR family physician OR primary care OR GP OR family physician ) **AND** ( Mental health OR psychological needs OR mental well being OR services ) **AND** ( Attitudes OR knowledge OR understanding OR understanding OR referral decision)

### **APPENDIX 3: Transcription notation key and coded section of transcript illustrating worked example of the analysis**

#### **3A. Transcription Notation Key**

The following notations were used in transcribing the interviews:

<>      Small interruption, acknowledgement from other

/          Speaker cut off by other

[]              Laughter, notable pauses, sighs, clears throat

[inaudible]      Inaudible section of transcript

[details replaced]      To protect confidentiality of participant or other named individuals

P7              Participant Seven

Transcripts were coded at both a semantic and interpretative level, denoted as 'S' and 'I' respectively in the coding labels.

In the worked example below, some sections have been blanked out to offer the participant additional confidentiality in presenting this material. These lines of the transcript contained information which the participant viewed as being particularly sensitive.

### 3B. Coded section of transcript illustrating worked example of analysis

CONFIDENTIAL		P7 TRANSCRIPT	
REFLECTIONS	STRUCTURES / CONTEXTS		CODES
<i>COHERENCY: Intro open Q (tell me as your experiences) - could respond in various ways</i>	60	Kate: a diverse range of people <P7: Yeah yeah> from different areas	
	61	of the world. And as you know my research um is specifically	
	62	aiming to explore GPs' understandings of the mental health	
	63	needs of refugee torture survivors <P7: Right> um so would you	
	64	be able to tell me a bit about your experiences of working with	
	65	this group?	
	66	P7: Um yes, not it, um yes I mean I suppose the, the, what I've, I've	
	67	often found quite um difficult in, in this particular area is, and, is	
	68	a, is a sense that some people that will come very upfront and	⑤ Coherence → less believable (BELIEVABILITY)
	69	say, have a very coherent story of, of torture <Kate: Mmm> and	
	70	it's almost like people who are most coherent I feel, I feel least	
	71	believable <Kate: right> in a strange sort of way, it's almost like	
	72	and I, I don't know if that's fair on, on the people who, who can	
	73	be articulate about it or whether it's something about a feeling	
	74	that, and, and there's probably cultural aspects that are quite	⑥ Cultural aspects (differences) - hard to understand
	75	difficult to disentangle there but, but I think I've seen some	
	76	women who I think are probably been hugely traumatized and	⑦ Inability to talk = more traumatized
	77	had, and raped and if you finally get them to start, if you finally	
	78	open up the question and they finally beginning to, they can't,	
	79	they can't talk about it, they just literally <Kate: Mmm> go silent.	
	80	Whereas there are some people who seem to be so chatty about	⑧ Coherence/ talk → telling story to get in to UK (BELIEVABILITY)
	81	it <Kate: Mmm> that you, that you end up thinking, they just	
	82	know they have to tell this story to get in, do you, do you know	
	83	what I mean? <Kate: Mmm> And I found that whole process	
	84	quite a difficult one because you know that on one level the, the	
	85	criteria for the Home Office are so massive that people do have	⑨ Difficult ⑩ Home Office criteria → people have to exaggerate
CONTEXT:	86	to [inaudible] their story to, to sound like they m, to get a chance	
ASYLUM	87	<Kate: Mmm> so, I don't know if [inaudible] is the right word, but	
CONTEXT,	88	you know it's make it seem, make it seem bigger <Kate: Mmm>	
HOME	89	and have some sort of evidence for that so you have to, you	
OFFICE	90	know you have to have the scars or you have to show that your	⑪ Impact of asylum context ↑ links between medicine & asylum process ↓ It's real 'forced' to combine medical & policing roles - but do they have to respond in this way?
CRITERIA	91	vagina's been upset or you have to, you know, that sort of	
	92	<Kate: Mmm> that sort of demand for evidence. Whereas	

93 actually you see some people who are just so withdrawn and so  
 94 unable to um to express anything and you think they're probably  
 95 been far more trauma, they've had much greater trauma than the  
 96 people who <Kate: Mmm> and it's [REDACTED]  
 97 [REDACTED]  
 98 [REDACTED]  
 99 [REDACTED]  
 100 [REDACTED]  
 101 [REDACTED]  
 102 [REDACTED]  
 103 [REDACTED]  
 104 [REDACTED]  
 105 [REDACTED]  
 106 [REDACTED]  
 107 [REDACTED]  
 108 [REDACTED]  
 109 [REDACTED] And so it, it's, it is  
 110 quite, it is quite hard, and I think the other thing in terms thinking  
 111 about how the mental health services, I mean the mental health  
 112 services in [local area] are, are poorly resourced and, and um  
 113 and the psychiatric services really only want to be bothered with  
 114 people who have severe enduring mental health <Kate: Mmm>,  
 115 and sometimes some of the people in this group will present with  
 116 what's apparently a psychotic breakdown, but it can also be  
 117 understood in a they are very distressed, but it can also be  
 118 understood that they have learnt somewhere that they need to  
 119 behave in a mad way for something to kick in so that they don't  
 120 get deported. And unpicking whether they're really, really mad or  
 121 whether they are behaving like that cos they know that's how  
 122 they have to behave <Kate: Mmm> and how much that is  
 123 nevertheless an element of the distress they are in <Kate:  
 124 Mmm>, it is an element of the distress they are in but it doesn't  
 125 fit neatly into the, the pigeon holes that we need, and the people  
 126 who don't fit the psychotic and are probably more just

⑤ Inability to  
 link = must be  
 more traumatised  
 (BLAMABILITY)

CONTEXT:  
 Resourcing  
 of mental  
 health  
 services

⑤ Limitations  
 of Mental Health  
 services  
 (resources)

⑤ Alternative  
 ways of understanding  
 'mentally ill'  
 behaviour in this  
 group:  
 - psychotic  
 (possibly II)  
 - understood  
 - functional

⑤ Need to  
 unpick causes  
 of behaviour -  
 'real' or functional

⑤ Always element  
 of distress

⑤ Traumatized  
 people don't fit  
 pigeonholes  
 (diagnosis)

127 traumatized <Kate: yeah> don't, don't sort of hit the hurdle and,  
 128 and also because I guess there's a way in which that sort of  
 129 distress is just a human, it's just, it's just part of a human process  
 130 in a way, I remember going to talk by a woman who's involved in  
 131 the [REDACTED]  
 132 [REDACTED] <Kate: Mmm, mmm hmm>, and she was talking about  
 133 how you have people who, who sort of use you and they go,  
 134 they use, you give them various drugs and they come and they  
 135 get various drugs and some of them they'll take and some of  
 136 them they don't and actually it's not really about, it's not really  
 137 about what the right drug for these people, what they really  
 138 mainly want is benzodiazepines cos they want to feel less  
 139 stressed <Kate: Mmm> a lot of them, I mean I've had ongoing, I  
 140 can think of a number of people who over time I've been very  
 141 careful giving them a week at a time of sleeping tablets but they  
 142 don't want to take an antidepressant and they don't want to take  
 143 an antipsychotic, because they, because all, what they want is  
 144 release from the, from the tension <Kate: yeah> and they, they  
 145 don't really mind about whether they get addicted to a  
 146 benzodiazepine, that's not high up in their priorities <Kate:  
 147 Mmm> so, so their agenda and my agenda is quite different in  
 148 that thing, but that's the drug that makes them feel they get a  
 149 little bit of, a little bit of separation from what crowds in on them  
 150 <Kate: Mmm mmm>. Um so that's quite and, and to sorry going  
 151 back to [REDACTED]  
 152 [REDACTED] you know what they're actually needing  
 153 is, is just somebody, they need an excuse to go somewhere  
 154 where somebody listens and just and just allows that process  
 155 <Kate: Mmm>. And I think in, in the first sort of decade of  
 156 working [REDACTED] I would say that I felt like you could just do  
 157 that because you didn't have, when people were claim, because  
 158 I think there is a difference, there was a sort of seismic shift  
 159 really when people stopped being called 'refugees' and started  
 160 being called 'asylum seekers' <Kate: Mmm> and, and I think the

⑤ Defines as human process (emot)

⑤ Patients 'use' you

① 'Use' - why does Dr. Patel do this here? Answer? Patients having diff. stress or what's left

⑤ Not about drug treatment - ① Not standard phs - implication

⑤ Patients need release from stress/tension

⑤ Dr. & Patient have different agendas  
↓  
① Implications for relationship...

⑤ Patients need someone to just listen

⑤ Impact of changing societal discourses on practice

Context:  
Distrustful  
society /  
culture  
after 9/11

161 whole society sort of emphasis and um change in perception  
 162 and the sort of increasing language of 'we're not really  
 163 welcoming people, we, they've got to jump through a million  
 164 hoops before' um even if we are, I suppose in my value system  
 165 we have been in part responsible for why they've ended up  
 166 having to flee where they're going, where they are coming from,  
 167 but we're not, we're not into that, you know our society, our  
 168 society in general it into taking that take a picture of it <Kate:  
 169 Mmm> they just see more and more people coming to use our  
 170 benefits service, you know rather than actually understanding  
 171 maybe what it's about. Although equally I guess that there are  
 172 people who, for whom there is a sort of economic, they are  
 173 probably economic mig <Kate: Mmm> um refugees rather than  
 174 actually people seeking asylum. But, but because it's probably  
 175 the richest and the wealthiest of that society who manage to get  
 176 out <Kate: Yes> um and, and that's that sort of dynamic that you  
 177 end up thinking um do you, does one, do I mind whether I'm  
 178 being taken for a story on this one <Kate: Mmm> or do I just  
 179 accept that this isn't what this person needs to do and  
 180 somewhere in that that's a reasonable <Kate: Mmm> process to  
 181 go through?

182 Kate: Mmm, how do you feel about that?

183 P7: I think it's probably varies from individual to individual <Kate:  
 184 Mmm>, that there are some people who, whom I feel more  
 185 empathy with than others and who I just think 'well [pause] you  
 186 know there but for the grace of God go I', <Kate: Mmm> do you  
 187 know what I mean? And then there are the other people who  
 188 maybe irritates you more or what they've chosen to do feels  
 189 more destructive or more difficult to deal with and, and then  
 190 maybe some of that societal judgement starts kicking in <Kate:  
 191 Mmm> does that make sense? <Kate: Mmm mmm>

RESERVATION/  
 IN PROCESS:  
 Disappoint  
 Seemingly to  
 think things  
 work out but  
 she feels as  
 those issues  
 as she talks.

① Impact of  
 GP's own  
 value system  
 on interactions  
 with this group  
 (in light of  
 societal  
 discourses)

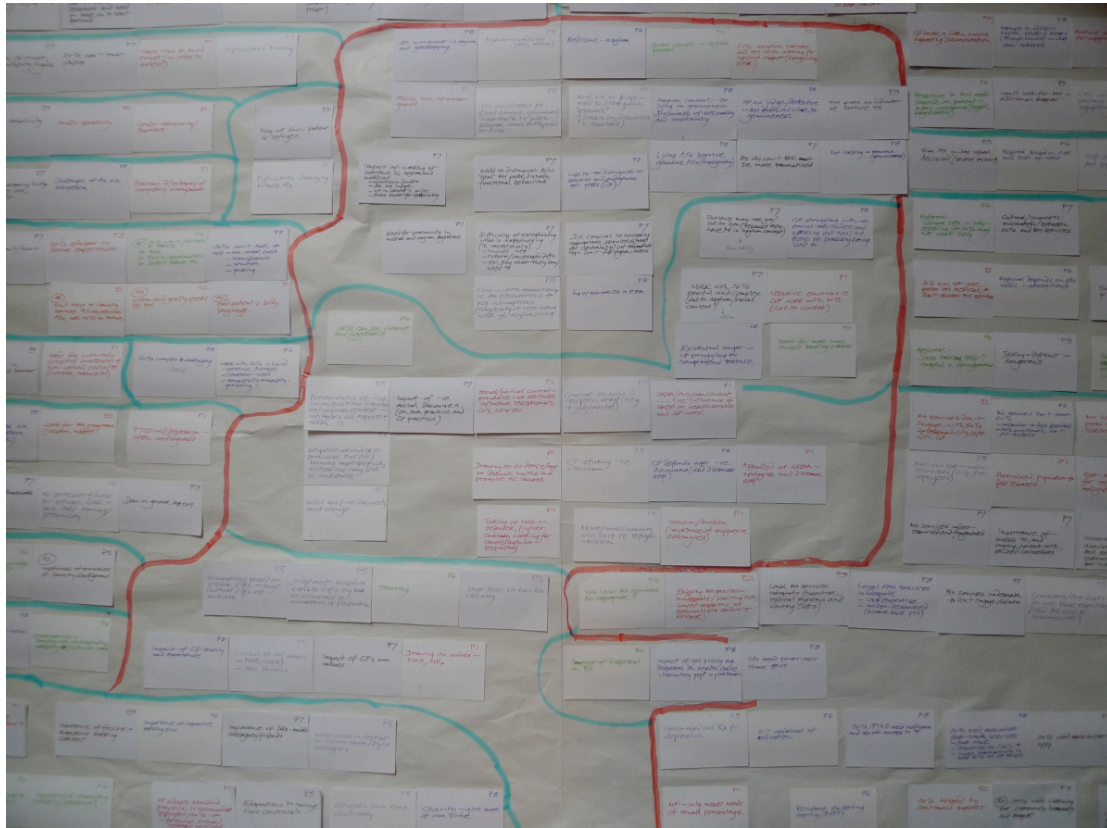
② Do I mind  
 whether I'm  
 being lied to?  
 (how to  
 position self)

① Factors  
 mediating reaction  
 to 'being lied to'  
 - Identification  
 with patient  
 - Negative personal  
 emotional reaction

① Idea of  
 distrustful social  
 discourses GP  
 has to fight  
 against

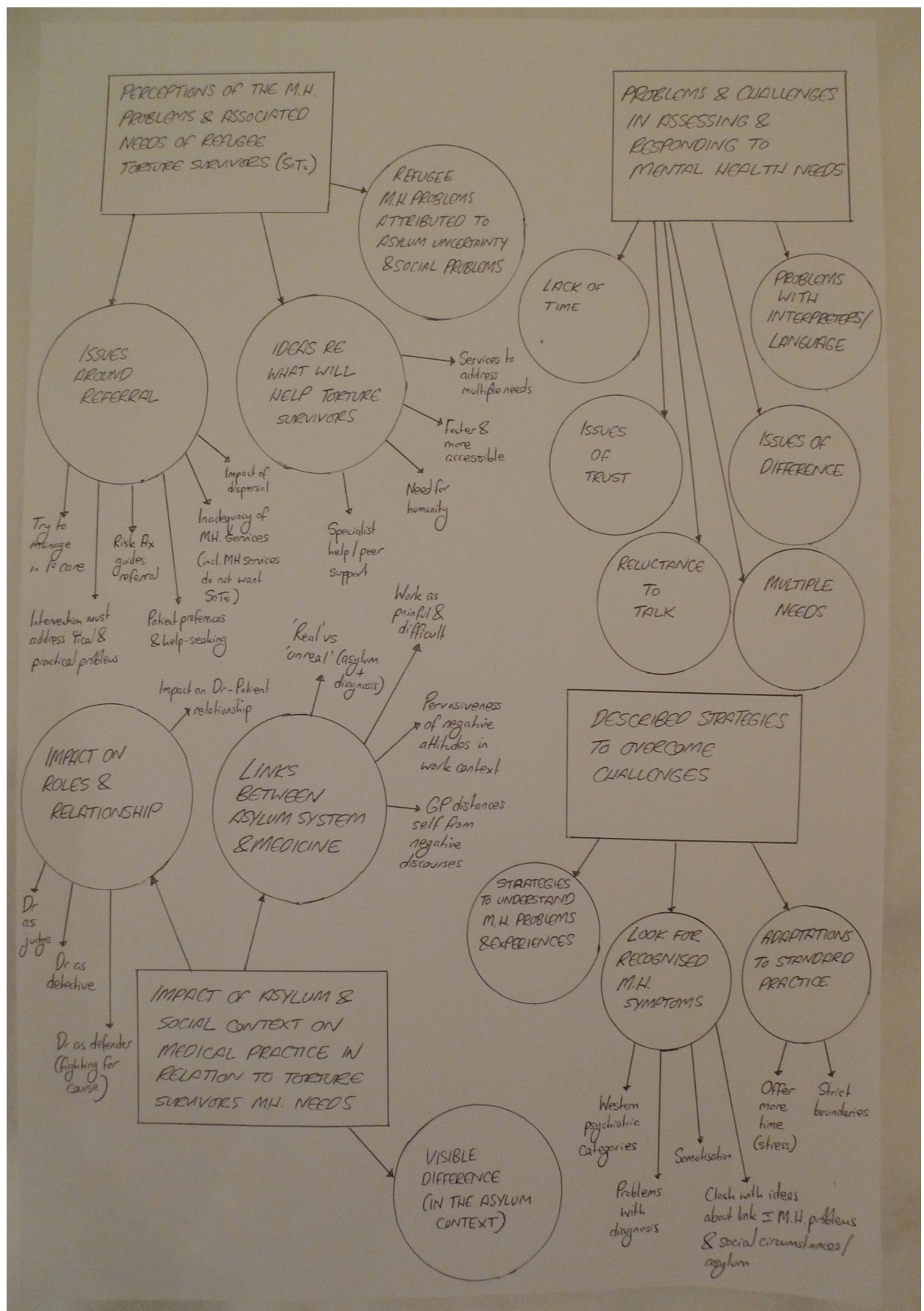
## APPENDIX 4: Initial, Developed and Revised Thematic Maps as used in the Analysis

### 4A. Photograph of initial thematic map (1<sup>st</sup> stage analysis)

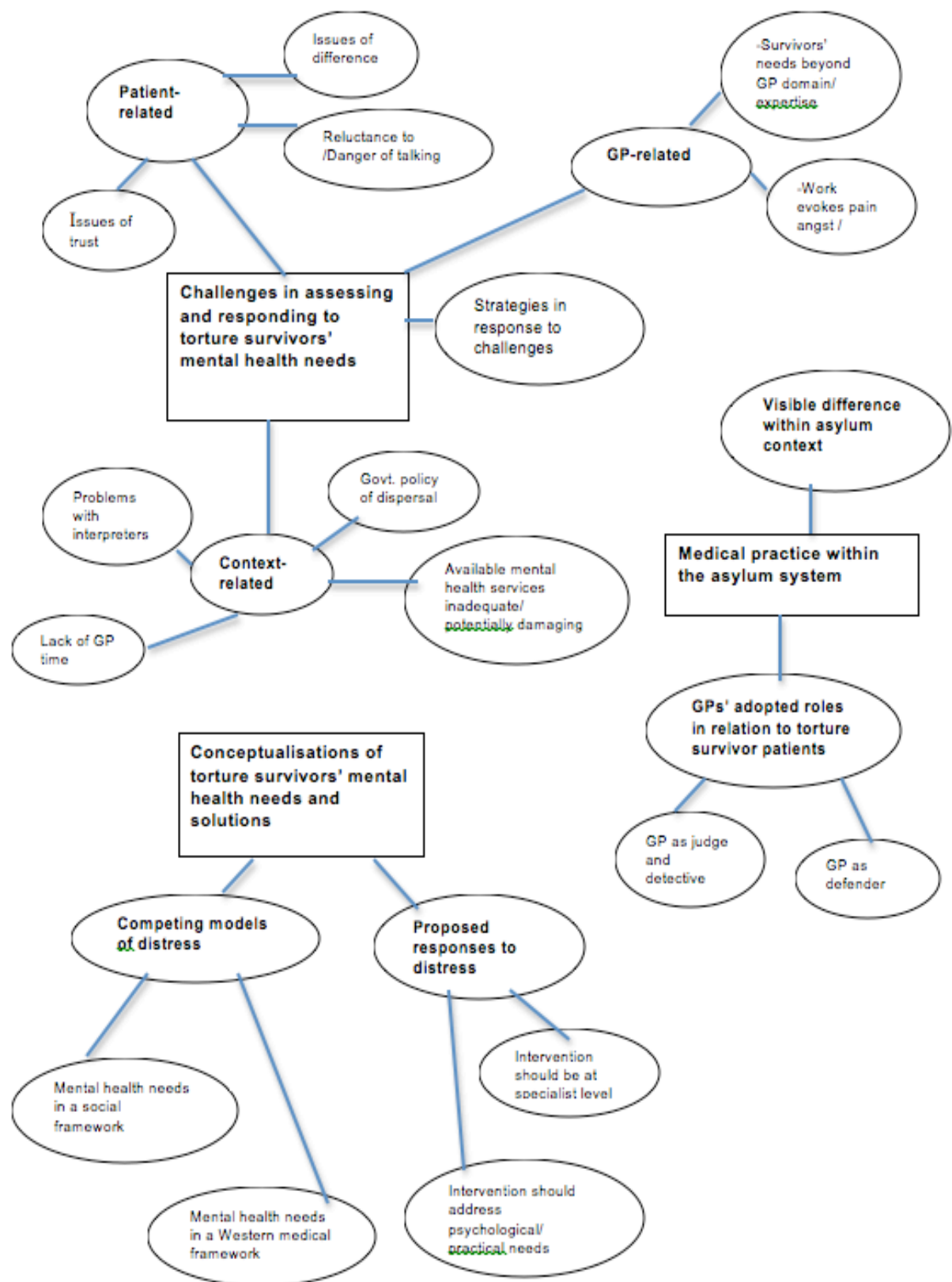




#### 4B. Developed thematic map (2<sup>nd</sup> stage analysis)



#### 4C: Final thematic map (3<sup>rd</sup> stage analysis)





**APPENDIX 5: Checklist of criteria for good thematic analysis (as taken from Braun and Clarke, 2006, p96)**

Process	No.	
Transcription	1	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	4	All relevant extracts for all each theme have been collated.
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you show you have done – ie. described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process; themes do not just 'emerge'.

## **APPENDIX 6: Letter of invitation to participate in the study and participant information sheet**



Kate Jacoby  
Department of Clinical Psychology  
University of East London  
London E15 4LZ

☎ 07572 946 039  
✉ [u0831969@uel.ac.uk](mailto:u0831969@uel.ac.uk)

Dear General Practitioner,

### **Invitation to participate in a research project:**

'The mental health needs of refugee torture survivors: exploring staff understandings'

I am currently recruiting participants for the above research project. I am hoping to speak to GPs who, through their work, may come into contact with refugees or asylum seekers who may be survivors of torture. It does not matter if you have only minimal experience in this area, as I am keen to speak to GPs with different levels of experience working in a range of settings.

I would be extremely grateful if you could take a few minutes to read the attached information and think about whether you would be interested in participating. It may be that you do not feel able to participate, but know someone in your practice or another organization who might be interested. In this case, please feel free to pass this information on to them.

This is an important study, which aims to contribute to improved access to appropriate mental health care for refugee survivors of torture, and better training and support for staff working with this group.

If you have any questions about the research or think you may be interested in participating, please do not hesitate to contact me (my contact details are listed above).

Many thanks for taking the time to read this information.

Yours faithfully

Kate Jacoby  
Trainee Clinical Psychologist

## **RESEARCH PARTICIPANT INFORMATION SHEET**

### **INFORMATION ABOUT PARTICIPATING IN A RESEARCH PROJECT:**

**The mental health needs of refugee torture survivors: exploring staff understandings**

**You are being invited to take part in a research project:**

- **Are you a GP?**
- **In your work, do you ever come into contact with refugees or asylum seekers who may be survivors of torture?**
- **Are you interested in taking part in research that aims to contribute to the development of: (a) more accessible and appropriate mental health services for refugee torture survivors, and (b) better training and support for staff working with this group?**

**If so, then I would like to speak to you...**

This leaflet provides you with the information you need to decide whether to participate in this study. Please take your time to read it and feel free to ask any questions you may have before making your decision. If you are interested in taking part or have any questions, please do not hesitate to contact the researcher by email or telephone (contact details below).

#### **About the researcher**

Kate Jacoby (Trainee Clinical Psychologist)

Department of Clinical Psychology, University of East London, London E15 4LZ

☎ 07572 946 039

✉ [u0831969@uel.ac.uk](mailto:u0831969@uel.ac.uk)

I am a final year student on the Doctoral Degree in Clinical Psychology at the University of East London, and am carrying out this research as part of my training.

#### **Research supervision**

This research is supervised by Dr Nimisha Patel, Reader in Clinical Psychology at University of East London & Lead Consultant Clinical Psychologist at Freedom from Torture (formerly known as Medical Foundation for the Care of Victims of Torture).

☎ 0208 223 4413

✉ [N.Patel@uel.ac.uk](mailto:N.Patel@uel.ac.uk)

#### **Ethical approval**

This research has received ethical approval from the University of East London and NHS Research Ethics Committees.

**What is the purpose of the study?**

The aim is to explore how GPs, working in settings where they may come into contact with refugee torture survivors, understand their mental health needs.

**Why is this study important?**

Many refugee torture survivors experience high levels of distress. They are entitled to receive mental health care in the UK National Health Service (NHS), but few access this care and there are concerns about the appropriateness of care available. At present, it is not fully understood why so few survivors access appropriate NHS mental health care. This is a complex and challenging area. However, one aspect about which we know little is how potential referrers make decisions about torture survivors' mental health needs.

**How will the study results be used?**

It is hoped that the results of this study will highlight areas for service development, advocacy and training. The results will initially be written up as a doctoral thesis but will also be disseminated more widely to ensure maximum impact (for example, in academic journals or to relevant organizations involved in advocacy). All participants who are interested will be provided with a summary of the study results, once the research has been completed.

**So, who can take part?**

Any general practitioner working in a setting where they may come into contact with refugee torture survivors. This will include:

- GPs working in NHS primary care practices
- GPs working in specialist practices (for example, practices for refugees and asylum seekers)
- GPs working in the voluntary sector
- GPs working in settings connected to the asylum process (for example, Initial Accommodation Centres)

It does not matter if you have only minimal experience in this area, as I am keen to speak to GPs with different levels of experience working in a range of settings.

**Do I have to take part?**

Participation in this study is entirely voluntary. If you do decide to take part you will be asked to sign a consent form. If you agree to take part you may change your mind at any point and withdraw from the study without giving a reason, even once the interview has commenced (as long as this is prior to data analysis and write-up).

**What will be involved if I decide to take part?**

If you agree to take part you will be invited to attend an interview with the researcher lasting 1 – 1.5 hours. The venue and time of the interview will be arranged for your convenience. During the interview, you will be asked some questions about your understanding of refugee torture survivors' mental health needs and how you might aim to respond to these. There are no right or wrong answers – this is a challenging area of practice and I am interested in your experiences and views. The interview will be recorded using a digital audio recorder, to ensure that I can accurately represent what participants have said.

**Will my taking part in this study be kept confidential?**

Participation in the study is strictly confidential. This means that no one apart from the researcher will know who took part in the study. Your name will not be written on the file of the audio recording or the interview transcripts, and will not be used in any reports on the study. The audio records of the interviews will be stored securely on a computer and deleted after the research has been examined. Interview transcripts will be stored securely on a computer, accessed via a password system, and will be erased after five years. Only the researcher, the supervisors and examiners will be able to read the interview transcripts.

When the results are written up, it may be useful to quote exact phrases that people have used. However, reports will not include your real name or any details that might identify you. In order to contextualize the results, it may be necessary to explain what setting each participant worked in, but care will be taken to ensure that individuals cannot be identified.

In the event of any serious breaches of governance being identified during the course of the research, I would be obliged by NHS Ethics to disclose them.

**Are there any possible disadvantages of taking part?**

I will aim to make the interview a comfortable experience for you. If for any reason the interview makes you feel uncomfortable or distressed, you will be offered a space to reflect after the interview. Afterwards, if you have any concerns or wish to discuss any issues related to the interview, please feel free to contact the researcher or the researcher's supervisor.

**Finally...**

If you have any questions about the way this research is being done please contact the servicing officer of the University Research Ethics Committee: Mr Merlin Harries, The Graduate School, University of East London, Docklands Campus, 4-6 University Way, London, E16 2RD. ☎ 020 8223 2009 ✉ [m.harries@uel.ac.uk](mailto:m.harries@uel.ac.uk)

**Thank you for taking the time to read this information.**

## **APPENDIX 7: Interview schedule (as approved by NHS Ethics Committee)**

### **INTERVIEW SCHEDULE: Version 2 (7.4.11)**

Participant number: .....

Participant's work setting: .....

Relevant demographics of patient population: .....  
(e.g. rough proportion of patients who are refugees / asylum seekers)

- 1. As you know, my research aims to explore GPs' understandings of the mental health needs of refugee torture survivors. What is your experience of working with this client group?**

Possible prompts:

- Not all refugees & asylum seekers are torture survivors – any different experiences within this heterogeneous group?
- Regular contact with people who may be torture survivors?
- Difficulties in distinguishing/identifying torture survivors amongst this group?

- 2. What is your experience of assessing the mental health needs of someone who may be a torture survivor?**

Possible prompts:

- If no experience, what might you do/expect?
- Guiding resources/guidelines/theoretical frameworks? How are these helpful?

- 3. What difficulties have you experienced (or would you anticipate) in identifying and assessing mental health difficulties in this group?**

Possible prompts:

- Practical issues?
- Cultural differences?
- Challenges of facilitating conversation re psychological health?
- (What helps – or would help – address these challenges?)

- 4. What helps you decide how best to respond to any mental health needs identified for someone who you believe may be a torture survivor? Why?**

Possible prompts:

- How decide re referral to psychological therapy? When helpful?
- What informs your view (e.g. experience, practice guidelines, evidence)?
- Where would you refer to & how would you decide?

- 5. In terms of pathways to care, what helps you decide why someone (who may be a torture survivor) should not be referred to mental health services?**



Possible prompts:

- Times when existing mental health provision not helpful? Why?
- Necessary adaptations?
- Why do you think some torture survivors with mental health needs never access mental health services?

**6. Now I'd like to ask you a bit about the government's proposals for GP Consortia to take on responsibility for commissioning mental health services (which would include commissioning of appropriate services for this group)...**

**What are your views on what are relevant services to commission for this client group and why?**

Possible prompts:

- Mental health services? Other services?
- Why would you suggest these particular services for this group?
- (Challenges in planning appropriate services for this group?)

**7. Is there anything important that I have missed? Anything else you would like to add?**

[Interviewer to follow up on any outstanding issues raised in the interviews]

**At the end of the interview:**

- The researcher will debrief with the participant to ensure that they were comfortable with the interview experience and address any queries or issues arising.
- The researcher will check with the participant whether they would like to receive a summary of the study results.

## **APPENDIX 8: Consent form**



### **CONSENT FORM FOR PARTICIPANTS IN THE RESEARCH PROJECT:**

#### **The mental health needs of refugee torture survivors: exploring staff understandings**

Name of researcher: Kate Jacoby (Trainee Clinical Psychologist)

Please read the following information carefully, tick each box if you are happy with the statement, and then sign at the bottom of the page to show you are happy to take part in the research:

I have read and understood the information sheet for this study and have had the opportunity to ask questions ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason for doing so ☐

I understand that my involvement in this study and the information I provide will be kept anonymous ☐

I agree to the interview being audio recorded, and understand that the audio records will be deleted once the research has been examined ☐

I agree that any words I may say during the interview can be used anonymously in the presentation of the findings of this research ☐

I understand that the research forms part of the requirement for a doctoral degree in psychology and the findings may result in publication ☐

I agree to take part in the study ☐

\_\_\_\_\_  
Name of participant      Date      Signature

\_\_\_\_\_  
Name of researcher      Date      Signature

## **APPENDIX 9: UEL Ethics Committee approval**



Dr Nimisha Patel  
Psychology  
Stratford

ETH/13/44

16 May 2011

Dear Nimisha,

### **Application to the Research Ethics Committee: The mental health needs of refugees torture survivors (K Jacoby)**

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.

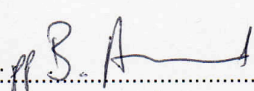
Yours sincerely

Debbie Dada  
Admissions and Ethics Officer  
Direct Line: 0208 223 2976  
Email: d.dada@uel.ac.uk

---

### **Research Ethics Committee: ETH/13/44**

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: 16/5/11  
(2nd signature)

Please Print Name:

## **APPENDIX 10: NHS Ethics Committee approval and correspondence**

Over the following pages, I have included my correspondence with the NHS Ethics Committee leading to final approval, as follows:

- 1. Provisional approval letter requesting changes to study design – see p.135**
- 2. My response to provisional approval letter – see p.138**
- 3. Final approval letter – see p.142**



## National Research Ethics Service

North West London REC 1

REC Office  
Maternity, Level 7  
Northwick Park Hospital  
Watford Road  
Harrow  
HA1 3UJ

Telephone: 020 8869 5446  
Facsimile: 020 8869 5222

15 December 2010

Ms Kate Jacoby  
Trainee Clinical Psychologist  
Doctorate in Clinical Psychology  
University of East London  
Stratford Campus, Water Lane, London  
E15 4LZ

Dear Ms Jacoby

**Study Title:** The mental health needs of refugee torture survivors: exploring staff understandings  
**REC reference number:** 10/H0722/85  
**Protocol number:** N/A

The Research Ethics Committee reviewed the above application at the meeting held on 13 December 2010.

### Documents reviewed

The documents reviewed at the meeting were:

Document	Version	Date
Participant Consent Form	1	23 November 2010
Letter from Sponsor	Letter from Dr Kenneth Gannon	18 November 2010
REC application		19 November 2010
Referees or other scientific critique report	University of East London - Doctoral Degree in Clinical Psychology - Research Proposal Feedback Form	23 November 2010
Letter of invitation to participant	1	23 November 2010
Investigator CV	CV for Dr Nimisha Patel	23 November 2010
Protocol	1	23 November 2010
Participant Information Sheet	1	23 November 2010
CV for Ms Kate Jacoby		23 November 2010
Draft Interview Schedule	1	23 November 2010

### Provisional opinion

The Committee would like to thank you for attending the meeting. The Committee found it very useful.

The Committee noted that the topic under research was very important but felt that the application needed to be revised to ensure that the research answers the research question.

Thus the Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.



The Committee delegated authority to confirm its final opinion on the application to the Chair, in consultation with two members.

#### **Further information or clarification required**

After discussion, the Committee agreed that the study would be given a favourable opinion once the following issues had been addressed.

1. The Committee expressed concern that the study did not appear to be approaching the right group of people to be able to answer the research question: you presumably want to be identifying those people who would be having some input into helping the person, or in directing them to the right people who could provide help whereas you seem to be looking for a much wider group of respondents. In light of this concern, the Committee asked if the investigator would consider focusing the research on the victim of torture or the health care professional most likely to make the referral?
2. The Committee also expressed concern that the questions detailed in the draft interview schedule would not illicit the right information to enable the researcher to answer the research question. The committee felt the questions should be reviewed to ensure the questions asked were more focused on identifying need?

#### **Participant Information**

It was agreed that the participant information sheets needed to be amended taking into consideration the following:

3. It was agreed that the information sheets needed to be spell checked and all typographical errors corrected.
4. Could the information under the heading "Do I have to take part?" needed to be relocated to nearer the beginning of the participant information sheet?
5. It was agreed that the participant information sheets should disclose that confidentiality would be broken should issues of malpractice be identified.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 14 April 2011.

#### **Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

#### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0722/85	Please quote this number on all correspondence
-------------	--

Yours sincerely

*Ms Stephanie Ellis*

**Ms Stephanie Ellis**  
**Chair**

Email: louise.braley@nhs.net

Enclosures:

*List of names and professions of members who were present at the meeting and those who submitted written comments.*

✓ Copy to:

Dr Kenneth Gannon  
University of East London  
Stratford Campus  
Water Lane  
London E15 4LZ

Doctorate in Clinical Psychology  
University of East London  
Stratford Campus  
Water Lane  
London  
E15 4LZ

7 April 2011

**F.A.O. Ms Stephanie Ellis, Chair**  
c/o Ms Louise Braley, REC Manager  
North West London REC 1  
REC Office  
Maternity, Level 7  
Northwick Park Hospital  
Watford Road  
Harrow  
HA1 3UJ

Dear Ms Ellis,

**Study title: The mental health needs of refugee torture survivors: exploring staff understandings**

**REC reference number: 10/H0722/85**

**Protocol number: N/A**

Thank you for your letter dated 15 December 2010, detailing the Committee's provisional opinion on the above application. I have given careful consideration to the Committee's feedback, and hope that my response satisfactorily addresses its requests.

Your letter stated that a favorable ethical opinion would be dependent on the following points being addressed:

### **1. PARTICIPANTS**

#### **Committee's request:**

*"The Committee expressed concern that the study did not appear to be approaching the right group of people to be able to answer the research question: you presumably want to be identifying those people who would be having some input into helping the person, or in directing them to the right people who could provide help, whereas you seem to be looking for a much wider group of respondents. In light of this concern, the Committee asked if the investigator would consider focusing the research on the victim of torture or the health care professional most likely to make the referral?"*

#### **Researcher's response:**

I wholly agree that, in seeking to answer the research question, the selection of appropriate participants is crucial.

The Committee expressed concern that the participant group targeted in my initial proposal (i.e. staff working in a range of settings in which they may come into contact with refugee torture survivors) was too broad. My interest in this broad group stemmed from the core clinical problem this research seeks to address, namely, despite refugee torture survivors' care entitlements, few access statutory mental health services in the UK. Since many torture survivors are never even registered with a GP, it may be necessary to look beyond standard NHS referral structures to understand why access to appropriate mental health care is so poor. As such, focusing on the "health care professional most likely to make the referral" will not necessarily provide a complete picture of the barriers faced by torture survivors in



accessing appropriate mental health care: there are many relevant staff groups, both within and outside NHS services, who may have a role in detecting mental health problems and directing torture survivors towards help (and their understandings of torture survivors' mental health needs remain an important area of future study).

However, for the *current* study, I accept the Committee's recommendation that it would be beneficial to focus on a narrower group of participants. While this will elucidate only a specific area of a complex picture, it will enable a more in-depth and focused exploration of this area. I therefore agree to amend my proposal, so that the study focuses on *GPs only*. The rationale for selecting this participant group is as follows:

- (i) The role of GPs as gatekeepers to NHS mental health services: Within existing referral structures, GPs act as the main referrers to many NHS mental health services. As such, even where staff in non-NHS settings identify a torture survivor as having mental health needs, a referral to statutory mental health services would likely still require channeling through an NHS GP. While many other staff will have important roles in identifying and directing torture survivors towards mental health care, GPs are indeed the "health care professional most likely to make the referral".
- (ii) The role of GPs in assessing health needs in various settings: Although refugee torture survivors are often not registered with a GP practice, they may come into contact with GPs in other settings connected to the asylum process (for example, during health screening assessments at Initial Accommodation Centres, or during the asylum determination process). In each of these settings, GPs will be responsible for assessing the health needs of refugee torture survivors. It is therefore important to understand how GPs in various settings assess and respond to the mental health needs of this group. Efforts will be made to recruit GPs working across these various settings. This will help to ensure that the research looks beyond standard NHS referral structures to understand why so few torture survivors access statutory mental health services.
- (iii) The role of GPs in commissioning health services: Under the coalition government's plans for NHS reform, GP consortia will take on responsibility for commissioning most NHS-funded services, including mental health services. It is therefore increasingly important to explore GPs' understandings of torture survivors' mental health needs, not only for the purposes of identification and referral, but also in commissioning appropriate services for this group.

## **2. DRAFT INTERVIEW SCHEDULE**

### **Committee's request:**

*"The Committee also expressed concern that the questions detailed in the draft interview schedule would not elicit the right information to enable the researcher to answer the research question. The Committee felt the questions should be reviewed to ensure the questions were more focused on identifying need."*

### **Researcher's response:**

In light of alterations to the participant group and the Committee's concerns above, I have re-drafted the interview schedule. A revised draft interview schedule (version 2) is attached for your appraisal. The Committee requested that questions be more focused on identifying need. The interview schedule therefore focuses on how GPs aim to identify mental health needs, what challenges they experience, and how they determine an appropriate response. These questions relate to the core tasks that GPs in various settings might undertake in work with this client group (identification of torture history, assessment/identification of health need and onward referral. In view of government proposals regarding GP commissioning (see section 1(iii) above), a question has also been included which aims to elicit GPs' views on which services should be commissioned for this client group.

Please note that this is a draft interview schedule at this stage, which will be further refined following piloting. As the Committee will appreciate, in qualitative research of this kind, development of the interview schedule is an iterative process and it may be necessary to

continue refining the schedule in the light of issues raised by individual participants during the course of the fieldwork.

### **3. PARTICIPANT INFORMATION**

#### **Committee's request:**

*"It was agreed that the participant information sheets needed to be amended taking into consideration the following:*

- (i) It was agreed that the information sheets needed to be spell checked and all typographical errors corrected.*
- (ii) Could the information under the heading 'Do I have to take part?' be relocated to nearer the beginning of the participant information sheet?*
- (iii) It was agreed that the participant information sheets should disclose that confidentiality would be broken should issues of malpractice be identified."*

#### **Researcher's response:**

I have amended the participant information sheets as requested above (and have also made further minor changes as necessary, in response to the requested changes to the participant group). I have also revised the invitation to participate, as required to reflect the altered participant group. I have therefore attached the following documents for your review:

- Draft email invitation to participate: Version 2 (7.4.11)
- Draft research participant information sheet: Version 2 (7.4.11)

Please note: The consent form remains unchanged, but I have attached a copy of this so that you have access to all relevant documentation when reviewing the revised documents.

<b>Additional changes to the research proposal:</b>
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In addition to the changes requested in your letter dated 15 December, some further changes have been made to maximise the quality of the research:

### **4. RECRUITMENT STRATEGY**

Following the alteration in participant group, the recruitment strategy has been further clarified. Essentially, the recruitment strategy will remain as described under section A27-1 of the NHS REC Form: namely, the researcher will initially attempt to recruit participants via existing professional networks (e.g. networks of professionals working with refugees and asylum seekers). Those receiving this information, and those who agree to participate, will be invited to pass on the information to other parties they think may be interested.

However, in order to recruit GPs working in standard primary care settings, it may be necessary to approach some practices directly and make a request to distribute information about the research to their GPs. Therefore I am planning to make a 'Research & Development' (R&D) application to cover a set of NHS trusts, and I will only approach practices, or enter NHS premises, for which R&D approval has been granted. GPs working in non-NHS settings will be interviewed in non-NHS premises.

For practical reasons, the researcher aims to recruit participants mainly from the London region. However, the experience of GPs outside London is highly relevant, as asylum seekers are increasingly dispersed outside London. The researcher has access to some funding (from the University of East London) for travel elsewhere in the UK if interested parties would like to participate. Due to the scale of the study, recruitment will be restricted to the London region plus one other identified site to which large numbers of asylum seekers are dispersed (for example, Liverpool, Birmingham or Manchester).

## **5. REVISED TIMETABLE FOR THE RESEARCH**

Please note that the timetable originally proposed for the research (detailed under section A13 of the NHS REC Form) has now been extended to allow greater time for completion of the research to a high standard. The revised timetable is as follows:

Recruitment and interviews: May – June 2011

Transcription and analysis of interviews: June – September 2011

Write-up of thesis: October – December 2011

Hand-in of thesis: January 2012

Examination/viva: March 2012

Summary of results to participants (and deletion of audio files): March 2012 following viva

Dissemination of results (e.g. via journal article): After March 2012

I do hope this answers your queries in full, but please do not hesitate to contact me if you require further information.

I look forward to your response.

Yours sincerely

Kate Jacoby (Chief Investigator)  
Trainee Clinical Psychologist, University of East London

Supervised by Dr Nimisha Patel  
Reader in Clinical Psychology, University of East London  
Consultant Clinical Psychologist, Medical Foundation for the Care of Victims of Torture

c.c. Dr Kenneth Gannon  
Doctorate in Clinical Psychology  
University of East London  
Stratford Campus  
Water Lane  
London  
E15 4LZ

### Enclosures:

1. Draft interview schedule: Version 2 (7.4.11)
2. Draft invitation to participate: Version 2 (7.4.11)
3. Draft research participant information sheet: Version 2 (7.4.11)
4. Draft consent form: Version 1 (23.11.2010) – for information only



## National Research Ethics Service

### NRES Committee London - Camden & Islington

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04 May 2011

Ms Kate Jacoby  
Trainee Clinical Psychologist  
Camden & Islington NHS Foundation Trust  
Doctorate in Clinical Psychology  
University of East London  
Stratford Campus, Water Lane  
London E15 4LZ

Dear Ms Jacoby

<b>Study title:</b>	<b>The mental health needs of refugee torture survivors: exploring staff understandings</b>
<b>REC reference:</b>	<b>10/H0722/85</b>
<b>Protocol number:</b>	<b>N/A</b>

Thank you for your letter of 07 April 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

#### Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

#### Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisation(s) involved in the study in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System (IRAS) or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Protocol	1	23 November 2010
Letter of invitation to participant	2	07 April 2011
CV for Ms Kate Jacoby		23 November 2010
Draft Interview Schedule	2	07 April 2011
Response to Request for Further Information	Letter to Ms Ellis from Ms Jacoby	07 April 2011
Investigator CV	CV for Dr Nimisha Patel	23 November 2010
Referees or other scientific critique report	University of East London - Doctoral Degree in Clinical Psychology - Research Proposal Feedback Form	23 November 2010
Participant Consent Form	1	23 November 2010
REC application		19 November 2010
Participant Information Sheet	2	07 April 2011
Letter from Sponsor	Letter from Dr Kenneth Gannon	18 November 2010

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

#### After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.



We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email [referencegroup@nres.npsa.nhs.uk](mailto:referencegroup@nres.npsa.nhs.uk).

10/H0722/85

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



**Ms Stephanie Ellis**  
**Chair**

Email: [louise.braley@nhs.net](mailto:louise.braley@nhs.net)

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Kenneth Gannon  
University of East London  
Stratford Campus  
Water Lane  
London E15 4LZ

1. The Chair and members acting in the research with the Research Ethics Committee that gave the favourable ethical opinion (referred to in this document as "the Committee") are the persons responsible for the research.

## 2. Commencement of the research

2.1 It is assumed that the research will commence within 12 months of the date of the favourable ethical opinion.

2.2 The research must not commence at any site until the local Principal Investigator (PI) or research collaborator has obtained management permission or approval from the organisation with responsibility for the research participants at the site.

2.3 Should the research not commence within 12 months, the Chief Investigator should give a written explanation for the delay.

2.4 Should the research not commence within 24 months, the Committee may review its opinion.

## 3. Duration of ethical approval

3.1 The favourable opinion for the research generally applies for the duration of the research. If it is proposed to extend the duration of the study as specified in the application form, the Committee should be notified.