POLISH IMMIGRANTS AND PSYCHOLOGICAL HELP: A QUALITATIVE EXPLORATION

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ABSTRACT

Polish immigrants are currently the largest foreign-born population in the UK. Nevertheless, their needs appear somewhat invisible. Research indicates that, despite experiencing high levels of psychological distress, the utilisation of psychological services amongst Polish individuals is low. This thesis explores factors affecting the psychological wellbeing of Polish immigrants, their access to services and their experience of accessing them. It also explores the understanding of this client group amongst psychologists, their training needs and ways to improve services. The study adopts a mixed methods design. An online survey was conducted amongst psychologists and the gathered data was analysed using content analysis. Semi-structured interviews were conducted with members of the Polish community who have accessed psychological help. Data was analysed using thematic analysis.

Psychologists responding to the survey acknowledged the impact of migration-related, socio-economic and cultural factors on the wellbeing of Polish clients. In considering access to services, the majority of responses located the barriers within the Polish community (e.g. help-seeking attitudes). Analysis of the interviews with Polish people who had accessed services identified three overarching themes encompassing the role of cultural factors, conceptualisations of distress, negotiation of migrant identity and the relationship with the NHS. The theme 'Occupying dichotomous positions' describes immigrants' position in relation to time (present/past), place (Poland/UK) and identity (Victim/oppressor, different/the same). The second theme 'Help through Polish cultural lenses' contains sub-themes conceptualising therapy as culturally unfamiliar, seeking help as connected to aspects of pride and shame, and perception of services as unwilling to help. The final theme, 'Understanding beyond language', conveys the importance of understanding the historical, political and cultural context as well as appropriately addressing language barriers.

Based on the findings, implications for clinical practice and future research are considered. The findings suggest that there is a need to improve the understanding of the Polish community within mainstream psychology services, and efforts should be made to improve the relationship between Polish communities and the NHS. The need to develop Community Based Participatory Action Research projects with the Polish community was highlighted as one of the future research implications.

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1. INTRODUCTION

1.1. Overview

The following chapter will situate the research topic in a wider socio-political context. It will take into account the current debates regarding the provision of mental health services to groups of minority ethnic backgrounds. It will also take into account the historical and political context of Polish presence in the UK. The chapter will include a review of the available literature regarding the factors affecting psychological wellbeing of Polish immigrants and factors affecting their access to psychological help. It will conclude with an outline of the rationale for the study, its aims and research questions.

1.2. Note On Terminology

When discussing issues related to minority populations in Britain, it is paramount to establish definitions of the terminology used in these discussions. Terms such as 'race', racism, culture and ethnicity alongside the references to BME (Black and minority ethnic) groups are commonly used in policy documents, research, media and popular discourses. Yet, definitions of these concepts are unclear and inconsistent.

1.2.1. 'Race'

While categorising human beings into 'races' based on skin colour, has long been discredited (Cornell & Hartmann, 1998), the notion of 'race' persists in modern society through the existence of racism (Fernando & Keating, 2008). Instead of representing a characteristic of a person, 'race' can be understood as a socially constructed (and problematic) concept reflecting historical discourses and practices (Durrheim, Hook & Riggs, 2009). 'Race' can also be understood politically. Not only is it "a descriptive term for physical difference but involves a potent cultural metaphor and value judgment justifying negative/discriminatory attitudes" (Vickers, Craig & Atkin, 2013, p. 12).

1.2.2. Ethnicity

The term ‘ethnicity’ has come to embody a broad range of ideas, such as shared heritage, sense of belonging, group identity, language, religion, culture or nationality (Fernando, 2010). Ethnicity is a fluid and flexible concept that is also value-laden. There is no clear definition of what constitutes an ethnic group and ethnic identification is self-defined and subjectively meaningful (Fernando & Keating, 2008). The descriptors currently used in policy and research (including pan-ethnic terms such as ‘Asian’ or ‘Mixed race’) are so vague that they lose meaning or utility. The ethnic category of ‘White’ is also problematic. According to Ware and Back (2002) ethnicity constructs individuals identifying as ‘Black’ and ‘Asian’ as ‘ethnic’ and those identifying as ‘White’ as non-ethnic. The use of binary terms such as ‘Black’ or ‘White’ might be seen as obscuring the existence of White minorities and rendering them invisible (Aspinall, 2002).

1.2.3. Culture

Culture is a dynamic term referring to the intergenerational transmission of shared history, practices, traditions, norms, values, belief ways of living (Betancourt & Lopez, 1993). Acharyya (1992) argued that “culture encompasses all of everyday life, from the mundane, such as the type of food eaten, even mealtimes, and clothes, to religious practices and important attitudes to others in terms of age, sex and social roles. Along with these, it includes the extent to which one can adapt to social change” (p.74).

Like ethnicity, culture is regarded as a fluid and flexible concept as individuals can change their ethnic or cultural identities through processes such as migration and acculturation (Smedley, 1993). Fernando (2002) describes a postmodern view of culture as “something living, dynamic and changing, a flexible system of values and world-views that people live by” (p. 113).

1.2.4. Racism

Racism can be defined as “any behaviour or pattern of behaviour that tends to

systematically deny access to opportunities or privileges to members of one 'racial' group while perpetuating access to opportunities and privileges to any other 'racial' group" (Ridley, 1995, p. 28). However, it has been argued that racism is not only limited to those discourses or practices related to 'race' categorization, but might also extend to categorisations related to culture, ethnicity, religion, or immigration status (Anthias, 1999; Patel et al., 2000). This process has been labelled as 'racialisation'. Traditionally understood racism can be seen in the discourses or practices positioning 'other races' as inferior, 'less developed' or dangerous. Through the process of racialisation the same discourses extend to 'other' cultures, faiths, ethnic communities, nationalities or kinds of people, which are conceptualised in the same way as 'races' (Fernando & Keating, 2008).

Therefore, it has been argued that 'racism' no longer operates solely on the Black–White binary (Gillborn, 2006; 2009; 2015.) Different groups can become 'racialised' irrespective of their skin colour. For example, anti-Semitic or anti-Islamic attitudes and behaviours can be viewed as 'racisms' perpetuated against religious groups constructed in a similar way to 'racial' groups (Fernando & Keating, 2008). Similarly, it can be argued that White immigrant communities (such as Polish or Irish) can become 'racialised' and therefore disadvantaged and victimised (McDowall, 2009). The term racism has been used to denote the experiences of racialised White minority migrant groups in a number of publications (e.g. Fox, 2013; Rzepnikowska, 2018). However, the experiences of racialised groups, and meanings associated with these experiences are likely to differ to those of groups discriminated and marginalised on the basis of their skin colour. Therefore, throughout this thesis the term racism will be placed in inverted comas when referring to the experiences of White minority groups.

1.2.5. Black And Minority Ethnic Groups

In the UK, the term 'BME' denoting Black and Minority Ethnic groups is regularly used as shorthand in research, policy documents, clinical practice and services. However, there are some inconsistencies in its usage. While some documents

include White minority groups in the broad BME category, others use the acronym to refer specifically to the populations of African and Asian backgrounds. Some do not define it at all. The broad use of the 'BME' acronym appears to imply the homogeneity of the group and obscures the nuanced diversity of various communities who might be identified as ethnic minorities (Fernando & Keating, 2008).

Wood and Patel (2017) suggest that the term BME can be seen as a social construct and conceptualised as "including all those who politically define themselves as 'Black' (oppressed on the basis of colour or assumed racial categories – including African and those of African heritage, Indian, Pakistani, Bangladeshi people) and those from minority ethnic groups in the UK context, who also suffer racism" (p.2). The Department's of Health (2005) definition includes individuals of Irish and Mediterranean origin and Eastern European migrants.

1.3. Setting The Context

1.3.1. Ethnic And Cultural Diversity In The UK

The United Kingdom has been multi-cultural and ethnically diverse to varying extents for centuries. Complex historical migration patterns alongside numerous legislative and economic changes contributed to the development of a multifaceted fabric of society in the UK (Ahmad & Bradby 2007).

1.3.1.1. Ethnic Groups In The UK

The latest census data (Office for National Statistics, 2012) suggests that in recent years the UK has become even more ethnically diverse. While the majority of the resident population of the UK identifies as 'White', the proportion of people identifying as 'White British' decreased from 87.4% in 2001 to 80.5% in 2011. In 2011 the second largest group was 'Asian/Asian British' (7.5%), followed by 'Black/ African/ Caribbean/ Black British' (3.3%), 'Mixed/Multiple' ethnic groups (2.2%), and 'Other' ethnic groups (1%).

However, since the expansion of European Union in 2004, significant numbers of immigrants from Eastern and Central Europe have contributed to an increase in the number of people from White backgrounds residing in the UK. Between 2001 and 2011 individuals identifying as 'White Other' increased by over one million and according to the census constituted 4.4% of the UK population. They were also most likely to be born outside of the UK. This broad and imprecise category includes Eastern, Central and Western Europeans, Israeli, Irish, Americans and Australians (ONS, 2015).

1.3.1.2. Migrant Communities In The UK

The migrant population in the UK continues to increase. The non-UK born population reached 9.4 million and the population of non-British nationals reached 6.2 million (ONS, 2018). The most common non-British nationality since 2007 is Polish. Poland also remains the most common country of birth for non-UK born residents. It is estimated that approximately 1 million Polish nationals lived in the UK in 2017, which equals 16% of the total non-British nationals. The second most common country of birth was India (829,000), following by Pakistan (522,000), Romania (390,000) and the Republic of Ireland (390,000).

1.3.2. Institutional Racism And Ethnic Inequalities

1.3.2.1. Institutional Racism

Within diverse societies the persistence of inequalities and institutional racism has been well documented with examples being prevalent within education, police and judicial services, the general workforce and health services (Fernando & Keating, 2008). The concept of institutional racism appears to capture the essence of ethnic discrimination and oppression and it has been suggested as one of the explanations for public services' inability to respond to the needs of people from BME backgrounds (Vickers et al., 2013).

The MacPherson Report (1999) defined institutional racism as *"the collective failure of an organization to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudices, ignorance, thoughtlessness and racist stereotyping, which disadvantages minority ethnic groups"* (p.28). Patel et al (2000) further defines it as "*the reproduction within institutions of practices of power, which discriminate against persons on the grounds of perceived 'race'. These practices maintain the status quo in institutions and can be practiced in the commission of racist acts or in the omission"* (p.31).

The persistence of institutional racism was demonstrated in the "Race Disparity Audit", which was published by the government in October 2017. The audit was met with a mixed political and media reception and perhaps unsurprisingly demonstrated the persistence of racial and ethnic discrimination across a range of public services and other areas, including socio-economic status, education, employment, housing, access to welfare services and health (Alexander, 2018).

1.3.2.2. Ethnic Inequalities In Mental Health

The continuous presence of ethnic inequalities in mental health has been documented in the report produced through the collaboration of the Lankelly Chase Foundation, Mind and the Afiya Trust and Centre for Mental Health (Fitzpatrick et al., 2014). The report highlighted a number of systemic challenges that affect the BME communities' experience of engagement with mental health services. These included:

- "The continuing disproportionate representation of black African and Caribbean men with mental health problems at the 'hard end' of services".
- "The continuing experience of Black African and Caribbean service users of impoverished or harsh treatment from primary and secondary mental health services".
- "Continuing poor access to adequate mental health services across different BME communities" (p. 7).

The contents of the Race Disparity Audit (2017) echo these findings. It indicated that Black women were most likely to have been diagnosed with anxiety or depression, whereas Black men were the most likely to have been diagnosed with a psychotic disorder. However, the group most likely to be receiving treatment for mental or emotional problem was White British and amongst those in receipt of psychological therapies, White individuals experienced better outcomes than those of other ethnic groups. Indeed, the persistent difficulties with accessing psychological therapies and the lack of appropriate or culturally and context-relevant services for people from BME backgrounds have been a feature of the UK's socio-political context (Wood & Patel, 2017).

While the numerous inequalities experienced by individuals of Black and Asian backgrounds have been widely documented, information about individuals from some other ethnic backgrounds – for example, minority White populations or newer and smaller migrant groups – is not separately available in many official data sets and research (Barnard, 2011). White ethnic minority groups have not been a strong feature of debates despite the presence of, for example, the Irish, Gypsy Roma and Traveller communities in the UK for centuries (Vickers et al., 2013).

1.3.3. Striving For Equality

Various initiatives to address ethnic inequalities in mental health have been developed. Some key publications, such as Delivering Race Equality in Mental Health Care (DoH, 2005) or Inside Outside: Improving Mental Health Services for Black and Minority Ethnic communities in England (NIMHE, 2003) set out action plans for addressing discrimination and improving mental health services for all people of BME status. Some more recent documents such as No health without mental health (DoH, 2011) or the NHS England Equalities 'toolkit' (DoH, 2013) conceptualise race as a 'protected characteristic' within the Equality Act (2010) and advocate for 'culturally competent' services. However, in the words of Sewell and Waterhouse (2012) "whilst numerous national and local initiatives have aimed to improve access, experience and outcomes for BME service users, concrete' evidence of improvement remains lacking" (p.5).

1.3.4. Clinical Psychology And Ethnic And Cultural Diversity

The idea that culturally competent services should be available to people of BME backgrounds has been widely discussed and the role of cultural competence in clinical practice has been acknowledged in the literature (e.g. Halsey & Patel, 2003; Patel & Fatimilehin, 2005; Sue, Zane & Berger, 2009). It has been argued that some of the aforementioned health inequalities arise due to the lack of cultural competence in services (Nazroo & King, 2002; DoH, 1999; 2005; NIMHE, 2003). Moreover, it has been argued that cultural competence (both organisational as well as individual) is crucial to the provision of high-quality mental health care (Bhui et al. 2007).

Therefore, as a profession, clinical psychology has had to consider the cultural appropriateness and utility of the treatment it provides (Patel & Fatimilehin, 2005). The relevance of the dominant therapy modalities and the notion of 'cultural competence' are topics of on-going debates within the field.

1.3.4.1. Defining 'Cultural Competence'

Defining 'cultural competence' is difficult. There are different ways to conceptualise both culture and competence within this context. Moreover, cultural competence has been argued to be contextually based rather than technique specific (Sue, 1998). Some definitions of cultural competence conceptualised it as a quality of a therapist. According to Sue "*one is culturally competent when one possesses the cultural knowledge and skills of a particular culture to deliver effective interventions to members of that culture"* (p. 441). It was proposed that cultural competencies are generally divided into three distinct interrelated components: *awareness* of the therapist's own cultural assumptions, *knowledge* of the worldviews and values of culturally diverse populations and specific *skills* for intervention with these populations (Sue et al., 1982).

It has also been argued that knowledge about particular culture is helpful but not sufficient. Sue (1998; 2003) believed that an essential skill for a therapist is

knowing when to generalise and when to individualise. He emphasised the importance of the therapist's ability to recognise when and in what way cultural values may be relevant to the client's problems. At the same time it is paramount that a therapist sees the client as an individual and avoids stereotyping. Cultural competence can be contrasted with the notion of "cultural encapsulation". This concept describes the unintentional ethnocentrism that might take place when therapists are unable to reflect on how their own culture affects their interpretations of, and responses to the material clients bring to therapy (Jim & Pistrang, 2007; Pedersen et al., 2002).

Other definitions of 'cultural competence' place more emphasis on the way the services are provided. Halsey and Patel (2003) suggested that *"the overall aim is not to form a body of experts in the field of race and culture, but to develop a service which can actively engage in a reflective process of the models adopted and think creatively about the service delivered to diverse populations" (p.32).* Therefore, delivering appropriate services to all individuals of BME backgrounds should be embedded within an educational and political framework (Dogra et al., 2007).

1.3.4.2. Levels Of Adjustment

In order to provide culturally competent, relevant and meaningful psychological services for clients of diverse ethnic or cultural backgrounds, a number of adjustments need to be made. This should happen on four levels (Tseng, 1995; 2004):

- Technical adjustments, which involve modifications of therapeutic methods, skills, and practices. This includes areas such as power in the therapist-patient relationship, ways of communicating (e.g. language, culturally-relevant metaphors), conceptualisations of distress and the selection of modes of therapy.
- Practical Considerations, including issues around access and resources, e.g. bilingual staff, interpreters, translated materials
- Theoretical modifications to the conceptualisations of human behaviour and the nature of difficulties. For example, the understanding of concepts

such as the ‘‘self’’ and ego boundaries, ideas about interpersonal dependency and independence and the interface between body and mind.

- Philosophical reorientation around what constitutes the nature of life, acceptance vs. overcoming, spirituality, as well as definitions of normality and maturity, which are seen as the goals of psychotherapy.

1.3.4.3. ‘Cultural Competence’ Across Cultures

Cultural aspects of therapy tend to be discussed only when there are clear and easily noticeable cultural differences between the therapist and the client. The focus is on cultural competence of White therapist to work with ‘difference’ (Fatimilehin & Coleman; 1999). Publications on cultural competence also mostly explore the perspective of the White clinicians (Iwamasa, 1996). This obscures the experiences of therapists from BME backgrounds and constructs ‘Whiteness’ as homogenous.

Therefore, it has been argued that cultural competence is paramount not only when working therapeutically with individuals of minority ethnic backgrounds or with immigrants. Cultural aspects of the intervention need to be considered for all therapist-client relationships, as every individual has a different internalized construction of their own cultural world (Sue et al., 2009; Wohl, 1989).

It can be argued that the current discourses regarding the needs of BME populations in the UK might obscure the needs of hidden minority populations such as ‘White Other’. This category is problematic as it groups people belonging to a number of very different cultures. Culturally relevant therapy for a person from the United States or New Zealand, might be very different to culturally relevant therapy for a person from Poland or Romania.

1.4. Polish Immigrants In The UK: A Hidden Giant

Polish immigrants are currently the largest foreign-born population in the UK. In 2017 over one million Polish nationals resided in the country and Polish

continues to be most widely spoken non-English language in England and Wales (ONS, 2018). The history of migration from Poland to the UK has been shaped by at least three generations (Garapich, 2007) and over the decades Polish immigrants have become a significant part of the British social and cultural landscape.

However, despite their large numbers and their established position within British social fabric, the needs of Polish immigrants as a minority group appear somewhat invisible. It is difficult to gain a comprehensive account of the mental health and psychological needs of Polish immigrants because much of the existing data operates within broad ethnic categories, but not migration variables such as the country of birth. The hidden position of Polish immigrants within the broad category of 'White Other' means that there is very little official data available regarding this particular group. The following sections aim to situate the Polish immigrants within a wider socio-political context and outline the current state of knowledge regarding this population.

1.5. Historical Context Of Polish Migration To Britain

Political and economic migration appears deeply embedded within Poland's history and Polish national identity. Garapich (2007) argued that "the act of emigrating is a widespread archetypical notion present in literature, arts, religion, political thought and is deeply entangled with Polish national identity. Through the literary work of poets in exile, emigration is thickly woven into a national narrative of land, belonging, family and loss" (p. 6). While this project focuses on members of the Polish community who arrived in the UK after the EU accession in 2004, this section aims to situate this most recent wave of Polish migration within the wider historical context of Poland and Polish migration.

1.5.1. Post World War II Migration

Migratory movements from Poland to the UK were described as occurring in three distinct waves (Garapich, 2007; Iglicka, 2001). While, some individuals

emigrated prior to World War II, it was during and shortly after this time that the first significant wave of Polish migration arrived in Britain.

In 1939, Poland was invaded by both Germany and from the Soviet Union (Erdmans, 1998). By the end of World War II, genocide and displacements had reduced the Polish population by 25%. The new Polish state was strictly controlled by the Soviet Union and staunchly pro-communist. By 1948 Poland become one of Moscow's satellite states and a part of the Soviet bloc (Davies, 2005). Between 1945 and 1950 an estimated 114,000 Poles migrated to Britain. These were mostly former members of the Polish army and their families. In addition, a number of formerly displaced Polish individuals arrived in Britain under the European Volunteer Workers' scheme. To help meet the specific needs of this population in 1947 the British government passed the Polish Resettlement Act (Zubrzycki, 1956).

Between 1950 and 1980, as the Cold War escalated, the migration movements from Eastern Europe were reduced, as people were not allowed to travel (Okólski, 1998). Throughout the 1980s a number of socio-political changes occurred in Poland. As the debt crisis increased, industrial strikes occurred throughout Poland and the Solidarity movement was born (Swain & Swain, 2017). With the end of the Soviet regime the emigration restrictions began to loosen throughout the Soviet Block, which facilitated mass migration movements from Poland.

1.5.2. Migration Post-Communism And Before EU Expansion

The collapse of the Communist regime and the sudden exposure to the international global capitalist market economy resulted in rapid and dramatic changes in the life of Polish nationals. Universal benefits and full time employment, which were associated with the Communist era, came to an abrupt stop. Unemployment rose and wage gaps increased rapidly. Consequently, poverty deepened and inequalities amplified (Hardy, 2009). In 1991 visa-free entry to EU member states was introduced for Polish citizens. The Polish were no longer held a status of refugees and asylum seekers. These

factors contributed to the rapid increase in emigration (Burrell, 2009; Cyrus, 2006).

1.5.3. Migration After The EU Expansion

In May 2004 the expansion of the EU gave EU citizenship to Polish nationals. As a result, the number of Polish migrants in the UK grew rapidly, rising from 75,000 in 2003 to one million in 2017 (ONS, 2018). Polish migrants arriving in the first years after the accession were frequently described as young, mobile, well educated, highly skilled and highly motivated (White, 2016). However, according to a report conducted by the Joseph Rowntree Foundation (Anderson, Ruhs, Rogaly & Spencer, 2006), while the employment rates were high, the conditions were oftentimes difficult and jobs tended to be temporary. It has been noted that there was a tendency for Eastern and Central European migrants to be employed in low-skilled jobs despite being highly qualified (Pollard, Latorre & Sriskandarajah, 2008). Lack of entitlement to welfare benefits and challenging housing conditions were amongst the challenges faced by the newly arrived migrants (Eade & Garapich, 2009).

1.6. Polish Immigrants In The UK Today

1.6.1. Diverse Community

The fabric of the Polish community in the UK was shaped by the long and complex history of migration. The population consists of individuals of diverse social, and occupational backgrounds, different levels of income and education and different attitudes towards integration into British society (Fomina, 2009). While many Polish migrants are well educated and occupy highly skilled professions (Fihel & Kaczmarczyk 2009), others might have poor English proficiency and only basic education. Marginalised sub-groups such as homeless individuals and Roma travellers are also included in this popuation (White, 2016).

The population is also characterised by divisions between different sub-groups and defined class boundaries (Garapich, 2007). The failure of the post EU accession Polish migrants to integrate into post-war diaspora networks was one of the themes that emerged in the Polish migration research conducted after 2004 (White, 2016). It points to a weak sense of ethnic solidarity, referring, for example, to such troubling situations as in-group abuse and exploitation (Eade, Drinkwater & Garapich, 2007; Parutis 2014). While expressing their distance to the broader ethnic community, Polish migrants simultaneously organise their sense of belonging along the lines of kin or friendship circles, assuming sometimes what Smoczynski, Fitzgerald and Zarycki (2017) referred to as 'a form of self-contained ghettos'.

Despite these divisions it appears that Polish immigrants have developed a strong presence in Britain. The variety of Polish churches, shops, beauty salons, and other small businesses, as well as the development of social networks are evidence of this (Burrel, 2009; Eade & Garapich, 2009, Garapich, 2007). It was argued that the scale of Polish business activity could be interpreted as an attempt to create a 'home away from home' and to make the UK less strange (White, 2016).

1.6.2. Reception From The Host Community

1.6.2.1. Media Representations

The topic of Polish migration has been subject of extensive coverage in British media and political discourse. The perceptions of Polish immigrants amongst the British public as well as the everyday interactions between the local and migrant communities were influenced by these discourses (Rzepnikowska, 2018). In the first years following the EU accession the British media initially portrayed the Poles as "model immigrants" who "reintroduced manual skills and a work ethic to the British economy" (Daily Telegraph, 2007). The Polish were constructed as a 'desirable' migrant group and it was argued that their Whiteness, shared with the dominant White British' group, rendered them 'invisible' (Rzepnikowska, 2018).

However, the economic crisis in 2008, witnessed a rhetorical shift. Immigrants from Poland increasingly started to be positioned as an economic threat and blamed for job shortages, unemployment and the strain on social services (Rzepnikowska, 2018). The analysis of the news media portrayals of Polish immigrants (Fomina & Frelak, 2008) indicated that media coverage contained perceptions of Poles that ranged from positive and commendable to hostile and threatening. In the words of Fomina (2009): “on the one hand, according to the newspapers, Poles are dynamic successful people who learn English quickly, are willing to integrate and become part of the new community (…). On the other hand, Poles have been portrayed as cheats, racists, drunks, losers, people fully dependent on the assistance of the welfare state, or poachers with a peculiar taste for swan meat and carp” (pp. 3-4). In 2009 The Federation of Poles in Great Britain submitted an appeal to the Press Complaints Commission regarding the level of perceived anti-Polish sentiment in certain newspapers.

In the run up to the Brexit vote in 2016, migrants were positioned as responsible for a number of Britain’s economic and social problems and the political and media rhetoric regarding Polish and other Eastern European migrants had became even more negative. For example, the article titled ‘A rapist protected by the police and the mining town that turned into little Poland’, published in The Daily Mail in May, 2016, included phrases such as ‘Polish invasion’ and comments regarding the lack of integration of Poles into British society. The article also referred to the visual and audible difference of Polish immigrants and published a number of images of Polish shops and other businesses. The use of Polish language was portrayed as ‘a barrier to stay separate’.

1.6.2.2. The Racialisation Of The ‘British Pole’

The issue of Whiteness

When discussing the racialisation of Polish immigrants, it is important to consider the concept of ‘Whiteness’. Despite the common assumption of its homogeneity, Whiteness can be conceptualised as having internal hierarchies and fluid boundaries, which might be intersected and climbed by different groups under particular circumstances (Dyer, 1997). For example, it has been

recognised that the Whiteness of the English or North Europeans is constructed somewhat differently to that of Eastern or Southern Europeans (ibid.). In the 19th century in the UK and in the USA Irish migrants were initially racialised and considered to be 'not-quite-White'. However, it was Whiteness that eventually played an important part in improving Irish migrants' situation in the labour market (Ignatiev, 1995). Also, after World War II in the UK, displaced individuals experienced benefits from immigration policies, within which racialised preferences for White workers were embedded (Fox, 2013; Rzepnikowska 2018).

Nevertheless, as Fox, Moroşanu and Szilassy (2012) suggest, *"the experiences of past generations of Irish, Jewish, and indeed earlier East European migrants would suggest that putatively shared Whiteness does not exempt them from the effects of racism"* (p.681). For example, up until the 1980s, Irish immigrants occupied an ambiguous position within British social fabric. On the one hand, they were seen as White, European insiders, on the other hand, as cultural outsiders experiencing high levels of prejudice, discrimination and hostility (McVeigh, 1992; Ryan, 2007). It can be argued that Polish immigrants occupy a similar position in the social fabric of the UK.

'Racism' experienced by Poles in the UK

The problems of racialisation, discrimination and prejudice faced by Eastern and Central European migrants after the 2004 accession period has been highlighted by a number of authors (e.g. Dawney 2008; Kempny 2011). Within all these publications the term 'racism' is used when referring to these experiences. Most recently Rzepnikowska (2018) explored the experiences of 'racism' of Polish migrant women in Greater Manchester before and after the Brexit vote. The study emphasised the need to develop a better understanding of how less visible minorities can become racialised and experience 'racism' despite their assumed Whiteness.

It was argued that the wave of hostility after the Brexit referendum exposed the extent of racism amongst the UK public (Rzepnikowska, 2018). This affected settled communities of BME backgrounds and multiple migrant communities,

including Polish nationals (Burnett 2017; Komaromi & Singh 2016; Myslinska, 2016a; 2016b). A number of 'racially' motivated attacks were reported in the media. For example, notes saying "Leave the EU/No more Polish vermin" in both English and Polish language were left outside a school and posted through letterboxes in Huntingdon (Cambridge News, 2016).

While anti-Polish sentiment has been particularly noted and commented on following the EU referendum, a number of authors argued that immigrants from Poland experienced various forms of 'racist' abuse prior to that (e.g. Rzepnikowska, 2018). The 'racism' experienced by the Polish has been legitimised not only by the Brexit vote, but also by other forms of racism embedded as national policy. This included the political and media discourses about 'benefits scroungers' and 'influx of immigrants' (Burnett, 2017). Rzepnikowska (2018) argued that Polish migrants become racialised and constructed through the category of 'race' because of their immigrant status. The word 'migrant' is not a value-free description of a person resettling in a foreign country. Like in the case of 'race', the conceptualization of 'migrant' can be seen as a socially constructed product of processes and practices of exclusion (Anderson, 2013).

1.7. Literature Review

1.7.1. Identifying Relevant Literature

There is a relatively large and diverse body of literature, which might usefully inform an understanding of factors affecting the psychological wellbeing of Polish immigrants in the UK, factors affecting their access to psychological help as well as their experiences of therapy. Identifying the most relevant literature is challenging because few research studies focused specifically on Polish communities.

In order to conduct a systematic review of the literature relevant to these issues, studies involving other migrant groups would have to be included. The challenge of this approach is twofold: firstly, the inclusion of studies relating to

other migrant groups would produce an unmanageable amount of data; secondly, generalising these findings to the Polish population in the UK might be problematic. Moreover, while focusing on a very specific client group, the scope of this project is very broad. Therefore, it appears that a narrative review would be more appropriate.

A narrative literature lends itself to conducting a meaningful synthesis of diverse research (Ferrari, 2015). It has a number of advantages, making it particularly suitable for the present study. By not adhering to the strict search protocol of a systematic review, a narrative approach allows for the inclusion of diversity publications pertaining to the particular issues surrounding the needs of Polish communities in the UK. However, this approach has also certain disadvantages. For example the representation of the literature can be to some extent biased by the researcher's prior knowledge, which affects the identification of starting points in the review process (Jones, 2004). The inclusion of systematic literature reviews can help to counterbalance this potential bias.

The literature discussed in the following sections was gathered through using PsycINFO, PsychARTICLES, CINAHL Plus and Scopus. Additional searches, using Google Scholar and other open source repositories (Academia, Research Gate, CORE), were performed within the grey literature. Following the identification of relevant articles, the reference lists of those articles were searched in order to find publications not brought up by previous searches. In this way, a balanced overview of the most relevant publications is hoped to be achieved.

1.7.2. Psychological Wellbeing Of Polish Immigrants

1.7.2.1. Psychological Impact Of Migration

One of the central concepts associated with psychological responses to migration is acculturation (Berry, 1997). Based on the theory of stress and coping (Lazarus & Folkman, 1984), acculturation theory provides a useful framework to aid understanding of cultural transition for individuals moving from

one cultural context or environment to another. It can be defined as *"an inevitable process human species undergo in an effort to manage and cope with stressors and changes brought upon by migration and by being in a prolonged contact with a new, host culture"* (Kuo, 2014, p. 21).

While there exist a number of theories of acculturation, coping and adaptation (e.g. Castro & Murray, 2010), the acculturation strategies framework described by Berry (1997) is the most widely researched and cited within the field of psychology and is seen as a cornerstone of acculturation research (Sam & Berry, 2006). Four 'acculturation strategies' have been proposed, which represent the coping attempts migrants adopt to manage their relationship with the host culture. These are: Integration, assimilation, separation and marginalization. Integration is seen as actively engaging with the new culture, while still maintaining the original culture; assimilation is seen as abandoning the old culture and embracing the new; separation refers to a complete rejection of the new culture whilst maintaining the old; and marginalisation is seen as distancing from both cultures, resulting in alienation (Berry, 2003; Kuo, 2014).

It has been argued that the most effective of these strategies is integration, whereas the least effective is marginalization, which alongside the separation are said to be linked with heightened levels of stress (Kuo, 2014). While widely influential, Berry's theory has been also criticized. For example, Berry's assertion that migrants can actively choose their acculturation strategy has been challenged by Phinney (2003) who instead emphasised the role of social context.

Additional factors associated with the difficulties faced by migrants include: low language proficiency, unemployment, and being rejected by the host community. The link between psychological distress and unemployment as well as the relationship between poor language skills and acculturative stress have been documented in the literature (e.g. Murphy & Athanasou, 1999; Bhugra, 2004). It has been argued that rejection by the host community can be especially damaging to psychological wellbeing. Fernando (1993) viewed racism as one of the most crucial risk factors for migrants' psychological health.

1.7.2.2. The Wellbeing Of Polish Immigrants

There is a body of literature exploring the mental health and wellbeing of Polish immigrants in the UK (e.g. Smolen, 2013; Weishaar, 2008). It indicates that this population experiences high levels of stress due to the challenges associated with migration. Feelings of alienation, a sense of being 'caught' between two countries, poverty, exploitation, loneliness and poor physical health are said to be amongst the factors negatively affecting the wellbeing of many Polish citizens living in the UK (Kozłowska, Sallah & Galasiński, 2008; Lakasing and Mirza, 2009). The Polish are a minority group whose experience is often marked by multiple social inequalities. Issues such as under-skilled employment, poverty, homelessness, 'racial' discrimination and abuse were commonly reported in scientific literature (Anderson et al., 2006; Drzewiecka 2014; Fox 2012; Garapich 2007; Gibson, 2015).

A recent systematic review conducted by Maciagowska and Hanley (2018) offers a more in-depth view of the aspects of psychological wellbeing of Polish immigrants. The reviewers were able to identify eight research studies concerning the psychological wellbeing of post-accession Polish immigrants. They included qualitative and mixed-method research papers published after 2004, which included personal accounts and views of Polish immigrants (Mole, Parutis, Gerry & Burns, 2014; Pearson, Hammond, Heffernan & Turner, 2012; Rabikowska, 2010; Selkirk, Quayle & Rothwell, 2012; Sime & Fox, 2015; Tribe & O'Brien, 2014; Weishaar, 2008; 2010). The review identified a number of factors, which affected the psychological wellbeing of Polish immigrants. While most of the interviewed migrants reported a successful adaptation following migration, all of them reported experiencing substantial stress.

Poor language skills: the difficulty to communicate in English was found to contribute to stress and frustration. It was described as affecting job-seeking and a main factor contributing to under-skilled employment which led to worry, uncertainty, frustration, loss of professional identity loss and, depression. "Language ineptness" was quoted as an preventing Polish migrants from accessing support services.

Financial difficulties: this was reported as one of the factors contributing to stress, frustration and anxiety. Low income was frequently linked to long working hours and night shifts, which were linked to psychological distress, including anxiety, low mood and sleeping problems. Low income was associated with decreased social participation, lack of opportunities for development for children and a limited choice in terms of living area (which was linked to higher vulnerability towards discrimination).

Discrimination: Discrimination and prejudice on account of being Polish was frequently reported by the participants and associated with experiencing distress. It was reported that witnessing the signs of discrimination led to social withdrawal and isolation in affected Polish children.

Lack of satisfying social interactions: Feelings of longing and homesickness associated with limited contact with family and friends back in Poland were described as contributing to loneliness and isolation. A tendency to restrict social circle to other Polish migrants and reluctance to interact with local communities was quoted as one of the factors preventing Polish immigrants from developing meaningful relationships with local populations.

The feelings of confusion and 'not knowing': Reviewed studies suggested that Polish immigrants were often unfamiliar with British culture and well as the benefit and tax system, confused with regards to what they are entitled to, how to go about engaging with the British society and where to seek support. These factors were described as contributing to isolation and distress.

Cultural stigma and shame: These were described as the "pre-existing, culture-specific factors" (Maciagowska & Hanley, 2018, p.229), which were argued to affect help-seeking attitudes and behaviour of Polish immigrants. These included the shame of admitting to having a problems (believed to be a sign of weakness) as well as the shame associated with the migrant status, which created a power imbalance between the host and immigrant population. Stigma was mentioned in the context of perceived intolerance of difference amongst the Polish, whereby markers of differences such as different sexual

orientation were perceived as shameful.

1.7.3. Seeking Psychological Help And Relationship With NHS Services

The reluctance of Polish immigrants to seek psychological help despite experiencing a considerable degree of distress has been described by a number of authors (e.g. Selkirk et al., 2012). The patterns of the Polish immigrants' relationship with NHS mental health and psychological services appear similar to those of other BME communities. Admissions to emergency psychiatric facilities and suicide rates amongst Poles are reported to be high (Carta *et al*., 2005; Smolen, 2013) but the use of primary care and psychological services appears to be low (Selkirk et al., 2012; Stefanicka, Erecinski & Kwiatwowska, 2016). Research suggests that the Polish might have limited knowledge about how to access mental health services and in general display distrusting attitudes towards the NHS (Kozlowka *et al*., 2008; Osipovic, 2013; Selkirk et al., 2012). In a recent survey conducted by the Polish Psychologists' Association (PPA, Stefanicka et al., 2016), 55% of respondents felt that they have needed psychological help at some point during their stay in the UK. However, only 24% were actually able to access it. Of these, 86% received help from either a private specialist or a charitable organisation and only 30% from the NHS. 41% of all respondents were not aware that they could have accessed free psychological services through the NHS.Very few published studies specifically addressing the help-seeking attitudes and behaviours of Polish migrants in the UK could be identified. The results of these studies are outlined below:

Using quantitative methods Bassaly and Macallan (2006) sought to explore the relationship between cultural identity and attitudes towards seeking psychological help. They argued that the participants, who were exclusively committed to what they believed were Polish cultural values, were less comfortable disclosing difficulties and less likely to report the need for psychological help. These individuals were found to be less confident in psychological services and also voiced more doubts about the possibility of being offered psychological intervention.

Findings of a qualitative study conducted in Scotland (Selkirk *et al.*, 2012), which investigated what factors might impact Polish immigrants' responses to distress as well as their decisions regarding seeking psychological help indicated that the way participants responded to distress was influenced by their cultural norms, their sense of identity and availability of community networks and support of their families. The role of their previous experiences with services (both in Poland and in Scotland) was also emphasised. The participants preferred to seek help from a close inner circle of family and friends. Those of working class and rural backgrounds appeared to be more attached to the aforementioned values and often viewed psychological services as irrelevant to them. Meeting with a psychologist was seen as 'fashionable' and more appropriate for those from urban, middle-class social groups. Previous negative experiences with Scottish primary care services were associated with reluctance to approach the NHS in times of emotional crisis. Seeking help from private specialists was reported to be a preferred option in Poland. This was linked to the preferences for seeking help from private Polish therapists in Scotland.

The study by Osipovic (2013) explored the views regarding the rationales and consequences of using NHS services by Polish immigrants in London. She argued that there is a number of behaviours that can be observed within the Polish community, which she described as reflecting negative and mistrusting attitudes towards the NHS. Examples of such behaviours included avoiding contact with public health services, seeking help from private Polish specialists, traveling back to Poland for medical care and self-medicating.

1.7.4. Help Within The Community

The role of the support provided within the Polish community was emphasised in a number of studies (as outlined in Maciagowska & Henley, 2018) However, what specifically this support consists of is often omitted in the literature or only vague references are made to 'informal social networks', 'Polish churches' or 'private psychologists' (Selkirk et al., 2012). One of these often-unmentioned community resources is the Polish Psychologists'

Association (PPA), a volunteer group of psychologists, therapists, pedagogues and sociologists who have been actively working with the Polish community since 2006. The organisation offers services such as individual and family counselling, telephone consultations, professional career coaching, training and workshops.

1.8. Rationale For Current Study

While there seems to be a general consensus in the literature that Poles are reluctant to seek help for psychological problems, little published work to date has explored in depth the factors influencing their access to psychological therapies in the UK. Some authors made general references to the unhelpful help-seeking attitudes of Polish migrants. The researcher has identified three studies that primarily examine these issues. However, the existing literature appears to have focused entirely on the analysis at the individual level, obscuring the context within which help is sought and/or accessed. The literature seems to be concerned more with "what it is about the Polish that makes them reluctant to seek psychological help?" rather than to explore whether the kind of services provided and how they are provided is in line the needs, values and beliefs of the community. Little attention is paid to any systemic issues affecting the Polish immigrants' relationship with services. The researcher was also unable to locate any studies investigating the experiences of Polish immigrants who have actually accessed psychological help.

While the aforementioned studies focus on the perspectives of Poles as a minority, they appear to assume that both majority and minority groups in this context are in a balanced relation of status and power. The answers given by research participants are seen as their "preferences" chosen within a free choice scenario, ignoring the political, social and economic power inequalities (Paloma *et al*., 2016). The existing research is also based only on the self-reports of Polish individuals seeking (or not seeking) psychological help, not taking into account the views and perceptions of the help providers. The researcher was unable to locate any articles addressing aspects of working psychologically with Polish immigrants.

Moreover, existing research seems to be mostly concerned with highlighting barriers to engagement, creating a discourse of deficit whereby the immigrants are ‘not utilising’ available services and/or the services are ‘not providing’ adequate help. Little attention seems to be paid to exploring the way existing resources can be helpful in addressing these issues. The perspectives of help providers are not explored. In particular, the non-public and voluntary organisations, which might be successful in engaging with the community, are largely ignored in the literature.

1.9. Summary And Aims Of Research

The proposed study aims to contribute to the current understanding of factors influencing Polish immigrants' wellbeing as well as their engagement and experience with psychological services. It seeks to facilitate the development of a dialogue and a shared understanding between those seeking help and those offering it. It also seeks to utilize community resources by including the voices of psychologists working in the NHS and Polish professionals offering help within the community.

1.10. Research Questions

- What factors influence psychological wellbeing of Polish immigrants?
- What are the factors influencing access to psychological therapy for Polish immigrants in the UK?
- What is the experience of Polish immigrants who have accessed psychological therapy in the UK?
- What are the experiences, knowledge and training needs related to working with Polish immigrants amongst psychologists?
- How can current service provision be improved to meet the needs of Polish immigrants?

2. METHOD

2.1. Overview

This chapter will begin with an outline of the epistemological position underpinning the present study and a reflection on my own position as a researcher conducting the study. Subsequently, the ethical considerations taken into account will be described. Implications of the consultation with the service user group will be then provided. This will be followed by a description of the research design, participants' demographics, recruitment strategy, materials and procedure. The analytical strategy applied to the data will also be considered.

2.2. Epistemological position

Epistemology is a branch of philosophy that focuses on the theory of knowledge (Willig, 2001) and is linked to ontology (which is concerned with the nature of reality and existence). The epistemological stance is important to consider as it has an impact on a number of research decisions, such as the approach to data collection and analysis. The present study adopted a *critical realist* position, which negotiates the dualism of realism and relativism. The critical realist paradigm entails that while an independent reality exists, it does not commit one to an absolute knowledge of that reality (Scott, 2005). Additionally according to Harper and Thomson (2012) reality might be interpreted in multiple ways because it cannot be accessed independent of our thinking.

The current study aims to develop better understanding of Polish immigrants' needs in relation to accessing psychological help in the UK, giving priority to the perspectives of those with this experience. From this perspective I take the position that there is an ontological reality to the act of emigrating from one country to another and to the provision of psychological services to immigrant populations in the UK. This means that I consider these to exist beyond the participant's accounts and my interpretations of them. However, the nature of the impact of emigration and particular experiences of seeking and receiving

help for emotional problems in foreign country, as well as the way this impact is constructed might be affected by multiple factors. These include individual's experiences and beliefs, their meaning making systems as well as the language and societal discourses.

2.3. Reflexivity

Reflexivity has been defined by Willig (2008) as the process through which researchers "reflect upon their own standpoint in relation to the phenomenon that they are studying and attempt to identify the ways in which such a standpoint has shaped the research process and findings" (p.6). When conducting qualitative research, based on interview data, the negotiation of meanings occurs within the social context of the interaction between the person conducting the interview and the interviewee (Oltmann, 2016). Taking this into consideration, it is paramount to reflect on the possible impact of my own context as an interviewer. I shared a number of characteristics of the study participants and some of the aspects of my personal context were seemed pertinent to the issues in this project. While Breakwell (1995) suggested that people are more likely to disclose personal information to an interviewer who they perceived as similar to them, it is possible that these perceived similarities might have impacted on the interaction between myself and the interview participants.

I am a 37-year-old White woman and just like the interview participants I am a Polish immigrant. I came to the UK approximately 10 years ago. I grew up in a post-communist Poland, and (just like the majority of the interview participants) I have distinct memories of the associated poverty and hardship. I also share the memories of the education delivered in all Polish public schools at the time (in particular the knowledge regarding Polish history and the glorification of Polish martyrdom delivered in the Polish Literature classes). Just like these participants I have accessed psychological therapy in the past. As a trainee clinical psychologist at the University of East London, I am influenced by the ethos of the institution, which is associated with the community and social constructionist and community psychology ideas that privilege the role of social

context in understanding distress as well as with its critical stance. Being a trainee clinical psychologist also means that I share the professional context with the survey participants who work in the NHS.

A reflective diary was kept throughout the research process from the point of designing the study through to write-up (extract included in Appendix A). In addition, experiences and reflections were discussed with the research supervisor and the impact of these on the interview process and analysis were considered.

2.4. Consulting With A Service Users Group

2.4.1. Involving Service Users In Research

The National Institute for Health and Research (NIHR, 2013) defined Service Users' (SU) involvement in research as active engagement of individuals with lived experience mental health difficulties and/or of using mental health services in planning, conducting and disseminating research. It has been argued that meaningful SU involvement helps bringing a different perspective to the research process and is highly relevant to clinical practice (Rose, 2003). There is also a strong moral case for SU involvement that is based on social justice (Kitcher, 2001).

2.4.2. 'Service Users And Carers Group Advising On Research'

Inspired by the motto 'Nothing about us, without us' the Service Users and Carers Group Advising on Research (SUGAR) was founded in 2009 by Professor Alan Simpson at City University London. SUGAR members meet monthly to discuss and contribute to different aspects of research projects. They have contributed to journal articles and presented at conferences.

2.4.3. Consultation With SUGAR

Before embarking on the current project I sought consultation with SUGAR

members. I met with the group in June 2017. The group consisted of 15 individuals of diverse ethnic and cultural backgrounds. During the meeting I presented my research proposal, answered the questions from the audience and gathered their feedback.

The members of SUGAR made a number of comments regarding the scope and focus of the project. Some of the main comments were:

- The attendees felt that my topic was an important one to explore
- They wondered how the fact that I am a Polish national might influence the way I would analyse and interpret my results. They felt that this should be mediated by the use of supervision.
- They felt that it would be important to hear from the carers and family members of Polish people who accessed psychological help.
- They felt that I should also think about how the needs to Polish LGBT community could be addressed in the project.

2.4.4. Outcome of the Consultation

The comments made by the SUGAR members were discussed with project supervisors. It was felt that the comments highlighted the importance of reflexivity and considering the impact of researcher's background and context on the process and outcome of the project. The comments highlighted the importance of taking account of intersectionality in the experience of participants, i.e. the impact of gender, sexuality, age, ability and other aspects of identity.

Including the perspectives of partners and carers of the project participants seemed problematic both methodologically and ethically. In discussions with the project supervisors, it was felt that asking to interview participant's partners and carers could raise numerous issues, such as confidentiality. Moreover, while some of the participants might want to include their partners or carers, others might not want to do this.

2.5. Design

The current project adopted a mixed methods design and consists of two studies:

- **Study 1:** This part of the study aimed to explore psychologists' experience, views and training needs related to working with Polish immigrants in the UK. Data was gathered through an online survey.
- **Study 2:** An exploration of the views and experiences of Polish immigrants who have accessed psychological help. Data for this part of the study was gathered through semi-structured interviews.

2.5.1. Study 1

2.5.1.1. Participants

The survey was initially directed at all qualified psychologists working in the London area. However, due to initially receiving very few responses, the inclusion criteria were expanded to include Trainee Clinical Psychologists and Psychotherapists.

2.5.1.2. Recruitment

Participants were recruited online through advertisements posted on Facebook groups such as 'UK based Clinical Psychology Facebook Group', 'London Counselling Psychologists' and the Polish Psychologists' Association (PPA) website and Facebook page. Face-to-face recruitment took place at an event organised by PPA. Participants were also recruited through word-of-mouth and snowballing

2.5.1.3. Materials

Data was collected through an online survey, developed using the Qualtrics tool (https://www.qualtrics.com). Using a survey allowed data to be collected from a

large number of participants. The survey was available in English and in Polish language and consisted of 12 questions in total (see Appendix E).

The survey was developed by the researcher in consultation with the research supervisor. Three trainee clinical psychologists and the research supervisor took part in the pilot. They were asked to comment on the clarity and coherence of the questions, ease of use and completion time. The survey was amended based on feedback provided. In designing the survey the guidelines recommended by Barker et al (2003) were taken into account. This involved:

- Adapting or removing the items viewed as too lengthy or unnecessary.
- Attending to the layout and typeface of the survey.
- Using jargon free language.
- Using both open ended and closed questions.

2.5.1.4. Procedure

Online adverts contained a link to the survey. After clicking the link the participants were firstly shown the information sheet (Appendix C2). They were then presented with the consent form (Appendix D). In order to proceed they needed to agree to all the points by ticking all of the boxes and clicking the 'Next' button. At the end the participants were asked whether they would like to be informed of the results of the project. The design of the survey ensured that the email addresses provided were stored separately form the survey answers, ensuring anonymity. The use of the Qualtrics platform helped to ensure confidentiality. The responses were gathered anonymously by the platform instead of being sent directly to the researcher. The same applied to the collected email addresses. The survey remained active and open to participation for eight months.

2.5.1.5. Analytic Strategy: Content Analysis

Total numbers of responses were collected and documented for the quantitative answers. Content analysis was used analyse the qualitative responses. Elo and Kyngäs (2008, p. 108) describe it as "*a research method for making replicable*

and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action". An inductive approach, whereby the categories are derived from the data was used, following the guidelines by Elo and Kyngäs (2008).

The process included:

- Preparation: Becoming immersed in the data and selecting the unit of analysis. In this project the analysis focused on the manifest content.
- Organizing: This included open coding, using coding sheets, grouping and categorization and abstraction
- Reporting: Generating a conceptual map of categories

2.5.2. Study 2

2.5.2.1. Participants

The participants were Polish nationals living in London who have accessed psychological therapy in the UK in the past. All participants were over 18 years old and were not receiving mental health or psychological services at the time of the interview. All of the participants arrived in the UK after 2004.

2.5.2.2. Recruitment

Participants were recruited through advertisements (in Polish and English), which were posted on Internet forums and Facebook Pages for Poles in the UK and in Polish shops. Participants were also recruited by word-of-mouth and snowballing.

2.5.2.3. Materials

Data was collected through semi-structured interviews. It has been argued that interviews are particularly suitable to explore research questions regarding participants' experiences (Braun & Clarke, 2013). Using semi-structured interviews is intended to allow the participant to bring up unanticipated topics,

therefore allowing the discussion of novel ideas. Additionally, the semi-structured interview style allowed asking follow up and clarifying questions. An interview schedule was designed following the guidelines by Wilkinson, Joffe and Yardley (2004). Interview schedule is included in the Appendix F.

2.5.2.4. Procedure

Participants were invited for a face-to-face interview. They were given a choice regarding the location between a community setting (i.e. Stratford Advice arcade) or a NHS site. The researcher ensured that the setting for the interviews was confidential. Participants were given a choice about what language of the interview (Polish or English).

Prior to the interview, the participants were given the Participant Information Sheet (Appendix C1). They were then asked to read and sign the consent form (Appendix D). They were given the opportunity to ask questions. Interviews lasted for approximately one hour. They followed the guidelines proposed by Smith et al. (2009). These were: ensuring that participants had enough time to give full and reach answers; using prompts and allowing flexibility in terms of order of the interview schedule where appropriate. Interviews were recorded using a Dictaphone and transcribed for analysis.

2.5.2.5. Analytic Strategy: Thematic Analysis

Thematic analysis highlights the most salient themes within the data. It considers individual contexts of participants to enhance understanding (Braun & Clarke, 2006). It was chosen as it allows the “gleaning of knowledge of the meaning made of the phenomenon under study by the groups studied and provides the necessary groundwork for establishing valid models of human thinking, feeling and behaviour” (Joffe, 2011, p.210). The participants of the study (despite some shared characteristics) were a relatively diverse group. Therefore, using a method suited to study wider populations was seen as beneficial. Thematic analysis was also chosen due to its epistemological flexibility. It is possible to apply it across a range of theoretical and

epistemological positions and is congruent with the critical realist stance.

The analysis process followed the six-phase approach proposed by Braun and Clarke, (2006): Familiarisation with the Data, Generating Initial Codes, Searching for Themes, Reviewing Themes, Defining and naming Themes and finally Producing the Report. The analysis took an inductive approach. This means that themes and sub-themes were generated from the data, taking a 'bottom up' approach. Rather than being shaped by any existing research and theory. An interview extract with initial coding can be found in Appendix G. Examples of coded extracts across data set can be found in the Appendix H.

2.6. Ethical Considerations & Approval

Ethical approval for the current project was gained from University of East London's Ethics Committee with no amendments (Appendix B1 and B2).

2.6.1. Informed Consent

Informed consent was sought from each individual. All participants were provided with the information regarding of the purpose of the research, aspects of confidentiality as well as the intended use of the data. They were given an Information sheets (Appendices C1 and C2) and they were offered an opportunity to ask questions. Written consent was obtained from all participants. A copy of the consent form can be found in Appendix D.

2.6.2. Right To Withdrawal

All participants were advised of their right to withdraw from the study at any time up to three weeks after the date of the interview without disadvantage to them and without having to give any reason. This was made clear to all participants in the information sheets and consent forms.

2.6.3. Confidentiality

A number of considerations were taken into account to ensure confidentiality. Firstly, participants were interviewed in a confidential space where the interview could not be interrupted or overheard. Secondly, interview participants were given pseudonyms and no personal details were collected from them. Thirdly, survey data was collected anonymously. The contact details collected at the end of the survey from those who wished to be informed of the outcome of the project were recorded separately from the survey responses. Finally, all information was kept secure in a password-protected file; no identifying information have been used in any part of the thesis write-up.

2.6.4. Consideration Of Distress

Efforts were made to ensure that all participants had access to appropriate aftercare should they become distressed by any aspect of their participation. The participants were advised that, should they experience any distress and they would like to seek further support, they should contact their GP. They were given contact details of a number of supportive organisations.

2.6.5. Debriefing

The interview participants were debriefed following the interview, asked how they experienced the process and made aware of supporting agencies. All participants were provided with contact details of the researcher and research supervisor should they wish to discuss any aspect of the project post-participation.

3. STUDY 1: STUDY OF THE EXPERIENCE, UNDERSTANDINGS AND TRAINING NEEDS RELATED TO WORKING WITH POLISH IMMIGRANTS AMONGST PSYCHOLOGISTS.

3.1. Overview

The following chapter will present the results of an online survey. The chapter will begin with an overview of participants' demographics, their professional context and their experience of working with Polish clients. Subsequently the content analysis of the survey responses will be presented following the order of survey questions.

3.2. Demographic Information

A total of 112 individuals completed the survey. Of these, 102 responses were collected online and 10 were collected in paper form. A number of the responses (33) had to be excluded, as the participants only submitted the demographic information. This left a total sample size of 79.

3.2.1. Gender

The survey allowed the participants to self-define their gender. The majority identified as female (81%), which is likely to be representative of gender distribution within the profession. Table 1 illustrates gender distribution amongst the survey participants.

Table 1: Gender of Participants

Gender	Responses (n=79)	Percentages of responses (%)
Female	64	81.01
Male	15	18.99

3.2.2. Ethnicity & Nationality

Both the ethnicity and the nationality were self-defined by participants. While there a small number of participants came from other backgrounds, the majority identified as White British (46.8%) and White Polish (27.8%). Table 2 illustrates the distribution of ethnicities and nationalities amongst the participants.

Table 2: Ethnicity & Nationality of Participants

Ethnicity & Nationality	Responses (N=79)	Percentage of responses (%)
White British	37	46.83
White Polish	22	27.85
White Irish	7	8.86
Asian British	3	3.80
Black British	3	3.80
Mixed British	3	3.80
White Finnish	1	1.26
White Greek	1	1.26
White Russian	1	1.26
White Other	1	1.26

3.3. Professional Context

3.3.1. Profession

The majority of participants identified as Clinical Psychologists (64.5%). The professions of the participants are illustrated in table 3. A number of Polish participants chose the option 'Other' and described their profession as *"Psychologist"* and *"Family Psychologist"*. It is possible that these descriptors seemed more suitable for psychologists qualified in Poland, where titles might be different from those used in UK.

Table 3: Profession of Participants

Profession	Responses (n=79)	Percentage of responses (%)
Clinical Psychologist	51	64.55
Trainee Clinical Psychologist	10	12.65
Psychologist	9	11.39
Counseling Psychologist	5	6.32
Family Psychologist	3	3.79
Forensic Psychologist	1	1.26
Psychotherapist	1	1.26

3.3.2. Public vs. Private Sector

The participants were asked whether they worked within the private or public sector. For this question multiple answers were available and a number of participants worked in multiple settings. The majority (76%) worked for the NHS, 32.9% reported working in private practice and 24.1% in charitable organizations. 87% of Polish participants reported working for the PPA.

3.3.3. Service Area

The survey was completed by psychologists from a range of service areas and many of the participants indicated working in more than one area (see Appendix I for more details). The majority reported working in adult mental health services (62%). The second most common service area was child and family services (25.3%).

3.3.4. Locality

The majority of participants worked in London. Of these, 46.8% reported working in East London boroughs. This might be due to the recruitment method of snowballing, which resulted in the recruitment of psychologists working within

areas where the researcher has been on clinical placements. There were also a number of participants from different areas of England as well as one from Scotland and one from Ireland.

3.4. Experience Of Working With Polish Immigrants

The majority of participants (84.8%) reported that they have worked with Polish clients in the past. A small number (5.1%) reported not knowing whether they worked with any Polish clients

The participants were also asked to estimate what percentage of the clients they saw in the past 6 months were Polish. Polish psychologists reported much higher percentages than non-Polish sample. The majority (63.6%) of Polish psychologists reported that in the past 6 months at least 50% of their clients were Polish. These psychologists mostly worked in private practice and for charities. Nearly half of the non-Polish sample (42%) did not see any Polish clients in the past 6 months. The majority of these (80%) worked exclusively for the NHS.

3.5. Factors Affecting Psychological Wellbeing Of Polish Immigrants

The participants were asked to describe factors they felt were affecting the psychological wellbeing of Polish immigrants. 95% of the participants answered this question. The responses can be divided into three broad categories: 'Migration-related' 'Socio-economic', 'and 'Cultural Factors'. Extracts from the responses are included in the Appendices J1, J2 and J3.

3.5.1. Migration-related Factors

'Negative attitudes of the host community' were mentioned by 69.6% of participants. A number of participants made explicit reference to 'racism' or discrimination (e.g. *"Experiences of racism/ discrimination/ prejudice, societal scripts/narratives regarding people from Polish communities, which links to ideas re social rank"*). The impact of Brexit was mentioned and the associated

sense of threat and uncertainty about the future. Participants also referred to hostility experienced from the general public or British media.

'Isolation and loneliness' was mentioned by 49.3% of the participants. Some specifically mentioned feelings of isolation/alienation or exclusion. Others referred to the separation from family and social networks back in Poland.

Factors related to the 'adjustment to life in the UK' were mentioned by 25.3 % of the participants. Some participants referred to acculturation and adjustment to life in the UK as a potential source of distress and some mentioned a general migration stress. Some mentioned the potential impact of pressure to succeed and achieve (e.g. *"An expectation for some Polish people that they must achieve, be perfect and (…), and that they have come to the UK to succeed"*).

A small number of participants mentioned 'language difficulties' (e.g. *"The ability to communicate with and understand others in order to be able to develop appropriate relationships"*), 'the availability of social support' and 'lack of awareness of services'.

3.5.2. Socio-economic Factors

References to socio-economic factors were present in 84% of responses. Within this category 'work-related issues' were most commonly mentioned. The responses included issues around finding employment, as well as under-paid and under-skilled employment (e.g*. "having to take menial jobs when they are actually very well qualified"*). Additionally, nearly half of Polish psychologists mentioned issues related to job satisfaction and the need for personal and professional development (e.g. *"Working in trained profession and ability to stay connected to professional network"*). A number of participants also mentioned 'financial hardship' (e.g. "*poverty") and* 'housing issues' (e.g. "*Several of the Polish service users I have met have been homeless for a period of time or lived in overcrowded conditions"*).

3.5.3. Cultural Factors

Within this category 25.3% of responses referred to factors related to the 'background and upbringing'. The majority of these responses came from Polish psychologists who mentioned the 'Adult Children of Alcoholics (ACoA) syndrome[1] (e.g. *"There are a number of individual with the ACoA syndrome amongst the Polonia in the UK, and it has huge impact"*). Additionally a small number of participants mentioned factors related to particular cultural heritage, including religious beliefs or belonging to an oppressed group (e.g. *"legacy of the holocaust for Jewish Polish"*).

20% of responses mentioned the availability of support within the Polish community. Within this category, a small number of responses indicated that there might be some unhelpful dynamics within the community (e.g. *"There was concern about this family being exploited within their own community, both in the UK and from Poland and seemingly little action that could be taken about this"*).

Factors related to the understandings and attitudes towards mental health and help seeking amongst Polish immigrants were mentioned in 14.6% of responses. This included views that the understanding of mental health amongst the Polish immigrants might differ to that of the local population. A number of participants mentioned stigma (e.g. *"Expectation for some Polish people that suffering mental illness would be seen by them or their community as a failure, a character flaw"*).

Some participants mentioned alcohol and substance misuse as a potential factor. There were some general references to cultural differences.

[1] ACoA syndrome is a descriptor of a particular set of difficulties believed to be

3.6. Factors Affecting The Number Of Polish Clients Referred To Psychological Services

This question was answered by 91% of participants. Of these, 13.9% responded: "I don't know". The remaining responses could be broadly divided into categories of 'factors within the Polish community' (Appendix K1) and 'factors within the services' (Appendix K2). The vast majority of responses included the views about what might be causing the low number of referrals.

3.6.1. Factors Within The Polish Community

The most common factors mentioned by the participants (59.7%) related to certain attitudes and behaviours that might be considered unhelpful. Responses indicated that Polish individuals might have difficulties in articulating their difficulties to their GP (e.g. *"Less likely to describe MH difficulties for what they are- explain physically"*). There were also references to the unhelpful help-seeking attitudes, beliefs and stigma. A number of participants felt that Polish migrants might prefer to seek help within their own community or travel back to Poland for treatment (e.g. "*Lots of minorities tend to try and look after themselves within their own communities as much as possible. Seems easier for Polish people to travel home and they may be receiving some healthcare there"*). Some participants felt that the low number of referrals might be due to a low number of Polish people seeking help.

30.6% of responses mentioned issues related to the 'lack of knowledge or awareness'. Some responses referred to the lack of awareness of available services (e.g. *"It could be Polish clients are not aware of the NHS structure and mental health services"*). A small number of participants mentioned that Polish clients might be unaware of the possibility to use interpreters or unwilling to do so (e.g. *"Unaware that there is a possibility to use an interpreter or that there might be Polish therapists within the service. Instead of using interpreters they may come to GP with friends/family who interpret and they're less likely to disclose MH issues"*).

A number of responses (26.7%) indicated that there might be practical barriers for Polish clients to be referred to psychological services. These included language barriers, not being registered with a GP (e.g. *"may not be registered with GPs etc. or engage with other agencies so might not get flagged up"*) and financial constraints. A number of Polish psychologists felt that there might be a preference to see Polish professionals.

3.6.2. Factors Within Services

A number of responses (29%) indicated that there might be gaps in knowledge and understanding of the referrers. Responses indicated that the referrers might find it difficult to recognise psychological problems in clients from Poland (e.g. *"difficulties not understood or manifested in same way as British clients resulting in them not being picked up by agencies"*), or hold unhelpful assumptions about Polish clients or who might benefit from psychological therapies (e.g. *"Referrer assumptions about polish clients' attitudes towards psychological therapies"*). One response suggested that professionals might have limited knowledge of the Polish community.

Some of the responses (8.3%) indicated that the language barrier might not be adequately addressed by the services (e.g. *"It could also be because of a lack of appropriate information regarding LD and LD services in appropriate and accessible language for the community"*).

A number of Polish psychologists (nearly a quarter of all Polish participants) felt that one of the factors affecting the number of referrals was the reputation of the service (e.g. "*Reliability confirmed in UK organizations, high-ranked services having competent specialists").*

There were some answers (5%) that indicated that experiences of racism and discrimination might impact the number of referrals (*"they may feel scared or discriminated against, narratives around "using NHS services" and racism may reduce requests for referrals"*).

3.7. Factors Impacting The Number Of Polish Clients Accessing

Psychological Services

After sharing their views regarding the factors that might affect the number of Polish clients referred to psychological services, the participants were asked what factors in their opinion might contribute to the number of Polish clients actually accessing the services. 89.9% of participants answered this question. 15.5% of these answered "I don't know". The remaining responses could be divided into two categories: 'Factors within the Polish community/ and 'Factors within services' (Appendices L1 and L2). The majority of responses referred to factors accounting for a low number of clients accessing services. Only four psychologists (mostly Polish) referred to factors contributing to the higher number of Polish clients accessing the service.

3.7.1. Factors Within The Polish Community

The responses within this category largely mirrored those given to the question about the number of referrals. The majority related to the unhelpful attitudes of Polish clients (41.6%). The remaining responses included language barriers, lack of awareness of services and preferences to see a Polish psychologist. Additionally, the participants mentioned the impact of possible different conceptualizations of mental health within the community (e.g. *"Different cultural constructions of mental health, lack of understanding of what mental health is*"), clients' concerns about psychological help (e.g. *"Concerns that UK psychologists will not understand Polish clients and their culture"*), and financial barriers to accessing private therapy.

3.7.2. Factors Within Services

13.3% of responses indicated that Polish clients are not being referred to psychological services (e.g. *"Referrers perceptions of who benefits from psychology – often people who don't have English as a first language are disadvantaged"*). Another 13.3% indicated that attitudes within the services might impact the number of Polish clients accessing them (e.g. *"Whether they feel welcome"*, *"Racism, discrimination – I feel Poles are often sent away*

without being offered any support"). 10% of responses referred to practical barriers to accessing the service, such as the availability of interpreters and written materials and the flexibility of services (e.g. *"timings of appointments, waiting times"*). Two answers referred to whether or not the services are actively reaching out to the Polish community, one response included a comment about the availability of culturally appropriate interventions and one referred to the understanding of needs of the Polish community.

3.8. Factors Impacting Polish Clients' Engagement With Psychological Services

This question was answered by 87% of the participants. Of these, 17.4% participants answered" "I don't know". One participant answered: *"Referral rates are so low that it's difficult to give an estimation of engagement post-referral and access".* Responses to this question can be divided into five categories: 'Language Barrier', 'Therapist Factors, "Service Factors', 'Client Factors and 'Wider Societal Factors' (see Appendix M).

3.8.1. Language Barrier

Nearly 50% of the participants mentioned a language barrier. While some participants only made general references to language, others pointed out issues around the availability of interpreters and written materials (e.g. *"Whether there is literature in Polish"*).

3.8.2. Therapist Factors

Nearly 50% of participants mentioned factors related to therapists' knowledge and abilities. Responses included references to therapists' ability to understand the client's cultural context (e.g. *"knowledge of clinicians regarding any cultural influences relevant to therapy"*). A number of participants also mentioned the quality of the therapeutic relationship.

3.8.3. Client Factors

20.6% of responses included references to client related factors. This included clients' understanding of the services' (e.g. *"how well they understand how the NHS works"*), stigma, clients' help seeking attitudes (e.g. *"Cultural beliefs about mental health support"*) and their motivation (e.g. *"their willingness and motivation to change"*). One response referred to the *"psychological mindedness of Polish clients"*.

3.8.4. Service Factors

Service related factors were included in 24.1% of the responses. These included the relevance or helpfulness of the service (e.g. *"The service fit with what help or support they want/need"*). Timings of appointments were mentioned and linked to wider socioeconomic factors by some of the participants. (E.g. *"Being flexible about people who have to work on zero hour contracts, e.g. a cleaner who has to work when he gets a text message from a company he is employed by, perhaps to travel to a place two hours away at short notice for a one hour job"*).

3.8.5. Social inequalities

The last category of responses to this question included references to the impact of social inequalities (e.g. "*social inequalities can impact on engagement e.g. poverty, housing issues, parents having to work long hours in low paid jobs, etc."*).

3.9. Factors That Might Impact The Quality Of Therapeutic Relationship With Polish Clients.

82.3% of participants answered this question. Of these, 7.7% responded: "I don't know". The remaining responses can be divided into four categories: "Therapist Factors", "Service Factors", "Client Factors" and "Language Barrier and Interpreters" (Appendix N).

3.9.1. Issues Around Language Barrier And Interpreting

Issues concerning language barriers and interpreting were mentioned in 56.7% of responses. Some responses mentioned the limited availability of Polish interpreters (which was linked to their consistency) and the quality of translation (e.g. *"I think language and the use of interpreters may affect the relationship. This includes how psychological terms are translated into polish if needed"*). Some of the participants also reflected on the use of family members as interpreters.

3.9.2. Therapist Factors

Comments regarding cultural competence were included in 50% of responses (e.g. "*being able to focus on any issues which might be linked to their Polish identity such as issues of culture, acculturation, displacement, discrimination, etc.").* The therapist's stance, including curiosity and openness was the second most prevalent response (e.g. *"Therapist adopting curious and open stance as cultural scripts around mental health may differ significantly"*).
Some responses (18.3%) indicated that the factors affecting the quality of the therapeutic relationship with Polish clients is shaped by the same factors as for any other client group (e.g. *"I can't think of any - my relationships have been the same with Polish clients as other clients"*).

Some of the responses suggested that a perceived similarity between a client and therapist, such as nationality or immigrant status might help to facilitate the relationship (e.g. *"Talking to a Polish psychologist, in Polish language, understanding of the cultural context, experience, - it increases the client's identification with the therapist and helps to develop therapeutic alliance, it strengthens transference and helps to strengthen the sense of security"*).

3.9.3. Client factors

Client related factors were mentioned in 33.3% of responses. Different conceptualisations of mental health amongst Polish immigrants were mentioned

(e.g. *"Lack of mutual understanding over frames of reference re. mental health. different understandings of mental health"*).

Some of the responses suggested that clients concerns about racism or xenophobia might impact the therapeutic relationship (e.g. *"There are such horrible media representation of Polish people they may think the therapist has the same view, so this may hinder the relationship"*). Some of the responses indicated that the TR might be impacted by clients' mistrust of the system or organisations offering help.

3.10. How Psychological Services Meet The Needs Of Polish Clients

Participants were asked whether the service they currently work in meets the needs of their Polish clients. 95% of participants answered this question. Of these, nearly half (49.3%) answered 'somewhat', 24% answered 'I don't know", 22.7% and 4% said 'no'.

Participants were then asked to expand on their answers. Those who responded 'yes' and 'somewhat' were asked to describe in which ways their services meet the needs of Polish clients. Three broad response categories were identified: 'Overcoming Language Barrier', 'Meeting the Needs the Same way as for other clients' and 'Consideration of Culture' (see Appendix O).

3.10.1. Overcoming Language Barrier

57.4% of participants referred to having interpreters within the service (*e.g. "We use interpreters to assist with language barriers"*). However, only 5.5% mentioned the availability of written materials in Polish (e.g. *"I've obtained CBT worksheets in Polish"*).

3.10.2. Standard Care

31.5% of participants felt that the needs of Polish clients are met in the same or similar way as any other client group (e.g*. "Needs are met in a similar way to*

other ethnic groups – i.e. services are available, but with no particular special provision around distinct needs"). Some of the participants who expressed this view felt that this was possible due to the presence of interpreters in the service (e.g. "*We have access to Polish language interpreters, so technically Polish clients should be able to access the same service as other clients*").

3.10.3. Consideration Of Culture

24.1% indicated that elements of Polish culture were considered in the service (e.g. *"We've learnt & found out about the cultural practices & diet for the Polish family; and learnt how in Poland diabetics are expected to count fats & proteins as well as carbs (only carbs are counted in UK diabetes care"*). Some of the responses indicated that involvement of a Polish professional within the services is a helpful factor. A number of Polish psychologists (14.8% of all responses) suggested that and intervention in Polish language or from a Polish psychologist is helpful (e.g. *"I am the only Polish psychologist within my service so any Polish clients we have would be usually referred to me. I guess sharing the language and at least some of the cultural context helps to build therapeutic relationship"*). Some non-Polish participants indicated that Polish professionals can be used as 'cultural consultants' to aid the understanding of the culture (e.g. *"We have a Polish therapist, who helps us to think about issues related to culture, and sometimes may work with Polish clients, depending on presenting issues and dynamics etc."*). Two participants also mentioned the service's ability to offer links to local Polish community services.

3.11. How Services Could Be Improved

Participants who answered 'No' or 'Somewhat' to the question of whether or not the service they work in meet the needs of Polish clients were also asked to expand on their answer and offer views on what could be improved (Appendix P). These can be divided into five response categories: 'Better Understanding of the Community', 'More Effort to Overcome Language Barrier', 'Links with Polish Community', 'Improving Awareness of Psychological Services' and 'Wider Organizational Structures'.

3.11.1. Better Understanding Of The Community

Answers related to developing a better understanding of the Polish community were present in 57.5% of responses. Participants commented on the need to understand specific needs of the community (e.g. *"more acknowledgement of the particular needs and adversities experienced by Polish people; albeit without wishing to stereotype"*) and to improve cultural awareness (e.g. *"Not as much effort goes into understanding the culture of Polish clients compared with that of other more prevalent demographic groups in this area (e.g. Bangladeshi, Somali)"*). Some participants commented on the low number of Polish clients seen within their service and indicated a need to further investigate this (e.g. *"We do not see many Polish clients and this begs the question of whether this is representative of the community or whether there are more potential clients out there who are not accessing our service and what the reasons for this might be. We need to know what the barriers are if we are to improve*").

3.11.2. More Effort To Overcome Language Barrier

37.5% of responses indicated a need of greater effort to overcome language barriers. Some indicated that more written materials in Polish language are needed. Some participants referred to difficulties in using interpreters with this population. However, it was unclear what these difficulties were as only one participant indicated that Polish clients might be worried about confidentiality (e.g. *"We have to organise interpreters which isn't always ideal given Polish community, so can be concerns about confidentiality"*). A couple of participants indicated that access to Polish/ Polish speaking/ bilingual professionals might be helpful.

3.11.3. Links With Polish Community

30% of the participants indicated that developing links to the Polish community would be helpful. Developing links with Polish organizations was mentioned (e.g. *"I personally don't know much about issues specific to Polish clients, or whether there are any social groups/activities/voluntary services for the Polish*

community in this area")". Some of the participants suggested the involvement of Polish service users (e.g*. "better representation of service users and families in service development and review"*).

3.11.4. Improving Awareness Of Psychological Services

A number of Polish psychologists (17.5% of those who commented on how services could be improved) suggested that efforts should be made to increase the awareness of available services amongst the Polish immigrants (e.g. *"Making the community aware that there are services, to which they are entitled free of charge and that interpreters are available. That they don't need to worry about paying for therapy or language barrier"*)

3.11.5. Wider Organizational Structures

One response suggested that attention should be paid to wider organizational structures *("I think that we try really hard to offer a culturally inclusive service, including the models of therapy we use, learning from clients about their cultural construction of their difficulties etc but I think that this is always constrained by a wider organisational structure which promotes working therapeutically in a very prescriptive, narrow parameter"*).

3.12. Training & Resources Needed

All participants were finally asked what training and/or resources they felt might improve their ability to work effectively with Polish clients. This question was answered by 76% of the participants. The responses could be divided into five categories: cultural competence training, links to the Polish community, overcoming language barriers, training around the needs of the community and continued professional development and supervision (Appendix Q).

3.12.1. Cultural Competence Training

38.33% of participants felt that training around cultural awareness/ competence

could be helpful. A number of participants wished to know more about Polish culture (e.g. *"More knowledge about Polish culture, I think people might be unaware of the history of the Polish people, and their involvement with the UK, perhaps some information on history might help to enrich our understanding and see the unique relationship that the UK has had with Polish people particularly before Poland's EU entry")*. Some participants mentioned wanting to know more about Polish clients' beliefs and understandings about mental health (e.g. *"how mental health/wellbeing is viewed in the community"*).

3.12.2. Links With Polish Community

Another 38.33% of participants mentioned developing links to the Polish community. Participants stated that learning about Polish clients' experiences of services and seeking consultation would be helpful (e.g. *"Hearing from Polish clients what has been helpful / not so helpful for them about the service"*). Some participants suggested seeking consultation from Polish organisations and community groups (e.g. *"I think that there is an opportunity for other organisations to aid statutory organisations in learning more about how to provide health care which is accessible to Polish people"*) and some felt that there should be more Polish psychologists who could act as 'cultural consultants' (e.g. *"More colleagues whom I might be able to consult with on issues of Polish culture"*).

3.12.3. Overcoming Language Barriers

18.33% of responses indicated that further efforts should be made to overcome language barriers. A number of participants wished for more translated materials and some felt that access to skilled interpreters would be beneficial.

3.12.4. Continued Professional Development And Supervision

A number of Polish psychologists expressed interest in continued professional development training or training related to a particular therapeutic modality such as systemic or CBT. Access to regular supervision was also mentioned.

4. STUDY 2: EXPLORATION OF THE VIEWS AND EXPERIENCES OF POLISH IMMIGRANTS WHO HAVE ACCESSED PSYCHOLOGICAL HELP

4.1. Overview

This chapter describes the main findings of the interview data analysis. It begins with summary of participants'' characteristics. A thematic map with an overview of themes and sub-themes is then presented. In subsequent sections each theme is discussed and illustrated with data extracts.

4.2. Participants

There were 10 participants (7 females and 3 males, mean age 35 years). The majority of the participants (70%) have lived in the UK for over 10 years. Demographic information is presented in Table 1, including the information regarding the nature of the service they accessed. The majority of participants (70%) were seen by non-Polish therapists, two were seen by Polish therapists and one participant reported meeting with both Polish and non-Polish therapists.

Table 1: Demographic characteristics of the participants

Pseudonym	Gender	Age	Years in the UK	Accessed help through
Ilona	Female	35	10	NHS – Primary Care, Charity
Aneta	Female	22	10	Private
Piotr	Male	36	12	Private
Sara	Female	35	6	NHS-CAMHS, Social services
Ela	Female	38	13	NHS-IAPT
Agnieszka	Female	30	7	NHS-IAPT
Alicja	Female	41	14	Charity
Sylwia	Female	37	14	NHS-IAPT
Dariusz	Male	35	3	NHS-IAPT, Private
Tadeusz	Male	42	14	NHS - Acute Psychiatric Ward

4.3. Thematic Map

Three overarching themes were identified, each consisting of several sub-themes (Figure 1). In the following sections, the identified themes and sub-themes will be described and analysed. Extracts from the interview transcripts will be included.

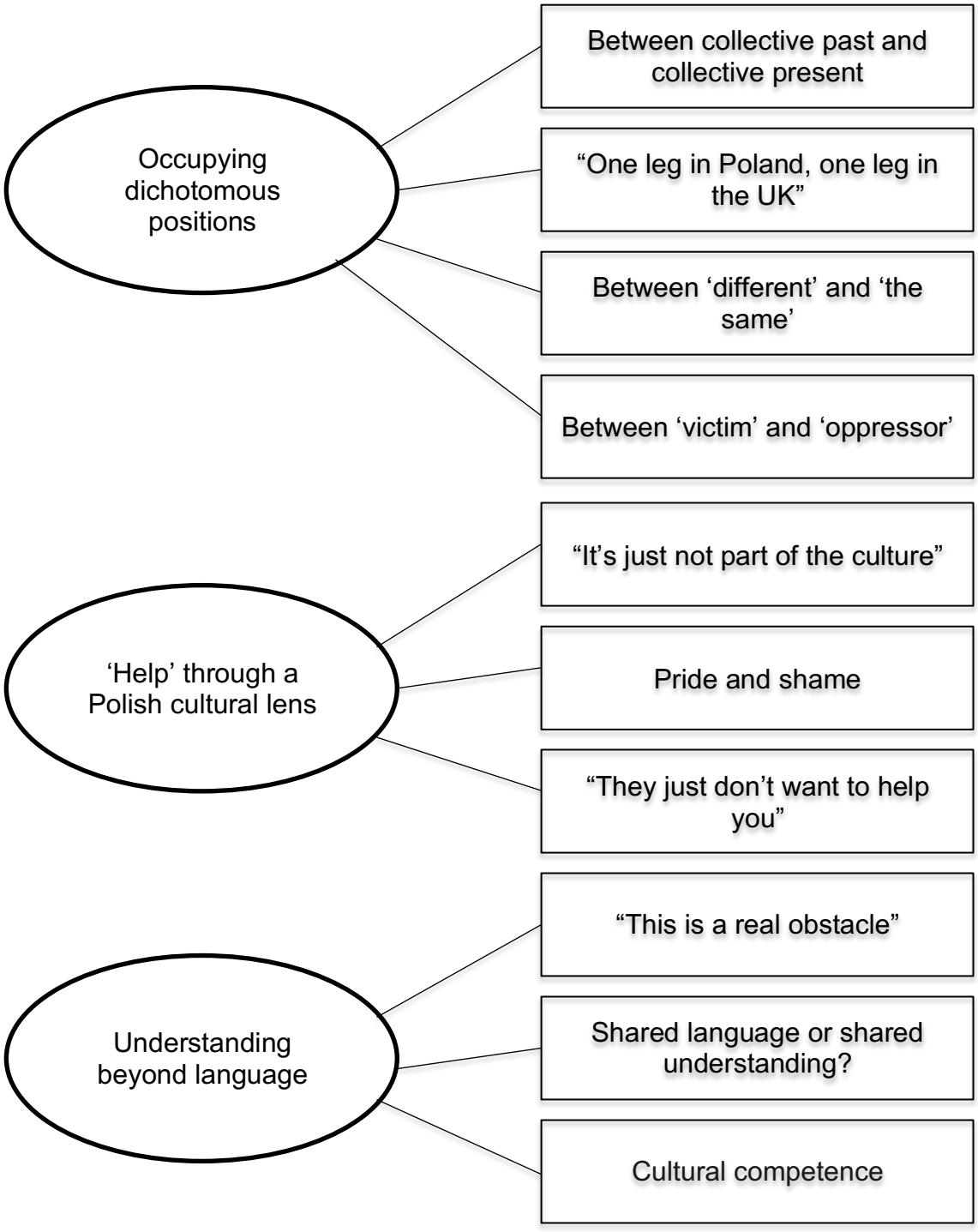

Figure 1: Thematic Map

4.4. Theme 1: Occupying Dichotomous Positions

An overarching theme, present across all interviews, was the sense that the participants were seeing themselves and other Polish immigrants as occupying dichotomous positions within realms of time, place and identity. Participants spoke about the impact that Poland's past historical and cultural context and traditions had on their current functioning: linking the collective past of the nation to their collective present (Subtheme 1). Participants also made references to immigrants living with *"one leg in Poland, one leg in the UK"* (Subtheme 2). Many of the participants made references to a double identity of Poles in the UK, which oscillated between feeling (and being positioned as) 'the same' and 'different' to the host community (Subtheme 3). Finally, while forms of current and historical oppression experienced by Poles as a nation were mentioned by all of the participants, many also commented on racism and discrimination displayed by Poles towards other nations, positioning them as perpetrators of oppression (Subtheme 4).

4.4.1. Subtheme 1: Between Collective Past And Collective Present

A number of participants made direct links between their own and other Polish nationals' current functioning and a particular socio-politico-cultural context of the time in which they grew up. When speaking about the impact of the past and the characteristics of Polish individuals as a group, all of the participants used the collective pronouns 'us' and 'we'. The perceived causal relationship between Polish historical and cultural context and the way Poles might think and behave is demonstrated in Alicja's account:

> **Alicja:** *About the culture. They should learn how this Polish civilization was developing, you know the culture... Relationships, you know, the functioning of the family, of the individual. (...) History, everything exactly. How... why do we behave like this as a nation, why we have certain character traits that differentiate us from others.*

Many of the participants, spoke about the impact of the Communist regime and its aftermath on what was frequently referred to as the 'Polish mentality'[2]. In the following extracts Sylwia and Tadeusz described the impact of growing up during this time, characterized by restrictions, censorship and constant threat, where any suspicion of political dissidence could lead to persecution (Checinski, 1982).

> **Tadeusz:** *Because it is, you know, Polish mentality. Carried away from the years of Communism. Do not trust anyone. Mind your own nose* [Mind your own business]*. That's how we grew up and that's the way we are now. We are closed inside ourselves. Emigration might have changed some things, it opened up some horizons, but inside, I think this mentality is still the same.*

> **Sylwia:** *I will always keep coming back to those years of Communism that have stupefied…demented the nation and have left a terrible mark on people, say, my age. Maybe the younger generation (…), maybe they are a little bit different. But those, you know adult people, who came here… the ones born in the 1970s and 1980s; they are still quite post-communist, closed inside themselves.*

Both participants used the expression "closed inside yourself" (*zamknięci w sobie*), which translates as 'withdrawn' or 'reserved'. This referred to what participants felt was the hesitant attitude towards speaking about things that are considered personal as well as a hesitant attitude towards integration.

Sylwia made further links between the particular political context of the oppressive practices of Communism and the role of religion in the shaping of Polish cultural identity.

[2] 'Mentality' as a concept is present within everyday Polish language (Galasinski & Galasinska, 2007). This is expanded on in Chapter 5.

> **Sylwia:** *We are a Catholic country and that has also had some impact on people's upbringing, it was all about punishment. The priest shouted, the priest punished. If you are bad, you will go to hell. And you learn that ... it's a police country ... if the police gets their hands on you, they will beat you up. You have to be careful. That is why these people are also not so open-minded.*

Sylwia used the expression "Catholic country", which goes beyond the description of the dominant religion and points to the integral role that the Catholic Church played and continues to play in Polish culture and politics (Marianski, 2004). This is demonstrated by Ilona's account. She points out the interconnectedness of Polish religious and national identity. Here, Catholicism and 'Polishness' go hand in hand.

> **Ilona:** *It is not possible to separate religion from Polishness, it is also connected with our history, right? As Poland was invaded - the church was like an institution that helped our culture to survive and it has left its mark on us.*

In a number of interviews drinking alcohol was mentioned as a part of Polish culture and tradition. Participants spoke about alcohol historically being viewed as a culturally acceptable means to cope with distress, particularly for men. Dariusz' account demonstrates how traditional cultural discourses regarding alcohol persist and continue to impact the way Polish individuals might think about addressing emotional difficulties.

> **Dariusz:** *Because you know in our culture, alcohol is good for everything. If you're unhappy, reaching for a bottle is like the most obvious way to cope. This is a normal part of our Polish mentality. My grandfather was a drunk, my father was a drunk. Everyone drank. And during Communism even more so. You couldn't buy anything in the shops. Nothing on the shop shelves, no food no nothing. But there was vodka! And this is also our way of thinking. You treat your sorrows with alcohol? Nobody will ever think twice. Normal. But when you go to the*

doctor with depression then, oh then they will soon say that he is mental or a loser.

A number of participants linked their own current or past emotional difficulties to the experience of growing up in families where alcohol was problematic. Some mentioned the concept of ACoA syndrome as a descriptor of their current difficulties.

Dariusz: *I am an ACoA and I have previously attended the ACoA workshops in Poland. Then I came here and I thought everything would be OK but these old demons keep coming back.*

The participants who mentioned ACoA also commented on the perceived widespread nature of this syndrome amongst Polish nationals both in Poland and in the UK. However, the participants felt that professionals in the UK are largely unfamiliar with this concept. For example, Ilona felt that many of her difficulties could be accounted for by her being ACoA and that familiarity with the concept might have helped her therapist better understand her context.

Ilona: *You know, I have read a lot about ACoA syndrome, etc. so I have most of the symptoms. I think to some degree, probably, knowing about this of this would have helped her understand where a large part of my problems is coming from.*

4.4.2. "One Leg In Poland, One Leg In The UK"

A number of participants expressed the view that many Polish immigrants seem to 'live in between Poland and the UK'. A number of participants described this as *"living with one leg in Poland and one leg in the UK"*. The participants described a number of ways in which the Polish maintain this 'in between' way of living. For example, Alicja, described Polish migrants, who while living and working in the UK, focus their attention on the life they left behind in Poland. She feels this prevents them from integrating with the host community.

> **Alicja:** *We often come here only to earn money and then we leave. And we are not interested in what is actually happening here in this country. We're going to work, getting on the bus, coming home and sitting at home in the room. We get up in the morning and you know... most of us have a family in Poland, and spend hours on the phone every day instead of going out and talking to somebody outside.*

The participants observed that many Polish immigrants restrict their social contacts to other Polish individuals and attempt to 'recreate Poland' in the UK by the means of Polish shops, churches, schools and media. Dariusz points out one of the possible functions of this behaviour, which is to minimise the distress associated with leaving Poland.

> **Dariusz:** *Many of us come here and we live in something like Polish communes. We live in Polish apartments, we work with Poles. For a beer after work, also with Poles. We buy food in Polish shops, we watch Polish TV. Its as if you never left Poland. If you stick to your own this emigration is not so terrible.*

Alicja brought in another perspective, viewing this as the community's attempts to preserve national identity and pride.

> **Alicja:** *Coming here… some of us feel humiliated because we had to leave, that we are no longer Polish, that this Polishness is already dying in us a bit. Therefore, our pride also dies. So we try, you know, we fight this with all we have, we try to prevent this. It's very hard for us to talk about it because it's hard for us to admit it. That is why all Polish churches, Polish shops, all of this continues to work… because we want to hold on to this Polishness, this pride.*

Descriptions of the attachment to traditional Polish family structures and values and of attempts to recreate them were also present in participants' accounts. Ela reflected on the sustainability of these attempts and their applicability to the new circumstances of migration.

> **Ela:** *I think that we, as Poles, are traditionalists, we are trying hard to maintain... We have old patterns in our heads constantly. We have our traditions, the roles we occupy in the family are as if set in stone. Yes, because my mother did it this way, my grandmother did it this way. This means, if you had broth for Sunday dinner your entire life, you must continue to have broth. But this does not work in today's realities, it's a different time. And especially for us living here, where things are so different. It does not work. It cannot work.*

Another dimension of living *"one leg in Poland, one leg in the UK"*, was not quite belonging in either of these realms. This is exemplified in Ilona's account.

> **Ilona:** *And also the feeling of loneliness and isolation somehow. You do not fit in there anymore but you don't fit in here either. Ten years passed by and, damn it, I still have a hopeless job, I do not earn money, parents, you know, expect me to already have bought a flat here and two in Poland.*

4.4.3. Between 'Different' And 'The Same'

A subtheme, present in a number of interviews, was a conflicting position of viewing oneself as the same as the majority host population, yet emphasising cultural differences and an 'outsider position' Polish immigrants appear to occupy. Dariusz' account points to the multiple similarities between the Polish and the British, including the status of an being 'European' (implying equality), but also he stressed the position of the Polish as cultural outsiders.

> **Dariusz:** *You see, we are kind of in between. That's what I think. On the one hand, we are in Europe, we are Europeans, we are White. We have everything the same as the West. But the mentality is different. The culture, the way of thinking ... we didn't have this before. And here, you know we are outsiders really. We want to be the same, but we are different.*

Dariusz' comment about "wanting to be the same" was reflected in the accounts of other participants. For example, Sylwia spoke about 'blending in' with the British and 'assimilating' as a way of negotiating her identity as a an outsider.

> **Sylwia:** *Here you have to assimilate. Just like in this saying: when you walk between crows you have to croak like them. So despite everything you have to assimilate with these people. You have to blend in.*

Some participants, like Sara mentioned that the visible characteristics of Polish immigrants might be obscuring the cultural differences and help the Polish to 'blend in'.

> **Sara:** *You know, Poles, especially those who work in higher positions, and not on some construction sites, it is very easy here to blend in with the crowd. And you cannot really see the difference between them and the British.*

Others felt that the visible and audible differences, in terms of clothing, accents, and foreign sounding names marked the 'otherness' of Poles.

> **Aneta:** *You can spot a Pole from a mile away. You know there is 'the look'. You can try to blend in, but your accent, your last name will betray you. I'm lucky because my last name doesn't sound Polish, and I'm trying, you know to work on my accent. But, you know, its still there. And it affects the way people treat you.*

4.4.4. Between 'Victims' And 'Oppressors'

Another subtheme observed in the majority of the interviews was a dichotomy between Polish immigrants' identity and experiences of being both victims and perpetrators of oppression.

The participants spoke about Poland's historical context of frequently

experienced oppression and about current experiences of anti-Polish sentiment and discrimination taking place in the UK. For example, Ilona brought up the historical context by speaking of the deep-rooted tradition of celebration of martyrdom and victimhood in Poland.

> **Ilona:** *Someone always was rolling through our country and doing bad things to us. Somehow, we see ourselves in a victim role, but we are somehow proud of it. You know all this Polish martyrdom we learned about in history and Polish literature classes, this glorification of suffering.*

Alicja links the historical context of victimhood with the dimensions of 'Polish mentality':

> **Alicja:** *We have such traditions because this is the kind of history we have. We have always been attacked, abused, exploited. Well, in general… this is the history we have and this is how we behave. We have a problem with opening up because we feel that everyone around us is exploiting and attacking us only wanting to benefit at our expense.*

In terms of current experiences of oppression, all of the participants spoke about either their own experiences of discrimination or those of other Polish immigrants. Many participants described this by using the term 'racism'. This is exemplified by Aneta's account.

> **Aneta:** *Well, there are many racists here. For example, it is often the case that when you are looking for jobs or something, they will not accept you because you are from Poland, or if you are looking for a flat it's the same. They treat you worse. This doesn't always happen, but such situations do happen. The Poles do not have a good reputation here in England.*

Some participants, like Piotr, commented on the increasing hostility experienced by Polish immigrants after the Brexit vote.

> **Piotr:** *It seems to me that, especially recently because of Brexit, everything suddenly changed by 360 degrees. Until now, the attitude of the British to Poles was OK, I guess (…). But it seems to me that now there is something quite unpleasant hanging in the air.*

While the impact of the oppression of Polish nationals was mentioned by all participants, some also spoke about their compatriots as perpetrators of oppression. Sylwia commented on the intolerance of difference, which she felt was a dimension of Polish mentality. She comments on the dichotomy of Polish identity as both victims and oppressors.

> **Sylwia:** *Polish mentality is so peculiar. You know, in Poland, there are usually no foreigners, and if they are, they are usually from Romania or Gypsy travellers. Poles even in Poland fight amongst each other, and even more so with other national or cultural minorities. There are some terrible comments on this subject, name-calling: you gypsies, you Jews, you this, you that. Oh Romanians have come here, you know, to work and so on. It is the same way when in here I hear the same comments about the Polish.*

This observation is also demonstrated by the account of Sara, who identifies as a Pole and Roma traveller and has experienced discrimination and prejudice from other Polish individuals.

> **Sara:** *Well, you know in Poland, especially in smaller towns, because I'm from X, three thousand people maybe. You are walking down the street and everyone is like: oh a Gypsy, terrible. People are afraid, they point at you. Here, this doesn't happen as much.*

4.5. Theme 2: 'Help' Through A Polish Cultural Lens

This theme included references to seeking and using psychological help in the context of Polish cultural beliefs and attitudes. This theme reflects participants'

views based on their own experiences and their views concerning the wider community of Polish immigrants. Participants made references to psychological help as something that is historically alien to Polish culture (Subtheme 1). Participants spoke about pride as one of the integral parts of Polish mentality. In this context seeking and using psychological help was seen as a failure to cope, which led to feelings of shame (Subtheme 2). A number of participants spoke of the difficult relationship between Polish immigrants and the NHS as one of the barriers to accessing psychological help (Subtheme 3).

4.5.1. Subtheme 1: "It's Just Not Part Of The Culture"

Some participants expressed a view that seeking help for psychological problems was not part of the Polish culture. Alicja makes references to the experiences of previous generations who were likely to be affected by the large-scale political changes occurring in Poland at that time. These changes and the hardships experienced by the nation might be reflected in her comment suggesting that people might have had different priorities at the time.

> **Alicja:** *It's not popular, we are just not aware of this really, because nobody used this in the past (…). We have not experienced it, our parents have not experienced it, our grandparents. It's just not part of the culture. There were different priorities back then.*

The historical unfamiliarity of the concept of psychological help is echoed in Sylwia's account. She mentions the impact of media, namely the absence of discussions regarding mental health and psychological help as contributing to these concepts not being normalised within Polish culture.

> **Sylwia**: *Now, people are a bit more open-minded because, you know, now there are conversations about it in the media. But back when my parents were younger or grandparents, what media? There was no media and the press didn't really concern itself with such things. After all, you know everything was controlled by the government, people were hounded and uneducated and did not know much.*

4.5.2. Subtheme 2: Pride And Shame

References to ‘pride’ as one of the vital components of ‘Polish mentality’ were present in the majority of the interviews. Linked with this was the shame associated with failing to cope with life challenges. A number of participants expressed a view that seeking help for psychological problems could be seen as a failure to cope with something that one should have been able to cope on their own. In Ela’s account links are made between seeking psychological help and admitting failure.

> **Ela:** *It’s all about pride, you know? I think, in the Polish mentality, admitting failure, that I cannot manage something, is very difficult. Because it is something else to moan and say that things suck and something else is bending your head and saying I can’t cope and I need someone else to show me the way.*

Some participants, like Sara expressed the view that seeking psychological help can be seen as self-pity and therefore something shameful.

> **Sara:** *I don’t know, I think that everyone avoids psychologists (...) because people are ashamed, because it's stupid, there are more important things than sitting and feeling sorry for yourself.*

A number of participants spoke about shame in the context of mental health stigma and social consequences of seeking psychological help. This is evidenced in Agnieszka’s account.

> **Agnieszka:** *It can also be a kind of shame. Because I myself, for example, I did feel ashamed, because, you know, a psychologist equals a psychiatrist, right? And a psychiatrist equals something bad because oh my God, you are mental and you are stigmatized by the society, right?*

Sylwia expressed a view that the stigma and social consequences of seeking help might be greater for these Polish immigrants whose social circle consists mostly of other Polish nationals.

> **Sylwia:** *And, you know another thing, in Poland, it's a bit like… if you go to a psychologist - you're already kind of stigmatized, so people are ashamed. And here, I think it is more so for those living in more of a Polish circle. Because they would immediately talk behind their back: oh, they're crazy, or freaks. I suspect that these things are more common in these more Polish environments.*

A number of participants worried about practical consequences of admitting to a 'failure to cope' by seeking psychological help. For example, Sara expressed a view that seeking psychological help can lead social services taking away the children away from the family.

> **Sara:** *Everybody knows that. You admit you can't cope and immediately they think children are at risk. They just look for a reason to take them away. You need to be careful. And they can be sneaky, they ask innocent questions and before you know it social services are at your doorstep.*

4.5.3. Subtheme 3: "They Just Don't Want To Help You"

The majority of the participants mentioned the difficult relationship between Polish immigrants and the NHS. Some participants based this opinion on their own experiences, others on the experiences of their friends and relatives. Some expressed more general opinions about how things are viewed amongst the Polish community.

Participants mentioned particular narratives regarding the NHS that are present amongst Polish immigrants. These included high levels of frustration, dissatisfaction and distrust towards the NHS, viewing it as a distant and impermeable entity that is unwilling to help. These views were frequently based

on experiences or community narratives of seeking help through General Practitioners (GPs). Many of participants viewed the GPs as unhelpful and dismissive. This is exemplified by Ilona's account:

> **Ilona:** *You know, there is this legend, that the NHS is horrible, that there is no reason to go there at all, because they will give you, you know, Paracetamol for a broken leg.*

Linked to the narratives about the poor quality of the NHS services was the view of psychological help being difficult to access through the GP. This is demonstrated in Alicja's account where a referral to psychological services is spoken of as something a patient is meant to fight for.

> **Alicja:** *They [GPs] are not keen to refer people to therapy. Unless you tell them yourself that this is what you need. You specifically tell them that you want to see a therapist and you really have to push them and know exactly what to say. Just don't take no for an answer.*

Sylwia compared the experiences of seeking help through the GP to the experiences of accessing healthcare in Poland.

> **Sylwia:** *I guess in Poland, when you go to a doctor you are not meant to be an expert. You say your symptoms and she tells you what you need. Here it seems you need to not only know what you need, but also be able to argue for it. I think many people wouldn't be able to do this. I don't know, maybe, they [GPs] are not trained to recognise these [psychological] symptoms?*

However, a number of the participants shared their experiences of feeling unable to access the kind of help they felt they needed despite their attempts to request it. For example, Dariusz spoke about his attempts to seek help for the difficulties he associated with the ACoA syndrome. It appeared that the language he used to describe his problems was not understood by the GP.

> **Dariusz:** *She did not understand that I wanted help for my ACoA syndrome. She kept suggesting substance misuse service, and I say to her but I don't drink and she just couldn't wrap her head around it. So I went online and found PPA and I found this private psychologist.*

The frustration of feeling unable to access help through the NHS is echoed in Aneta's account. She shared the experience of reaching out to the PPA, when she was unable to receive help from the NHS.

> **Aneta***: So we told her [GP] that I was so unhappy ever since I came here. When I had therapy in Poland before it really helped. But she just gave me medication and said to try this for few months and then come back. But, I said, I need help now, not in few months. And she was like: "If you're so unhappy, can't you just go back to Poland?". It was just like… they just don't want to help you. So my mum's friend suggested we look through PPA.*

Besides the narratives regarding the unhelpfulness of GPs and difficulties in accessing psychological help through the NHS, there were numerous comments suggesting that many Polish immigrants did not know that they could access psychological help free of charge. Ela speaks about this lack of knowledge as commonly occurring amongst Polish immigrants:

> **Ela:** *There is very little awareness of how the system here works and what you are entitled to.*

Tadeusz shared his own experience of learning about being entitled to psychological services only when he was hospitalised under a Mental Health Act section

> **Tadeusz:** *I've lived here for so many years and I had no idea you can ask your GP to refer you to talk to someone about the voices. Only once in the hospital they told me: oh, you could have gone to your GP.*

4.6. Theme 3: Understanding Beyond Language

The final overarching theme concerned aspects of the participants' accounts specifically relating to understanding and being understood in the context of seeking and using psychological help. A number of participant's accounts related specifically to issues around language barrier and the use of interpreters (Subtheme 1). A number of participants spoke about advantages of seeing a Polish psychologist, which went beyond the shared language and included the assumption of shared understanding (Subtheme 2). Finally, the participants spoke about the role of cultural competency as a prerequisite to meaningful engagement and therapeutic relationship (Subtheme 3).

4.6.1. Subtheme 1: "It's A Real Obstacle"

All of the participants mentioned language difficulties as a barrier to accessing psychological help. This included low-level proficiency in English amongst some Polish immigrants and issues arising when attempting to seek help. Sylwia's account describes how language barriers can affect the attempts to seek help by searching the Internet. Comments about the lack of accessible information about available services in Polish language were present in the majority of the interviews.

> **Sylwia**: *Many people don't speak English or they just don't feel confident using it. It's a real obstacle, you know? It's bad that you can't explain to the doctors what's wrong with you, but you can't even properly search for help in English. So people just end up searching in Polish. And there just isn't any info there.*

A number of participants also spoke about issues around accessing help from interpreters. For example, Dariusz did not know that he could have been provided with an interpreter for his GP appointment. He was not informed of having this option.

Dariusz: *My friend told me, she is studying psychotherapy here, that I can go to GP and ask for therapy. But my English is not very good and the first time I went, I didn't know how to explain what I meant (...) So I came back later with her* [his friend] *because I thought she would explain it better in English.*

He spoke about a similar experience when accessing IAPT service.

Dariusz: *Well, I went there, but again, language. This lady tried to talk to me, but that really got us nowhere (...) This psychologist asked if my friend, the one who went with me to the GP could come with me to help with translation, but you know she isn't a very close friend, and you know in therapy you need to really open up and I also did not want her to know everything about it.*

A number of other participants also spoke about what they believed was a common practice, for family and friends to offer interpreting or a random Polish staff member being asked to translate. For example, Ela spoke of her own experiences as an NHS employee:

Ela: *It happens all the time. On average twice, three times a week I am asked to go back to X to help some random patient with interpreting.*

This is echoed in Sylwia's account:

Sylwia: *I know it is possible to get help with the language. There might not be Polish doctor to see you, but you know there are often other staff members. My sister, I told you, she just finished her nursing degree. She said that when she was on placement in hospitals there were many Polish families who did not speak any English and they often needed to translate something or just communicate with staff. So they just asked my sister to help.*

4.6.2. Subtheme 2: Shared Language Or Shared Understanding?

The majority of the participants, even those with good English language skills, said that given a choice they would have preferred to be seen by a Polish psychologist. While shared language appeared to play an important role in their preference, upon exploration it appeared that it was not the language itself but the assumption that a Polish professional would share the understanding and knowledge of important cultural factors and historical context. This is demonstrated in Sylwia's account:

> **Sylwia:** *So, I thought that if I could choose, that I would choose someone from Poland. Maybe they would be better able to understand me. Because we have the same background and so on.*

Those participants who accessed help from Polish psychologists spoke about the helpfulness of having a shared understanding of concepts they believed were specific to Polish culture. Dariusz spoke about the helpfulness of sharing the understanding of conceptualising emotional difficulties as an ACoA syndrome.

> **Dariusz:** *I found the PPA and I contacted them and started talking with one psychologist. And it was a totally different conversation. I told her I was ACoA and she immediately knew what I meant. She knew what I was saying from the very beginning.*

Tadeusz' account demonstrates that the appreciation of encountering a Polish professional went beyond shared language and included the shared understanding of cultural courtesy norms.

> **Tadeusz:** *She just said 'Good morning, Mr Tadeusz'. And you know, firstly it was like blessing to hear your own language, to finally be able to communicate normally, not by Google Translate. And secondly, here, you know I cannot stand that they say 'You' to everyone. I know it's different here but I still think it's rude. Like here, you know a twenty*

something girl, a nurse is saying to me: you do this, you do that. I could be her father… And this girl, this student was so, you know, normal, polite.

4.6.3. Subtheme 3: Cultural Competency

The final subtheme, which was present across all the interviews, was the importance of understanding Polish cultural and historical context was a prerequisite to engaging the immigrant community and offering meaningful psychological help. Alicia's account exemplifies this:

> ***Alicja:*** *So when you go to an English psychologist, they must first understand... you know, we grew up in this way, and then we came here. It shaped us. And for them it is something different to what they are used to.*

A number of participants spoke about the negative impact of what they felt was a lack of cultural knowledge and understanding from a non-Polish psychologists, who seemed to find it difficult to understand the cultural nuances and the context of client's difficulties.

> **Ilona:** *Sometimes I had the impression, for example, when I told her about problems with my father and so on, I just… you know, I felt like I'm telling her a story from Mars - she just couldn't understand, you know, what its like to have this ultra patriarchal figure at home and the alcohol problem there and so on. I felt these problems for her were, you know... so distant. I clearly saw that she was not able to understand this sort of, you can say Eastern European cultural heritage of some sort.*

However, participants who were seen by Non-Polish psychologists also mentioned that the lack of cultural knowledge could be mediated by the psychologist's curiosity about the cultural aspects, their willingness to learn and their ability to reflect on the impact of the cultural factors on current difficulties.

Alicja: *I think we spent a lot of time talking about it because she was very interested in it. And for me it was you know ... I was glad that I could explain something to her, we spent a lot of time talking not only about me, but also about the Poles in general, how it is all done in our culture, about the family, education, how it impacts later behaviour and family problems. And how Poles find themselves here or rather how they do not find themselves. And how it all affects us.*

5. DISCUSSION

5.1. Overview

This study had a number of objectives. Firstly, it aimed to contribute to the existing knowledge base regarding the factors influencing the psychological wellbeing of Polish immigrants in the UK. Secondly, it sought to develop a better understanding of factors that affect Polish immigrants' access to psychological services and their experience of accessing and using them. Thirdly, it sought to develop a better understanding of experience, perceptions and training needs related to working with Polish immigrants amongst psychologists. Finally, the study endeavoured to offer some insights into how psychological services might be improved in order to better meet the needs of their current and future Polish clients.

In this chapter a summary and discussion of the findings as they relate to research questions will be presented. Implications for clinical practice and future research will then be outlined. This will be followed by an evaluation of the study. The chapter will conclude with a critical review.

5.2. Summary Of Findings

5.2.1. What Factors Influence Psychological Wellbeing Of Polish Immigrants?

The results of the present study largely reflected the findings in the existing

literature regarding factors affecting the mental health and wellbeing of Polish immigrants. Survey respondents brought up a number of factors in line with the findings of previous research, which included socio-economic challenges, such as financial hardship, employment and housing issues as well as migration related factors, such as negative attitudes from the host community. Isolation and loneliness, language barriers, general migration/acculturation stress, discrimination and barriers to seeking psychological help (Maciagowska & Henley, 2018). Some mentioned the impact of the cultural context. These included: factors related to background and upbringing, support from Polish community (or lack of it) and understanding/ attitude to mental health.

The analysis of the interview data offered more in-depth views, in particular regarding the role of cultural factors, conceptualisations of distress, and negotiation of 'in-between' migrant identity in terms of acculturative adaptation and perceived social (and 'racial) hierarchies in the UK. These will be discussed in the following sections.

5.2.1.1. Aspects of cultural context

Narratives of how the Polish cultural and historical context might affect the wellbeing of immigrants were present in the accounts of all interview participants but very few survey responses. The results indicated that culture and historical context were seen as crucial factors affecting Polish immigrants' experience. However, in interpreting these findings it is important to avoid cultural essentialism, which assumes that a "national culture" affects uniformly all members of a given community (Polavieja, 2015).

History, Communism and 'Polish mentality'

The subtheme *"Between collective present and collective past"* captured the ways participants made links between the current experiences and ways of living of Polish individuals and the socio-politico-cultural context of the time-period and environment in which they grew up. This included the impact of the oppressive practices of the Communist regime and the integral role of the Catholic Church as well as the community narratives celebrating Poland's

‘martyrdom’ in the context of historical invasions of Poland and freedom fighting. The participants spoke about the impacts of these factors on what they referred to as ‘Polish mentality’.

The notion of ‘mentality’ can be understood as a social theory concept of habitus (Bordieau, 1991). It can be defined as “the collective, learned system of usually unconscious or implicit rules which shape the value that individuals place on practices” (Kelly & Lusis, 2006, pp. 834–835). According to Wacquant (1992) “habitus consists of a set of historical relations ‘deposited’ within individual bodies in the form of mental and corporeal schemata of perceptions, appreciation, and action” (p. 16). Habitus is also viewed as a structuring mechanism enabling individuals to draw upon their past experiences and collective cultural narratives as a way to navigate changing environments and to cope with novel situations such as navigating the complexities of settling in a foreign country (Tatcher, 2016).

It has been argued by social theorists that as a nation, Poland has a collective consciousness in which Communism has been deeply embedded (Garapich, 2011; Tatcher, 2016). The concept of ‘Polish mentality’ (or habitus) has been described as inherited from the communist period. It includes a “set of norms and values that emphasize the moral worth of anti-institutionalism, ‘beat the system’ attitudes, the functionality of informal connections, bending the formal rules and hostility towards the elites” (Garapich, 2011, p. 324) and has been labelled the ‘homo sovieticus’ syndrome (ibid.).

Although it has been nearly 30 years since the collapse of Communism in Poland, the majority of the participants were born under the communist regime. In 2016, around 50% of Polish immigrants in the UK were aged 30-49 (Hawkins & Moses, 2016). Therefore, a significant number of Polish individuals living in the UK shared the experiences of growing up under the Communist regime or during the transition from Communism to Capitalism. It can be argued that some of the cultural norms and values associated with ‘Polish mentality” might have an impact on aspects of the immigrants’ experience. This includes their current ‘ways of living and understanding’ and the way they might position

themselves within British society (Tatcher, 2016). This might also have an effect on attitudes towards integration with British society, relationships with both British and Polish communities in the UK or the attitudes to seeking help from institutions. However, while some aspects of 'Polish mentality' can be seen as obstacles, they are also "known and tested strategies of survival in the face of uncertain future and contestation of power relations" (Garapich, 2011, p. 325).

Conceptualizations of emotional difficulties: Alcohol and ACoA

Alcohol consumption plays a particular role in Polish culture and it has been mentioned in both the interviews and the survey responses. However, while non-Polish psychologists made general references to "alcohol and substance misuse", the interview participants and Polish psychologists situated it more within Polish culture. This included, on the one hand, the association of alcohol with masculinity, social bonding and a socially accepted way of responding to distress (Moskalewicz, 2000). On the other hand, through the discourses of the Adult Children of Alcoholic syndrome, it included the construction of alcohol as the root cause of emotional difficulties and family disturbances.

The concept of ACoA syndrome as a set of distinct characteristics and personality traits surfaced in the 1980s (Woititz, 1990). In late 1980s the discussions and publications around ACoA syndrome entered into the public discourse in Poland (Wlodarczyk, 2016). While growing up in a family with an alcohol problem is associated with a number of difficulties in later life (e.g. problems with self-regulation, hypervigilance, anxiety, shame, depression and low self-esteem (e.g. Pasternak & Schier, 2012)), the concept of the ACoA syndrome has been widely criticised and has even been described as one of the 'modern myths of pop psychology' (Lilienfeld et al., 2011). Nevertheless, it continues to be a widely popular concept in Poland as evidenced by numerous publications, online articles and websites encouraging self-diagnosis (e.g. www.dda.pl; www.ohme.pl, 2016). The popularity of the concept is also evident in the multitude of available therapies and treatments both in Poland and in the UK (i.e. a large number of Polish language ACoA meetings, private Polish psychologists offering specialised treatment, e.g. www.polskipsychoterapeuta.co.uk/dorosle-dzieci-alkoholikow/).

The popularity of conceptualising emotional difficulties as ACoA syndrome was explained by the 'Barnum Effect' (Forer, 1949). It suggests that people tend to accept specific descriptions of personality as accurate (while in reality they are vague and ambiguous statements) when these descriptions are related to socially desirable and accepted features. Conceptualizing emotional difficulties as an outcome of parental alcohol addiction might be more acceptable and less stigmatising than the medicalised discourse of psychiatric diagnoses.

5.2.1.2. Negotiating the relationship with Poland and with the UK

Factors associated with adjustment to migration and life in the UK were mentioned by both the interview participants and survey respondents. The psychologists felt that Polish immigrants might be affected by the isolation, social exclusion and disconnection from the host community as well as by the separation from their families or social networks back in Poland. These accounts are in line with previous findings (Maciagowska & Henley, 2018). Within the interview data the subtheme *"One leg in Poland, one leg in the UK"* appears to reflect the ways in which immigrants attempt to negotiate an 'in-between' position, where, on the one hand, they live and work in the UK, yet attempt to stay connected to Poland. This is also echoed in the '*Between 'different' and 'the same'* subtheme, which reflects the ways Polish immigrants negotiate their national and cultural identity the context of the complex dynamics of the interaction with the multicultural society in the UK.

This process can be understood from the point of view of Berry's (1997) acculturation theory, whereby the four previously described acculturation outcomes, can be seen as coping responses to manage the relationship with the host cultural group. While 'blending in' with the British described in the "*Between 'different' and 'the same'* subtheme appears to reflect the process of assimilation, the desire to 'recreate Poland away from Poland' described in the *"One leg in Poland, one leg in the UK"* subtheme appears to reflect separation.

It has been argued that the acculturative outcome of separation might be problematic as it can be seen as an unsuccessful coping and acculturation

experience, which can lead to high levels of stress (Kuo, 2014). A tendency amongst Polish immigrants to create small, insular groups, typified by mistrust towards outsiders and hesitant attitudes towards integration, which was captured within the *"One leg in Poland, one leg in the UK"* subtheme might be seen as an example of separation. This was also described in the previous literature (e.g. Ryan, 2010). The social support obtained through these groups might be helpful for some. However, it has been argued that it might lead to difficulties in developing meaningful relationships with local population (Rabikowska, 2010). It might also make it more difficult for Polish individuals to seek support outside of these circles.

Both aforementioned subthemes appear to reflect a form of tension and inner conflicts between valued positions, such as:

- valuing the positive aspects and opportunities associated with migration and maintaining a strong attachment to Poland
- valuing the uniqueness of Polish culture and traditions and holding on to the "Polishness" and the desire to be seen as 'a Westerner', no different to British citizens

5.2.1.3. Discrimination and 'racism'

Both the survey respondents and interview participants spoke about the negative and discriminatory attitudes Polish immigrants experience from the host community. Discrimination and 'racism' were amongst the most common survey responses to the question about factors affecting psychological wellbeing of Polish immigrants. All of the interview participants spoke about either their own or other Polish immigrants' experiences of discrimination and hostility from the local population ("*Between victim and oppressor"* subtheme).

Psychological impact

The issues of discrimination, racialisation and prejudice by the local populations towards Polish and other East European immigrants have been previously described in a number of studies (Kempny 2011; Rzepnikowska 2017). It has been argued that rejection in the form of racism from the host community is one

of the factors that are likely to contribute to poor psychological wellbeing of migrant populations (Bhugra, 2004). There is evidence that experiencing racism is associated with negative long-term effects on the mental and physical health (e.g. Wallace, Nazroo & Bécares, 2016). The majority of the evidence, however, comes from studies conducted with people of African or Asian heritage. While the impact of 'racism' and discrimination on the mental health of White minority migrant groups appears to be a severely under-researched topic, the effects are likely to be detrimental to their psychological wellbeing.

'In-between' position within perceived hierarchies

As discussed in Chapter 1, the experiences of 'racism' of Polish immigrant are complicated by their Whiteness. The results of the present study highlighted another aspect of their experiences, that further adds to this complexity. The "*Between 'victims' and 'oppressors'"* subtheme captured the perception of the dichotomous position Polish immigrants appear to occupy in relation to 'race' and oppression. While a number of publications highlight the experiences of Polish immigrants finding themselves on the receiving end of 'racial' discrimination and prejudice, other research describes prejudiced attitudes that Polish immigrants display towards other nations, in particular these of ethnic minority backgrounds (Nowicka 2012; 2017; Rzepnikowska 2017).

It has been argued that these attitudes might be an outcome of the pre-migration experience of functioning within a homogenous society (Sales et al., 2008). However, it can also be argued that minority groups might reproduce the racialised discourses of the majority group (Clarke & Garner, 2010). Tatcher (2016) argued that Polish migrants' speech can become "infiltrated" by the language of the host society, which influences their practices. These include the way they position themselves in perceived social hierarchy between migrant and settled groups (McGhee, Heath,& Trevena, 2013).

Pervious literature regarding Polish migrants (e.g. Fox et al., 2012; Garapich, 2008) demonstrated that they perceive an existence of "racial hierarchy" operating in British society and in order to position themselves within this hierarchy, they draw on racialised discourses. Tatcher (2016) argued that upon

arrival Polish individuals frequently experienced de-skilling downward mobility and status degradation. In order to negotiate this position, they had to redefine their perceptions regarding class and power. Tatcher felt that this process occurred mainly through Polish immigrants positioning themselves oppositionally to disadvantaged sections of society such as ethnic minority groups, other migrants and the White working class. In this context the "blending in with the British" described in the "*Between 'different' and 'the same"* subtheme can be seen as an attempt to align oneself with the culture and values associated with Whiteness and 'Britishness" promoted by wider political rhetoric and seen as more 'desirable' or 'acceptable' and hence less stigmatized and less discriminated.

5.2.2. What Are The Factors Influencing Access To Psychological Therapy For Polish Immigrants In The UK?

5.2.2.1. Psychologists' Perceptions

Survey responses suggested that the prevailing view was that a comparatively low number of Polish clients accessed psychological services. While some barriers to access have been identified within services themselves, the majority of responses indicated that the psychologists located the barriers to accessing psychological help within the Polish community.

Factors within the Polish Community

The survey responses indicated a prevailing view amongst the psychologists, whereby some of the characteristics or behaviours of the Polish immigrants had prevented them from being referred to psychological therapies. Not disclosing their difficulties to their GPs or presenting their emotional difficulties in a way that might make it difficult for the referrers to recognize them were frequently mentioned.

Unhelpful help-seeking attitudes and beliefs of Polish migrants were most commonly quoted as factors affecting referral rates, access and engagement with services. These included stigma and a perception that Polish migrants

prefer to seek help within the Polish community or that they might prefer to go back to Poland for treatment. The lack of knowledge and understanding of available services was also listed as one of he most common barriers to accessing psychological therapies. A number of responses indicated that Polish individuals might have a different understanding of mental health and a small number of respondents felt that Polish clients might have unrealistic expectations towards services. A commonly mentioned barrier, quoted as affecting the referral process as well as access and engagement with services, was poor English proficiency. A number of participants felt that Polish clients might be unaware or unwilling to use the interpreters available within services and prefer to use family members. Only a small number of responses suggested that Polish individuals might be concerned whether non-Polish psychologists would be able to understand Polish culture. A number of Polish psychologists felt that clients might prefer to see Polish professionals, which was linked both to language and to cultural understanding.

While the majority of comments were in line with the findings of the existing literature, they also demonstrate a presence of a particular discourse within the responses. Through these discourses an ascribed identity of Polish immigrants appears to be constructed in the interest of the dominant groups in society, whereby “the problems that people face are then seen as of their own making, or at least as inseparable from their particular nature. The phenomenon is naturalised, seen not as a socially determined reality, but as something to be expected given the way the person is” (Kagan et al, 2002, p.7).

Factors within services

A comparatively small number of responses indicated that there might be some factors within the services that might affect the referral rates, access and engagement with services amongst Polish immigrants. Some comments suggested that there might be gaps in the knowledge and understanding of the Polish community amongst the referrers. A number of participants mentioned practical barriers, such as the lack of language resources within the services and inflexible timing of appointments. Service attitudes, such as its ability to make clients feel welcome, were also mentioned. A number of Polish

psychologists indicated that the reputation of the service might affect the number of Polish clients accessing it and a small number of answers suggested that access to psychological services might be affected by whether or not the service actively reaches out to the Polish community.

One factor mentioned by the majority of the survey participants, albeit in different contexts, was the cultural competence of services and clinicians. While gaps in knowledge regarding the Polish community by the referrers was mentioned by nearly 30% of respondents, only two participants referred to cultural competency as a factor affecting access to services. A small number of responses indicated that cultural competence was an important factor affecting engagement with services. However, 50% of responses indicated its importance for the therapeutic relationship.

5.2.2.2. Clients' Narratives

Perceptions of psychological help within culture

The *"Its just not part of the culture"* subtheme reflected the perception of psychological help as not normalized within Polish culture. The historical context of clinical psychology in Poland plays an important role in making sense of participants' comments. In the early 50s psychology as a profession was abolished in Poland for political reasons, including a ban on the use of psychological tests. Psychologists held subjugated positions of psychiatric assistants and lab technicians (Obuchowski, 1965). The scientific development of clinical psychology in Poland only began in the early 60s and to date the profession is still not clearly regulated (Cierpialkowska & Sek, 2015). The historical unfamiliarity of the profession might be seen as one of the factors accounting for the relative reluctance of Polish individuals to seek psychological help. This is consistent with the findings of the study by Pleitgen (2014), whereby the interview participants displayed a degree of confusion between the roles of psychologists and psychiatrists or viewed psychological therapies as "simple conversations" or a 'softer' alternative to psychopharmacological treatment.

Concerns about consequences

The subtheme *"Pride and shame"* reflected the role of pride as an aspect of 'Polish mentality'. Linked with this was the discourse of shame associated with failing to cope with life challenges. Seeking psychological help was seen as "admitting to failure". Stigma and being ostracised in social circles were mentioned amongst the social consequences of this admission. The concerns about these consequences were described as more salient within the small insular Polish groups described previously. This appears consistent with the findings of Selkirk et al (2012), who suggested that approaching services for assistance with emotional problems might be incongruent with traditional Polish cultural values. It also resonates with the findings related to the negative perceptions of individuals with mental health problems amongst Polish individuals (e.g. Pleitgen, 2014). Besides the social consequences of seeking psychological help, the participants also spoke about their concerns about the consequences of an involvement of social services, including possible removal of children. In this context in addition to the shame associated with 'failing to cope' with emotional difficulties, there is an added dimension shame of being seen as 'failing' as a parent. The fear of such consequences might prevent people from seeking assistance from services.

Relationship with the NHS

The subtheme *"They just don't want to help you"* highlighted the challenges in the relationship of Polish immigrants with the NHS. According to the participants the narratives of the unhelpfulness of the NHS services (in particular GPs) are prevalent amongst the Polish community. This is consistent with the existing research suggesting high levels of dissatisfaction, frustration and distrust in the NHS. The presence of these narratives within the Eastern European communities are also well documented (Madden et al., 2017; Osipovič, 2013; Sime, 2014)

Lack of knowledge or lack of accessible information?

Linked to the narratives about the poor quality of the NHS services was the view of psychological help being difficult to access through GPs. The participants' accounts suggested that there is a perception that in order to be

referred to psychological services by a GP, a patient needs to know that they need psychological help, that they are entitled to it and that the GP practice is an appropriate place to seek the referral. The interviewees pointed out that a lack of knowledge might be linked to a lack of accessible information. In particular the participants pointed out that Internet browsing might frequently be the first step in seeking help. These searches, if performed in Polish inevitably led to results in Polish, which in practice led to private Polish therapists and Polish organisations. For example, performing a Google search on phrases, such as “pomoc psychologiczna w Londynie” (psychological help in London) and “psycholog w Londynie” (psychologist in London) yielded no results related to help offered through the NHS.

Wanting to be understood beyond language

The impact of language barriers on seeking and accessing psychological help has been mentioned in the accounts of all interviewees. Both the interview participants and Polish survey respondents spoke about the preference to see a Polish professional. Selkirk et al (2012) also suggested that the greater ease of communication with a Polish therapist might be beneficial due to the shared language. The results of the current study suggest that the perceived benefits of contact with a Polish professional went beyond the language and included the assumption of a shared understanding of concepts that might be seen as specific to Polish culture.

The preference to see a therapist of the same ethnic, religious or cultural origin has been previously noted by various authors (e.g. Karlsson, 2005). While ethnic matching has been suggested as a way of addressing cultural differences, there is little evidence that it leads to improved outcomes (Bhui & Morgan 2007). Same authors point out to the role of the perception of shared experience (e.g. of racism, migration or social exclusion) might be encouraging for some clients to enter therapy. However, it has also been argued that while ethnic matching might be helpful, aspects of cultural competency, such as the therapist’s ability to reflect on their preconceptions and cultural identity might be more important (Carter, 1995).

5.2.3. What Is The Experience Of Polish Immigrants Who Have Accessed Psychological Therapy In The UK?

5.2.3.1. Understanding Cultural Context

Whether or not their cultural context has been understood by the therapist was the most salient element of participant's accounts of their own experience of accessing psychological services. This was reflected in the "*Cultural competence*" subtheme in which it was described as a prerequisite to engaging the Polish immigrant community and offering meaningful psychological help. In a number of accounts the lack of familiarity with Polish cultural context was seen as a barrier to engagement. However, this was mitigated by a particular therapist's stance and qualities e.g., being non-judgmental and someone who can be trusted.

The accounts of the participants also suggest that cultural competence goes beyond knowledge of a particular culture. An important component of cultural competence appears to be the therapist's effort to understand the person and to make sense of their distress within the context of possible cultural (and other) influences. Therefore, it is important for clinicians to adopt an open and curious stance about cultural influences and reflexivity about their own cultural values and assumptions. This can allow them to anticipate and recognise how and when these enter into the process of therapy (Jim and Pistrang, 2017).

5.2.3.2. Language And Interpreting

Matters related to language were common in the accounts of the interview participants as well as the survey responses. A number of issues around the use of interpreters were brought up by the participants of both studies. There were a number of contradicting accounts regarding the use of interpreters with Polish clients. While a number of survey participants made references to the unavailability of interpreters, there were also comments suggesting that Polish clients might be unwilling to use interpreting services available and prefer to use friends or family members instead. Indeed, some studies suggest that clients

may have a preference for a family member interpret because of a greater feeling of trust towards them (e.g. Greenhalgh, Robb & Scambler, 2006).

However, the accounts of interview participants suggest that some of them did not know that they were entitled to receive support from an interpreter and some were not offered this opportunity. One participant spoke of having to use Google Translate to communicate with a psychiatrist during ward rounds and the ward being unable to book an interpreter for him during the three weeks of his stay at the hospital. Another participant, who was a (non-clinical) NHS employee, shared her experiences of being asked to translate for Polish patients during clinical appointments without any consideration for confidentiality or her skills as an interpreter.

5.2.4. What Are The Experiences, Knowledge And Training Needs Related To Working With Polish Immigrants Amongst Psychologists?

5.2.4.1. Experience And Knowledge

The results indicated that the majority of the Non-Polish psychologists did not have much experience of working with Polish clients. Approximately half of the sample did not see any Polish clients in the past 6 months. Psychologists had some awareness of the difficulties encountered by the migrant populations in the UK. While the majority of responses were in line with existing research, many responses were fragmented, incomplete or generic.

It appeared that for those non-Polish psychologists who had in the past worked with Polish clients, the experience was frequently marked by communication difficulties encountered in the form of difficulties in using interpreters, or unavailability of written materials in Polish language.

While the importance of cultural competence of the therapist was highlighted as a factor affecting engagement with the services and the therapeutic relationship, few respondents made links to cultural background of the clients when giving responses regarding the factors affecting psychological wellbeing.

5.2.4.2. Training And Resources Needed

The psychologists' responses to survey questions highlighted a number of training and resource needs:

- Cultural awareness/competence training: this was the most commonly mentioned need amongst the survey responses[3].
- Developing links to the Polish community through working closer with Polish organisations as well as service user involvement.
- Developing appropriate written materials in Polish and utilising qualified Polish interpreters.
- Polish psychologists felt that they would benefit from regular supervision, Continuous Professional Development opportunities and training in particular therapeutic modalities.
- A small number of participants suggested more research is needed to better understand the needs of Polish immigrant population.
- While the majority of non-Polish participants indicated training and resource needs that were directly related to improving their ability to work with Polish community, the responses of some of the Polish psychologists indicated different types of needs. A number of Polish psychologists suggested that they would benefit from access to regular supervision and training in specific therapeutic modalities (such as CBT). These responses might have come from these Polish psychologists who were already working extensively within the Polish community and did not feel they needed to improve their skills and knowledge with regards to this community. Therefore they might have felt that training facilitating their continuous professional development and their clinical skills might be more helpful for them. The responses indicating the need to access regular supervision might be explained by considering different professional training routes undertaken by psychologists who qualified in Poland (MSc in Psychology with little clinical experience in Poland vs.

[3] Interview participants were specifically asked what in their opinion psychologists needed to know about them or Polish immigrants in general in order to offer quality psychological services. Every participant emphasised the importance of the awareness of the Polish cultural and historical context.

Professional Doctorate with prominent clinical component in the UK). Moreover, the profession of a psychologist is still not clearly regulated within Polish law, which means that there are no clear guidelines with regards to clinical supervision. Many of the Polish psychologists who completed the survey mainly worked within their private practices and therefore might have found it difficult to access supervision.

5.2.5. How Can Current Service Provision Be Improved To Meet The Needs Of Polish Immigrants?

5.2.5.1. How Do Services Currently Meet The Needs Of Polish Clients?

The survey participants expressed a number of views:

- Some felt that the services were addressing the issue of language barriers by using interpreters. However, the majority felt that quality interpreting services were largely unavailable.
- A small number of answers indicated that some written materials are available in Polish, but more psychologists felt they did not have enough of translated resources.
- A small number of responses indicated that there is some consideration of Polish culture within the interventions even though many commented on the need to cultural considerations were not sufficiently considered.
- A small number of respondents felt that the presence of Polish professionals in the service helps to address the needs of Polish community.
- A number of respondents indicated that the needs of Polish clients are met in the same way as any other client groups.
- Two respondents reported that their services offer links to Polish community.

5.2.5.2. Suggestions For Improvement

The most common response category suggested the need to develop a better understanding of the Polish Community. A number of responses indicated that developing links with the Polish community would be helpful. Some Polish

psychologists suggested that efforts should be made to improve the awareness of psychological services in the community. One person suggested the need for "changes within the wider organisational structure, which promotes working therapeutically in a very prescriptive, narrow parameter".

5.3. Clinical Implications

The implications of the current study were threefold. Firstly, the findings emphasised the role of cultural competence. Secondly, they pointed out the importance of developing a more positive relationship between the NHS and the Polish community. Finally, they highlighted the apparent lack of resources in terms of the availability of appropriately trained interpreters and translated therapy materials.

5.3.1. Cultural Competence And Cultural Humility

The results of the study demonstrated that the therapist's ability to understand clients' presenting problems within the context of their cultural background was particularly important to the interview participants. The need to develop knowledge and an understanding of the cultural context of Polish community in the UK was also evident in the survey responses.

5.3.1.1. Steps To Cultural Competence

In line with the recommendations of Sue et al (1982), psychologists need to take a number of steps in order to offer culturally competent therapy to clients from Poland:

- Develop better awareness of their own cultural assumptions. An example of such an assumption might be situating the factors affecting the access to psychological help within the characteristics of the Polish community, rather than considering the way services are delivered. Another example could be the assumption that the needs of all migrant communities can be addressed in the same way.
- Develop a better understanding and knowledge of the worldviews and

values of the Polish community while keeping in mind the diversity within the population. For example, the experiences of living under the Communist regime might not affect each Polish individual in the same way. However, it is possible that situating people's difficulties within this context and being open to discussing them from a curious yet informed position might help to make sense of their experience.

Also, in line with the guidance offered by Tseng (1995), a number of adjustments could be made to better provide competent, relevant and meaningful psychotherapy for Polish clients:

- Technical Adjustments: e.g. exploring the conceptualisations of distress, such as viewing it through the lenses of 'ACoA syndrome'
- Practical Considerations: e.g. ensuring that translated materials are available, using appropriately trained interpreters, hiring bilingual staff
- Theoretical modifications: e.g. exploring of the way family relationships and hierarchies are conceptualised.
- Philosophical reorientation: e.g. considering the role of spirituality and religion.

5.3.1.2. Cultural Competence Training

Training in cultural competence has been advocated as a means of improving mental health care for BME populations (NIMHE; 2003). It, therefore, can be argued that developing a cultural competency training for working with the Polish migrant population might also be beneficial for individual practitioners and services. Developing a degree of awareness and understanding of the Polish cultural and historical context (including perhaps some of the aspects highlighted by the present study) might increase clinicians' ability to develop cultural formulations in collaboration with the clients (Jim & Pistrang, 2007).

However, in designing such a training package cultural competence should not be seen as the mastery of a finite body of knowledge. Tervalon and Murrary-Garcia (1989) advocated that the outcome of such training should not be competency but rather 'cultural humility', which they defined as "contiguously

engaging in the process of self reflection and self critique as lifelong learners and reflective practitioners, (…) bringing into check the power imbalances that exists in the dynamics of physician-patient communications [and] (…) developing and maintaining mutually respectful and dynamic partnerships with communities" (p.121).

5.3.2. Improving The Relationship Between Polish Community And The NHS

5.3.2.1. Service User Involvement: Consultation And Co-Production

It has been argued that the perspectives of migrants have rarely been included in the development of guidelines designed to address low uptake of psychological services. O'Reilly-de Brún et al. (2002) argued that, "migrants have been consistently excluded from participation in primary healthcare research as they are considered 'hard-to-reach' on the basis of language barriers and cultural difference" (p. 1). However, it has been argued by the same authors that in order to develop services relevant to all populations the view of all stakeholders need to be taken into consideration. Therefore, involving Polish service users in co-production initiatives is paramount to development of services that are better able to respond to the needs of this population.

5.3.2.2. Working with Polish Organizations

Developing links to and working in partnership with Polish organisations might help to develop a better understanding of the needs of the population. Co-development of cultural competence training might make it more relevant and practice rather than theory-driven. Moreover, developing a strong working relationship with Polish organisations might help to facilitate outreach, demystify the NHS and develop a more positive relationship with the community. This in turn might help to facilitate the involvement of Polish service users in research, consultation and co-production initiatives.

5.3.2.3. Changing Narratives Though Accessible Information

It appeared that the community narratives regarding the unhelpfulness of the NHS and inaccessibility of psychological help persist through the telling and re-telling of stories of negative experiences. Information, which could contradict these narratives, e.g. what services are actually available through the NHS and how they can be accessed does not seem to be available to Polish speaking individuals. Internet searches appear to be a frequent first step to seeking help for psychological problems. It might be helpful to present accessible information on platforms that are frequently visited by Polish community. Examples might include online portals such as www.londynek.net, or Facebook Groups such as "Mieszkamy w Londynie" (We live in London) or 'Polish professionals". Introducing alternative narratives of the NHS and psychological help might challenge existing views. Publishing information about cooperation with Polish organisations and co-production with Polish service users, might also improve the reputation and credibility of NHS services.

5.3.3. Language And Interpreters

Equal access to interpreting and communication resources for all non-English speaking service users has been recommended by the Audit Commission and is supported by a number of authors (e.g. Phelan & Parkman, 1995). However, it is still not uncommon for mental health services to have insufficient interpreting resources and to use untrained bilingual staff (such as ward clerks or secretaries) or family members for interpreting (Raval, 2003; Tribe & Lane, 2009). It has been suggested that models of service provision that are accepting of such practices "raise both ethical and moral questions, as well as questions whether service providers are going against the spirit of equal opportunities legislation" (Raval, 2003, p.13). Therefore, ensuring that trained interpreters are available within services seems paramount to providing culturally competent care to migrant populations.

5.4. Implications For Future Research

5.4.1. Large Scale Epidemiological Research

It appears that the current knowledge about the mental health needs of Polish immigrants is largely based on the results of small-scale projects, such as doctoral or masters theses (e.g. Selkirk et al, 2012) or local service initiatives (e.g. HealthWatchReading, 2014). However, the data regarding the actual uptake of mental health services by Polish migrants is unavailable. This might be partially due to the fact that data about Polish or Eastern European migrants is lost in the 'White Other' category in official data sets. It might be beneficial to conduct a nationwide epidemiological study in order to investigate the differences within the White Other category and to obtain a clearer picture of the needs of very distinct populations comprising this ethnic group.

5.4.2. Community Based Participatory Action Research

It appears that the exiting research about the Polish community in the UK has been gathered through traditional methods where the data was collected by an academic or professional researcher and the members of Polish community as the research subjects. This type of research tends to focus on problems rather than solutions and maintains the status quo, whereby the NHS continues to be constructed as the institutionally empowered provider of services while the communities continue to be positioned as passive recipients. The Community Based Participatory Action Research (CBPR) involving Polish communities in the UK might be helpful in challenging this status quo by developing relevant solutions and more equitable and sustainable outcomes and achieving progressive social change (Hall, 1981).

5.5. Evaluation Of The Current Study

The current study will be evaluated using the criteria outlined by Spencer and Ritchie (2011) and Yardley (2008).

5.5.1. Sensitivity to Context

This can be understood as explicitly demonstrating and being aware of a number of factors: the context of what was previously written about the related topics using similar methods, the socio-political context of the study and the relationship between the researcher and participants. In Chapter 1 a review of the existing literature about the psychological wellbeing of Polish immigrants and factors affecting their access to services was provided. In discussing the findings of this study the overlap to previous findings was highlighted. Chapter 1 situated the study within the wider socio-political context and the Chapter 2 outlined the aspects of my own and the participants' personal contexts that were pertinent to the current study.

5.5.2. Credibility And Rigour

Credibility of the study can be defined as the "defensibility and plausibility of claims made by the research", whereas rigour refers to "the appropriateness of research decisions, the dependability of evidence and the general safe conduct of research" (Spencer & Ritchie, 2011, p.229). Credibility was demonstrated through the inclusion of an explicit description of how data was collected and analysed in order to reach conclusions. Tables illustrating categories and subcategories of the survey analysis (including extracts of raw data) can be found in the Appendices. A thematic map demonstrating the main themes and sub-themes was also included, with each sub-theme supported by extracts. In order to ensure transparency of the research process the interview schedule (Appendix F), survey questions (Appendix E), an extract from the interview transcript with initial codes (Appendix G), and examples of coded extract across data set (Appendix H) are attached to this report.

5.5.3. Impact And Importance

The results of the current study provide novel understandings of the factors affecting the psychological wellbeing of Polish immigrants in the UK and factors affecting their access to and experience of psychological services. The findings

have multiple implications for training needs and general service improvement. A summary of the main findings and implications of this research will be disseminated at a conference organised by the PPA as well as within the East London NHS Foundation Trust (ELFT). A training package aiming to increase the cultural competence in working with Polish immigrant clients will be developed in cooperation with the PPA and the BME Access service at ELFT.

5.6. Critical Review

5.6.1. Study 1

5.6.1.1. Participants

The majority of the participants were from the boroughs of East London. This might be due the recruitment method of snowballing, which might have led to recruiting psychologists working within the same settings. Boroughs, such as Hackney or Tower Hamlets, are not widely populated by Polish immigrants. Recruitment in boroughs with a higher percentage of Poles might have produced different responses.

The inclusion of psychologists working solely in private practice or for charitable organisations complicated the analysis slightly. In particular, the majority of Polish psychologists taking part in the survey worked privately or were involved with the PPA. It is likely that psychologists working in non-NHS settings might have encountered clients presenting with different types of difficulties to those seeking help in the NHS.

5.6.1.2. Survey Questions

It is possible that there were too many questions and that the questions were asked in a way that did not facilitate meaningful engagement with the survey. For example, the question regarding the overview of the issues discussed with Polish clients was omitted in the analysis, as it did not offer data that was pertinent to the research questions. Asking separate questions about factors

affecting referral rates, the number of clients accessing services, client engagement and factors affecting the therapeutic relationship was intended to elicit in-depth responses about perceptions of the overall experience of Polish clients. However, it appeared that this caused a degree of confusion resulting in responses that were frequently copied and pasted across the questions. The multitude of qualitative questions also produced a large amount of data, which posed additional challenges to the timeliness of the analysis.

5.6.2. Study 2

5.6.2.1. Participants

Inclusion criteria

Having past experience of accessing psychological help in the UK was one of the inclusion criteria for the participants of this study. In designing the study it was felt that the accounts of individuals with these experiences would be most helpful in answering the research questions. It was believed that individuals who have accessed therapy would be best suited to share their experiences of seeking and accessing help. Moreover, they would be able to share the views and experiences of their engagement with services and the therapeutic process itself. However, applying these inclusion criteria meant that the potential accounts of individuals who might have sought psychological help but were not able to access it were not taken into consideration in this study.

It is possible that including the accounts of these who were unable to access psychological help in the UK could have offered more insights into both individual as well as systemic barriers to seeking and accessing services. Future research aiming to explore the perspectives of those who have not accessed psychological help for their emotional distress might provide further understanding of these barriers. It is possible that the Community Action Research approach might offer a collaborative and no-blaming way to explore these issues.

Participants' demographic information

Limited demographic information was collected regarding the participants of this study. These were basic demographic information such as: gender and age. In order to place the participants' accounts in the wider context they were also asked how long have they lived in the UK and also where they were able to access help. It is possible that inclusion of only such limited demographic information might have obscured some aspects of the context within which the participants sought and accessed psychological help. Collecting additional information, such as the participants' levels of education, socioeconomic status or sexuality might have added additional layer of context and impact the analysis and interpretation of the data.

5.6.2.2. Data Collection And Analysis

Semi-structured Interviews

Using semi-structured interviews to generate data has a number of limitations. While following an interview schedule helps to ensure the relevance of the interview content to the research questions, it also constrains the participants' freedom to come up with novel ideas. Moreover, all the interviews were conducted in the Polish language. The thesis supervisor is not a Polish speaker. Therefore, she was only able to see and comment on the translated transcripts.

Using Thematic Analysis

Thematic analysis is defined as the process of identifying patterns or themes within qualitative data and making sense of it by following a number of very specific procedures. This study adopted the 6-step framework proposed by Braun and Clarke (2006). Each step of the process was discussed with the thesis supervisor, in particular steps 4 and 5: reviewing and defining the themes. The data associated with each theme was examined in order to consider to what degree it might support it. This was followed by the consideration how the themes function in the context of the entire data set.

While thematic analysis has a number of advantages, the active and involved role of the researcher in categorizing, interpreting and making sense of the data can be seen as one of its weaknesses. It carries a risk that the researcher's attitudes, values and assumptions may affect the data (Braun & Clarke, 2006). This is particularly important in the development of the latent themes, which goes beyond the purely semantic approach and involves a more interpretative level of theme development. In this approach the wider assumptions and structures of meaning are seen as underpinning the participants' accounts. This has been addressed in supervision through in depth discussions of the analytic process, including my interpretation of the data in the context of my own position.

5.6.2.3. My Own Position

Researcher reflexivity is believed to play an important role in producing qualitative research of high quality (Willig, 2008). Reflexivity refers to the ability to notice and reflect on how researcher's assumptions, values and biases might affect how research is conducted and how the findings are interpreted.

As previously mentioned I shared a number of characteristics with the study participants. I belong to the same generation as the majority of the participants and, importantly, I shared some of the experiences described by them, such as growing up in post-communist Poland. In addition to the shared language, this might have led to both the participants and myself assuming that a shared understanding of certain concepts and values exists within the context of the interview. There were also a number of differences that might have affected the way participants related to me, which might have influenced their responses. My reasons for moving to the UK, primarily the pursuit of education, were different to the majority of the participants. Many of them talked about financial reasons framed in terms of "survival" and "having no choice". Moreover, as a trainee clinical psychologist pursuing a doctoral degree I might have been seen as someone occupying somewhat of an 'elitist' position in society. I was also associated with the NHS, which is frequently portrayed as "not to be trusted". It is possible that both my assumptions about the participants and the way the

participants might have viewed me, alongside the associated power imbalance might have impacted the interview process.

It is also possible that the ideological influences associated with being a trainee at the University of East London (i.e. an attachment to critical, community and social constructionist ideas and well as the emphasis of the importance of social context in making sense of distress) might have influenced the way I engaged with the data and my interpretation of the results. These issues were regularly discussed in supervision in order to recognise their role in the analytic process and minimise their impact. Supervision has played an important role in recognising and interrogating how my own assumptions my impact my interpretation of the data.

5.7. Summary & Conclusion

This study aimed to contribute to the growing understanding of factors affecting the psychological wellbeing of Polish immigrants. It also sought to explore factors affecting their experience of accessing and using psychological therapies in the UK. Furthermore, the study aimed to explore the understanding of this client group amongst psychologists, their training needs and potential ways to improve services. The results were considered within the context of existing literature.

The study emphasised the impact of cultural factors on the wellbeing of the members of Polish communities in the UK. This included the role of the nations' history and associated ways of living and understanding that might be shared amongst Polish individuals in (e.g. the impact of Communism, the concept of "Polish mentality"), particular conceptualizations of distress (e.g. ACoA), and negotiation of an 'in-between' migrant identity in terms of acculturative adaptation and perceived social (and 'racial') hierarchies in the UK. It is possible that considering these factors in developing formulations might aid the understanding of the context within with which psychological problems occur. The interviews analysis in particular indicated that understanding the cultural context amongst professionals mattered to Polish clients. This finding was

matched with the view commonly expressed by psychologists who completed the survey whereas cultural competence was listed amongst the most important facilitators of therapeutic relationship. Indeed, developing a greater cultural competence amongst psychologist was highlighted as a main training need.

The results also indicated that when thinking about factors that might affect access to services the socio-cultural context within which help was sought and offered (e.g. the community's relationship with the NHS, accessibility of information, services' understanding of the community's needs). This was echoed in the findings regarding the potential pathways to service improvement, which included developing a greater understanding of the Polish community, improving the relationship with the NHS and enhancing communication through accessible information. Developing links to and working together with Polish community-based organizations was highlighted as one of the ways this could be achieved.

The study contributes to the existing literature highlighting the importance of cultural competencies and cultural humility when working with different populations. It emphasises the need to constantly interrogate and challenge the assumptions we as clinicians might develop regarding working with "difference". Importantly it highlights the importance of co-production in the development of culturally appropriate services.

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APPENDIX A: Extract from the reflective diary

Extract 1: a note following the meeting with SUGAR

The meting did not really go according to plan. The SUGAR members asked a lot of questions throughout my presentation, which unfortunately left very little time for feedback. We only managed to very briefly discuss how this feedback could shape my project considering the limited time and resources as well as the context of my research questions.

However, the discussion and questions asked during my presentation also were quite thought provoking. Attendees made comments such as: *"I heard that the Polish, they prefer to go back to Poland to get their medical treatments and therapy. Clearly this is something they feel more comfortable with, just to get therapy amongst their own. Maybe if they prefer this they should just do this."* We spent a little bit of time thinking together about how it might be like to have to go to a different country for treatments one is eligible for in the UK. Or being told that this is what they should do. I was struck by this comment, not only because it mirrored the unhelpful attitudes I have previously encountered amongst professionals. I was reminded of the article by Paloma et al (2016) and the authors comments regarding the conceptualizations of migrants' "preferences" – as if they were made within a free choice scenario, without acknowledging the political, social and economic power inequities. I wondered why it seems like these power inequalities seem to be more invisible in the case of Polish immigrants.

The attendees also asked me if there are Polish mental health clinics and psychological services in London. I shared some information about the PPA, and also told the audience that PPA was the only Polish charitable organisation offering psychological help that I was aware of. The attendees wondered if perhaps it would be helpful to create more of such institutions for the Polish to attend. I wondered what might be the reason why the SUGAR members felt that this would be a preferable option to perhaps improving the existing NHS services so that more Polish individuals would attend these.

We also spent some time talking about the stigma around having mental health problems and the attendees wondered if perhaps there is more such stigma in Poland and maybe this is why the Polish do not want to attend services. There were also some comments such as: "*The Polish, you know, they work hard and they play hard"* or other broad descriptions of "the Polish" as homogenous group. We spent some time thinking together about the helpfulness of such assumptions and what it means for a community to have certain descriptors attached to them based o their belonging to certain nationality.

APPENDIX B1: Application for research ethics approval

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR BSc RESEARCH

FOR MSc/MA RESEARCH

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

*Students doing a Professional Doctorate in Occupational & Organisational Psychology and PhD candidates should apply for research ethics approval through the University Research Ethics Committee (UREC) and not use this form. Go to: http://www.uel.ac.uk/gradschool/ethics/

If you need to apply to have ethical clearance from another Research Ethics Committee (e.g. NRES, HRA through IRIS) you DO NOT need to apply to the School of Psychology for ethical clearance also.
Please see details on www.uel.ac.uk/gradschool/ethics/external-committees.
Among other things this site will tell you about UEL sponsorship
Note that you do not need NHS ethics approval if collecting data from NHS staff except where the confidentiality of NHS patients could be compromised.

Before completing this application please familiarise yourself with:

The *Code of Human Research Ethics (2014)* published by the British Psychological Society (BPS). This can be found in the Ethics folder in the Psychology Noticeboard (Moodle) and also on the BPS website http://www.bps.org.uk/system/files/Public%20files/code_of_human_research_ethics_dec_2014_inf180_web.pdf

And please also see the UEL Code of Practice for Research Ethics (2015) http://www.uel.ac.uk/gradschool/ethics/

HOW TO COMPLETE & SUBMIT THIS APPLICATION

3. Complete this application form electronically, fully and accurately.

4. Type your name in the 'student's signature' section (5.1).

5. Include copies of all necessary attachments in the **ONE DOCUMENT** SAVED AS **.doc** (See page 2)

6. Email your supervisor the completed application and all attachments as **ONE DOCUMENT**. INDICATE 'ETHICS SUBMISSION' IN THE SUBJECT FIELD OF THIS EMAIL so your supervisor can readily identity its content. Your supervisor will then look over your application.

7. When your application demonstrates sound ethical protocol your supervisor will type in his/her name in the 'supervisor's signature' section (5.2) and submit your application for review (psychology.ethics@uel.ac.uk). You should be copied into this email so that you know your application has been submitted. It is the responsibility of students to check this.

8. Your supervisor should let you know the outcome of your application. Recruitment and data collection are **NOT** to commence until your ethics application has been approved, along with other research ethics approvals that may be necessary (See 4.1)

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

1. A copy of the invitation letter that you intend giving to potential participants.
2. A copy of the consent form that you intend giving to participants.
3. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.

- Example of the kinds of interview questions you intend to ask participants.

- Copies of the visual material(s) you intend showing participants.

- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).

Disclosure and Barring Service (DBS) certificates:

- **FOR BSc/MSc/MA STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** A scanned copy of a current Disclosure and Barring Service (DBS) certificate. A current certificate is one that is not older than six months. This is necessary if your research involves young people (anyone 16 years of age or under) or vulnerable adults (see Section 4 for a broad definition of this). A DBS certificate that you have obtained through an organisation you work for is acceptable as long as it is current. If you do not have a current DBS certificate, but need one for your research, you can apply for one through the HUB and the School will pay the cost. If you need to attach a copy of a DBS certificate to your ethics application but would like to keep it confidential please email a scanned copy of the certificate directly to Dr Mary Spiller (Chair of the School Research Ethics Committee) at m.j.spiller@uel.ac.uk
- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

- **Your name**:

Karina Pleitgen

- **Your supervisor's name**:

DoS: Trishna Patel
Second supervisor: Angela Byrne

- **Title of your programme**: (e.g. BSc Psychology)

PROFESSIONAL DOCTORATE IN CLINICAL PSYCHOLOGY

- **Title of your proposed research**: (This can be a working title)

POLISH IMMIGRANTS AND PSYCHOLOGICAL HELP: A QUALITATIVE EXPLORATION

- **Submission date for your BSc/MSc/MA research:**

MAY 2018

- **Please tick if your application includes a copy of a DBS certificate** ☐

- **Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)** ☐

- **Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics** (See links on page 1) ✔

2. About the research

- **The aim(s) of your research:**

The proposed study aims to contribute to the current understanding of factors influencing Polish immigrants' wellbeing as well as their engagement and experience with psychological services. It seeks to facilitate a development of a dialogue and a shared understanding between those seeking help and those offering it and to utilise community resources by including the voices of Polish professionals offering help within the community and psychologists working in the NHS.

Research questions

1. What are the experiences, knowledge and training needs related to working with Polish immigrants amongst London psychologists?
2. What are psychologists' views on what factors might influence Polish immigrants' access to psychological therapies?
3. What are the factors affecting the psychological wellbeing of Polish Immigrants?
    1. What are Polish immigrants' experiences of accessing psychological therapy in the UK?
    2. What are Polish immigrants' views on what factors might influence Polish immigrants' access to psychological therapies?
    3. How can current service provision be improved to meet the needs of Polish immigrants?

- **Likely duration of the data collection from intended starting to finishing date:**

From the date of ethical approval (June 2017) – April 2018

Methods

- **Design of the research:**

(Type of design, variables etc. If the research is qualitative what approach will be used?)

Data will be gathered through a survey and a set of interviews. The study will be conducted in three stages.

Stage 1: Consultation with Service Users participation group
The research proposal will be reviewed by a Service User participation group or a research advisory panel. Contact will be made with organisations such as Service User and Carer Group Advising on Research (SUGAR), The Service User Research Enterprise (SURE), and ResearchNet. The group or panel will be invited to provide feedback and/or suggestions on survey and interview questions.

Stage 2: Survey
An online survey will be conducted amongst psychologists working in the London area. This group will include psychologists working within the NHS, the private sector and charitable organizations. The survey will involve questions relating to psychologists' experiences, knowledge and training needs of working with Polish immigrants. The draft of the survey is attached (see Appendix A). Total responses and percentages will be gathered and documented for the quantitative questionnaire items. Question items that require a qualitative response will be analyzed using content analysis, following the guidelines suggested by Braun and Clarke (2006). This will enable patterns to be drawn from the data and then counted to establish the frequency of particular responses. The survey will be directed at psychologists of any nationality living in London and will be presented in English language. However, because I am also interested in hearing from Polish psychologists, the survey will include an option of completing it in Polish language. The results of the survey will inform the interview question in the 3rd stage.

Stage 3: Interviews
The final stage will include a set of semi-structured interviews with Polish immigrants living in London who have in the past accessed psychological therapy in the UK. There will be 8-10 participants. The draft of the interview schedule is attached (see Appendix B). The interviews will be audio-recorded and transcribed for analysis.

The data will be analyzed using thematic analysis (TA), which has been defined as "a method for identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.6). TA was chosen as a method of analysis due to its flexibility as well as its ability to 'highlight the most salient constellations of meanings present in the data set' and to "identify a set of manifest themes, which point to more latent level of meaning" (Joffe, 2012, p. 209).

12. The sample/participants:
(Proposed number of participants, method of recruitment, specific characteristics of the sample such as age range, gender and ethnicity - whatever is relevant to your research)

Survey respondents: The survey will be directed at qualified psychologists working in the London area. This group will include psychologists working within the NHS, the private sector and charitable organizations. The participants can be any nationality, any gender, working in all kinds of settings.

- Participants will be recruited through British Psychological Society special interest groups (I will contact relevant persons within the BPS to find out

what would be the most appropriate way to recruit participants).
- An advert will also be posted on the 'UK based Clinical Psychology Facebook Group'.
- Participants will be also be recruited through the Polish Psychologists' Association (PPA). I will contact relevant persons within this organisation to find out what would be the most appropriate way to recruit participants.
- Adverts (in Polish and English) will also be posted in Polish Express, on Internet forums for Poles in the UK and in Polish shops. Participants will also be recruited by word-of-mouth.

Interviewees: Members of the Polish community in London who have accessed psychological therapy in the UK in the past.

1. Participants will be over 18 years old and will not be receiving mental health or psychological services at the time of their participation in the group.
2. They will be Polish nationals who have immigrated to the UK following the expansion of the European Union in 2004.
3. Participants will be recruited through advertisements (in Polish and English), which will be posted in Polish Express, on Internet forums for Poles in the UK and in Polish shops. Participants will also be recruited by word-of-mouth and snowballing sampling.

13. Measures, materials or equipment:
(Give details about what will be used during the course of the research. For example, equipment, a questionnaire, a particular psychological test or tests, an interview schedule or other stimuli such as visual material. See note on page 2 about attaching copies of questionnaires and tests to this application. If you are using an interview schedule for qualitative research attach example questions that you plan to ask your participants to this application)

The drafts of the survey questions and the interview schedule are attached (see Appendix A and B). The survey and the interview questions will be further refined in consultation with supervisors and in consultation with the service user participation group in the 1st stage of the project. Interviews will be recorded using a Dictaphone and then transcribed using my personal computer.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

N/A

15. Outline the data collection procedure involved in your research:
(Describe what will be involved in data collection. For example, what will participants be asked to do, where, and for how long?)

- An online survey was developed using the Qualtrics tool (https://www.qualtrics.com).
- Link to the survey will be sent to these psychologists who agreed to participate and will be posted on online Facebook Forum.
- Before completing the survey, the participants will be presented with an information sheet and a consent form.

- The survey participants will be provided with the researcher's contact details and will be able to make further enquiries regarding their participation and the study itself.
- The interviews will be conducted in the counselling room at the Stratford Advice Arcade (http://stratfordadvicearcade.org.uk) or at the UEL Stratford campus or at another suitable venue with a private meeting room.
- The aim is to conduct interviews in July 2017.
- Each interview will last approximately 1h.
- Participants will be asked the questions outlined in the Appendix B.
- Interviews will be conducted in Polish or English language, depending on the participants' preference.
- Should the participants prefer to be interviewed in Polish language, the method of back-translation, whereby the extracts will be first translated from Polish to English by the researcher and then translated back to Polish by an independent interpreter will be used in order to ensure the accuracy of the translation.
- The interviews will be recorded, transcribed and analysed for the purpose of the thesis.
- Following the thesis submission, results of the project will be disseminated to the survey participants and the interviewees.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research (and parents/guardians if necessary): Would the participant information letter be written in a style appropriate for children and young people, if necessary?

- The advertisements for potential survey participants and interviewees will include information regarding the nature and the purpose of the study.
- Potential interview participants, who express an interest in taking part in the study, will be sent an invitation letter outlining the nature and purpose of the research and their rights (e.g., choice to withdraw). They will also be invited to get in touch with the researcher should they have any further questions before they decide to participate.
- This information will be included in the adverts for survey participants and on the front page of the qualtics survey.
- On the day the interview participants will be given an information sheet and they will be offered an opportunity to ask questions. This will also be explained verbally.
- An information sheet will be displayed prior to completing the online survey and researcher's contact details will be included in order to provide the respondents with the possibility to ask questions.
- Written information will be provided in both Polish and English language. Verbal explanations and answers to interviewee's questions will be offered in Polish or English, depending on the participants' preferences.

17. Obtaining fully informed consent from participants (and from parents/guardians if necessary): Would the consent form be written in a style appropriate for children and young people, if necessary? Do you need a consent form for both young people and their parents/guardians?

Participants will be given information regarding the research as outlined above, and will be given a consent form to sign before the group discussions commence. Consent forms for groups will be provided in both Polish and English language.

18. Engaging in deception, if relevant:
(What will participants be told about the nature of the research? The amount of any information withheld and the delay in disclosing the withheld information should be kept to an absolute minimum.)

The proposed research involves no deception at any stage of the study.

19. Right of withdrawal:
(In this section, and in your participant invitation letter, make it clear to participants that 'withdrawal' will involve deciding not to participate in your research and the opportunity to have the data they have supplied destroyed on request. This can be up to a specified time, i.e. not after you have begun your analysis. Speak to your supervisor if necessary.)

Participants will be advised of their right to withdraw from the research study at any time up to 3 weeks after the date of the interview without disadvantage to them and without being obliged to give any reason. Should they decide to withdraw during the interview, I will make it explicit that I will not use their data. This will be made clear to participants in the invitation letter, on the information sheet and consent form.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?
(i.e. this is where you will not know the names and contact details of your participants? In qualitative research, data is usually not collected anonymously because you will know the names and contact details of your participants)

NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?
(How will the names and contact details of participants be stored and who will have access? Will real names and identifying references be omitted from the reporting of data and transcripts etc? What will happen to the data after the study is over? Usually names and contact details will be destroyed after data collection but if there is a possibility of you developing your research (for publication, for example) you may not want to destroy all data at the end of the study. If not destroying your data at the end of the study, what will be kept, how, and for how long? Make this clear in this section and in your participant invitation letter also.)

- All names and contact details will be kept in a password-protected folder on the researcher's personal computer separate to any data collected.
- Signed consent forms will be kept in a locked cabinet at the researcher's home separate from any data collected.

- Audio recording files will be stored on a password-protected computer file, and deleted after examination. Only the researcher will have access to these files.
- Transcripts will be stored on a password protected computer file, and only the researcher, Supervisors and Examiners will have access to transcripts.
- The participants will be informed that the project supervisors and examiners will be able to read the translated extracts from the anonymised transcriptions of interviews.
- All names and identifying references (e.g., a name of a place) will be changed or removed from interview transcripts and extracts in the final thesis and any resulting publications.
- Participants' contributions will be reported using pseudonyms.
- Data will be deleted within 5 years of the end of the study.

22. Protection of participants:

(Are there any potential hazards to participants or any risk of accident of injury to them? What is the nature of these hazards or risks? How will the safety and well-being of participants be ensured? What contact details of an appropriate support organisation or agency will be made available to participants in your debrief sheet, particularly if the research is of a sensitive nature or potentially distressing?)
N.B: If you have serious concerns about the safety of a participant, or others, during the course of your research see your supervisor before breaching confidentiality.

The project is not intended to cause any harm or distress to participants and there are no physical risks to participants taking part in this study. However, participants may become upset if they talk about topics that are distressing or emotional. The researcher will pay attention to any signs that someone is becoming upset or distressed, and ask the participant what they would like to do (e.g., withdraw, take a break, etc.). The researcher will have details for organisations that can offer support, which will be provided to all participants.

The participants will be advised that, should they experience any distress following the interview or survey completion and they would like to seek further support, they should contact their GP. They will also be given contact detail of the following organisations:

Samaritans (Confidential support for people experiencing feelings of distress or despair)
Phone: 08457 90 90 90 (24-hour helpline)
Website: www.samaritans.org.uk

Sane (Charity offering support and carrying out research into mental illness)
Phone: 0845 767 8000 (daily, 6pm-11pm)
Email: sanemail@org.uk
Website: www.sane.org.uk

Interview participants will be informed that the interviews will be recorded and they will be advised not to disclose personal or sensitive information, or bring up upsetting, personal stories

23. Protection of the researcher:

(Will you be knowingly exposed to any health and safety risks? If equipment is being used is there any risk of accident or injury to you? If interviewing participants in their homes will a third party be told of place and

time and when you have left a participant's house?

There are no identified risks to the researcher. I will be conducting interviews in public spaces and the project supervisor will be aware of the dates, times and locations of the interviews.

Modes of contact with the researcher:
An email address will be created specifically for the purpose of the study in order to make the communication easier, in particular for the Polish-speaking participants. Email address: polacy_i_pomoc_psychologiczna@hotmail.com (translation: the Polish nationals and psychological help) might be easier to remember than numerical UEL student email address.

Adverts will also contain a mobile number – a disposable pay-as-you go card and a spare mobile phone will be used for the purpose of the research.

24. Debriefing participants:
(Will participants be informed about the true nature of the research if they are not told beforehand? Will participants be given time at the end of the data collection task to ask you questions or raise concerns? Will they be re-assured about what will happen to their data? Please attach to this application your debrief sheet thanking participants for their participation, reminding them about what will happen to their data, and that includes the name and contact details of an appropriate support organisation for participants to contact should they experience any distress or concern as a result of participating in your research.)

Following the interview each participant will be offered time to ask questions and/or raise any concerns then may have. Participants will be reminded of what will happen to the data and asked if they are still happy to take part in the study (i.e., consent to data being used).

25. Will participants be paid? **NO**

26. Other:
(Is there anything else the reviewer of this application needs to know to make a properly informed assessment?)

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

NO

If your project involves children at a school(s) or participants who are accessed through a charity or another organisation, you must obtain, and attach, the written permission of that institution or charity or organisation. Should you wish to observe people at their place of work, you will need to seek the permission of their employer. If you wish to have colleagues at your place of employment as participants you must also obtain, and attach, permission from the employer.

If YES please give the name and address of the institution/organisation:

Please attach a copy of the permission. A copy of an email from the institution/organisation is acceptable.

In some cases you may be required to have formal ethical clearance from another institution or organisation.

28. Is ethical clearance required from any other ethics committee?

NO

If YES please give the name and address of the organisation:

Has such ethical clearance been obtained yet? N/A

If NO why not?

If YES, please attach a scanned copy of the ethical approval letter. A copy of an email from the organisation is acceptable.

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*

NO

If YES have you obtained and attached a DBS certificate? N/A

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

N/A

If NO please give reasons. (Note that parental consent is always required for participants who are 16 years of age and younger)

* You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2) 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people (particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example.

Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

30. Will you be collecting data overseas?

NO

This includes collecting data/conducting fieldwork while you are away from the UK on holiday or visiting your home country.

* If YES in what country or countries will you be collecting data?

Please note that ALL students wanting to collect data while overseas (even when going home or away on holiday) MUST have their travel approved by the Pro-Vice Chancellor International (not the School of Psychology) BEFORE travelling overseas.

http://www.uel.ac.uk/gradschool/ethics/fieldwork/

IN MANY CASES WHERE STUDENTS ARE WANTING TO COLLECT DATA OTHER THAN IN THE UK (EVEN IF LIVING ABROAD), USING ONLINE SURVEYS AND DOING INTERVIEWS VIA SKYPE, FOR EXAMPLE, WOULD COUNTER THE NEED TO HAVE PERMISSION TO TRAVEL

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Karina Pleitgen

Student's number: u1323545 Date: 08.06.2017

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Dr Trishna Patel Date: 13/06/2017

APPENDIX B2: Notice of ethics review decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: Anna Stone
SUPERVISOR: Trishna Patel
COURSE: Professional Doctorate in Clinical Psychology
STUDENT: Karina Pleitgen
TITLE OF PROPOSED STUDY: POLISH IMMIGRANTS AND PSYCHOLOGICAL HELP: A QUALITATIVE EXPLORATION

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

approved

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEARCHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐	HIGH
☐	MEDIUM
x	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Dr Anna Stone

Date: 22 June 2017

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):*
Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

APPENDIX C1: Information Sheet for Interview Participants

INFORMATION SHEET:

Polish Immigrants and Psychological Help

About the researcher:
Karina Pleitgen (Trainee Clinical Psychologist)
Department of Clinical Psychology
University of East London
Water Lane, London, E15 4LZ
Tel: [redacted]
Email: u1323545@uel.ac.uk

Supervisors:
Dr Trishna Patel (T.patel@uel.ac.uk) Dr Angela Byrne (A.Byrne@uel.ac.uk)

I am a trainee clinical psychologist on the Professional Doctorate in Clinical Psychology course at The University of East London (UEL) and I would like to invite you to take part in a research project. The results of this project will be written up as part of my doctoral thesis

Before you decide if you would like to participate it is important for you to understand why the research is being carried out and what it will involve. Please read this information sheet carefully and feel free to discuss the details with friends/family and/or ask the researcher any questions about the information in this sheet.

About the study:
The aim of the study is to explore factors that influence access to psychological therapies for Polish immigrants living in London. As a part of the project, I am interested in the views of Polish Nationals about their experiences of accessing psychological help in the UK.

For the purpose of this research, I will be conducting interviews with Polish Nationals who have accessed psychological help in the UK in the past.

What will taking part involve?
During the interview you will be asked about your experiences of seeking and accessing psychological help in the UK and your views about it. The questions will be focussed on what you found to be the most helpful and what in your

opinion could be improved. You will also be asked to think about what in your opinion psychologists should know, or learn more about in order to be able to offer you a better service.

You will not be asked to disclose any personal details. The interview will be audio recorded and then transcribed for analysis. Anonymised extracts from the interview will be included in my thesis.

The interview will be conducted in Polish or in English language, depending on your preference.

What if I change my mind?
Taking part in this study is entirely voluntary. If you agree to participate you are free to withdraw at any time up to 3 weeks after the interview date. Should you decide to withdraw, the data from your interview will not be used in this project. You do not need to give a reason for your decision.

Is data collected confidential?
All data used for this project will be kept confidential. Any names and contact details provided will be stored on a secure password protected computer file, which only the researcher will have access to. Data collected via audio-recording will be anonymised (i.e., all names will be substituted with a pseudonym, so it will not be possible to identify you). All names and identifying references (e.g., a name of a place) will be changed. Once the project is completed, the audio recordings of the interview will be destroyed and only anonymised transcripts retained. The transcripts will be deleted within 5 years of the end of the study

Are there any disadvantages or risks to taking part?
There are no identified risks involved in participating in this research, however, sometimes people find discussing their experiences of seeking help to be upsetting. If you find any of the topics difficult, you are free to have a break or end the interview. You can contact the researcher or supervisors to discuss where to seek help if you continue to feel upset after taking part in the study.

What will happen to the results of the research study?
The interview will be audio recorded, typed up and analysed to address the aims of the study. The results of this project will be written up as part of a doctoral thesis and may be published at a later point in an academic journal. The anonymised and translated extracts from the interview will be used in the thesis (which is read by the project supervisors and examiners).

Once the research is completed, you will be able to request written feedback about the findings of the study. This is expected to be around July 2018.

What support is available after I have taken part?
If you have any further questions about the research project or want to discuss any issues related to the interviews or questions asked, please feel free to contact the researcher at the contact details on the first page.

Further support
Although it is not likely, if you experience any distress following the interview and you would like to seek further support, you should contact your GP. You may also contact these organizations:

Samaritans (Confidential support for people experiencing feelings of distress or despair)
Phone: 08457 90 90 90 (24-hour helpline)
Website: www.samaritans.org.uk

Sane (Charity offering support and carrying out research into mental illness)
Phone: 0845 767 8000 (daily, 6pm-11pm)
Email: sanemail@org.uk
Website: www.sane.org.uk

Consent to participate
Should you agree to participate in the research project, you will be presented with a consent form to sign.

Ethical approval
This research project has ethical approval from the University of East London.

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

APPENDIX C2: Information Sheet for the survey

INFORMATION SHEET: Survey

Polish Immigrants and Psychological Help

About the researcher:
Karina Pleitgen (Trainee Clinical Psychologist)
Department of Clinical Psychology
University of East London
Water Lane, London, E15 4LZ
Tel: (pay-as-you-go number to be purchased)
Email: u1323545@uel.ac.uk

Supervisors:
Dr Trishna Patel (t.patel@uel.ac.uk, +44 208 223 6392)
Dr Angela Byrne (angela.byrne@elft.nhs.uk)

I am a trainee clinical psychologist on the Professional Doctorate in Clinical Psychology course at The University of East London (UEL) and I would like to invite you to take part in a research project. The results of this project will be written up as part of my doctoral thesis

Before you decide whether or not you would like to participate, it is important for you to understand why the research is being carried out and what it will involve. Please read this information sheet carefully and feel free to discuss the details with friends/family and/or ask the researcher any questions about the information in this sheet.

About the study:
The aim of the study is to explore factors that influence access to psychological therapies for Polish immigrants living in London. As a part of the project, I am interested in psychologists' experiences of working with Polish immigrants as well as potential training needs. For the purpose of this research, I am conducting an electronic survey amongst qualified psychologists working in London.

Who is invited to participate?
I am interested to hear from psychologists working in a range of settings, including those working within the NHS, private sector and charitable

organisations. I am hoping to hear from the psychologists who currently are or have in the past worked with Polish immigrants living in London as well as those who never worked with this client group.

About the survey:
The survey consists of 11 questions and should take approximately 15-20 minutes to complete. The questions are a mixture of multiple choice and free text.

You will be asked to provide basic demographic information (e.g., age, gender, etc.). The main survey questions will focus on your experiences of working with Polish immigrants, your views with regards to the needs of this particular group and how these are met within your service.

The survey is available in English and in Polish.

What if I change my mind?
Taking part in this study is entirely voluntary. If you agree to participate you are free to withdraw at any time up to 3 weeks after you complete the survey. Should you decide to withdraw, the data from your survey will not be used in this project. You do not need to give a reason for your decision.

Is data collected confidential?
All data used for this project will be kept confidential. All names and contact details provided will be stored on a secure password protected computer file, which only the researcher will have access to. Any names and identifying references (e.g., a name of a place) provided in the free text questions will be changed. The transcripts will be deleted within 5 years of the end of the study

Are there any disadvantages or risks to taking part?
There are no identified risks involved in participating in this research. You can contact the researcher or supervisors to discuss where to seek help if you experience any distress after taking part in the study. A list of supporting agencies will be provided to everyone who opts to take part in the survey.

What will happen to the results of the research study?
The results of this project will be written up as part of a doctoral thesis and may be published at a later point in an academic journal. The anonymised extracts from the qualitative parts of the survey will be used in the thesis (which is read by the project supervisors and examiners).

Once the research is completed, you will be able to request written feedback about the findings of the study -this is expected to be around July 2018.

What support is available after I have taken part?
If you have any further questions about the research project or want to discuss any issues related to the questions asked, please feel free to contact the researcher at the contact details on the first page.

Consent to participate
Should you agree to participate in the research project, you will be presented with a consent form to sign.

Ethical approval
This research project has ethical approval from the University of East London.

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

APPENDIX D: Consent form

CONSENT FORM
Polish Immigrants and Psychological Help

About the researcher:
Karina Pleitgen (Trainee Clinical Psychologist)
Department of Clinical Psychology
University of East London
Water Lane, London, E15 4LZ
Tel: (pay-as-you-go number)
Email: u1323545@uel.ac.uk

Supervisors:
Dr Trishna Patel (T.patel@uel.ac.uk) Dr Angela Byrne (A.Byrne@uel.ac.uk)

Instructions
Please tick each box when you agree with the statement attached to it.

1. I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.. ☐

2. I understand that my involvement in this study, and particular data from this research will remain confidential. Only the researcher(s) involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. ☐

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

4. Having agreed to take part, I understand that I have the right to withdraw from the research at any time without disadvantage to myself and without the need to give a reason. ☐

Name of participant	Date	Signature
Name of researcher	Date	Signature

APPENDIX E: Survey Questions

1. Demographic Information

1. Ethnicity/ nationality
1. Gender
2. Part of London currently working in
3. Do you work in (multiple options available):

3.1. The NHS,
3.2. Private practice
3.3. Private health care provider
3.4. Charity
3.5. Other

4. Are you:

4.1. A clinical psychologist
4.2. A counselling psychologist
4.3. A forensic psychologist
4.4. A psychotherapist
4.5. Other (please specify)

2. What services do you work in?

- Adult Mental Health

1. Older Adults
2. Health
3. Child and Family Services
4. Learning Disabilities
5. Other (please specify)

3. Are there any Polish psychologists, psychotherapists or counsellors in your service? If yes, how many?

- Yes (space for a number)
- No
- I don't know

4. Have you ever worked with Polish clients?

- Yes
- No (go to Q7)
- I don't Know (go to Q7)

5. In past 6 months, approximately what percentage of your clients were Polish?

6. In very general terms what issues were discussed as part of your work?

7. In your opinion, what might be the main factors contributing to the psychological wellbeing of Polish community living in the UK?

8. In your opinion, does your service meet the needs of your Polish clients?
- Yes
  o In what wa
- Somewhat
  o In what way does your service meet these needs? In what way might your service be improved in order to meet the needs of Polish clients?
- No
  o In what way might your service be improved in order to meet the needs of Polish clients?
- I don't know

9. In your opinion, what might be the main factors affecting the: **1.** Number of Polish clients referred to your service **2.** The number of Polish clients that access your service **3.** Their engagement with the service **4.** Their satisfaction with service provided
10. In your opinion what factors might affect the quality of the therapeutic relationship with your Polish clients?
11. What training and/or resources do you feel would improve your ability to work effectively with Polish clients?

APPENDIX F: Interview schedule

Experiences of psychological help

- Brief history of how and why the participant had sought help and their expectations for therapy, what service did they use, for how long, whether they experienced any barriers
- Helpful and unhelpful aspects of therapy,
- Cultural issues, i.e., whether and how cultural values held by the participant or the therapist entered into the therapeutic process.

Improving the service

- What could have been done differently
- What psychologists need to know about Polish immigrants in the UK to provide them with a better service (based on personal experiences and general views)

Polish immigrants and psychological therapy

  - Views on what factors might affect the psychological wellbeing of Polish immigrants in the UK
  - Views of what factors might affect Polish immigrants' access to psychological therapies.

APPENDIX G: Interview extract and initial coding

R: What in your view might be affecting the psychological wellbeing of Poles here?
Sylwia: Well, certainly they are far away from family home, from their families, they're kind of taken out from their environment, there might be language barriers, and certainly cultural barriers.

Attachment to Poland

Language barriers

R: Cultural barriers?
Sylwia: You see, I've noticed that Poles, we like to be in a group. Things are easier in a group. So. So, I know many Poles personally who live in groups, in Polish houses, communicate practically only in Polish. In terms of work also, you know… you work only amongst other Poles and... And, you know another thing, in Poland, it's a bit like… if you go to a psychologist - you're already kind of stigmatized, so people are ashamed. And here, I think it is more so for these living in more of a Polish circles. Because they would immediately talk behind their back: oh, they're crazy, or freaks. I suspect that these things are more common in these more Polish environments

Collective 'us'/ what are we like?

Limiting social circles to other Polish

Shame/ Stigma in Poland

Social consequences of seeking help

More stigma within Polish circles

R: Anything else?
Sylwia: I think being homesick also, missing their family. And… I know that there are many Poles here who sit here and they don't accept all these different races and cultures. Which is some one big misunderstanding for me, they can even be aggressive.

Attachment to Poland

Racism perpetrated by Poles

R: Where do you think this comes from?
Sylwia: Polish mentality is so peculiar. You know, in Poland, there are usually no foreigners, and if they are, they are usually from Romania or Gypsy travellers. Poles even in Poland fight amongst each other, even more so with some national or cultural minorities. There are some terrible comments on this subject, name-calling: you gypsies, you Jews, you this, you that. Oh Romanians have come here, you know, to work and so on. It is the same way when in here I hear the same comments about the Polish. That Poles came here, that they take away jobs and you know, it's contemptuous. I've experienced this side too.

Polish mentality: intolerance of difference

Dichotomous positions/ oppressed vs oppressor

R: You did?
Sylwia: You know, I'm a quite an open person and I have no trouble communicating with people and…

where I work, very often I was surrounded by British actually, and when I tried approaching them with, with an open mind I was somehow pushed away or aside. They didn't even want to engage with me in any way.

Rejected by locals

R: Why do you think this happened?

Feeling disconnected from the British

Sylwia: These were places where I was… the only Polish person, the only immigrant. These were very British places. Especially that the majority of people don't leave in London at all but outside London. In some small villages. And there, in those villages, there are no immigrants and you read bad things about immigrants in the press. How can it be that they came here, took away our jobs, ate swans and God knows what else, right? I don't know whether you've experienced some repercussions after Brexit, but I surely have. I don't know… some sort of dislike towards Poles, almost like racism, but it is expressed directly. Sometimes mean comments, sometimes, you know, no reactions whatsoever, they don't even acknowledge you. But…you know, Here you have to assimilate. Just like in this saying: when you walk between crows you have to croak like them. So despite everything you have to assimilate with these people. You have to blend in.

Negative media portrayals

Brexit, 'racism', hostility

Having to 'blend in' / assimila-tion

R: What in your opinion might impact whether or not a Polish person in the UK would use psychological help?

Shame/ stigma Psychology vs psychiatry

Sylwia: I think this is still seen as something shameful. It's a kind of shame associated with being judged, that you are some sort of freak or something. There's psychological help and there are psychiatric hospitals, these are two different things and you have to understand this, right? People often don't know this. And there are also language barriers. Many people don't speak English or they just don't feel confident using it. It's a real obstacle, you know? It's bad that you can't explain to the doctors what's wrong with you, but you can't even properly search for help in English. So people just end up searching in Polish. And there just isn't any info there. Also just look at my example. So, I thought that if I could choose, that I would choose someone from Poland. Maybe they would be better able to understand me. Because we have the same background and so on. And also because maybe it would be easier for me. It's just that in English I might use a wrong word to describe something, like an emotion or some other stuff, right? I think that I made a few such errors in my therapy.

Language Barriers

No information in Polish/ web

Assump-tion that a Polish psycholo-gist will under-stand better

Language barrier/ not confident

APPENDIX H: Examples of coded extracts across data set

Code	Extracts
Impact of communism/	***Tadeusz:*** *Because it is, you know, Polish mentality. Carried away from the years of Communism. Do not trust anyone. Mind your own nose [Mind your own business]. That's how we grew up and that's the way we are now. We are closed inside ourselves. Emigration might have changed some things, it opened up some horizons, but inside, I think this mentality is still the same.* ***Tadeusz****: I think that if they could understand how we used to live. Like when there was nothing, nothing in the stores. I remember, just vinegar bottles were on the shelves. And vodka! Everything was controlled by government and by the Church. You know, during the komuna [Communism]. Maybe they would be better able to make sense of how we as Polish often behave now?* ***Sylwia:*** *I will always keep coming back to those years of communism that have stupefied…demented the nation and have left a terrible mark on people, say, my age. Maybe the younger generation (…), maybe they are a little bit different. But those, you know adult people, who came here… the ones born in the 1970s and 1980s; they are still quite post-communist, closed in themselves. They were not taught this openness, because no one at school taught this at that time* ***Sylwia:*** *... it's a police country ... if the police gets their hands on you, they will beat you up. You have to be careful. That is why these people are also not so open-minded.* ***Sylwia****: Now, people are a bit more open-minded because, you know, now there are conversations about it in the media. But back when my parents were younger or grandparents, what media? There was no media and the press didn't really concern itself with such things. After all, you know everything was controlled by the government, people were hounded and uneducated and did not know much.* ***Dariusz****. Because you know in our culture, alcohol is good for everything. If you're unhappy, reaching for a bottle is like the most obvious way to cope. This is a normal part of our Polish mentality. My grandfather was a drunk, my father was a drunk. Everyone drank. And during Communism even more so. You couldn't buy anything in the shops. Nothing on the shop shelves, no food no nothing. But there was vodka! And this is also our way of thinking. You treat your sorrows with alcohol? Nobody will*

	ever think twice. Normal. But when you go to the doctor with depression then, oh then they will soon say that he is mental or a loser.. ***Dariusz**: I think they should learn a little about our history. Those years of communism, you know, that really damaged us as a nation. People have learned to live certain way, they learned certain values from their parents and they have brought these values with them here. And then they try to translate it [the values] into the local reality but here, it's a different culture. And I think that as Polish, as a nation, we are not that easy understandable to the British .* ***Ilona:** God, the whole historical and social picture, really, because, because we are… I'm not sure how to describe this…we are heavy, you know. All these years, invasions, occupations, communism. They left it's mark.* ***Ilona:** you the poverty many of us experienced during communism. You know the way we went crazy about anything that came from the west, or whatever.* *.* ***Alicja:** So when you go to an English psychologist, they must first understand... you know, we grew up in this way, and then we came here. It shaped us. And for them it is something different to what they are used to.* ***Alicja:** I don't know how ... you know ... culture in our country and those years of komuna [communism] and so on. It somehow really devastated the nation and we are what we are, right? Tired, somewhat closed in ourselves in, a little hounded... but I think that now these young generations are already a little more normal, Westernised.* ***Sara:** How old are you? 30-35? Then you know how it was like back then. The poverty, everything. It was hard being a child then. And I think this still affects people you now? My kids now they think differently. It's a different mentality.*

Code	Extracts
Cultural context not understood	***Ilona:*** *Sometimes I had the impression, for example, when I told her about problems with my father and so on, I just… you know, I felt like I'm telling her a story from Mars - she just couldn't understand, you know, what its like to have this ultra patriarchal figure at home and the alcohol problem there and so on. I felt these problems for her were, you know... so distant. I clearly saw that she was not able to understand this sort of, you can say Eastern European cultural heritage of some sort.* ***Aneta****: I think she didn't understand how the families are like in Poland. It's hard to explain but I just thought she didn't understand the culture.* ***Sara:*** *Because you know they confuse us, you know the Gypsies and Poles and other travellers. We are different. But we are Gypsies, but we are Poles too. And it's a different culture to other travellers. But after a while I even stopped explaining. She clearly knew better who I was, so what do I care.* **Dariusz:** *She did not understand that I wanted help for my ACoA syndrome. She kept suggesting substance misuse service, and I say to her but I don't drink and she just couldn't wrap her head around it. So I went online and found PPA and I found this private psychologist.* ***Tadeusz:*** *…here, you know I cannot stand that they say 'You' to everyone. I know it's different here but I still think it's rude. Like here, you know a twenty something girl, a nurse is saying to me: you do this, you do that. I could be her father…* ***Tadeusz:*** *I don't think they really knew what I was talking about. First, I thought it was because I typed in my phone and translated with Google. So not a normal conversation. But it just seemed to me that when I talked about how I lived in Poland, which my parents and all, this ,you know, what happened in the 70s-80s in Poland all that didn't really make sense to them.*

APPENDIX J1: Survey responses: migration related factors

Migration-related Factors	***Respon-ses***	***Sub-categories***
Negative attitudes of the host community	*55*	• ***Discrimination/ Racism*** *(22):* e.g. “anti-immigrant & anti-Polish prejudice and discrimination”, “Experiences of racism/ discrimination/ prejudice, societal scripts/narratives regarding people from Polish communities, which links to ideas re social rank” • ***Impact of Brexit*** (18): e.g. “Broader sense of threat in light of Brexit”, “Experiences of racism and prejudice following the Brexit vote” • ***Media Hostility*** *(15):* e.g. “the narrative of ‘they're taking our jobs’”; “xenophobic media influences”; “directly experienced hostility towards Eastern Europeans”
Isolation/ loneliness	*35*	• ***Feelings of social isolation/alienation/exclusion*** *(21):* e.g. “exclusion, & isolation”, “feelings of social isolation”, “not feeling part of local community”, “social exclusion”, • ***Separation from the family/community in Poland*** *(14):* e.g. “issues related to immigration such as separation from family and community”, “family/main social support network still based in Poland”, “Lack of access/ estrangement from family”.
Adjustment to life in the UK	*19*	• ***Adjustment/ Acculturation*** *(11):* e.g. “Identity and culture - the impact of potentially living in a new culture and the impact this may have on sense of identity”, “Fitting into a different culture and maintaining a Polish culture, as a part of migration”, • ***General migration related stress*** *(8):* e.g. “Immigration stress “, “all the usual stuff plus extra issues relating to migration”, “migration” • ***Pressure to succeed*** *(5):* e.g. “An expectation for some Polish people that they must achieve, be perfect and (…), and that they have come to the UK to succeed; Pressure of coming to UK to be "successful" - psychological impact of "failure"”, “Reasons they came to uk and how expectations are or aren't being met”
Language barrier	*14*	• e.g. “English as a second language and accessing resources”; “The ability to communicate with and understand others in order to be able to develop appropriate relationships”
Availability of support	*10*	• e.g. “social support”, “support from friends”, “connectedness with family and friends”
Lack of awareness of services	*8*	• e.g. “Lack of awareness”. “Lack of awareness of mental health services to access support”

APPENDIX J2: Survey responses: Socio economic factors

Socio-economic Factors	***Respon-ses***	***Sub-categories***
Work-related Issues	*35*	• ***Lack of employment*** *(15): e*.g. “difficulty finding work”, “difficult working conditions”, “unemployment’, “lack of employment opportunities” • ***Underpaid/ under-skilled employment*** *(10)****:*** *e.g. “*having to take menial jobs when they are actually very well qualified”, “underpaid employment”, • ***PL sample only: Professional development and job satisfaction*** *(10)****:*** e.g. *“*Opportunities for professional development”; *“*Working in trained profession and ability to stay connected to professional network”, “job satisfaction”
Financial hardship	*15*	• ***Poverty*** *(9): e.g. “poverty”, “*pressure to provide for family back home” • ***Low socio-economic status*** *(6): e.g. “*socio-economic deprivation”, “Low SES”
Housing Issues	*13*	• ***Poor Living Conditions*** *(9):* e.g. “inadequate, overcrowded housing”, “poor quality housing” • ***Homelessness*** *(4):* e.g. “Several of the Polish service users I have met have been homeless for a period of time or lived in overcrowded conditions”

APPENDIX J3: Survey responses: Cultural factors

Cultural Factors	***Respon-ses***	***Sub-categories***
Factors related to background and upbringing	*16*	• ***PL sample only: "Adult Children of Alcoholics"*** *(10):* e.g. "There are a number of individual with the ACoA syndrome amongst the 'Polonia' in the UK, and it has huge impact", "Many of the clients come with problems related to ACoA syndrome", "Many people ate ACoA, that's why there the self-help groups are so popular" • ***Background/ Heritage*** *(6):* e.g. "catholic beliefs (guilt)", "possible legacy of coming from a family background of poverty (not everyone)", "legacy of the holocaust for Jewish polish", "Negotiating living in secular country with liberal values versus having a repressive Roman Catholic background".
Support Polish community (or lack of it)	*15*	• ***Support from Polish community*** *(13):* e.g. "presence of strong Polish community in the area", "Polish churches, mass in Polish", "Connections with other Polish people" • ***Unhelpful dynamics within the community*** *(2):* e.g. "The dynamics of an expat/diaspora community, both for relationships within the family/community, as well as the issues between the Polish community and the "host" country"; "There was concern about this family being exploited within their own community, both in the UK and from poland and seemingly little action that could be taken about this"
Understanding/ attitude to mental health	*11*	• ***Different understanding of mental health*** *(7):* e.g. "Understanding/ attitude towards MH", "Different conceptualisations of mental health"" less likely due to perception of mental health services to access support" • ***Stigma*** *(4):* e.g. "expectation for some Polish people that suffering mental illness would be seen by them or their community as a failure, a character flaw", "Stigma around mental health might be greater in Polish communities than UK as a whole"
Alcohol. Substance misuse	*9*	• e.g. "alcohol problems", "alcohol and substance misuse"
Cultural differences	*3*	• e.g. "differences in parenting norms and cultural experiences", "Lack of understanding from others of cultural traditions and norms"

APPENDIX K1: Survey responses: Views about factors affecting the number of Polish clients referred to psychological services: Factors within Polish community

Factors within the community	***Respon-ses***	***Sub-categories & quotes***
Unhelpful attitudes/ behaviours	*37*	• ***Polish people not communicating their difficulties (13)*** e.g. “Potentially difficulties articulating difficulties”, “Less likely to disclose mental health difficulties due to cultural understanding of what it means”, “Whether clients ask for help or not”, “Less likely to describe MH difficulties for what they are- explain physically” • ***Help seeking attitudes of Polish people (8)*** e.g. “people's attitudes, understanding & reluctance towards mental health”; Cultural beliefs about mental health support”; “cultural influences on help seeking behaviour”; I wonder if there is a particular reluctance to seek out help as a minority expat community; some type of resistance (I mean that non-pejoratively) to seeking help from the "host" culture?” • **Stigma (7)** e.g. “I also believe there is some greater degree of stigma associated with mental health problems in Polish communities”, “Stigma of mental health”, “Fear of being judged” • ***Perceived preference to seek help elsewhere (6)*** e.g. “using community support/community organisations as an alternative”, “Lots of minorities tend to try and look after themselves within their own communities as much as possible. Seems easier for Polish people to travel home and they may be receiving some healthcare there, I know people often 'go home' for physical health care”. “They may think that we don’t offer what they would receive in Poland, which might be a different system of mental health treatment and intervention, for example hospitalisation, medication, or better than what we offer. Often when I did work with polish clients they wanted to speak to doctors and were more preferential to medication than therapy options, so may be less likely to ask for therapy”. • **Low numbers seeking help** (3) e.g. “there are not that many Polish people seeking help for psychological problems”
Lack of awareness	*19*	• ***Lack of awareness of the available services (14)*** e.g. *“*Awareness of our services among Polish people and that they can access them”, “it could be Polish clients are not aware of the NHS structure and mental health services”, “Perhaps not knowing what mental health services were on offer” • **Polish clients are unaware that interpreters are available or unwilling to use them (5)** e.g. “Unaware that there is a possibility to use an interpreter or that there might be Polish therapists within the service”, “language barriers”, “instead of using interpreters they

		may come to GP with friends/family who interpret and they're less likely to disclose MH issues)"
Practical barriers	*16*	• ***Language barriers (11),*** e.g. ***"***difficulties with language", "language barriers", "Language" • ***Not being registered with the GP (3)*** e.g. "may not be registered with GPs etc or engage with other agencies so might not get flagged up" • **Financial (2):** "affordability of private therapy", "financial"
Preference to see a Polish Professional	*4*	• **(PL only):** e.g. "they prefer to speak to a Polish psychologist"; "the nationality of the Psychologist (preference for someone who speaks their own language)"

APPENDIX K2: Survey Responses: Views about factors affecting the number of Polish clients referred to psychological services: Factors within services

Factors within the services	***Respon-ses***	***Sub-categories & quotes***
Gaps in referrers' knowledge	*18*	• ***Psychological problems not recognized by referrers (10),*** *e.g*. "It may, perhaps be due to under recognition by professionals, there is a general lack of misunderstanding regarding LD and this may be further complicated when individuals are from another country or are from another ethnicity", "Perhaps mental health problems are not as easily noticeable by GPs if there are language and cultural barriers", "GP/other agencies less likely to detect mental health need, especially if there is language barrier" • **Referrer's assumptions about Polish clients (7) e.g.** "Referrer assumptions about polish clients' attitudes towards psychological therapies", "Referrer opinions about the suitability of psychological services in the UK for Polish clients", "Ideas/assumptions about the 'psychological mindedness' of Polish clients", "Services may not refer because they hold assumptions about who the service would be helpful for" • **Limited knowledge of the Polish community (1):** "Lack of knowledge about the community in professionals (i recognise i have little knowledge about how to increase access to this group)"
Language barrier	*5*	• **Lack of resources to offer interpreters (2)**, e.g. "lack of interpreters", "it could be a lack of resources around interpretation" • **Lack of written information/ materials in Polish (3):** e.g. "It could also be because of a lack of appropriate information regarding LD and LD services in appropriate and accessible language for the community", "it could be a lack of resources around interpretation and provision of leaflets etc in translation"
Reputation of the service	*5*	• **(PL only)** e.g. "if service which is recommended by satisfied patients", "Reliability confirmed in uk organizations, high-ranked services, competent specialists", "I think if the GP surgery has a good reputation or relationship with the local community, patients are more likely to talk about mental health problems".
Racism/ disctimina-tion	*3*	• e.g. "Racism, I don't know but I could imagine it might be around discrimination against people with Eastern European labels, they may feel scared or discriminated against", "narratives around "using NHS services" and racism may reduce requests for referrals"

APPENDIX L1: Survey responses: Views about factors impacting the number of Polish clients accessing psychological services: Factors within Polish community

Factors within the community	***Respon-ses***	***Sub-categories & quotes***
Unhelpful attitudes/ behaviours	*25*	• ***Stigma (12):*** *e.g. "S*tigma - both of mental health generally and within Polish community"; "Mental health stigma", "Shame about mental health difficulties", "stigma", • ***Help seeking attitudes of Polish people (9)*** e.g. "people's attitudes, understanding & reluctance towards mental health"; "Cultural beliefs about mental health support; cultural influences on help seeking behaviour" • ***Mismatch between expectations and reality (2)*** *e.g.* ***"***expectations of services vs what services offer" • **Perceived preference to seek help elsewhere (2),** e.g. "Lots of minorities tend to try and look after themselves within their own communities as much as possible".
Language barrier	*13*	• e.g. ***"***language barriers", "Language"
Lack of awareness	*10*	• e.g "Lack of awareness by Polish Community of what is available", "Understanding of the service on offer and how to access",
Understand-ings of mental health	*8*	• e.g. "The way mental health is considered in their culture", "Different conceptualisation of mental health which doesn't match clinician's", "Different cultural constructions of mental health", "lack of understanding of what mental health is"
Concerns about psych.help	*7*	• e.g. "Psych not seen as accessible? 'The psychologist aren't like me'" "Concerns that UK psychologists will not understand Polish clients and their culture", "Concerns that UK psychologists will not work with issues of faith and religion"
Preference to see Polish psychologist	*3*	• e.g. They may have a preference for Polish-speaking therapists, My own nationality and preference for a Polish therapist
Financial	*3*	e.g. "Financial (e.g. time off work)", :Financial (in other words affordability of private therapy):

APPENDIX L2: Survey responses: Views about factors impacting the number of Polish clients accessing psychological services: Factors within services

Factors within the services	***Respon-ses***	***Sub-categories & quotes***
Referrers are not referring	*8*	• e.g. "Referrers perceptions of who benefits from psychology – often people who don't have English as a first language are disadvantaged". "Referrers may not be thinking about people within their whole context", "the number of referrals made by referrers"
Service's attitudes	*8*	• ***Making Polish clients feel welcome by the services (6)*** e.g. "beliefs about attitudes of staff or service", "How welcomed they feel", "Whether they feel welcome" • **Discrimination (2):** "Racism, discrimination – I feel Poles are often sent away without being offered any support"
Practical barriers to access	*6*	• ***Availability of interpreters and written materials (4)*** e.g. "whether there is literature in polish, whether there are translators", "providing interpreters where needed", "accessibility in terms of information and materials being translated". • **Flexibility (2)** e.g. :Flexibility, e.g. timings of appointments**,** waiting times"
Reaching out to the community	*2*	• e.g. "Lack of services outreach to Polish communities"**,** **"**We were assertive in our approach to outreach which was needed"
Culturally appropriate interventions	*1*	• "Cultural appropriateness/acceptability of any intervention"
Understanding the needs of the community	*1*	• "understanding of needs of Polish community"

APPENDIX M: Survey responses: Views about factors that might affect Polish clients' engagement with psychological services

Factors affecting engagement	***Respon-ses***	***Sub-categories & quotes***
Issues related to language	*28*	• ***General references to language (10),*** e.g. "language", "language barrier" • ***Issues around interpreters (10),*** e.g. "Ability of services to access interpreters if required". "Access to interpreter/Polish speaking therapists". "Lack of interpreting services" • ***Availability of written material (8),*** e.g. "Appropriateness of written materials"
Therapist factors	*28*	• ***Therapists' ability to understand cultural context (16)*** e.g. "doubts about the therapist's ability to understand them and their cultural background"; "knowledge of clinicians regarding any cultural influences relevant to therapy", "I imagine some service users might like to be able to choose to work with someone who has experience or knowledge of their cultural background, and although we have a Polish therapist, such choice is not given to the service users but is made by the team" • **Therapeutic relationship (12)** e.g. "How well we build a rapport with the client, attitudes of staff (or perceived attitudes), how heard and respected they feel", "hard to trust services", "quality of therapeutic relationship"
Client factors	*15*	• ***Clients' understanding of the service (5)*** e.g. "how well they understand how the NHS works", "they might be unclear what they can expect from the service". • ***Stigma (4)*** e.g. "Speaking about difficulties may reflect badly on the family", "stigma" • **Help-seeking attitudes (3)** e.g. "Cultural beliefs about mental health support, people's attitudes, understanding & reluctance towards mental health" • ***Client's motivation (2)*** e.g. "whether they really want help", "their willingness and motivation to change" ***Psychological mindedness (1):*** "Psychological mindedness of Polish clients"
Service factors	*14*	• ***Relevance/ helpfulness of the service/ intervention (7)*** e.g. "The service fit with what help or support they want/need", "Perceived helpfulness/ helpfulness of what can be offered:, "May feel service is not helpful", "Service not meeting their needs" • ***Appointment times (7)*** .g. "Flexibility, e.g. timings of appointments", "Service hours make it difficult to attend sessions for working clients".
Social inequalities	*11*	• e.g. "social inequalities can impact on engagement e.g. Poverty, housing issues, parents having to work long hours in low paid jobs, etc.", "Also the level of unmet basic needs made it difficult for families to focus on much else". "Social issues as a primary difficulty".

APPENDIX N: Survey responses: Views about factors affecting therapeutic relationship

Factors affecting therapeutic relationship	***Respon-ses***	***Sub-categories & quotes***
Therapist factors	*30*	• ***Cultural competence of therapist:*** e.g. “being able to focus on any issues which might be linked to their Polish identity such as issues of culture, acculturation, displacement, discrimination, etc.”; “Keeping cultural factors in mind”, “Awareness of political context and wider discourses that may be shaping experience”, “Whether the client perceives or whether the clinician does not understand potential cultural differences”, “We might assume that all Polish people are the same and compare them with the one or two people we met in the past which would not be ok”, “We might have a reluctance to engage with the Polish Community or to explore possible support networks out clients might have access to”, “We might assume that the client's culture was more important than it was, assuming they want to access Polish only services when they might not”.
	20	• ***Therapist’s stance/ curiosity/ openness:*** e.g. “Therapist adopting curious and open stance as cultural scripts around mental health may differ significantly”, “I would feel I should be curious when I don't think I do understand and be open and ask questions etc.”, “the therapist’s receptive stance and keenness to understand the client”, “the therapist not being interested in exploring sociocultural factors relevant to the client’s presentation”, “Willingness to discuss race and culture and difference”, “willingness to accept different perspectives, trust and power”
	11	• ***Same factors as for any other clients (11)*** e.g. I can't think of any- my relationships have been the same with Polish clients as other clients”, “I don't think they are any different to any other client group - need to be understood, feel that they are respected”, “I imagine the same factors that affect the quality of the therapeutic relationship with others”. “From my limited experience of working with the polish community, no particular factors stick out to me”. “Do not feel in a position to offer to offer such a generalised answer”. “All those that I have seen have engaged well”.
Client factors	*12*	• **Different ways of understanding mental health (5)** e.g. **“**Different way of describing and understanding emotions and mental health difficulties”. “Lack of mutual understanding over frames of reference re. mental health”. “different understandings of mental health” • **Fear of racism/ xenophobia (5)** e.g. **“**Fear of xenophobia on part of therapist?”**, “**Concerns of client around prejudices and assumptions”. **“**the individual's experiences of wider society (e.g racism, explicit or

		otherwise)". **"**There are such horrible media representation of Polish people they may think the therapist has the same view, so this may hinder the relationship". • **Perceived similarity to the therapist (5)** e.g. "the therapist also being of non-UK background (may reduce the power imbalance)", "I think having experienced migration myself, I would have an understanding of these issues"; "talking to a Polish psychologist, in Polish language, understanding of the cultural context, experience, - it increases the client's identification with the therapist and helps to develop therapeutic alliance, it strengthens transference and helps to strengthen the sense of security". • **Clients' mistrust (2):** "Trust in organisation", "mistrust of system"
Issues around the language barrier and interpreting	*34*	• **General references to a language barrier (20)** e.g. "Language", "Language barriers", "Difficulties making contact with client to change sessions due to language barrier"; "being able to speak to therapist in mother tongue" • **Access to interpreters (5),** e.g. "easy access to interpreting services", "Having interpreters where needed". "Access to interpreters who could speak and understand the dialect" • **The role of the interpreter in the therapy room (5).** e.g. "access to good polish interpreters with and understanding of therapeutic work". "I think language and the use of interpreters may affect the relationship". This includes how psychological terms are translated into polish if needed" , "Extent to which an interpreter has to be involved". • **Family as interpreters (2) "**Inclusion of family in the work". "family translators" • **Consistency of interpreters (2)** "We might not be able to provide the same interpreter each time which could cause difficulties, consistency with same interpreter may be an issue"

APPENDIX O: Survey responses: Views about how services are already meeting the needs of Polish clients

What is already being done?	***Responses***	***Sub-categories & quotes***
Overcoming language barrier	*31*	• ***Availability of interpreters*** *(28): e.g. "*We use interpreters to assist with language barriers", "Translators can be used if necessary", Translators are available to help overcome language barrier. • ***Written materials in Polish*** *(3):* e.g. "We've supported our patient & her family to obtain literature about her insulin, insulin pump & diabetes care in Polish, and psychologically, I've obtained CBT worksheets in polish", "Letters and correspondence can be translated if required"
'Standard care'	*17*	• e.g. "We would meet their needs in the same way that we would meet the needs of anyone accessing secondary mental health care", "Needs are met in a similar way to other ethnic groups - ie. services are available, but with no particular special provision around distinct needs"
Consideration of Polish culture	*13*	• *e.g. "*I think that we try really hard to offer a culturally inclusive service, including the models of therapy we use, learning from clients about their cultural construction of their difficulties etc but I think that this is always constrained by a wider organisational structure which promotes working therapeutically in a very prescriptive, narrow parameter", "We've learnt & found out about the cultural practices & diet for the Polish family; and learnt how in Poland diabetics are expected to carbohydrate count fats & proteins as well as carbs (only carbs are counted in UK diabetes care)"
Polish professional in the service	*10*	• ***PL sample only: Intervention in Polish/ with a Polish psychologist*** *(8)* e.g. "Being able to speak to someone in Polish without the presence of an interpreter", I am the only Polish psychologist within my service so any Polish clients we have would be usually referred to me. I guess sharing the language and at least some of the cultural context helps to build therapeutic relationship • ***Polish professional as 'cultural consultant' (2):****e.g."* There is Polish Trainee here if there is a need to understand cultural issues"; "We have a Polish therapist, who helps us to think about issues related to culture, and sometimes may work with Polish clients, depending on presenting issues and dynamics etc.
Links to Polish community	*2*	*e.g. "*Can offer links to local Polish community services"

APPENDIX P: Survey responses: Views about how services could be improved

What can be improved?	***Respon-ses***	***Sub-categories & quotes***
Better understanding of the community	*20*	• ***Understanding the needs of the community*** *(7)**:*** e.g. ***"***We could be more aware of the issues facing immigrants in the UK currently and try to understand the barriers people might face", "Needs assessment – e.g. would different opening hours or settings be more accessible for them? are the services we're offering relevant?", "more acknowledgement of the particular needs and adversities experienced by Polish people; albeit without wishing to stereotype". • ***Improving cultural awareness*** *(7):* e.g. "better cultural awareness", "I think that a lot of my colleagues would consider cultural differences but other staff would not think it was relevant and would not even understand where Poland was to be honest", "Not as much effort goes into understanding the culture of Polish clients compared with that of other more prevalent demographic groups in this area (e.g. Bangladeshi, Somali)". • ***Finding out if this is an underrepresented group*** *(6): e.g. "*We do not see many Polish clients and this begs the question of whether this is representative of the community or whether there are more potential clients out there who are not accessing our service and what the reasons for this might be. We need to know what the barriers are if we are to improve", More attention in ethnic monitoring - we're not even sure how many people we see
Overcoming language barrier	*15*	• ***Written materials needed*** *(6): e.g.* It was hard to find information written in polish. I don't have any info leaflets in Polish • ***Language barrier in general*** *(3):* e.g. "language barrier", Communication I don't speak polish" • ***Issues around using interpreters*** *(3)*e.g. We have to organise interpreters which isn't always ideal given Polish community so can be concerns about confidentiality, "it is tricky if translator required" • ***Polish/Polish speaking Professionals*** *(2)* e.g. "Access to Polish/ Polish speaking health care professionals would be beneficial", "bilingual workers" • ***Access to interpreters*** *(1)* e.g. Access to skilled interpreters
Links with Polish community	*12*	• ***Linking with Polish organisations/ services/ community groups*** *(9): e.g. "*We could engage with the Polish Community in London, there has been a large Diaspora in the UK for many years but the newer wave of immigration may be excluded from those who emigrated to the UK around the time of the 1950s

		following the War", I personally don't know much about issues specific to Polish clients, or whether there are any social groups/activities/voluntary services for the Polish community in this area", "Partnership working with Polish organisations" • ***Service user involvement*** *(3):e.g. "*better representation of service users and families in service development and review", "Could include service users and ask them what can we do better?"
Improving awareness of psychological services	*7*	• ***PL sample only****: e.g. "*Reaching out to Polish community to improve their awareness of services available within the NHS", "advertising psychological services amongst local 'polonia'", "Making the community aware that there are services, to which they are entitled free of charge and that interpreters are available. That they don't need to worry about paying for therapy or language barrier".
Wider organizational structures	*1*	• "I think that we try really hard to offer a culturally inclusive service, including the models of therapy we use, learning from clients about their cultural construction of their difficulties etc but I think that this is always constrained by a wider organisational structure which promotes working therapeutically in a very prescriptive, narrow parameter".

APPENDIX Q: Survey responses: Training and resources needed.

Training & Resources needed?	***Respon-ses***	***Quotes***
Cultural awareness/ competence training	*39*	• ***Knowledge about Polish culture*** *(13):* e.g. "Some more teaching on polish cultural beliefs and practices", "cultural learning, shared language", "More knowledge about Polish culture, I think people might be unaware of the history of the Polish people, and their involvement with the UK, perhaps some information on history might help to enrich our understanding and see the unique relationship that the UK has had with Polish people particularly before Poland's EU entry" • ***Cultural competence*** *(13):* e.g. "Just some basic cultural competence", "Cultural competence training" ***"***Training about: the patterns of immigration from Poland to the UK, e.g. what were the most common reasons for the move; and difficulties faced by the Polish community living in the UK", "Information around (...) common experiences of life in the UK, experiences of discrimination etc","I really wanted to try to understand the context and experiences of the polish Roma community from an independent source", "It would be good to know more about help-seeking and ways of coping, including how services are in Poland. Diversity within the community – e.g. different generations, different issues facing first and second generation people", "Possibly an understanding of legal/social implications of Polish people living here and working without paying tax or national insurance and what impact this has on social or health care allowance that they qualify for, as this is an issue I come across most in my line of work. This applies to any EU member and would be of particular importance given Brexit". • ***Understanding of mental health*** *(4):* e.g. "how mental health/wellbeing is viewed in the community", "training in polish culture and associated trends around understanding health including mental health"
Links with Polish community	*23*	• ***Feedback from Service Users*** *(10):* e.g. "Polish representation in service user networks", "Hearing from Polish clients what has been helpful / not so helpful for them about the service", "Training in psychological formulation which would ensure the incorporation of both individual intrapsychic factors AND cultural and social factors in how we understand the service user. We could actually ask some polish people, or community workers to come and talk to us", "We could ask service users themselves what they would like and how they would like us to have more understanding, services, knowledge etc" • ***Links to Polish organisations/ community groups*** *(8):*e.g I think that there is an opportunity for other organisations to aid statutory organisations in learning more about how to provide health care which is accessible to Polish people, onnection with local Polish

		community groups, Seeking consultation, It would be good to know about Polish community-organisations that we could work in partnership with • ***Polish Psychologists as 'cultural consultants'*** *(5)* e.g. More colleagues whom I might be able to consult with on issues of Polish culture, Having colleagues from culturaly diverse background and working with them in supervision or other setting.
Overcoming language barrier	*11*	• ***Translated materials*** *(8)* e.g. "translated leaflets and resources (eg. we use youtube videos sometime in the work or give information about child development but the main I know of are in english, I would have to hunt for Polish resources)", Potentially some Polish language resources for clients to read/ worksheets, which may be more meaningful to the client • ***Skilled interpreters*** *(3)* e.g. "Good quality interpreters", "Being able to work with interpreters who can provide a perspective on pertinent cultural issues and perceptions of various things is really useful on top of basic interpretation".
CPD/ specific therapeutic modality	*9*	• ***PL sample only:*** e.g. "training which would allow to expand current knowledge, Personal development of a therapist", "training in systemic theory", "Workshops about burnout", "training in 'RDI Method'", "CBT training"
No training/ resources needed	*5*	• *e.g. "*Personally, I cannot really identify a specific training need. If I was seeing a client where some cultural aspect that I did not understand influenced the work, I would research it", Don't think there is anything in particular. If I need to speak to Polish psychologist, I have colleague I could probably approach. If there are any particular issues I can take to supervision and we can make a decision as to how to progress.
Supervision	*4*	• ***PL sample only:*** • e.g. "access to supervision", "regular supervision"
Research	*3*	• e.g. "more research into the needs of this population", "Research into any specific factors which may influence access, engagement and experiences of mental health or other psychological services"
Other	*1*	• "Less training, but more explicit permission to work therapeutically in a less prescriptive manner"