

Full Length Research Paper

# Perspectives of mental health professionals on treating refugees and asylum seekers in the United Kingdom

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Questions about providing mental health care to forcibly displaced individuals in an effective way have long challenged experts (Karachiwalla, 2011; Miller, 1999; Blackwell, 1989). Concerns about the suitability of providing psychological support in the context of significant instability and about the efficacy of Western-derived treatments for an overwhelmingly non-Western population are at the forefront of contemporary disagreements in the field (Miller and Rasmussen, 2010; Neuner et al., 2002). Yet little is known about the perspectives the clinicians who treat forcibly displaced individuals, namely refugees and asylum seekers, hold about their work. The following study presents the results of a qualitative investigation in which five semi-structured interviews were conducted in 2011 with clinicians treating displaced individuals in the greater London and Cambridgeshire areas. These interviews were analyzed using interpretative phenomenological analysis (IPA). The findings convey how professionals practicing with this population maintain a positive outlook on the efficacy of their treatments. While the group attributed some barriers to cultural differences, they also identified the two essential prerequisites of *understanding* and *interest* on which successful counseling was predicated. The participants offered insights into how they view the acculturation process as having a beneficial impact on their clients' ability to make gains in counseling.

**Key words:** Refugees, asylum seekers, mental health, counseling, psychotherapy, IPA, acculturation.

## INTRODUCTION

The number of forcibly displaced individuals around the globe totaled 35.8 million at the end of 2012 (UNHCR, 2013). Of these, approximately 900,000 were seeking asylum and over 836,000 individuals had been granted resettlement status in the developed world in the preceding ten years (UNHCR, 2013). In the United Kingdom, the number of individuals living as a refugee, asylum seeker, or as stateless comprised approximately

0.33% of the national population as recently as 2012 (Silverman and Hajela, 2012). Mostly, the refugees and asylum seekers in the UK have been arriving from Afghanistan, Iran, Pakistan, Sri Lanka and Eritrea (Blinder, 2013)—countries that have been either enduring serious conflict or struggling with significant human rights abuses.

Irrespective of legal status, resettling refugees and

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Abbreviations: Interpretative Phenomenological Analysis – IPA; General Practitioner – GP

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asylum seekers often arrive to lives defined by financial insecurity, legal confusion and cultural alienation. Typically lacking established social networks, employment opportunities, safe housing, familiarity with the English language and social customs, this group faces poverty, isolation and, for asylum seekers especially, an anxiety-provoking series of legal negotiations. Yet for all these challenges, government services take care to provide refugees with the same access to social services as resident aliens and to support them in connecting with the basic needs of housing, food and education that may not have been available to them before. Those who arrive to the UK seeking asylum are currently afforded Asylum Support so long as their application is under review, which includes basic access to housing (not in an area of their choosing), education for minors and a modest cash support stipend of 36 pounds per week (UK Border Agency, 2014). Until their claims are processed, asylum seekers must also endure the waiting game of not knowing the outcome of their application. Included among the services offered to both refugees and asylum seekers is access to health care through the National Health Service (NHS, 2013).

If a psychiatric need is identified, refugees and asylum seekers in the UK are typically referred to mental health services by a General Practitioner (GP) or by the Refugee Council's Therapeutic Casework Unit (Refugee Council, 2014)<sup>1</sup>. Despite their apparent availability, the process of gaining access to these resources can be a confusing process fraught with bureaucratic complications and language barriers. For asylum seekers, concern over legal status pervades, and can take priority over addressing mental health needs, especially in the first months and years after arrival (Lopez and Guarnaccia, 2000). There is also a possibility that providing the highest standard of care for this particular group, largely comprised of ethnic minorities and exclusively of foreign-born individuals, is further complicated by an implicit provider bias (Blair et al., 2013), whereby individuals of an ethnic minority are at risk of receiving lower quality care and attention from their providers. Provider bias by physicians has also been

identified in the context of the treatment of individuals with serious mental illnesses (Stuber et al., 2014), suggesting that war-affected, ethnic minority refugees or asylum seekers who are also suffering from significant mental distress may be at an even greater level of risk for facing barriers to care at multiple levels.

While refugees and asylum seekers are living in unstable situations—either temporary or protracted—the appropriate role of the mental health service provider may seem difficult to determine. As a result, refugee mental health has been at the center of an ongoing debate about the ethics of treating displaced people from non-Western backgrounds with psychiatric medications and therapies developed in the West (Summerfield, 1999; Bracken et al. 1997, Miller and Rasmussen, 2010)<sup>2</sup>. Underlying this debate is the complicated question of how and to what extent it is appropriate to treat refugees and asylum seekers—individuals who are overwhelmingly of non-Western origin—with treatments, such as narrative exposure therapy, EMDR, and traditional insight-oriented talk therapy, all treatments that have been developed by Western clinicians and scientists on individuals of largely Western origin. An additional and particularly heated point of contention is whether or not it is appropriate to apply diagnostic categories developed in the Western psychiatric system, such as Post-Traumatic Stress Disorder and Depression to certain war-affected populations (Summerfield, 2000; Gilbert, 2008). Several experts in treating displaced individuals in the UK have emphasized how mental health practitioners may be most helpful in advocating for their clients when political and legal issues arise in the aftermath of human rights abuses and how at times this duty may take priority over the psychotherapist's more traditional role of alleviating emotional distress (Summerfield, 2000; Patel and Mahtani, 2007). The challenge in determining the appropriate way of integrating mental health treatment into the overall support extended to refugees and asylum seekers stems not only from the many social and legal pressures facing this group of patients, but also from what mental health care providers identify as their feelings of helplessness in providing support to this particular group (Patel and Mahtani, 2007). Such challenges in determining the significance of mental health treatment in a time of significant transition and often upheaval brings to mind Maslow's Hierarchy of Needs, a framework that is often engaged in the literature about prioritizing the needs of refugees and other similar populations of concern (PHPCR, 2004; Meredith et al., 1986; Maslow, 1987).

<sup>1</sup> Though they are often grouped together in the relevant scholarly literature, refugees and asylum seekers occupy distinct legal positions—refugees enjoying far more legal stability than those still seeking asylum. In the mental health literature, resettling refugees and asylum seekers are often grouped together as having a similarly unique risk for mental health problems associated with relocation, fear of persecution, and histories of trauma (Bhugra et al., 2010), and who can benefit from similar therapeutic approaches (Drozoek & Wilson, 2004; Kohli, 2008). Similarly, the United Kingdom's Refugee Council approaches mental health treatment for refugees with leave to remain and those going through the process of applying for asylum in a parallel way (Refugee Council, 2014). Despite this significant crossover in the literature and service sector, however, the literature does not always group these two categories of forced migrants together. In particular, investigators have paid special attention to the mental health implications of the increasingly common practice of detaining those seeking asylum in industrialized nations (Silove et al., 2001; Robjant et al., 2009).

<sup>2</sup> While the terminology designating a person 'Western' or 'non-Western' in reference to origin or culture bears strongly on the debate about refugee mental health, these terms should only be engaged with an understanding of how they risk reducing a person's identity to his region of birth, religion, skin tone, and native language. 'Non-Western' is used here to describe a person who, due to his country of origin and cultural upbringing, is likely to have not encountered the types of psychotherapy practiced in the mainstream health services in the UK.

The leading solution for addressing the challenges of providing effective care to this unique population is to provide treatments that are culturally sensitive and that are facilitated by practitioners skilled in treating patients of diverse ethnic and cultural backgrounds. 'Transcultural' counseling, also known as 'cross-cultural' and 'multicultural' counseling, an established facet of the mental health treatment literature (Johnson and Nadirshaw 1993; McFadden 1999; Van Beek 1996; Pedersen 1985), focuses on the importance of training practitioners to be multiculturally competent, culturally sensitive and aware of how cultural dynamics might play into identifying psychopathology, a client's experiences of distress and treatment processes (Sue and Sue, 2012). This perspective is well integrated into the literature on best practices of mental health care for refugees and asylum seekers from non-Western backgrounds (Hinton et al., 2012).

In essence, transcultural counseling is not structurally unique to other forms of counseling and therapy. As d'Ardenne and Mahtani (1989) explain in their book on the subject, this type of counseling "is not about being an expert on any given culture, nor does it adhere to a particular school of counseling. Rather, it is a way of thinking about clients, where culture is acknowledged and valued" (1989, p. x). In other words, being skilled in transcultural counseling implies that the practitioner is aware of the ways in which his or her client's cultural background might influence the counseling dynamic. Embracing a 'client-centred' approach, it follows that all factors—not just a client's cultural background—but her gender, age, occupation, race and educational level would be relevant and valued within a culturally aware therapeutic relationship.

Perhaps most critically for this investigation, the literature of transcultural counseling acknowledges how working with clients of many different cultural communities often presents several unique challenges that, when not addressed, can lead to a less beneficial outcome. These challenges include language barriers, conflicting world views, differing perspectives about the origins of mental distress, as well as the relevance of the client's past in explaining his or her distress (d'Ardenne and Mahtani, 1989). Yet, by no means do these challenges render therapy across significant cultural differences a fruitless exercise. In fact, the literature emphasizes how the factors that facilitate successful therapy cross-culturally are identical to those that render therapy effective in any context. Mostly, these factors relate to the strength of the therapeutic relationship, the importance of the client and counselor sharing common goals for therapy, as well as to the importance of the client and counselor having a shared understanding of the sources of the clients' suffering (Frank and Frank, 1993; O'Mahony and Donnelley, 2007). In a transcultural context, d'Ardenne and Mahtani emphasize how the

basic skills of good listening, "facilitating understanding, managing problems" and maintaining a "focus on feeling" is paramount for success (1989, p. 38). These skills enhance the strength of the client and practitioner's relationship and pave the way for the mutual understanding that is essential for supporting the client's therapeutic change.

Overall, it seems that in the context of mental health treatment, a client's cultural background can be understood as an indelible, influential and sometimes challenging factor in a therapeutic relationship. And yet, the role of a client's culture in counseling should not be overstated. Alarcon et al. caution mental health professionals from 'overculturizing' the client's symptoms of distress because in the process they may run the risk of trivializing concerns of a truly clinical nature (1999). A professional who is skilled transculturally should be able to discern whether cultural factors explain a particular behavior or rather influence the particular manifestation of a client's distress (Alarcon et al., 1999).

Despite the well-developed literature on addressing the mental health needs of refugees and asylum seekers, surprisingly little has been contributed to the conversation by the mental health professionals who regularly treat this group. In other words, only a handful of the primary voices in the conversation come from the professionals working in refugee camps abroad or the clinics serving asylum seekers living in the cities of the Western world. One study, conducted in Alberta, Canada by O'Mahony and Donnelly in 2007 examines the way immigrant women in Canada seek help for mental health needs by interviewing mental health service providers. They found that language difficulties, unfamiliarity with services, gender issues and socioeconomic factors all played a role. In Finland, a similar study investigated the perspectives of asylum seekers and the physicians, social workers and nurses providing treatment in order to understand how the clinicians' level of 'transnational competence' influenced the asylum seekers' experiences of health care (Koehn, 2005). While these studies privilege the perspectives of the clinicians engaging in treatment with the immigrants in Canada and the asylum seekers in Finland, they do so in the spirit of uncovering information about the service users. Contrarily, this investigation pursues a comparatively *reflexive* goal: to understand how professionals perceive the treatment with refugees and asylum seekers in the context of mental health care in the modern industrialized world. Therefore, the findings taken from this investigation will not venture to make claims about the service users themselves, but will shed light upon the mechanisms of psychotherapy through the lens of the practitioners. This study focuses on obtaining the valuable perspectives of the mental health practitioners who work with this unique population directly, in hopes of ascertaining their opinions on how the theoretical and academic debates referenced

above play out in the therapeutic process. In order to understand the *processes* of mental health treatment with this group, engaging the perspectives of the service providers will yield valuable insights into the broader debate about how to best address the mental health needs of the refugee and asylum-seeking community.

## MATERIALS AND METHODS

Interpretative phenomenological analysis (IPA) was chosen as the best-fit methodological framework for collecting and analyzing data. Interpretative Phenomenological Analysis, according to Jonathan Smith, the psychologist who developed it, is “a qualitative research approach committed to the examination of how people make sense of their major life experiences” (Smith et al., 2009, p. 1). Although the method’s roots are firmly rooted in psychology, it is increasingly used in the health sciences and social sciences as well (Smith et al., 2009). Its philosophical underpinnings are derived from phenomenology and hermeneutics and it therefore stresses the importance of understanding lived experience and also the importance of interpreting these experiences from an outside perspective. Like grounded theory, IPA offers an inductivist approach to research (Smith et al., 2009). Given that I was planning to ask questions during interviews that would invite psychological, insight and perception-oriented answers from the participants, IPA seemed like a strong methodological fit, both philosophically and practically.

Consistent with IPA, purposive sampling was used to contact potential participants, specifically by calling government agencies and charities involved in migrant mental health care. Five participants practicing in the Cambridge and London areas were identified and interviewed in the spring of 2011. Prior to collecting data, the interviewer (the author of the present study) had received graduate training in conducting qualitative research encompassing interviewing methods. While the five participants whose data was used is homogenous because they all regularly provide mental health treatment to asylum seekers and refugees, demographically and professionally they are quite diverse. Of the five, four identify as non-British migrants from Zimbabwe, Saudi Arabia, Iran and Albania. The British-born participant is a white Caucasian male; the other four are female. One participant is a doctorate-level clinical psychologist, another a certified nurse practitioner and the other three are masters-level counselors. All signed consent forms acknowledging the voluntary nature of the study.

A small sample size was chosen in keeping with the ideographic approach of IPA, which focuses less on identifying nomothetic trends across a larger sample and more on the perspectives of individuals. Smith recommends that three to six participants is a reasonable size for a sample with a project of this scope (Smith et al., 2009). Samples in this range, he explains, provide enough variation across participants to develop a multifaceted understanding of the phenomena under investigation, while they are also small enough to allow space and time for deep qualitative analysis without being overwhelmed by material.

To ensure consistency throughout the interviews, an interview schedule was developed with a set of ten questions, each with follow up prompts. Questions for the semi-structured interviews ranged from the broad (“What are your goals when working with your clients?” and “Without revealing any sensitive information, can you describe a recent case you’ve had with a refugee or asylum seeker?”) to the more targeted (“What differences do you identify between your refugee and asylum seeking clients and your clients who were born here?”). For the most part, the goal was to

investigate guiding research questions with each participant by asking questions of them in a sideways manner – one that would encourage the interviewee to speak freely about their perspectives on relevant topics. An identical interview schedule was followed with each participant, giving the interviewer maximal control over each of the interview sessions, and strengthening the reliability of the data acquisition process (Smith and Osborn, 2008). By nature of their candor-oriented profession, this group of mental health service providers were easy to develop rapport with quickly and demonstrated no hesitation answering probing questions within minutes of meeting. The interviews ranged from 37 to 69 minutes in length, depending on the schedule of the participant. Overall, the flexibility allowed by the semi-structured interview supported the inherently subjective task of learning about the participants’ “lifeworld” (Smith et al., 2009) in regards to their work as therapists.

Following the guidelines set by IPA, my analysis of the five interviews encompassed four major phases. With over 35,000 words of transcription, I had to be selective as to which material I would highlight in the results. With each step, as recommended by Smith (2004), the analysis moved farther away from the transcripts and relied increasingly upon independent interpretation of the data. First, after several readings of each transcript, initial observations were made in the right-hand margins, noting descriptive, linguistic and conceptual details in the interviewees’ commentary. The second phase of analysis drew from the initial set of comments and focused on the development in the left hand margin transcripts of ‘emergent themes’ – the basic units of observation, or what Smith et al. describe as a “concise and pithy statement” (2009, pg. 92). Such themes include observations such as “challenge of differing expectations” and “poverty compounding problems,” statements that are generally not longer than four or five words and that go beyond basic paraphrase to offer a first level of interpretative commentary. Third, the analysis moved to grouping each of these emergent themes into broader categories and mapping how they relate (Smith et al., 2009). Up to this third phase, analysis had been entirely independent within each case. In the fourth stage I considered categories of themes across cases in order to develop an understanding of inter-case patterns. With each step the analysis moved farther away from the transcripts and relied increasingly upon my interpretation of the data. Only after the most salient inter-case patterns had been identified did the analysis return to the transcripts to identify the quotations from each interview that would best illustrate the superordinate themes explored below.

## RESULTS

Four primary findings emerged from the interpretative phenomenological analytic process. First, from the perspective of the participants, beneficial counselling with refugees and asylum seekers appears to be dependent upon a) a client’s awareness of what counselling involves and can realistically achieve and b) the client’s willingness to engage with services. Second, the participants do not necessarily perceive their client’s cultural background to be a pressing factor in the context of therapy—unless it prevents the client from being able to comfortably engage with services. Third, while the clinical themes of diagnosis and trauma inform the way the service providers perceive their clients, they refrain from using this language with clients, and typically only

engage it on a systems level with other professionals. Finally, the participants identify time as an important factor on how they understand that their clients are able to engage with services. They perceive that those who have been in the UK long enough to have stability, and who have adjusted and acculturated to some extent, seem better served by counselling services. The following analysis outlines the four primary findings, supporting each one with quotations directly from participants. Pseudonyms were used in place of the names of the five participants to maintain anonymity.

### **Theme 1: Two Perceived Prerequisites for Beneficial Treatment**

The first finding addresses the question of whether or not the participants perceive counseling as an effective method of addressing the mental health needs of refugees and asylum seekers in the UK. The analysis suggests that while the sample believes that productive counseling can occur with refugee and asylum-seeker service users, it is contingent upon two fundamental conditions: a) that the service users are aware of what counseling involves, and b) that they are willing and interested in engaging in with it.

Asking the participants if they felt the counseling and therapy treatments they provide are effective with their refugee and asylum-seeking clients elicited a range of reactions. Some were unabashedly positive, like Pauline, a Saudi Arabian counselor who reflected on her fifteen years treating clients in exile saying, "from my experience, I could see that it worked with a lot of clients, and it helped." But according to the broader sample, when refugees and asylum seekers first engage with mental health services, they appear to represent the full spectrum of awareness about what counseling involves. Some appear to have never heard of the concept of talk therapy before, and others, according to Julia, have "read the books" in their native language to the point of being able to define psychological terms. Guy, a clinical psychologist who has worked extensively with teenage Afghani asylum seekers, describes some of the barriers he has faced:

Guy: ". . . the Afghani group . . . they probably have no idea why they're coming to see me."

The challenges posed by this lack of initial awareness are compounded by the limited formal education his Afghani patients have:

Guy: "You know a lot of them have no education and no understanding of the mind and the body . . . I think trying to have a shared understanding of what's going on is helpful."

As he suggests here, educational levels pose an additional challenge to developing the shared understanding between service user and provider that is a pillar of productive treatment. The participants explain how the process of familiarizing refugee and asylum-seeking clients who are new to counseling takes time, and can delay the momentum of the therapy itself. Ella, a nurse employed by a UK government agency that addresses the needs of asylum seekers and resettling refugees, explains about her work caring for the psychological needs of recently arrived individuals:

Ella: ". . . a lot of work goes into giving them information about what the counseling entails or what are the benefits, how this will help [sic]."

After the service providers establish an understanding about counseling, the decision is then left up to the service user about whether or not counseling is worthwhile. Once again, refugees and asylum seekers appear to fall at all points along the spectrum of interest. Some clients seem to trust the process from the beginning as an effective method for addressing their needs. As Pauline explains:

Pauline: "They think it's good and, you know, they don't care, they just, they trust it."

Yet others reject the notion of counseling entirely. Ella describes her work assessing new arrivals and explaining the psychological services she offers:

Ella: "It's not unusual for me to sit there, do a full health assessment and a person tells me, 'I don't want anything you are offering.'"

Guy reflects on the high rate of attrition among the Afghani adolescents whom he treats:

Guy: ". . . so once we've got over that barrier [of establishing what counseling involves and can achieve] . . . I would say that about fifty percent are engaged in coming back . . ."

More than any other indicator, participants perceive attendance as a signal that therapy is engaging their clients in a way they perceive to be helpful. Two of the five participants, when asked to describe one of their current cases with a refugee or asylum-seeking client, detailed their experiences with male clients who they did not recognize as being well situated to gain from counseling, but whose unbroken attendance alone convinced them otherwise.

Margaret: ". . . he's coming to the session. It means quite a lot . . . he's never missed a session and never came late, to me . . . that says something."

Along similar lines, Julia describes one of her experiences:

Julia: "I had a client who kept coming . . . and every session he just talked about how he cannot bear to be away from his wife . . . no more depth . . . but then I realized he's in such a low place that coming and sitting and saying how awful he feels . . . it was a release, so I think that for him it was holding him on."

When asked to explain what makes the difference for clients who return, Pauline explained how, beyond mere consent, she perceives that her clients who come back have a sincere *desire* to get better, and they accept therapy as a means of reaching that goal.

Interviewer: "And for those people [who find counseling helpful], what do you think makes the difference for them?"

Pauline: "I think it's the desire or the need, you know? I think, the need, there is a decision. And there is, there is something there. You know, 'I have to do something about it.'"

## Theme 2: The Disputed Significance of Culture

The second finding relates to the question of how the interviewees understand the impact of their clients' cultural background on the therapy process. The interviews reveal a significant range of opinions on this matter even within individual cases, ranging from perceiving culture as having no significant impact on therapy, to attributing the difficulty of counseling with refugees and asylum seekers almost entirely to cultural differences. Several participants readily proclaimed how their techniques have the potential to be universally beneficial for clients willing to engage. Yet, paradoxically, the participants also attributed various barriers to effective therapy to a client's cultural background including language differences, a client's reluctance to 'open up,' and the perceived causes of distress.

Most of the study participants identify their work as following client-centered principles of counseling. Pauline describes one of her primary techniques as "person-centered;" Julia explains how, "I don't think I determine the goal [of counseling] . . . I think the client determines it;" and Margaret notes how, "for me it's all about giving [control over sessions] to the client." Ella also perceives her work with the UK government agency to be client-centered in that it focuses on addressing the broad needs of each newly arriving refugee and asylum seeker. In the context of such client-centered work, they seem to think of their client's cultural background as being largely irrelevant given their shared regard for the universally applicable nature of their work.

Margaret, after establishing that she draws upon psychodynamic techniques within her "integrative," client-centered approach, was asked about whether or not she finds that the Western influences of the psychodynamic counseling she practices clash with her client's cultural background. She articulates her objection to the notion that her methods would work less well with a client of one culture versus another:

Margaret: ". . . to me it's no difference whatsoever. It's all about the core of it that whatever we went through in childhood, or whatever is something, an event that effected our life, and how it is effecting our present. . . it doesn't matter what language you work in—if that is the core of the work that you do . . . it doesn't make a difference to me, it's not at all to do with the culture [sic]."

In addition to adopting client-centered principles, three out of the five interviewees explain that they draw upon psychodynamic theory and treatment practices, which involve reflecting on developmental experiences to make sense of a client's current situation. Yet what is notable in Margaret's commentary above is that, like Julia and Pauline, she believes that the specific therapeutic ingredients she brings to the counseling dialogue are the agents of change for her clients. Understanding and willingness may be prerequisites, but the therapeutic treatment she offers is what she believes truly enables a client to heal.

When asked about their perspectives on using therapeutic techniques derived largely in the West, participants expanded upon how easily they perceived their approach as translating, even with asylum-seeking and refugee clientele. Julia explains:

Julia: "Psychodynamic models is just one model, and other models are more or less telling us the same thing as that really from whatever aspect we look at, more or less we're going back to childhood and unmet needs, and how does it affect us, how do we develop our personalities, so, no . . . I'm getting it from a different level not necessarily intellectual level, but emotional level so it's possible for others so I'm not necessarily communicating something, not on the intellectual level but on the emotional level [sic]."

She seems to say that psychodynamic therapy can be used with anyone so long as the client is able to connect emotionally. Pauline offers another insight on how she perceives her specific repertoire of techniques, influenced by "Islamic counseling," has wide-reaching potential, regardless of her client's cultural or religious background:

Pauline: "I think I use some aspects of Islamic counseling . . . Now the Western approach, it's more to mind and body. The Islamic approach is more to heart, body and mind. Everything, starts from the heart in the Islamic

approach. Which I do believe, because, I could see when a client comes, and says, 'you know, we feel empty here' [gestures to chest], they don't say we feel empty in the head. We think about it, but where is the feeling? I go by the heart to be honest. And I invite the client to talk about what they're feelings in the heart . . . how does it feel [sic]."

These perspectives on the universality of therapeutic techniques do not consistently represent the whole sample. The participants, including those above, highlight the barriers to effective treatment they have encountered with their refugee and asylum-seeking clients, many of which they attribute to cultural factors. At the broadest level, Guy identifies culture as the greatest factor distinguishing his refugee and asylum-seeking clients from his British-born clients. When asked about the biggest differences between his two client groups, Guy explains:

Guy: "Well, there's just millions of differences aren't there. Just the language barrier as well, the cultural things, the educational levels and most of the people in Britain aren't experiencing culture shock and you know the kind of asylum process and missing their family and all that, their family life."

In explaining how he understands that these differences are impacting the therapy process itself, Guy explains how "I think our goals and expectations are very different." Drawing on the first theme relating to how participants perceive effective therapy as dependent upon clients both understanding and investing in treatment, Guy highlights how he understands that cultural factors are often linked to clients not necessarily understanding the goals and parameters of talk therapy. The data suggest that another way in which cultural background may influence how refugees and asylum seekers engage with services relates to how the participants perceive their comfort level with talking during counseling sessions. Margaret explains how she links culture with the ease she recognizes among some of her clients:

Margaret: "It can effect, the culture, in a way because when it effects, or when the culture comes in, and effects the *work* that you do it's because some cultures find it very easy to talk about things. Because they're raised in that environment where people are free to talk, no one judges—people will not be as judgmental as in some other countries for example where you do not talk about things with other people [sic]."

In other words, Margaret understands that the pre-existing openness of a client to talk during counseling can be either a benefit or a hindrance. In this way, Margaret

suggests that cultural background can aid or curb the potential ease with which a refugee or asylum seeking client first engages in the therapeutic process. Guy describes how this factor has been a hindrance to his work with Afghani youth:

Guy: "I think they just don't really understand why talking can be of any help. I think they kind of mix up the idea that if they talk about their difficulties it's going to make things much worse. So they'd rather just avoid . . . I think it's just a coping style really."

Julia elaborates on the specifics of the communication challenges:

Julia: "They see you as the expert and want you to draw things out of them, so they're not always able to even if they want to because of their level of education and their background, and they're not even open—especially if they're men—they can't open up. So they sit there and say, 'yes Madame, you are asking a question, how can I be?' literally, 'what can I say?' And so you just have to guide them along and ask them questions . . ."

Even though this perceived uneasiness with opening up in counseling can function as a barrier to effective therapy, it is not necessarily an insurmountable one. Julia describes the transformation she has witnessed:

Julia: "When they open up they really open up, not all of them, women talk faster, but uh . . . yeah they do, they do talk about really intimate issues that they had never been able to speak about with any friends or anyone."

The participants perceive how ideological factors can also impede refugee and asylum-seeking clients from engaging with counseling and associated medicated interventions. As Ella explains, conflicting attitudes towards the etiology of mental health problems can interfere with a client's willingness to engage:

Ella: "If they don't view their condition as a biomedical or pathological condition it's so hard to convince them to take medicine if they think it's an evil spirit or punishment from a divine entity that is causing their problem."

This aversion plays out especially when refugees or asylum seekers are prescribed medication from a GP:

Ella: "There's just a concept about needing a pill to have your mind function that's difficult for a lot of people to think 'gosh, I'm so reduced to needing this pill for my head to function properly.'"

Indeed, stigma against mental illness and psychiatry plays a significant role in a patient's willingness to engage. While such stigma may not be unique to non-



British clients, it certainly seems pronounced in the participants' views of their refugee and asylum-seeking client.

### Theme 3: Differing Idioms of Distress

Keeping counseling diagnosis- and label-free in the therapy room may be a useful practice to follow with clients new to psychotherapy regardless of whether or not they are refugees. But with this particular population, the importance of "talking the language [clients] can understand," as Margaret strives to, is made all the greater because of the differing idioms of distress that clients may use. Guy explains how in his practice, Guy:

"Well you know the language that we use in the West such as depression or post-traumatic stress disorder is not what's used in the villages of Afghanistan. They express their distress very differently."

Because of these differences, the necessity of the practitioners to communicate effectively with their non-British born clients becomes all the more pronounced. Guy explains how, especially with an interpreter, this can be a challenging balance to achieve:

Guy: "So that's really important that you can trust the interpreter's going to be describing things, using the language that the patient is using . . . so if a patient says he's using the terms to describe what I would describe as depression, but they're using a phrase like 'I have a heavy heart' . . . then I could be using that language for that . . . so, it's really important to use the language that they're using to describe what's going on."

Once again, the data demonstrate how the participants encounter differing languages of distress with their refugee clientele. To what extent these linguistic differences reflect contrasting experiences—in this case in regards to the experiences of depression and having a "heavy heart"—is hard to know.

Post-traumatic stress disorder (PTSD) has an especially prominent focus for any mental health study involving refugees and asylum seekers, and this study proved no exception. What did stand out, however, is the range of perspectives the participants demonstrated on how applicable such a diagnosis is for their clients. On the one hand, Julia seems not to question the efficacy of giving her clients the PTSD label during her interview:

Julia: "There are certain issues especially with Afghans, there's a huge amount of PTSD because they've experienced war and brutal killings and so on, and so there really is quite deep PTSD traumas . . . often they've either witnessed rape or have been raped but they're not quite able to talk about it . . . [sic]".

Guy appears to have a half-hearted commitment to the concept of PTSD in relation to his clients, choosing not to label them as having PTSD, but rather as demonstrating "quite a lot of PTSD symptoms." Ella suggests that the assumption that her clients are ill due to their traumatic experiences is questionable altogether. Echoing some of the ideas presented by Summerfield, Ella speaks to the importance of distinguishing between those who are truly traumatized and those who are having natural, healthy reactions to very negative experiences:

Ella: "there's . . . a split between people who are traumatized, for lack of a better term, post-traumatic stress issues, and then people who've just been effected by bad experiences, so, a lot of our assessments go into determining their viewpoint, because surprisingly a lot of people don't actually view the experiences as illness or as pathological [sic]."

Not only does she suggest that the "post-traumatic stress" terminology is somewhat impoverished, but she emphasizes how the client's perspective as to whether or not they are actually ill is an important part of the assessment and treatment equation.

### Theme 4: Adjustment and Acculturation Facilitating Ease with Counseling

Perhaps the finding most pertinent to the broader debate about talk therapy as an appropriate treatment for refugees and asylum seekers is the forth observation regarding how participants perceive that a client's time in the UK influences the extent to which he is likely to benefit from counseling. The participants agree that in the first months and years after asylum seekers have arrived, their ability to benefit from counseling is severely diminished by the anxieties they face due to their often tenuous legal status, as well as the practical concerns they may face regarding housing, employment and basic security. As Guy explains:

Guy: ". . . certainly if someone is living in urban poverty and isn't working then there's a limit to what therapy can really achieve without changing the bigger picture."

And Pauline:

Pauline: "[Those who] have been here for ten-fifteen years, they get used to it, they are in the situation of accepting and trying to accommodate and adapt. The newcomers are in a total status of shock and denial. They are angry, they don't accept the rules because they want accommodation, they want their legal status, their case have been in the home office for seven years, five years, they don't know where to stay, they have no money, they have to rely on either relatives or stay in a



hotel, and so it's really unsettled . . . they don't see anything basically. They don't see light, the only light is through their legal status."

The powerlessness of the asylum seeker situation can also be frustrating for the counselor:

Margaret: "They're going through so much, and it's a bit like they cannot do anything about it. It's . . . being powerless, and working with that is quite difficult . . ."

Julia explains how the inability of the client to be present due to overwhelming circumstantial concerns acts as another barrier to productive therapy:

Julia: "For some the issues are very much to do with the status, getting the status and getting accommodation—they're just not there with you, they're not present. I think those who are not present because of so much apprehension . . . it's difficult to get engaged and to make that connection."

While these perspectives would seem to suggest that counseling with refugees and asylum seekers is an ineffective use of time and resources, further investigation reveals quite a different perspective. Once asylum seekers in the UK have received legal permission to remain in the country, or once housing has been secured and employment obtained, these clients may actually seek out the counseling that seemed less urgent upon arrival. Pauline explains, speaking as one of her clients at the London clinic:

Pauline: "I've got my legal status now. I could talk about my pain.' You see, when they are stuck, if you like, in this position, they're not able to talk about their emotions."

Guy explains how the focus of his work with asylum-seeking clients shifts as they become more settled:

Guy: "I'm working on symptom management and trying to change things . . . and not necessarily working on trauma with someone that's so destabilized . . . I think quite often what can happen is that they aren't in the space to work on, say trauma, but maybe once they get their right to remain here they may come back five years later feeling more able to deal with their problem because they're just more stable in other areas . . ."

The participants characterize the shift they perceive in clients' openness to therapy as happening suddenly. Pauline explains:

Pauline: "I ask her a little bit about what reminds her of her country, because it's a huge revisit of that trauma, you know saying 'nothing's wrong with me' and then all of

a sudden something happens. Something has triggered this pain, which is deeply settled, it's unsettled but deeply covered."

And Ella:

Ella: "Sometimes it kicks in at a later stage, once you've addressed your needs of having a basic home, settling into a new environment, having basic money, sometimes a pin drops and people think, well, actually, I might need to see that woman again and explore what else can be done."

Clearly, time appears to be a significant factor in the participants' perceptions of their refugee and asylum-seeking clients' interest in pursuing counseling. After time has passed and a client has established residency and basic stability in life, the participants recognize how he may suddenly discover a newfound interest in connecting with mental health services<sup>3</sup>.

Synthesizing the perspectives of the participants suggests how they perceive a relationship between the length of time their refugee clients have been in the United Kingdom and the extent to which they are able to engage in beneficial therapy. This trend might be explained simply by the fact that, in general, after more time, the basic needs of housing, sustenance, and employment are more likely to be met. However, it is also possible that the refugee clients become increasingly acculturated to the UK, and are more able to engage with Western-derived talk therapies. Acculturation consistently appears in the data as a factor that the participants perceive as impacting the ability of clients to benefit from therapeutic interventions. Margaret explains how she understands familiarity with the UK, which enhances the potential of counseling:

Margaret: "If it's someone who is raised here it is much easier for them to understand."

Beyond the therapeutic relationship, the lack of acculturation that the participants ascribe to recently arrived refugee and asylum-seeker clients can interfere with their perceived ability to interface with social services. Ella explains how especially with women who are victims of rape, acculturation factors can influence their ability to effectively advocate for themselves. Ella: "The bulk of a lot of women I encounter are not acculturated, it's extremely, extremely difficult, and it effects some asylum claims."

<sup>3</sup> It is worthwhile to note also how the topic of Maslow's Hierarchy was raised by three of the five participants. Mostly, they seemed to agree with Maslow that psychological needs come after the basic needs of shelter, food and security (Maslow 1987).

The perspectives the participants offer about acculturation and the timeframe in which their clients appear to desire therapy are especially pronounced because they emerged from interviews and analysis without prompting by any of the initial questions listed on the interview schedule. Such a finding speaks to the strengths of an exploratory, qualitative analysis that might not have emerged if a different methodology had been used. Furthermore, it is worth noting that all four themes were addressed in some capacity by each of the five participants, reinforcing the validity of the findings as relevant to issues mental health professionals face when treating this population. Yet some meaningful differences in the data also emerged across the participants. Guy, employed as a psychologist by the NHS, and Ella, a nurse at the Refugee Council, were the only participants who reported working with clients who were disinterested in treatment and uneducated about the general endeavor of psychotherapy. This is likely explained by the fact that both Guy and Ella work in settings where refugees and asylum seekers are being referred to or offered treatment as an option for treating signs of their distress, whereas the three other participants (Pauline, Julia and Margaret) each work in a clinic where new patients seek out treatment themselves, already having identified the therapeutic process as one that may be helpful to them. Therefore, not all participants need to conduct psychoeducation with their clients about the mechanisms and benefits of treatment, though those with clients new to psychotherapy were more likely to encounter resistance.

## DISCUSSION

Reflecting on the initial questions motivating this study, it is interesting to consider how the data clearly respond to some questions and others hardly at all. The questions pertaining to the general effectiveness of psychotherapy for the displaced population, and, for the most part, those pertaining to the influence of a client's cultural background yielded rich responses. Yet, those questions of a more theoretical nature—relating to how the participants perceive the utility of the diagnostic system, and their thought about the ethics of using treatments developed in the West with clients of non-Western backgrounds—returned hazier perspectives, and thus are addressed just briefly in this discussion<sup>4</sup>. Perhaps such responses suggest that theoretical concerns pertain tangentially to the work these practitioners conduct with their clientele. The insights of the theme about adjustment and accul-

turation present the most novel and unexpected perspectives to emerge from the analysis. Each of the participants identified a relationship between the amount of time a refugee or asylum seeker has lived in the UK and the likelihood of his benefiting from treatment.

As the results section demonstrates, the primary themes that emerged reflect a group of mental health professionals who carry a largely positive, though not unqualified outlook on the potential of their therapeutic techniques in addressing the needs of refugees and asylum seekers living in the UK. To a significant extent, the perspectives about the influences of cultural background and the seemingly necessary ingredients for beneficial therapy highlighted by the first two themes corroborate existing insights in the literature pertaining to psychotherapy and to transcultural counseling specifically (Frank and Frank, 1993; McFadden, 1999).

The cultural issues to which the second theme draws attention relate almost identically to themes outlined in the literature. D'Ardenne and Mahtani explain how language barriers, conflicting perspectives on the origins of mental distress, and differing levels of familiarity with individually or collectivist-oriented societies can all present challenges when counseling people initially unfamiliar with psychotherapy (1989). However, in light of the challenges a client's cultural background can present, the participants also explained how in some respects they do not perceive culture as a barrier at all—how, rather, through use of client-centered and feeling-centered techniques, cultural background becomes one of many characteristics, including gender, age, occupation, etc. While these perspectives may seem paradoxical in light of simultaneous articulations of culturally-derived barriers, many of the participants seemed to believe that their treatments have universal potential. Such openness and flexibility in light of cultural differences is consistent with existing approaches to transcultural counseling, which do not convey a client's culture as an inherent challenge to contend with, but rather as an additional way of thinking about clients in treatment that values culture and considers the nuances of it in a client's life deeply.

The insights gleaned by the first theme about the perceived importance of a client's understanding and interest in treatment also corroborate existing literature. The theme emphasizes the foundational importance the participants attribute to a client's understanding of and willingness to engage in the psychotherapeutic process in order for treatment to be effective. These insights reflect perspectives established in the transcultural counseling literature (Moodley and West, 2005). Synthesizing the five interviews, the participants point to the importance of the practitioner-client relationship, the significance of developing a shared understanding, and the necessity of creating a safe environment in which therapy can occur.

It comes as no surprise that these two factors—estab-

<sup>4</sup> Perhaps it is an artifact of the sample that concerns about provider bias or institutional barriers to care were also absent, given that each of the participants devote many hours a week to treating individuals who have been displaced. Although, several participants commented on how funding limitations at both private and public institutions had forced clinics to cut back on the number of clinicians available for displaced clients and also reduced the number of sessions they were able to offer clients.

lishing understanding of what counseling entails and working with a client who is invested in treatment—are so fundamental. These two factors relate directly to what Frank and Frank (1993) outline as shared features of all effective psychotherapies. They highlight how “a ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patients health” (p. 43) is critical for a successful treatment. Furthermore, their point indicates the extent to which effective therapy with refugees and asylum seekers is dependent upon their *understanding* of the counseling process.

The participants demonstrate wisdom about addressing cross-cultural differences in a mental health care context that appears to value the variation with which their clients discuss their experiences—both as individuals and within their broader cultures of origin. The participants acknowledge how their clients “express their distress very differently,” and therefore they attempt to work with these idioms in order to “talk the language they can understand.” Such sensitivity reveals the mark of a good clinician, and also the benefit of using a client-centered approach. The insights conveyed by the third theme offer a valuable, practice-oriented, new voice in the debate about the appropriateness of using a Western psychiatric framework with displaced individuals. In practice, it seems, the clinical language particularly of PTSD is used seldom if at all in the context of a counselling session. The service providers refrain from using it primarily because they sense that it would alienate, and potentially offend their clients. However, they do find that the diagnostic categories provide a helpful structure for processing their clients’ distress and for communicating in the context of a supervision or case report. In this way, it seems that, at least according to the participants, the Western diagnostic system’s use is curtailed to a systems-level function, and according to the perspectives of the interviewees, is not impacting their counseling sessions with refugees and asylum seekers in an inappropriate way. Tensions about the universality of diagnoses like PTSD may still be relevant in the wider debate about the ethics of labelling non-Western individuals with such terminology. But the practice of counseling and psychotherapy, it seems, plays out on a different, more grounded register, where such disputes have little bearing on the therapeutic exchange between the practitioner and client.

The fourth finding offers the greatest potential for advancing the dialogue about the value of psychotherapy for non-Western individuals conducted in clinics like those of the participants of the present study. It suggests that the utility of counseling for refugees and asylum seekers is more limited when they are recently arrived and still primarily concerned with their basic needs. Yet, once these needs have been addressed and they gradually adapt to the customs of their surrounding

society, the participants perceive that counseling has much greater potential for therapeutic benefit. This perspective has direct bearing on the wider debate about addressing refugee mental health needs. Rather than supporting either side of the debate, this perspective suggests that, once the acculturation process has naturally influenced an individual, he may be open to counseling as a helpful and appropriate option. This fourth insight, therefore, resonates with the first as a reflection of how an individual must willingly, openly take on and even *believe in* the process of talk-therapy in order to benefit from the experience. Although further research needs to be conducted to test the veracity of such an impression, it is likely that interest and belief in counseling as a beneficial endeavor may grow stronger the longer the individual has resided in the UK.

Such hypotheses align well with a substantial body of literature about acculturation. It is widely understood that individuals respond to the expectations and influences of the cultural context in which they live (Berry et al., 1992); although acculturation does not always occur along a continuous timeline (Berry, 1992), in general an individual will adjust his behaviors to those of broader society. The psychologist John Berry and many others have written about the complex relationship between acculturation and mental health (Koneru et al., 2007; Rogler et al., 1991; Bhui et al., 2005; Jayasuriya et al., 1992), on which the fourth theme has direct bearing. The way in which the theme hints at how the participants perceive how an individual may alter his openness to counseling is reflective of a type of acculturation with inherently psychological properties. The psychological adaptation of migrants, including refugees and asylum seekers, involves the adjustment of an individual’s behavior and way of thinking to what is considered appropriate in his new context, which is often accompanied by “culture shedding,” or “the unlearning aspects of one’s previous repertoire that are no longer appropriate” (Berry, 1997, p. 12-13). Eventually, an individual may experience an adjustment in values, and may adopt values typical of his new cultural context. These changes include “language shifts, religious conversions and fundamental alterations to value systems” (Berry, 1992, p. 17). As this investigation demonstrates, psychotherapy in the UK carries with it a set of assumptions about the value of talking as a means to healing, and the importance of a person processing his circumstances, often with reference to his past. It is possible that as refugees and asylum seekers adjust to life in the United Kingdom, they may experience an alteration in their own value system that opens them to the concept of therapy with a professional as practicable and potentially healing.

## CONCLUSION

On the whole, this investigation has articulated the critical

importance that mental health professionals attribute to the adjustment and acculturation process in order for clients to benefit from treatment. The study has also contributed a grounded, practical voice to the debate about the ethics of applying a Western psychiatric framework to individuals from non-Western backgrounds.

The limitations of this study and its findings must also be considered. This study investigates the perceptions of a small number of clinicians, who are additionally limited by geography.

The results of this study cannot be generalized to clinicians in parts of the United Kingdom not represented, nor to mental health professionals who do not work with refugee and asylum seeking clientele. Yet, given the study's exploratory nature, it has the potential to yield observations that can inform future survey-based research on a larger scale. A population-level analysis would be needed to account for the number of refugees and asylum seekers who are 1) accessing care through the NHS, 2) referred for treatment for mental health problems and 3) electing to follow through with treatment. The findings of this study reflect the perspectives of mental health professionals who are working with those refugees and asylum seekers who fall into this final category, as well as those individuals who seek out counseling independently.

Policy recommendations point to the need to employ counselors capable of speaking the languages of their clients, especially in areas outside London. Given the extent to which sensitive expression is essential for effective therapy, and the hindrance that working with interpreters can impose, hiring counselors capable of speaking the languages of refugee communities would be a beneficial enhancement of services. Overall, however, the data suggest that the existing counseling and therapy services offered by the NHS and collaborating charities provide a valuable service to those refugees and asylum seekers who choose to use them.

This study has uncovered perspectives that could serve as springboards for future investigations. Such studies might include an investigation of the relationship between levels of acculturation and comfort with using mental health services among refugees and asylum seekers in the UK; a similar investigation with mental health professionals working with refugees in a comparatively less developed country; and also a parallel ideographic study of the refugees and asylum seekers engaging with counseling services in the UK. Such studies offer additional perspectives to the broader debate, and they would enhance understanding of how refugees and asylum seekers interface with services in general. These investigations would also allow scientists and policy makers to better identify the most effective, appropriate and intelligent way of addressing the mental health needs of the refugee and asylum-seeking community, on both local and international scales.

## Conflict of Interests

The author(s) have not declared any conflict of interests.

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