A portfolio of Academic, Therapeutic Practice and Research Work

including an investigation of the process of adaptation among international students and factors that contribute or hinder effective cross-cultural therapy with this client group.

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This portfolio is dedicated to my mother without whose love and support none of this would have been possible.
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Introduction to the portfolio

This portfolio contains work submitted in partial fulfilment of the requirements for the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. It will be divided in three dossiers. The first dossier contains examples of essays and reports drawn from classes and workshops under the following titles: ‘Theoretical Models of Therapy’, ‘Advanced Theory and Therapy’, ‘The Context of Counselling Psychology’ and ‘Issues in Counselling Psychology’. The second dossier focuses on work related to therapeutic practice and reflections on my own professional development. The third dossier includes the research projects carried out during the three years.
Academic Dossier
Introduction to the academic dossier

The academic chapter of the portfolio consists of five essays. Three of these are based on the psychodynamic and cognitive-behavioural frameworks of psychological therapy. In the first one Freud's and Jung's views on the nature and purpose of dreams will be explored. Their theories about the interpretation of dreams will also be discussed. The second essay focuses on the historical development of the term of transference in Freud's writings while discussing its theoretical rigour and practical usefulness. The third essay looks at the role that an effective therapeutic alliance may play in cognitive-behaviour therapies.

Essays four and five deal with issues in counselling psychology practice which arouse out of reading, discussions and experiences on placement. Essay four explores cultural issues in psychotherapeutic practice and essay five focuses on the supervisory relationship, in particular, factors that may hinder the development of the supervisory relationship.
Freud's and Jung's theories on the interpretation of dreams

What are dreams? What are they for? Do dreams have a meaning despite their meaningless appearance? How can they be interpreted? These are questions that mankind has asked for centuries, and there is still no clear answer to. Dreamwork and dream theories have an ancient and rich history with religious, spiritual and paranormal links. All modern dream workers consider that Freud's work, *The Interpretation of Dreams* (1900), marks a crucial turning point in the history of the study of dreams (Cushway & Sewell, 1992). Jung's theoretical approach to dreams was greatly influenced by Freud's theories, first as a model for practical therapy, and later as a model to react against, to modify and to extend (Stevens, 1994). In the interest of clarity I will be addressing the elements of Freud's and Jung's theory of dreams and the interpretation of dreams under the following headings: the nature and purpose of dreams, the dream language, the interpretation of dreams and contemporary Freudian and Jungian dream analysis.

The nature and purpose of dreams

According to Freud (1900), dreams are essentially the fulfilment of a wish. To the extent that Freud considered that repressed wishes in the unconscious mind find substitute gratification during sleep in the form of dreams, he believed that the dream is a kind of neurotic symptom. Dreams fall into three categories according to their attitude to wish-fulfilment. The first class consists of those which reflect an unrepressed wish undisguisedly; these are the dreams of an infantile type which become rare in adults. Freud gave the example of a small boy who dreams of eating a basket of cherries which he was not allowed to eat the day before. Secondly, there are dreams which express a repressed wish disguisedly; these form the majority of our dreams and need analysis to be understood. Thirdly, there are the dreams which represent a repressed wish but do so with no disguise. These are accompanied by anxiety which interrupts them. Freud focused on the second type of dreams. Anxiety is avoided in them due to the existence of a mental agency, which he first named "the censor" and later "the super-ego", that forbids the open expression of wishes that are
considered unacceptable or offensive, represses them and only allows their expression if they are distorted into unrecognisable and incomprehensible forms. In Freud’s view then, dreams are a compromise between the repressed wish which if unexpressed would awaken the sleeper and the agency forbidding its open expression. The compromise is achieved by expressing the repressed wish in concealed terms so the offensive repressed wish is disposed of without the dreamer becoming aware of its nature and meaning. Therefore, “we shall no longer have any difficulties in discovering the function of dreams as the guardians of sleep” (Freud, 1952, p.61).

The concept of compromise led Freud to make a distinction between the manifest and the latent content of dreams. The manifest content “designates the dream before it receives any analytic investigation, as it appears to the dreamer who recounts it” (L’aplanche & Pontalis, 1973, p.243). The latent content or dream-thought is “a group of meanings revealed upon the completion of an analysis of a product of the unconscious. Once decoded, the dream no longer appears as a narrative in images but rather as an organisation of thoughts, or a discourse, expressing one or more wishes.” (ibid. p. 235). Freud believed that dreams fashioned their manifest content out of memory residues from two sources: from events of the previous day and from childhood. Moreover, Freud believed that the forbidden wishes responsible for the production of dreams were predominately sexual in origin.

Initially, Jung went along with Freud’s approach but he quickly saw its limitations: “Freud’s view that dreams have an essentially wish-fulfilling and sleep-preserving function is too narrow” (CW VIII. para. 487). Against Freud’s view that the dream is essentially a wish-fulfilment, Jung saw the dream as “a spontaneous self-portrayal, in symbolic form, of the actual situation in the unconscious” (ibid. para. 505). “They do not deceive, they do not lie, they do not distort or disguise. They are invariably seeking to express something that the ego does not know and does not understand” (CW VII. para. 189). Jung accepted Freud’s view that dreams are a result of memory residues from the previous days’ events and from childhood but he went further maintaining that dreams draw on a third, much deeper, source belonging to the
evolutionary history of our species, which he called "the collective unconscious". In addition, Jung was convinced that dreams had their own origins in wider concerns than erotic wishes, that is, the basic issues of human existence (Stevens, 1994).

As far as the function of dreams, he distinguished between the compensatory function and the prospective function of dreams. Jung believed that the psyche is a self-regulating system. Therefore, a compensatory mechanism operates between the conscious and the unconscious (Bennet, 1966). Jung wrote:

"dreams add to the conscious psychological situation of the moment all those aspects which are essential for a totally different point of view. It is evident that this function of dreams amounts to a psychological adjustment, a compensation absolutely necessary for a properly balanced action." (CW VIII. para. 469).

A compensatory content in dreams is especially intense when it has a vital significance for conscious orientation. As an example, Jung presented a dream about a man who had gone to see him because he had an interest in psychoanalysis from a literary point of view. The client said that he was in the best of health and that he was not to be considered as a patient. The night before he visited Jung he had the following dream:

I was in a bare room. A sort of nurse received me, and wanted me to sit at the table on which stood a bottle of fermented milk, which I was supposed to drink. (CW VIII. para. 249).

He gave a number of associations until the patient reached, "bottle of fermented milk", to which the patient said, "Fermented milk is nauseating, I cannot drink it... I remember I was once in a sanatorium- my nerves were not so good- and there I had to drink fermented milk" (ibid. para. 249). At that point Jung asked him if his neurosis had totally disappeared to which the patient admitted that he still had his neurosis. According to Jung, from this we can see how the patient had falsified the situation. The dream rectifies the situation and contributes the material that was lacking and thereby improves the patient's attitudes. Jung viewed the process of psychic
compensation as individual and this makes the task of proving their compensatory character considerably difficult.

Regarding the prospective function, Jung described it as "an anticipation in the unconscious of future conscious achievements" (CW VIII. para. 472). Since dreams result from a fusion of subliminal elements such as perceptions, thoughts and feelings which consciousness has not registered, they are often in a much more favourable position than consciousness to make a prognosis of a situation. However, Jung warned not to over-estimate the prospective function of dreams because one might easily be led to believe that dreams provide a superior knowledge and that infallibly guide life in the right direction. As a result, one might over-estimate the significance of the unconscious when, according to Jung, the importance of the unconscious is about equal to that of the conscious. Only when there is an obviously unsatisfactory and defective conscious attitude we can give the unconscious a higher value. What does Jung mean by "unsatisfactory and defective conscious attitude"? How much is a "higher value"?. These are important issues that are raised from the above view, however, an attempt to address them is beyond the scope of the present essay.

Whereas Freud held the purpose of the dream to be on deception, Jung thought its purpose was to serve individuation by making valuable unconscious potential available to the whole personality.

The dream language
Freud in *The Interpretation of Dreams* (1900) regarded the dream thoughts and the dream content as two representations of the same meaning in two different languages. The dream content appears as a translation of the dream thought into another form of expression. The transformation of the dream thought into the manifest content of the dream is what constitutes the dream-work. The mechanisms which serve to change and distort the latent content into the manifest content were divided by Freud into two types of mental functioning, namely, primary and secondary processes. Primary processes are characterised by condensation, displacement and symbolisation.
Condensation means that in the manifest dream, one idea can stand for many associations which, in turn, will lead to quite separate although frequently overlapping ideas in the latent content. Displacement is the process whereby the emotional charge is separated from its real object or content and attached to an entirely different one (Stafford-Clark, 1965). Since most dreams result from sexual wishes, Freud explains in his book *On Dreams* (1952) that the material of the sexual ideas must not be represented as such, but must be replaced in the dream by similar forms of indirect representation which must not be directly intelligible leading to symbolisation. This would explain the meaningless and incomprehensible appearance of dreams. Freud described such modes of representation as "symbols" of the things they represent. He identified a number of symbols which bear a single meaning almost universally. The male genitals may be represented by sticks, umbrellas, posts, trees, knives, daggers, spears, sables, rifles, pistols, revolvers, water-taps, watering cans, fountains, pencils, balloons, and flying machines. Examples of female genitals representations are bottles, boxes, trunks, cases, chests, pockets, ships, rooms, doors, gates, mouth and so on (Stafford-Clark, 1965).

The secondary processes are governed by the laws of grammar and formal logic and eliminate the dream’s apparent absurdity and incoherence by filling in the gaps, partially or totally reorganising it and attempting to make it something like a daydream. Secondary processes constitute the second stage of dream-work, therefore, they precede primary processes. As a result, Freud held that the primary processes are archaic, primitive and maladaptive, thus, dreaming is in principle a neurotic symptom. The division between primary and secondary processes has in Rycroft’s (1979) mind four serious defects. Firstly, the conceptualisation of dreaming as a symptom. The fact that everybody dreams means that everyone is neurotic, therefore, any distinction between health and neurosis is futile. Secondly, the idea that the development of secondary processes, i.e. the capacity for rational, depends on the repression of primary processes which implies that human beings enter the world totally unadapted to meet it which has been disputed by biological evidence. Thirdly, the assumption that primary processes are by nature primitive, maladaptive and irrational meant that
Freud had to categorise imagination, creative activity and even intuition as neurotic, regressive and symptom-like. Finally, Rycroft expresses doubts about Freud's formulation that primary and secondary processes are essentially differing ways in which mental energy moves or remains static within different parts of the mental apparatus. However, concepts such as mental energy have not been defined properly, and we do not really know what they mean.

Reverting to symbols, Freud tended towards a fixed meaning of symbols. A symbol was a figurative representation of an unconscious idea, conflict or wish. It effectively disguises the true meaning of the idea it represents. Jung did not consider the Freudian symbol as a symbol at all but instead as a "sign" because Freudian symbols refer to something that is already known or can be known and they have a fixed meaning. To Jung, archetypes are at the root of symbols. Archetypes contain information gathered throughout the evolution of the human species. Symbols have no fixed meaning, all the dream images are important in themselves, each one having significance by themselves. They make possible the development of the personality and the resolution of conflict.

**The interpretation of dreams**

If dream-work is the process which transforms the latent content into the manifest content of dreams through the mechanisms described above, the counterpart process which transforms the manifest content into the dream-thought was named by Freud "the work of analysis". In order to analyse dreams Freud used the technique of "free association". The first step for free association is to tell the patient to direct his/her attention on to a specific image of the dream and report whatever occurs to his/her mind without any exception, and that he/she must not allow himself/herself to suppress one idea because it seems too unimportant or irrelevant. By this method we turn our attention to associations which are involuntary and are normally dismissed by our critical faculty as worthless. Therefore, they are not subject to strict censorship. Once the material has been collected, Freud found that it was connected to the dream-thought. According to Rycroft (1979), if someone has a dream the meaning of which
he/she is ready to accept, he/she will produce associations which lead him directly to the dream-thought. However, if someone has a dream which he/she is not ready to understand the associations he produces to it will be chosen to ensure that the dream is not understood.

The technique of dream interpretation used by Jung is “amplification”. The dreamer is asked to amplify on the dream, to give his impressions of it, to say what strikes him particularly about it. It is a way of encouraging the dreamer to enter, while awake, into a frame of mind similar to dreaming (Rycroft, 1979) so its impact on consciousness is enhanced (Stevens, 1994). It can be noted that amplification is carried out on a conscious level whereas the therapeutic procedure of free association, in which the patient speaks of the first thing that comes into his mind and so allows the unconscious to express itself, is carried out at an unconscious level (Bennet, 1966).

The first task when analysing dreams, according to Jung, is to use amplification around particular images of the dream, this will allow to establish the context of the dream in the life of the dreamer, so as to understand something that is purely of personal significance. Jung believed that without the knowledge of the conscious situation, the dream can never be interpreted with any degree of certainty. There is a complex and subtle compensatory relationship between the conscious and the unconscious so when we set out to interpret a dream it is always helpful to ask what conscious attitude it compensates. Jung states that a definite structure can be perceived in dreams which he divided into four stages: (1) the exposition which sets the place and often the time of the action, as well as the protagonists, (2) the development of the plot in which the situation becomes complicated and a definite tension develops, (3) the culmination when something decisive happens or something changes drastically, (4) the lysis, the conclusion, the solution (Stevens, 1994).

Samuels (1985) gives a brief example applying this structure to a dream brought by an anorexic patient of his.
I am in a hospital for an operation on my hip. A nurse comes in and tells me that a mistake has been made (exposition). I have now got cancer because of this mistake (development). I am very upset and angry but I decide not to say anything or do anything (culmination) because I do not want to upset the nurses feelings (solution). (p. 233).

It is often important to see whether the dream is part of a series, and, if so, how the thematic material has been developed or not. Moreover, Jung gave considerable importance to dreams presented at the beginning of the analysis, as he believed that these summarise the situation and give some kind of prognosis.

For Jung, dreams are naturally clear and it is only when we do not understand that things appear unintelligible. On the contrary, Freud thought that dreams are deceiving by nature and only the analyst holds the key to their interpretation. Most of Freud’s hypothesis have proven untenable in the light of dream research, while Jung’s have stood up to the pass of time. For example, the well-established observation that all mammals dream and that human infants spend most of their time in dream sleep, would seem to dispose of the idea that dreams are disguised expressions of repressed wishes or that their principal function is to preserve sleep. Stevens’ (1994) view is that it is more likely that dreams are, like Jung maintained, natural products of the psyche, that they perform some self-regulatory function and that they obey the biological imperative of adaptation in the interests of personal growth and survival.

**Contemporary Freudian and Jungian dream analysis**

Rycroft in his book *The Innocence of Dreams* (1979) disagrees with Freud in that dreams are a symptom similar to the hallucinations of the insane. Instead he believes that dreaming is an imaginative activity occurring during sleep. This would allow to consider dreaming as a universally occurring, healthy and normal experience and not a pathological one. He also asserts that symbolisation is a natural, general capacity of the mind and not a method of disguising unacceptable wishes. The language of dreams is metaphorical. Rycroft explains dreaming as:
a form of communicating with oneself and is analogous to such waking activities as talking to oneself, reminding oneself, frightening oneself, entertaining oneself or exiting oneself with one's own imagination— and perhaps to such waking meditative imaginative activities as summoning up remembrance of things past or envisaging the prospect of things future. (1979, p. 45).

His approach seems to be closer to Jung's ideas than to Freud's views. Perhaps, a dream I had, might serve as an example to illustrate Rycroft's idea of dreaming as an intra-personal communication.

I am walking on a very narrow and muddy path surrounded by trees and foliage. I knew that parts of the path were pools of mud that if I stepped on I would sink and possibly die. I had to very carefully scrutinise the path to look for imprints of footsteps or bicycle tracks on the mud which had been left there by people passing before me. If I followed them I would be safe.

I dreamt it at a time where I was not sure of what plan of action to take to resolve a difficult situation. At the time, I felt I had two options: to do as I had done before and try and forget about the whole incident or to assert myself ('stand my ground'). It seemed obvious from the dream that I was in slippery and dangerous ground. Therefore, I had to be extremely cautious and it was best to follow previous tracks ('track records') if I was not to sink in the mud and avoid 'being in deep shit'. It seemed as if the dream was a communication between two aspects of myself, one giving advice to the other.

According to Rycroft (1979), although contemporary Freudian analysis still subscribe to the view that there is a general human tendency towards wishful thinking and hallucinatory gratification, it is more likely to assume that dreams represent the total psychological state of affairs at the time the dream is dreamt, and that figures appearing in the dream are likely to symbolise aspects of the dreamer's own personality. In general, there seems to be a move in psychoanalysis away from seeing the dream as a disguise of a forbidden wish. The psyche is represented as more creative than deceptive.
Contemporary Jungian approaches do not deviate in any marked way from Jung's position. However, Samuels (1985) points out three important modifications. They are: (1) more stress on the importance of the dream ego, (2) making sure that one analyses the patient and not just the dream, (3) drawing a different distinction from Jung's between the nightworld of dreams and the dayworld of consciousness.

Dieckmann (1980) points out that the behaviour of the dreamer in the dream is often similar to that of when awake. He feels that there is another way to look at dreams, different from wish-fulfilment and compensation. For him, dreams express what is happening in the dreamer's waking life but, for the moment, not available to the dreamer's waking self. The second modification to Jung's approach was put forward by Lambert's (1981) critiques. He felt that if dreams are elicited from patients, the analyst will hear what he wants rather than what the unconscious of the patient is trying to say. Furthermore, the dream may be examined by the analyst and the patient in a detached manner which would avoid the experiencing of deep emotions. Finally, he felt that the dream may be presented as a product of the transference-countertransference interaction. Lambert's (1981) point is crucial but according to Samuels (1985) most analytical psychologists are aware of the transference-countertransference implications of the introduction of dreams. The third modification is put forward by Hillman (1979). Hillman suggests that dreams are phenomena that emerge from a precise archetypal location and have a purpose of their own. Therefore, he is not interested in interpreting dreams. Hillman tries, through the dream, to reach the archetypal layers of the psyche. Using free association the dream leads to the nightworld (Samuels, 1985). In a sense, Hillman is closer to Freud than he is to Jung.

My view of dreams resembles Rycroft's idea of dreams, inasmuch as I believe that dreams are some kind of communication between two aspects of ourselves. They contain information that is accessible to us but not available to the waking self. It is as if during sleep our defences are not as strong and there is more flow of information. In that sense I would agree with Jung that some dreams are in a more favourable position to convey the meaning and significance of a situation. The images in dreams have a
significance to the individual. Therefore, it is important that when interpreting dreams we try to understand the client’s specific circumstances and background to them. Moreover, I feel that interpreting dreams is not suitable for some clients. For example, during a session with one of my clients, he presented a nightmare. Due to my interest in dreams, I asked him if he could tell me a bit more about the dream but unfortunately we did not get very far. His dream was as follows:

I am sleeping in bed and I wake up to realise that there is a stranger in my room but I cannot see his face, he is like a shadow. He approaches me and starts to smother me with the pillow. I struggle

During the session, the client and I had explored the idea that sometimes he had a role to play in the sort of difficulties he was encountering and I had a strong feeling that possibly the shadow in the nightmare was his “internal saboteur”, or even his “shadow” on Jung’s terms. Due to the client’s inability to expand on the meaning of the dream, I was not able to check this hypotheses but I did feed back to him that he seemed to be going through a particular difficult time and that it appeared like a real struggle to him, like in the dream. He went on to expand on that.

My personal experience of dream analysis comes from presenting a dream during my personal therapy, it was a very interesting experience and at the end it struck me that I felt as if the dream had lost its ‘magic’ and its ‘power’ which I believe would be particularly relevant when dealing with nightmares or dreams that cause anxiety to the dreamer. In my opinion, the interpretation of dreams is part of the therapeutic process, thus, it is important to take into account where the client is at and take things at their pace. The analysis of dreams can be done at various levels of depth, therefore, it can be accommodated to the client’s needs and level of self-awareness.
References


An analysis of the concept of transference according to Freud

The analysis of transference is the centrepiece of mainstream psychoanalytic treatment. It is, therefore, fundamental both clinically and theoretically. The discovery of the concept of transference has given a definite meaning and function to psychoanalytic therapy. The aim of the present paper is to present a brief analysis of Freud’s principle definitions of the concept of transference and their implications for both patient and therapist.

Freud first introduced the term “transference” in *Studies of Hysteria* (Freud & Breuer, 1895). Freud believed that transference was based on a “false connection” (p. 302) between an idea appropriate to a past situation and the analyst. In other words, it is an association that the patient makes between distressing material that arises from the analysis and the person of the analyst (Smith, 1991). According to Freud:

> there seems to be a necessity for bringing psychical phenomena of which one becomes conscious into causal connection with other conscious material. In cases in which true causation evades conscious perception one does not hesitate to make another connection which one believes although it is false. (Freud & Breuer, 1895, p. 67.)

The term false connection is employed to denote a kind of causal illusion (Smith, 1991). Thus, transference was viewed as a source of resistance to the analytic work. Freud believed that the analytic treatment strives to make the libido accessible to consciousness. Throughout this process, resistances emerged against the analytic work. Every act and association by the person under treatment must take into account the resistance and find a compromise between the forces that are striving towards recovery and the ones that want to maintain the status quo. It is at this point that the transference process takes place.
Freud invented the concept of transference in order to interpret the experience that his colleague Breuer had with a patient known as Anna O. During treatment, Anna O. developed intense erotic feelings towards Breuer which ended in her throwing her arms around him and a phantom pregnancy. Breuer became overwhelmed by Anna O.'s eroticism and gave up such work altogether (Szasz, 1981; Shlien, 1987). According to the theory of transference, the figure of the analyst comes to symbolise someone else in the eyes of the patient. Therefore, the patient's sexual desires are really meant for others and not for the analyst. Similarly, Anna O.'s desires were not really meant for Breuer himself but for someone else. Szasz (1981) believes that such explanation served two purposes. Firstly, it legitimised behaviour that would otherwise have been considered obscene at the time. The theory of transference was needed in order to make the kind of experience that Breuer and Anna O. had, acceptable for the medical circles. In Szasz (1981) words: "what stands between obscenity and science is the concept of transference" (p. 35). This meant that material that would have been kept unseen was able to be published. In consequence, the process of analysis became more accessible to other analysts and open to scrutiny and questioning from the profession which may have favoured higher standards of practice.

Secondly, the concept of transference served to reassure Breuer and Freud that they themselves were not encouraging the patient's behaviour. If the analyst is a mere symbolic substitute for the patient's real love object then the person of the analyst is not considered an active participant in the process. In this way the person of the therapist is placed beyond the reality testing of patients, colleagues and self. Thus, the concept of transference could potentially be seen as a defence for the analyst.

The next description of transference appears in *The Interpretation of Dreams* (Freud, 1900). Here, Freud believes that transference is a hypothetical intrapsychic process that intermediates between unconscious wish and conscious cognition and behaviour. Transference is regarded as the main mechanism by means of which unconscious ideas impact upon conscious material. Similarly to dreams, transference is the royal
road to the unconscious. Up to this point, the process of transference is a source of resistance for analysis but now the idea that it also provides the analyst with the means to access the unconscious wishes is put forward. In the same way that the analysis of dreams is a key technique to access the unconscious, the analysis of transference also becomes a core tool for the practice of psychoanalysis.

The next important text that deals with the concept of transference is Freud’s case presentation of Dora (Freud, 1905b). Freud wrote:

What are transferences? They are new editions or facsimiles made conscious during the progress of the analysis; but they have this peculiarity, which is characteristic of their species, that they replace some earlier person by the person of the physician. (1905b. p.139).

He also suggests that transferences “may become conscious by cleverly taking advantage of some real peculiarity in the physician’s person or circumstances and attaching themselves to that” (1905b. p.116).

With this statement, transferences seem to have been personified and made accountable for “attaching themselves” to individual characteristics of the person of the analyst. It takes away any responsibility from the therapist’s part and places it on the transferences. It suggests that the therapist does not play an active part in the development of transference, therefore, remaining a non-participant in the patient’s preoccupation for him/her. Although Freud seems to acknowledge that the unique attributes of the analyst have a role in the development of transference, such role seems unclear.

Freud’s position becomes clearer in Five Lectures on Psycho-analysis (1910). Freud seems to abandon the idea that the peculiarities of the analyst play any role in the transference. He asserts, “the patient directs towards the physician a degree of affectionate feeling (mingled, often enough, with hostility) which is based on no real relation between them” (1910. p.51).
Later he would also say: “Just as happens in dreams, the patient regards the products of the awakening of his unconscious impulses as contemporaneous and real; he seeks to put his passions into action without taking any account of the real situation” (1912a, p.199).

In later writings, Freud will continue to view the patient’s feelings as originating in the past and not related to the here-and-now in any way. “This affection is not accounted for by the physician’s behaviour, nor the relationship nor situation” (1935, p.383).

Such views seem to imply that an attitude of the patient towards the analyst is inappropriate to the contemporary situation. As Little (1951) notes, to label a patient’s behaviour as transference implicitly denies that the behaviour has a basis on reality. From this point, the notion of transference will be considered as giving rise to illusion and fantasy. According to the patient, Szasz (1981) explains, what he/she is feeling is love or aggression, according to Freud it is an illusion. In these cases, there is a conflict of opinion between patient and analyst that gets resolved according to the analyst’s judgement, i.e. his view is correct and considered reality and the patient’s view is incorrect and considered transference. The use of the term transference in clinical practice, he continues to say, should not mask the fact that the term is not a neutral description of well-attested phenomena but rather the analyst’s judgement of the patient’s behaviour. The analyst’s perception of the facts is seen as more accurate than the patient’s which gives rise to a power imbalance in the therapeutic relationship.

If one focuses on the trajectory of Freud’s positions in relation to the concept of transference, one notices its inconsistency. Two important shifts on his thinking will now be considered. Firstly, transference is believed to be the strongest weapon of resistance whereby it interfered with the analytic work. In fact, transference was an obstacle that made the method of psychoanalysis more complicated (Lemma-Wright, 1995). However, Freud’s position shifts to one where transference is regarded as a
valuable tool to gain access to unconscious wishes. As Lemma-Wright (1995) states, transference became so important for psychoanalysis that patients who were unable to develop it were untreatable. Freud seemed to swing from one position to the next without providing any adequate explanation for it. The progression of his thinking and the reasons why a certain position was adopted rather than another which is, seemingly, as valid are not made transparent resulting in inconsistency.

The second major inconsistency is pointed out by Smith (1991). In Freud’s first definition, he refers to transference as the hypothetical intrapsychic processes that mediate the expression of unconscious material into conscious cognition and behaviour. In this sense, transference is seen as a hypothesis striving to explain certain phenomena. In 1905 a shift occurs, Freud now refers to “transferences”, rather than “transference”, to describe a set of structures instead of processes. As a result, the concept of transference was equated to a set of observable clinical phenomena. The distinction between the phenomena and the processes that explained it became obscured. What to begin with was a hypothesis became the phenomenon itself. In true scientific style a hypothesis is a supposition that can be discarded once its inadequacy has been proven. Therefore, Smith (1991) believes that the moment the concept of transference became a set of certified phenomena it made it very difficult to debate its validity because arguing against the idea of transference is taken as a denial of observable phenomena rather than as a questioning of a hypothetical process. The theory of transference lost its scientific spirit with such shift. Later on there was yet another conceptual change reverting back to the term of transference as a process.

Such conceptual confusion and inconsistency seems to be reflected in the many different definitions of transference that are currently employed. Indeed, Bateman & Holmes (1995) summarise seven different ways in which transference could be understood. As Sandler et. al. (1981) point out if there are so many different concepts of transference, communication becomes riddled with misunderstandings. When psychoanalysts speak of transference to one another or teach about transference we might enter an area of miscommunication. The variety of definitions reflect the
richness and complexity of the field. On the other hand, in order for the term of transference to be meaningful and useful a degree of consensus might be needed.

To conclude, Freud's dictum that the patient's experiences his transference as contemporaneous and real while the analyst searches their meaning in the patient's past relationships has very often served as a means of denying nondistorted aspects of the patient's experience and has also served as a means of denying the analyst's disruptive inputs. As Lemma-Wright (1995), points out while it is important to acknowledge the potential for such misuse it is not to say that making sense of the client's material in terms of transference is abusive per se but that it can be open to abuse.

Furthermore, transference was an innovative and insightful concept that has become a powerful tool for bringing the patient's conflicts into the therapeutic setting in a very direct way (Lemma-Wright, 1995). In addition, it encourages therapists to pay close attention to the dynamics of the therapeutic relationship and provides them with the means to make sense of them.
References


What role does an effective therapeutic alliance play in the use of cognitive approaches in therapy?

Prior to addressing the question of what role an effective therapeutic alliance has in cognitive therapy, the concept of therapeutic alliance will be clarified. According to Goldfried and Raue (1995), from a cognitive-behavioural point of view, the concept of "alliance" did not exist up until recent years. They continue to say that the literature predominantly refers to the therapeutic relationship which encompasses more than just the "alliance". Gelso and Carter (1985) describe three components of the therapeutic relationship which include the working alliance, the transference relationship and the 'real' relationship. According to them, cognitive-behavioural therapists seek to promote an effective working alliance as well as the real relationship to the extent that it facilitates the alliance. Although, the transference relationship may exist in cognitive-behavioural therapy it does not play a central role in therapy. In the present paper it will be argued that in recent years, cognitive-behavioural therapy is beginning to view the therapeutic relationship which includes the three components mentioned above as central to the therapeutic process, in particular when working with clients with long-term difficulties. As a result, for the purpose of the present paper, therapeutic alliance and therapeutic relationship will be employed interchangeably.

Traditionally, cognitive-behaviour therapy has placed greater emphasis on the development of techniques than on the significance of the therapeutic relationship. The cognitive-behaviour therapist has been viewed as a skilled technician whose capabilities stem primarily from expertise in applying specific techniques (Jacobson, 1989). Piasecky and Hollon (1987) provide the following definition which seems to capture the essence of such view: "...the therapist in cognitive therapy takes on the role of a teacher... The goal is to impart skills... Our stance is that of an expert, with specific and delimited areas of competence closely related to methodology, rather than on an authority, someone presumed to know the answers" (p. 141-142).
Thus, in contrast to other therapeutic approaches, the task of cognitive therapy is seen to be to resolve the client’s problems as far as possible, using the tools of cognitive therapy rather than employing the therapeutic relationship per se. From a traditional cognitive-behavioural point of view, a good relationship is necessary in order to proceed with therapy. The core conditions which facilitate the development of a therapeutic alliance, namely, empathy, understanding, genuineness, respect, congruence and positive regard (Rogers, 1957) are acknowledged by cognitive-behaviour therapists as important factors that need to be in place before any therapeutic work can proceed. However, they are not considered as sufficient for therapeutic change (Goldfried & Davison, 1976; Wilson & Evans, 1977; Beck et al., 1979). Within cognitive approaches, techniques and a good therapeutic alliance go hand in hand. The tools of cognitive therapy, without the core conditions, and vice versa, are not sufficient for therapeutic change (Scott & Dryden, 1996; Wills & Sanders, 1997). The specific techniques are deemed to be the active ingredients of the change process, although, these need to be integrated in the context of the therapeutic relationship. Successful cognitive-behavioural interventions are unlikely to occur unless there is a good therapeutic bond.

As a result, the therapeutic alliance functions in a facilitative rather than a curative capacity. Goldfried and Raue (1995) list some of the principal functions of the alliance. They include: facilitating risk taking in-between sessions, encouraging clients to carry out home assignments, increasing positive reinforcement, facilitating modelling, overcoming any resistance or non-compliance and instilling hope and positive expectancies. However, if problems begin to occur in the course of cognitive-behavioural therapy, the alliance may become the focus of the therapy, as without the re-establishment of a good therapeutic alliance, therapy would not be able to continue.

One important way in which cognitive therapy differs from other forms of therapy stems from the specific nature of the therapeutic relationship. The therapeutic relationship is said to be collaborative whereby the therapist and the client work as a team (Raue & Goldfried, 1994). As Beck (1979) put it: “It is useful to conceive the
patient-therapist relationship as a joint effort. It is not the therapist’s function to reform the patient: rather his role is working with the patient against ‘it’, the patient’s problem” (p.221).

The development of a collaborative relationship is predominantly achieved by reciprocity and avoidance of hidden agendas (Beck et. al., 1985). By reciprocity it is meant that both therapist and client are working together towards finding solutions to the problems and difficulties facing the client. The cognitive-behaviour therapist gets alongside the client and they both work together. In order to maintain a spirit of collaboration, it is important to make the therapeutic process as explicit as possible by avoiding hidden agendas. The therapist tends to be clear and explicit about his/her thoughts and the client is encouraged to do the same so agendas for therapy as a whole, as well as for individual sessions are known to both the client and the therapist.

Despite the emphasis placed on techniques and the ‘necessary but not sufficient’ view of the therapeutic relationship, more attention is now being paid to the importance of the therapist-client relationship (Jacobson, 1989; Raue & Goldfried, 1994; Wills & Sanders, 1997). Raue & Goldfried (1994) cite a number of studies conducted on the therapeutic alliance in cognitive-behaviour therapy which concluded that clients recognised the role that specific techniques had played in their improvement. However, greater weight was placed on the therapeutic alliance. Furthermore, it was found that the early development of a strong alliance is a good predictor of treatment dropouts and immediate outcome. Safran (1990) suggests that these findings are consistent with the growing empirical evidence emphasising the centrality of the therapeutic alliance to the change process. More attention is being paid to ways in which the therapeutic relationship can be used as an active ingredient in therapy (Jacobson, 1989; Beck et. al. 1990; Safran & Segal, 1990; Safran, 1990; Young, 1994). In particular, in the treatment of “interpersonal disorders”, a term coined by Jacobson (1989) which may include depression and personality disorders.
Jacobson (1989) asserts that it is when therapy moves to the phase where underlying assumptions and core beliefs are explored that the therapeutic relationship can play a particular important role. He believes that when working with depressed clients the development of the therapeutic alliance may create a forum where the relationship can either replicate patterns of previous significant relationships or it may provide a new type of experience for the client by allowing depressed clients the opportunity to explore new ways of being in a safe interpersonal environment. Jacobson continues to say that to the extent that the therapeutic alliance parts from previous dysfunctional interpersonal patterns, the depressed client may be ready to extrapolate his/her new behaviours into the natural environment. However, cognitive-behavioural therapists tend to offer focused time-limited treatment which means that examination of underlying assumptions and core beliefs may not receive the necessary attention in order to be changed. Yet, Jacobson (1989) argues, if Beck’s theory is correct (Beck et. al., 1979), these core beliefs need to be modified if cognitive-behavioural therapy can be expected to have a preventative effect. It is at this point that the development of an interpersonal perspective to cognitive therapy is of paramount importance.

Safran (1990) and Safran and McMain (1992) have developed such a perspective in relation to the treatment of personality disorders. Safran (1990) argues that the therapeutic relationship provides an important source for both assessing and challenging core cognitive structures. The growing interest in the application of cognitive therapy to clients with personality disorder and the acknowledgement of the limitations of traditional cognitive therapy techniques with this particular population has given rise to the need to develop alternative conceptual approaches (Safran & McMain, 1992). It is in this context that the cognitive-interpersonal approach has been developed.

Safran (1990) argues that because of the intrinsic connection between cognitive and interpersonal levels of functioning, it is difficult to accurately assess the cognitive processes that are central to an individual’s problems without understanding the interpersonal aspects. The therapeutic relationship provides an arena where the
client’s interpersonal style is played out. Thus, what goes on in the therapeutic relationship can be used as valuable information to help to understand and conceptualise the client’s difficulties.

The client may engage in schema-driven and schema-maintenance behaviours within the therapeutic alliance. Therefore, what happens in the therapeutic relationship is likely to mirror the client’s psychological make-up. The core beliefs and assumptions and the mechanisms by which the client confirms these assumptions are illustrated in vivo (Beck et al., 1990; Safran, 1990; Safran & Segal, 1990). In the same way that a client may use the processes of schema maintenance, schema avoidance and schema compensation (Young, 1994) in their interactions with others, the therapeutic alliance will also be affected by them. Wills and Sanders (1997) suggest that it is likely that the client will be testing out the therapist to check for a good ‘fit’ with their assumptions and beliefs. Thus, leading to schema maintenance. For example, the belief that ‘I am boring’ may lead the client to speak or behave in a flat, boring manner, or selectively attend to any tiny cues that the therapist is finding them boring. Schema avoidance describes the affective, cognitive and behavioural processes employed to avoid activating schema. For example, the client would laugh or change the subject whenever something painful was being approached. Schema compensation describes the process of acting in a way opposite to that predicted by schemas. For instance, if a client has a ‘dependence’ schema and refuses to trust the therapist, or prematurely discontinue therapy saying that he/she would prefer to continue alone.

In order to be able to identify whether the processes mentioned above are being played in the therapeutic alliance, Safran (1984a, 1984b) believes that one of the most important cues available to the cognitive therapist regarding the client’s dysfunctional behaviours and communication styles is their own feelings and reactions to the client. As Sullivan (1953, 1956) suggested, the therapist can function as a “participant-observer” in the interaction with the client. The therapist reacts to the client’s interpersonal style like others, yet, is able to monitor his or her own feelings and
responses and to use them to generate hypotheses about the client’s dysfunctional interpersonal style. The therapist’s thoughts, schemata, emotions, feelings and reactions are viewed as a valuable means of gaining a deeper understanding of the client’s difficulties. Whilst it is important to note these reactions it may not be appropriate to share them with the client, being too threatening for the client and risking the therapeutic alliance (Wills & Sanders, 1997). Nevertheless, the therapists’ feelings can pinpoint particular areas of the client’s behaviours and communication style which may warrant cognitive exploration since it is likely that the occurrences of those interactional patterns would be problematic for the client and will be accompanied by the cognitive processes that play a crucial role in maintaining the dysfunctional cognitive-interpersonal style (Safran, 1990). It is essential to stress the fact that these cognitive-interactional patterns are often subtle and therefore difficult to identify. As Safran (1990) explains the therapist must begin by explicitly identifying characteristic feelings and responses that the client evokes in him/her. Then, the client’s specific behaviours and communications that evoke these responses are identified. Such information can then be used to generate hypotheses.

The therapist role as “participant-observer” becomes particularly important when working with clients who suffer from personality disorder. Clients with personality disorders are characterised by extreme and rigid interpersonal styles shaped by dysfunctional interpersonal schemas providing them with a rigid and constricted sense of who they must be in order to maintain relatedness (Safran, 1990). Due to their extreme and rigid way of being in the world, clients with personality disorders are likely to evoke powerful reactions in the therapist. If the therapist is not able to become aware of the interpersonal pattern being played up, he/she will confirm the client’s dysfunctional interpersonal schema. If, on the other hand, the therapist is able to release him/herself from the client’s dysfunctional cognitive-interpersonal style, the therapist can provide a powerful means of disconfirming the client’s dysfunctional interpersonal schema, thus, bringing about change. For example, if a client has avoidant personality disorder, the key feature of the disorder is that others can be seen as critical and demeaning (Scott & Dryden, 1996). However, due to the client’s
extreme and rigid way of interacting with the therapist, the client may evoke those same feelings in the therapist. If the therapist is not able to identify such reactions as being part of the interpersonal pattern being set up, he/she is likely to get ‘hooked’ into it, thus, being critical and demeaning to the client which may result in the confirmation of the client’s dysfunctional cognitive-interpersonal schema. Conversely, if the therapist is able to observe him/herself in this process and to be able to acknowledge their own feelings then he/she is more likely to behave in a way that will disconfirm the client’s dysfunctional cognitive-interpersonal schemas, for instance, by taking special care to elicit from the client whether anything has been said or done by the therapist that has upset them.

Traditionally, resistance and ruptures in the therapeutic alliance have been seen as difficulties that need to be resolved before the real therapeutic work can commence. However, within the cognitive-interpersonal perspective working on this difficulties may in itself be central to the therapeutic process. Since difficulties in the therapeutic alliance are likely to occur when the therapist’s actions are consistent with the client’s dysfunctional interpersonal schemas, important interpersonal schemas may be activated during difficulties in the therapeutic relationship. Thus, providing an excellent opportunity for clarifying the nature of the underlying schemas (Safran, 1990). Therefore the resolution of an alliance rupture can provide a powerful schema-disconfirming experience, particularly for clients with long-term difficulties characteristic of the personality disorders (Young & Klosko, 1993; Young, 1994). Wills and Sanders (1997) list the benefits of sorting out difficulties in the therapeutic relationship. It may be a means of helping clients to sort out difficulties in other relationships, providing a model for the client to solve relationship difficulties. The relationship can act as a testing ground for challenging beliefs. Careful self-disclosure from the therapist can offer experimental evidence for clients about the possible impact of their way of being. Similarly, resolving difficulties can be used as a behavioural experiment in order to test and challenge beliefs, particularly about others.
Despite the fact that in the cognitive-interpersonal approach the use of the therapeutic relationship is seen as central to the change process which is a view also held by psychodynamic and interpersonal therapies, the current approach emphasises a particular style of therapeutic relationship. As mentioned above, it is characterised by collaboration whereby both the therapist and the client are encouraged to express their thoughts clearly and explicitly as they emerge.

In conclusion, in recent years cognitive-behavioural approaches have begun to focus on the importance of the therapeutic relationship as a source of valuable information in order to generate hypotheses about the client’s difficulties and as a means of therapeutic change per se. Such way of working with the therapeutic relationship is particularly relevant with clients who suffer from personality disorders and those clients where relationships are of central concern.
References


Counselling psychology across cultures

The terms "culture", "race" and "ethnicity" are widely employed within a cross-cultural context. Therefore, an essential first step is to clarify what it is meant by such terms.

Culture is "that complex whole which includes knowledge, belief, art, morals, law, customs, and any other capabilities and habits acquired by man as a member of society" (Tyler, 1874, p.23). It is acquired through the process of socialisation (Draguns, 1996) and it is to do with social conventions. The elements which constitute culture like art, norms, customs and practices are learned, group-specific and arbitrary (Rack, 1982). Race refers to "differences in the inherited, i.e. genetic, constitution of different groups within a species" (Rack, 1982, p.15). Race is a biological term. According to Rack (1982), culture is more important in relation to the behaviour and reactions of an individual than genetics, although, genetically determined biological variations cannot be entirely overlooked. For example, he continues to say, there is some evidence to suggest that the breakdown of some drugs is different in members of certain groups so they are likely to be less effective or more toxic. Ethnicity is used to "denote groups that are mainly identified by their culture and in which marriage within the group has been the norm" (ibid. p.18). From this term we can infer that within an ethnic group, culture is transmitted from one generation to the next and that a common genetic ancestry is shared. In addition, it seems that ethnicity comprises both the cultural and racial aspects of individual differences. Culture impinges in the whole person and the whole of society. Therefore, it would seem important that, as professionals delivering psychological therapy, we are aware of the impact that culture has on us and our clients.

Trans-cultural or cross-cultural therapy first arose out of the realisation that therapy as usual did not work with many clients outside the cultural mainstream. Multicultural therapy is by its nature diverse because different theories have distinct features that appeal to different cultural groups (Corey, 1991).
D'Ardenne and Mahtani (1996) emphasise the active and reciprocal aspects of the therapeutic process when dealing with clients from diverse cultures. As with all therapeutic encounters, there are three key elements to trans-cultural therapy: the client, the therapist and the therapeutic process. Due to restrictions of space, the present paper will focus mainly on the therapist and the therapeutic process.

The client
Clients come to therapy holding a number of expectations and attitudes about the content of the sessions, the therapeutic relationship, the role of the therapist and the aim of therapy. Such expectations may not be expressed during the session, however, the therapist ought to be aware of and address them appropriately, otherwise, they may become part of a large hidden agenda which may hinder the therapeutic process (D’Ardenne & Mahtani, 1996). For example, the expectation that the therapist holds similar attitudes to the client or whether prejudices have any bearing in the therapeutic relationship.

The therapist
Effective multicultural practice demands that therapists become aware of the professional and personal influences, assumptions and biases that determine and direct their interventions. Therapists that depend entirely on their own internalised value assumptions become as Pedersen (1988) defines, “encapsulated”. He explains encapsulation as a process in which professionals rely on stereotypes in making decisions about people from different cultural groups, ignore cultural differences among clients and define reality according to one set of cultural assumptions. Unaware of how culture influences us or of the cultural dimension that our clients bring to therapy we may ascribe universal value and importance to such factors as individualism, progress and rigid timetables which may result in misunderstandings and clashes of expectations. In consequence, clients may be viewed as unmotivated, resistant and lacking in ability to think through and communicate their problems and experiences in a meaningful way. Similarly, practitioners may be viewed as remote and uninterested (Draguns, 1996).
Corey (1991) believes that the key to effectiveness rests with the attitudes and beliefs of therapists and it involves examining one’s own expectations, attitudes and assumptions about working with culturally different clients. Firstly, it is essential to outline the assumptions implicit within the theoretical approaches that professionals are trained on and work with. Such models have been developed by white, middle-class practitioners enmeshed in western cultural values. Within the white western culture, the internal self and the independent individual are given overriding importance, thus, psychological therapy is aimed at encouraging self-centredness, self-exploration, self-disclosure and self-determination. On the other hand, these goals may not be suitable for people from cultures where the interdependent self is more important, that is, cultures that put family or another social unit above the individual, and interdependency is considered not only healthy but necessary (Casas & Vasquez, 1996). Secondly, cultural differences may surface when evaluating “acceptable” patterns of clients’ behaviour. The interpretation of behaviour in terms of the therapist’s values rather than those of the client can result in erroneous assessment and diagnosis, and potentially ineffective interventions. For example, silence at the beginning of the session may be interpreted as resistance. However, clients may perceive the therapist as an authority figure who needs to be listened to respectfully. Casas and Vasquez (1996) specify that what is considered “acceptable” behaviour must be evaluated and understood according to the situation, the cultural background and the time in which the behaviour is observed. Furthermore, ethnic minority groups may be subject to socio-economic stresses including adjusting to a new culture, feelings of isolation, economic disadvantage and harassment which may contribute to their difficulties.

In order to work effectively with clients from diverse cultures, counselling psychologists need multicultural training that emphasises differences in the behaviour of individuals that seek help, as well as differences in perceptions of mental health (Wright, Coley & Corey, 1989). A list of competencies which were proposed to be incorporated in training programmes for multicultural therapy was developed by the
Counselling Psychology Division of the American Psychological Association (Sue, 1981; Sue et. al., 1982). Corey (1991) lists some of the characteristics:

1.- Beliefs and attitudes of multiculturally effective therapists: They are aware of their own values, attitudes and assumptions and how these are likely to affect the therapeutic process. They can appreciate and respect diverse cultures and believe that an integration of the therapist’s and the client’s culture can contribute to their growth. Finally, they are empathic and sensitive to circumstances.

2.- Knowledge of therapists that work trans-culturally: They understand the impact of oppression and racism and are aware of institutional obstacles that prevent ethnic minority groups from making a full use of psychological services. They are aware of the basic assumptions of major theoretical approaches and how they interact with the values of different cultural groups. They have an awareness of culture-specific ways of helping and they have specific knowledge about the historical background, traditions and values of the group they are working with.

3.- Skills of therapists dealing with clients from other cultures: They are able to employ a wide range of methods and are capable of adapting and modifying conventional approaches to accommodate cultural differences. They have the ability to send and receive verbal and non-verbal communications accurately and appropriately and they are able to take an advocacy stance when it is necessary.

Without specific training therapists may fail to appreciate the role that culture plays in psychological development and functioning. In addition, they may concentrate solely on the presenting problem, failing to evaluate it within an appropriate socio-cultural context (Casas & Vasquez, 1996).

**The therapeutic process**

A basic component of the therapeutic experience that remains constant across cultures is a trustful and open relationship between the therapist and the client. As Draguns
(1996) indicates, the relationship is generally more important than technique. Practising across cultures requires flexibility in adapting therapeutic approaches, formats and interventions that are congruent with the value systems of diverse ethnic groups. A crucial part of the therapeutic process is the establishment of boundaries. Some are made explicit in the agreement or contract with the client such as the time and place of the meetings, procedure for cancellations and absences and whether one can phone the therapist in an emergency. Other boundaries may not be so explicit and may include non-verbal behaviour like how far apart one arranges the chairs, touching and eye contact. In trans-cultural settings, clients may be unfamiliar with the therapeutic process. Thus, Hare-Mustin et. al. (1979) specify the importance of letting clients know about the procedures and goals of therapy.

Another important aspect of psychological therapy is the way in which clients communicate their distress. There is general consensus that complaints and presenting difficulties differ across cultures (Draguns, 1996). Cultures may vary in the amount of self-disclosure that they encourage or tolerate and in the methods employed to express distress. For example, East Asian civilisations rely more on non-verbal and immediate experiences than on verbal and analytical communications (Morsbach, 1973) and in China somatic channels are preferred (Kleinman & Lin, 1981). Rack (1982) gives the example of an Indian woman who was complaining of pain in the back, limbs and head, and generalised weakness. Asking the right questions, feelings of unhappiness and other features of depression were elicited. In contrast, a British woman described her mood first and her somatic symptoms after.

Clients may be influenced by cultural taboos against openly discussing personal or family matters. According to Casas and Vasquez (1996), most of the world's cultures view revelations of a personal nature to strangers as unacceptable. The acceptable pattern is to handle difficulties within the family or other natural support system. In order to establish a therapeutic relationship, the therapist needs to respect and understand the client's worldview rather than challenge it. In this way, as the clients'
trust builds and they gain an understanding of how therapy can be used for their benefit, they are more likely to be open and share their experiences with the therapist.

To conclude, all therapy occurs within a cultural context and, as Draguns (1975) describes, culture is the invisible and silent, yet crucial, component of the therapeutic experience. Therefore, if we are to conduct effective psychological therapy across cultures we need to be aware of and address such essential component. In the light of the existing literature, the practice of counselling psychology in a trans-cultural context would need to be based on:

1.- Developing an ability to see clients as having unique experiences.
2.- Maintaining an appropriate perspective on the differences between the client’s and the psychologist’s cultural environment.
3.- Awareness of the implications that culture has on both the client’s and the therapist’s worldview and behaviour.
4.- Evaluating presenting problems within an appropriate socio-cultural context.
5.- Employing research to assess psychologist’s interventions and encourage understanding about clients from different cultures.
6.- Specific training.
7.- Flexibility.

Presently, most of the skills mentioned above form part of what counselling psychologists can offer. However, it seems that an increased emphasis and awareness on cultural issues need to be particularly attended to by practitioners and training courses, in order to be better equipped to practise effectively across a variety of contexts and settings.
References


Factors that may hinder the development of the supervisory relationship

Given the relative small number of Chartered counselling psychologists and the growing demand from some counselling psychology courses to offer their trainees a counselling psychologist as placement supervisor, it is very likely that providing supervision will form an integral part of counselling psychologists’ professional activities.

It could be argued that experiences as practitioners and supervisesees provide sufficient knowledge and skills to become competent supervisors. However, the literature suggests otherwise. Neither clinical competence as a therapist nor experience as a supervisee is a guarantee of competence as a supervisor (Clarkson & Gilbert, 1991; Farrell, 1996).

Farrell (1996) explains that although there are considerable overlaps between the practice of counselling psychology and the supervision of counselling psychologists, they remain separate areas of professional activity and as such they require their own training and professional development. Yet, at present, in the UK, supervisor training and recognition pertains almost solely to the field of counselling. He continues to say that the provisions for supervision of counselling psychologists preparing for the BPS Diploma in Counselling Psychology are minimal.

In view of the likelihood that supervision will form an important aspect of counselling psychologists’ professional activities, the present paper will explore issues related to the process of supervision. In particular, the supervisory relationship and factors that may hinder the development of such a relationship. Due to limitations of space, a detailed discussion of the different models of supervision will not be included. For a review of different models of supervision, please refer to Hawkins and Shohet (1989) and Carroll (1996).
Carroll (1996) divides supervision into training supervision and consultative supervision. Training supervision is part of the ongoing educational training of a student. Consultative supervision, on the other hand, is an arrangement between two qualified practitioners. Throughout this paper, the term supervision will refer to one-to-one training supervision.

Kurpius et. al. (1991) present a broad definition of supervision of helping professionals which has been put forward by several educators: “[Supervision is a] Teaching procedure in which an experienced person aids a less experienced person in the acquisition of a body of knowledge and experience that will foster competence and skill in handling therapeutic situations.” (p.48).

Other definitions are provided by Carroll (1996):

An arrangement whereby a student who is training in counselling/ psychotherapy/counselling psychology meets with a supervisor who is an experienced counsellor/psychotherapist/counselling psychologist to review and reflect on the therapeutic work of the trainee. Thus, the main purposes of this relationship are the professional development of the supervisee and the welfare of the client. (p.8)

And the guidelines for the professional practice of Counselling Psychology: “Supervision/ consultative support is a contractually negotiated relationship between practitioners with the purpose of supporting, evaluating and developing professional practice” (2.1.1).

From the above definitions, it can concluded that one of the core aspects of supervision is that it involves a relationship between supervisor and supervisee. As in the therapeutic relationship, there are factors that may hinder the development of the supervisory relationship and also require some ethical consideration. Such factors include: previous relationships, power differential and blurred boundaries. Below, each of these factors will be considered in turn.
**Previous relationships**

As Shohet & Wilmot (1991) point out, previous experiences of supervision and other relationships may colour how the supervisor is seen by the trainee, particularly if such experiences have been negative. Also, previous experiences with other supervisees may influence how the supervisor interacts with the supervisee. It is assumed that because supervisor and supervisee may already be colleagues or may become so in the future, the influence of previous relationships is not as strong as in the therapeutic relationship. However, this may not be the case.

Thus, in order to address such issues, Shohet and Wilmot (1991) recommend that supervisors and supervisees share their history of giving and receiving supervision.

**Power differential**

The teaching and caretaking components of the supervisory relationship are hierarchical functions whereby the more experienced person (the supervisor) is entrusted with the well-being of the less experienced person (the supervisee). This sets up a dynamic of power imbalance in the supervisory relationship.

As Pinderhughes (1983) wrote, power and powerlessness operate hand in hand whereby individuals who feel powerless and vulnerable may cope with it by assuming a power stance over others. Thus, in situations where a supervisor feels unsupported and undervalued by the institution or is vulnerable to self-doubts about his/her own competence, there is a serious potential for using his/her power to gratify self-esteem needs of his/her own (Alonso, 1985; Jacobs, 1991). A supervisor may use the “helping role to reinforce... [his or her] own sense of competence by keeping subordinates in a one-down position” (Pinderhughes, 1989, p.111).

Such power imbalance may foster an atmosphere of mistrust in which the trainee may feel devalued, humiliated, ignored or critised in a nonconstructive way by the supervisor. The implications for the supervisory relationship are twofold:
Firstly, supervisees may not feel safe enough to be open about what goes on in their work. Instead, they search for what the supervisor is looking for and wants to hear (Boudry, 1993). As a result, when there are problems in the relationship, trainees seem to be more concerned with concealing difficulties in their performance than with exploring and learning from them. If this is the case, supervision does not fulfil any of its purposes as stated by Carroll (1996). On the one hand, the supervisor is not able to aid the development of the trainee. On the other hand, neither the supervisor nor the supervisee are in a position to keep the client’s welfare at the heart of their concerns which goes against the guidelines of professional practice of counselling psychology. The guidelines state that: “The responsibility of both supervisor and supervisee to the client is paramount” (2.1.9).

Secondly, trainees may be reluctant to voice any disagreements with the supervisor even when they might have reasonably good grounds to do so. Pinderhughes (1989) claims that in any hierarchical situation, the people in power define reality. Thus, supervisors can refute or pathologise students reactions, including healthy, assertive behaviours, without threatening their own reputations or institutional base of support. As “experts”, their power advantage includes enhanced credibility. Even in clear-cut conflicts such as students’ complaints of insufficient supervision time, the student’s credibility is at risk in a my-word-against-yours presentation of events.

Not addressing conflicts in the supervisory relationship leads to a greater alienation on a personal level between the supervisor and the supervisee, which can only have a harmful effect on the educational process. It leads to a build-up of negative affects which can result in mistrust and withdrawal. Thus, the supervisor’s ability and willingness to deal with conflict in an open discussion is an important aspect of the supervisory relationship (Shohet & Wilmot, 1991).

Furthermore, acceptance of the supervisee’s negative feelings is not only important for the sense of safety and for ensuring good work, It also acts as a role model for the relationship between the supervisee and the client. Such position is congruent with the
guidelines for professional practice in counselling psychology which state that: “The relationship between the supervisor and supervisee will be characterised by mutual respect for competence and differing values, non-exploitation and good modelling” (2.1.5).

Further recommendations for supervisors are made by The Association for Counsellor Education and Supervision Standards (1988). It notes that supervisors should feel comfortable with their authority yet recognise their limits (2.3), strengths and weaknesses (2.8) and patterns in interpersonal relationships (2.9). These standards highlight the potential problem areas in which the supervisor may not fully recognise the establishment of his/her own agenda such as using power and authority for self-fulfilment. Kurpius et. al. (1991) also recommend that supervisors, just like therapists, require peer evaluation, consultation and support and sometimes personal therapy, in order to maintain objectivity toward the supervisee in situations that might involve authority and power.

**Blurred boundaries**

The guidelines for professional practice of counselling psychology state that: “As in client/practitioner relationships, the personal and often intense nature of supervision and training relationships in counselling/psychotherapy require practitioners to be especially sensitive to boundary issues and particularly careful in the area of dual relationships.” (2.3).

In this section, the very diffuse boundary between the roles of supervisor and evaluator and between supervision and therapy will be addressed.

**Supervisor versus evaluator**

The supervisory process requires on the part of the supervisee a considerable amount of personal involvement and degree of revelation about the workings of his/her mind and sharing emotions. This process creates intimacy and is also quite threatening. In contrast to the therapeutic relationship in which clients are assured of a non-
judgmental reception, supervisees know all the time that they will be judged and evaluated by their supervisor and that to a greater or lesser degree, advancement in their careers is dependent on the type of evaluation they receive (Baudry, 1993).

The prospect of being evaluated engenders in the supervisee fears about needing to appear competent in front of someone in whose hands one’s future may lie. Many of the conflicts in supervision reflect the fact that the supervisor functions both as mentor and as evaluator. Greenburg (1980) recognises that to the degree an evaluation is seen as potentially threatening, the supervisee is proportionately likely to be pushed toward performing for and pleasing the supervisor. While some anxiety is functional in providing motivation for change, too much anxiety may restrict the supervisee’s openness and initiative.

In order to address such anxieties, Feltham and Dryden (1994) suggest the negotiation and implementation of reciprocal evaluative review sessions on a regular basis. They believe that without some mechanism for standing back and getting a perspective on supervision, there is the danger that the teaching alliance will be weakened and the supervisee’s work undervalued. Furthermore, as Davies (1989) comments “evaluation occurs whether or not it is made explicit or formalised. On balance there are advantages to formal and reciprocal evaluation procedures” (p.36). Attention needs to be drawn to the reciprocal nature of such sessions. Thus the focus is not only on how the trainee is doing but also on concerns from both parties about the supervisory relationship.

Concerning the supervisees, often they want to know how they are getting on and gain a sense of their own weaknesses and strengths which they derive from the supervisor’s feedback, thus, clear feedback is particularly necessary (Feltham & Dryden, 1994). Friedlander et. al. (1989) define feedback as “a statement with an explicit or implicit evaluation component that refers to attitudes, ideas, emotions or behaviours of the trainee or to aspects of the trainee-client relationship or the trainee-supervisor relationship” (p.151). Whatever model of therapy and supervision practitioners adhere
to, and whatever supervisory method is predominantly employed, it is important to consider what is hoped to be achieved and whether the feedback is as clear, constructive and helpful as it might be. Supervisors’ feedback does not always have to be positive but it needs to be specific, contextualised, jargon-free, mutually understood and useful. Feltham & Dryden (1994) list a number of factors that may impede clear feedback:

- Assumptions about the trainee’s knowledge may lead to the supervisor to either talk down or to talk over the trainee’s head.
- Differences between the supervisee’s and supervisor’s culture, class and other significant social variables may lead to misunderstandings.
- The supervisor’s emotional reaction to the trainee may lead the supervisor to convey conflicting messages or overwhelming criticism.
- The supervisor may offer non-specific feedback in global terms such as “I think you are doing really well” or “you’ve got a lot of improvements to make” which do not identify precise ideas for consideration.

These points are intended to show that there is ample scope for miscommunication so careful consideration of the messages that supervisors are trying to convey is necessary.

With regards to the review of the supervisory relationship, salient areas to explore about the supervisory relationship could be: Are we trying to achieve the same goals in supervision? Is the style of supervision helpful?. Exploring such issues face-to-face may be too challenging for supervisees, specially given the power differential. Thus, one way of gaining detailed information on the supervisee’s perception of the quality of the supervision is to use a comprehensive questionnaire. When these are employed, it is important to give permission and encouragement to supervisees to be frank and also to follow up on the evaluation. This exercise obviously requires a highly non-authoritarian approach. Indeed, it is crucial to the entire atmosphere of review sessions that both parties respect each other’s right to give constructive feedback.
Supervision versus therapy

Supervision is a unique learning situation which cannot be limited to the intellectual plane alone, and which, because of the emotional charge involved, is highly suggestive of the therapeutic situation.

In some instances the supervisee will allude to certain crises in his or her outside life. These events cannot be entirely ignored, particularly if they have some obvious impact on the supervisee’s capacities or relate to the work with the patient in a more direct fashion. Berman (1988) and Ben David (1994) believe that the need to address the emotional level in supervision results from recognising the emotional intensity that can accompany the supervisory process and from the agreement that the intervention of the supervisor on this level contributes to advancing the learning process and formulating the professional identity of the supervisee. Yet intervention is liable to jeopardise the supervision by spilling over onto the therapeutic relationship, a result that may harm the effectiveness of the supervision, the supervisee, and professional ethics.

Itzhaky and Itzhaky (1996) point out that the integration of therapy in supervision remains a subject of controversy while on the practical level there are not enough guidelines for carrying out the various recommendations. The supervisee’s confrontation with a dead end or a blind spot is liable to constitute the first step in the direction of therapy. How can the supervisor prevent this?

Baudry (1993) first talks about what does not work: a repetitive confrontation of the supervisee’s difficulties discussed only on the technical level is likely to be experienced as humiliating. A suggestion that he/she requires more therapy or should examine himself/herself will probably seem intrusive or judgmental. The supervisor needs to bear in mind that the role of supervision is to help the supervisee work with patients. Thus, the most appropriate and least damaging approach would probably be to simply identify the supervisee’s dilemma in relation to the client or the supervisor.
To conclude, a summary of the recommendations will be presented below. They include recommendations already mentioned in the discussion in addition to other recommendations presented in the existing literature about teaching supervision.

**Recommendations**

- Supervisors and supervisees are encouraged to share their history of giving and receiving supervision.
- Emphasis is given to the ability and willingness of supervisors to deal with conflict in an open and mutually respectful manner.
- There is a need to accept the supervisee’s negative feelings.
- Supervisors need to feel comfortable with their authority, yet recognise their limits, weaknesses and strengths and patterns of interpersonal relationships.
- Supervisors require peer evaluation, consultation and support.
- It is important that supervisors negotiate and implement reciprocal evaluative sessions on a regular basis.
- Supervisors may need to address the emotional level in supervision but keeping in mind that the role of supervision is to help the supervisee work with clients, thus, it is necessary to keep supervisee’s issues in the context of their work with their clients or the supervisory relationship.

- The literature on training in counselling psychology clearly points out the need for supervisors to be trained. Clarkson and Gilbert (1991) have set out the most comprehensive view of the requirements for the training of supervisors, although this is in relation to their preparation for the training of counsellors. In the field of training counselling psychologists this has yet to be made explicit.
- As part of setting the supervisory relationship, clear contracting is needed. Ground rules need to be established about the purpose of supervision, frequency, duration, place and about how cases are to be discussed and also about how the supervision and work will be reviewed and evaluated.
References


Therapeutic Practice Dossier
**Introduction to the therapeutic practice dossier**

This section of the portfolio contains work related to the three practical placements completed over my training and the development of therapeutic skills. It includes a short description of each of the placements followed by a brief overview of the three years experience. In addition, a summary of four client studies and a discussion of process issues derived from three process reports will be presented.

In order to preserve clients' confidentiality, names or any other identifying information has been changed. Furthermore, the originals of the client studies and the process reports will not be included in this public document.
Outline of the first year placement

The first year placement was for two days per week in a Community Mental Health Team. The team was comprised of various mental health professionals which included community mental health nurses, social workers, a support worker, occupational therapists, two consultant psychiatrists and a clinical psychologist. Clients tended to be referred to the team primarily by general practitioners but referrals from other health and social care professionals were also considered. The population served by the team was within the 16-65 year age range with short, long term and acute mental health problems. The team held a weekly meeting when referrals were allocated to the most appropriate professional according to the clients' presenting difficulties. An initial assessment was then carried out by that particular professional in order to gather background information and ascertain the client's specific concerns. Depending on whether the mental health practitioner felt that he/she could meet the client's needs, he/she would offer the client the necessary help or would bring the case back to the allocation meeting so another professional more pertinent to the client's difficulties may be involved. The allocation meetings were also a forum where team members could bring their difficult cases for discussion. As an active member of the team, I attended allocation meetings in order to take on psychology referrals.

Clients referred for psychological therapy presented with phobias, anxiety, eating difficulties, relationship problems, low self esteem and depression. There was no restrictions on the number of sessions offered but, on the whole, the agreed number of sessions offered were six to twelve. Individual supervision with the team's clinical psychologist was on a weekly basis and the style of supervision tended to be person-centered. However, depending on the nature of the therapeutic work, supervision also included cognitive-behavioural approaches.
Outline of the second year placement

This placement entailed providing one-to-one psychoanalytic psychotherapy two days per week at the premises of a Community Mental Health Team. The psychotherapy services of the area were run by a consultant psychotherapist and a small number of honorary psychotherapists under his supervision. Clients were referred to the consultant psychotherapist by general practitioners and community mental health practitioners such as the psychiatrist. Clients were then assessed by the consultant psychotherapist in order to ascertain their suitability for long-term psychoanalytic psychotherapy. Once clients were found suitable for psychotherapy, they were placed in the waiting list until a space became available with an average waiting time of about three months. Prior to taking on any cases, the consultant psychotherapist would make available to the honorary psychotherapist the client’s assessment notes and discuss the client with him/her to ensure that it was an appropriate referral.

During this year, I saw a small number of clients for the duration of the placement. Their difficulties included depression and problems in anger management. Supervision was with the consultant psychotherapist on a weekly basis. The style of supervision was psychoanalytic both in a one-to-one and group context. Towards the end of the year, I was involved in the assessment of clients referred for psychotherapy and also co-facilitated an anger management group with an occupational therapist.
Outline of the third year placement

During the final year, the placement was for two and a half days per week in a Community Mental Health Team. The team was comprised of community psychiatric nurses, occupational therapists, a support worker, approved social workers, mental health social workers, two consultant psychiatrists, a consultant clinical psychologist and a counselling psychologist. Referrals to the team were primarily made by the general practitioners of the area. The population served by the team was within the 16-65 year age range with short, long term and acute mental health problems. The team held weekly meetings were referrals were allocated to a practitioner who would then assess the client’s needs. Details of the assessment were brought back to the allocation meeting when in the light of the client’s needs, the team would discuss what services would be most appropriate. Clients referred for psychological therapy were put on a waiting list. Prior to taking on any cases, they were discussed with my supervisor. There was no restriction on the number of session offered. However, therapy contracts tended to be between six and twelve sessions. The client group psychologists served was varied in terms of age, gender and presenting difficulties. Presenting problems included phobias, anxiety, depression, obsessive-compulsive disorder, post-traumatic stress disorder, eating difficulties and sexual abuse.

Individual supervision with the consultant clinical psychologist was on a weekly basis. The style of supervision placed emphasis on the development of cognitive-behavioural techniques in line with the third year training requirements but was also integrative paying attention to both psychodynamic and cognitive-behavioural approaches according to the type of presenting problem and individual client characteristics.
Overview of my experiences on three placements

The present paper is an overview of the three years of professional practice throughout my training. My clinical experience focused on adult mental health whereby placements are undertaken for twelve months. They will be presented in chronological order starting with my first year placement followed by the second and third year placements.

During my first year, I was in a community mental health team supervised by the team’s clinical psychologist. As an active member of the team, I attended allocation and departmental meetings. Participating in the team and departmental activities allowed me to gain a deeper understanding of organisational issues. What I remember most vividly was the introduction of the governmental policy on supervised discharge and experiencing for the first time how government policy filtered down to affect directly the team’s policies and the role of the various professionals within it. In addition, I had the opportunity to shadow some members of the team which enabled me to observe how other mental health professionals operate and gain a better understanding of their particular role in the community.

The most challenging aspect of my first year placement was the fact that it was my first experience of working therapeutically. Following an intense skills training at the beginning of the course, I started my placement were clients were referred to me for psychological therapy. It was very daunting to think that these were real clients with real difficulties who expected me to help them in some way. Particularly difficult was the application of the theoretical knowledge that we acquired at university to real cases. The emphasis on my practice at that stage was trying to follow as closely as possible what I had been taught hoping that I was doing it right. As a first year trainee I did not feel very confident in my own abilities as a practitioner which manifested itself on both a tendency to blame myself if a client dropped out of therapy and on a need for reassurance from my supervisor.
Supervision throughout the first year would have been better if it had provided a forum where I could reflect on my practice and bridge the gap between theory and practice. This meant that at times while trying to make sense of the clients' material and its impact of the therapeutic relationship I felt somewhat confused and overwhelmed. One of my year colleagues was also placed in the same setting and I found myself turning to her for support. The university group supervision and my personal therapy became essential components in contributing to my development as a practitioner. Nevertheless, supervision was good as a place to discuss the management of difficult cases which enabled me to develop an awareness of a wider perspective in terms of where psychology services fitted in with team service provision policies and governmental policies.

My first year experience made me realise about the importance of supervision as a means to reflect on my practice which would then result in heightened self-awareness, awareness of the client's and process issues and awareness of the therapeutic relationship. As a result, having a good supervisor became the main requisite for my second year placement.

During my second year placement, I worked within a psychoanalytic model supervised by a consultant psychotherapist. Initially, I had a number of concerns about practising psychoanalytically which made me feel somewhat anxious. Firstly, I had the feeling that in the practice of psychoanalysis there were a number of 'dos and don'ts' which seemed to exacerbate my sense of having to get it right and live up to my supervisor's expectations. Secondly, I believed that psychoanalytic psychotherapy was more demanding and intense leading to me questioning whether I would be able to tolerate it. However, with the help of supervision and the opportunity to observe my supervisor, those concerns dissipated and I gradually became more confident in my capabilities.

An important aspect of my development during the second year was the sense I had of my supervisor's trust in my abilities. I felt treated with respect and as a colleague at
the same time as being contained which resulted in a heightened sense of identity as a professional and an increased confidence as a competent practitioner. Due to the nature of the work and the set up of the team, close involvement in the team’s activities proved difficult which meant that particularly at the beginning, I felt somewhat isolated. The group supervision played an important role in lessening my feelings of isolation and as my self-confidence grew, I welcomed the opportunity to work more independently. Towards the end of the placement, I was entrusted by my supervisor to conduct extended assessments in order to establish clients’ suitability for long-term psychotherapy. I was also co-facilitator in an anger management group which run for six weeks which enabled me to broaden my therapeutic skills.

In retrospect, I found working psychoanalytically somewhat restrictive due to its emphasis on boundaries. I recall during a session with a client when she was telling me about a dream where she was painting a big mural and was explaining to me what she was painting, I felt like discussing with her the possibility of actually painting it. However, I was unable to suggest it because I felt it would not be a psychoanalytic intervention. On the other hand, one of most valuable aspects of my experience in my second year placement was having the time and space to reflect on my practice. As a result, awareness of the client’s issues, awareness of my own feelings engendered in the session and the impact that these may have on the therapeutic relationship increased.

My third year placement was in a community mental health team supervised by a consultant clinical psychologist. Once more, as an active member of the team, I attended both team and departmental meetings. Being a final year trainee, I was encouraged to work in a flexible and independent manner whereby I assessed and treated clients with appropriate interventions according to their needs. To do this, I utilised humanistic, cognitive-behavioural and psychodynamic approaches. At the beginning, I was somewhat apprehensive about working within an integrative framework. My fear was that I would become a “jack of all trades and master of none”. Contrary to my belief this was not the case, I feel that my understanding and
application of various psychological theories was firmly consolidated. Working integratively provided me with the flexibility I was hoping for. On the other hand, it also engendered certain amount of anxiety which Cooper and Lewis (1983) termed a "crisis of relativism" in relation to students trying to cope with a diversity of theoretical approaches to psychological therapy. However, I became aware that being able to hold such anxiety was part of a growing maturity as a practitioner. In previous years, there was an emphasis on trying to find out about and follow the 'rules' but in my final year I felt more of a letting go of the anchor and security that the 'rules' provided me. The emphasis seemed to be on my clinical judgement rather than on following a set of rules. I believe that such shift has been possible with the support of my supervisor. She has provided me with the encouragement and reassurance I needed.

Due to the large number of client hours I needed to accumulate in my final year, I was unable to participate in other activities such as observational opportunities, shadowing other members of the team or attending seminars. I feel that being a practitioner is not only about therapeutic practice but also about being aware of organisational issues and continuing professional development. The focus on client hours has meant that I felt I did not make the most of the training opportunities that my placement had to offer me which was somewhat frustrating at times.

In the main, my working experience has been in community mental health teams. Being part of a team has provided me with ample exposure to the ways in which other mental health professionals operate, recognising and valuing their contribution. As a result, I have developed an ability to work effectively within a multi-disciplinary framework and to liaise appropriately with other professionals. In addition, being a member of a larger psychology department has highlighted the value of professional support and the importance of developing psychology services.
References

Summary of the first client study

Presenting problem
Ms. A. is a 60 year old married Greek lady whose main concern was to find the reasons behind the onset, a year ago, of a series of panic attacks. Since the onset of the panic attacks, she had been unable to enjoy the things that she used to like doing and feels demotivated.

Relevant background information
Ms. A. recalled her childhood in Greece during World War II being full of anxiety and uncertainty. Poverty and starvation were widespread and the need to survive was paramount. The relationship with her parents and two younger brothers was very close, in particular with her father who, according to Ms. A., had a great influence in her life. He was outgoing and domineering but was also able to offer her support at difficult times. She described her mother as introvert, perfectionist and dutiful but Ms. A. never felt she could confide in her. Ten years ago, her father died of lung cancer. During that time, Ms. A. stayed day and night at the hospital to nurse him. Following her father’s death, she became preoccupied by her mother’s health who later was diagnosed with a degenerative illness leading to her death three years later. Soon after her mother’s death, Ms. A. began to suffer from panic attacks.

Formulation
Throughout Ms. A.’s account, a theme of losses became apparent. She lost her childhood to the war, her home country by coming to England and both her parents. Ms. A. grew up as a ‘survivor’ where emotions were possibly secondary to the need to survive and be strong. This may have resulted in a tendency to push feelings aside and ‘get on with it’. Thus, Ms. A.’s feelings engendered by the many losses she has experienced seemed to have been pushed underground. However, the death of her mother appeared to have acted as a trigger to the unresolved feelings from previous losses which are manifested in the anxiety symptoms.
The therapeutic relationship
Ms. A believed that physiological rather than psychological factors were underlying her difficulties. Therefore, initially, she seemed doubtful about the benefit of psychological therapy in order to address her panic attacks which meant that the working alliance was somewhat weak. Furthermore, during the initial sessions, she tended to challenge my ability to help her which exacerbated my own doubts as a first year trainee making me feel overwhelmed and underskilled. As a result, I felt reluctant to make interventions which probably fuelled her belief that I would not be able to help her. Once I became aware of these dynamics, I was able to feel more confident about making interventions and take a more directive approach with positive results. Ms. A. regained confidence in my ability to help her and the therapeutic relationship strengthened.

Outcome
During therapy, we explored strategies which would help Ms. A. to manage her anxiety and the panic attacks. She was motivated to employ these strategies which she found very helpful leading to a lessening on the number of panic attacks she experienced. As the therapy progressed, her feelings about her parents’ death were touched on, although Ms. A. remained reluctant to discuss her emotions.
Summary of the second client study

Presenting problem
Mr. O. is a 32 year old man who has been experiencing a long standing low mood with occasional suicide thoughts. He also expressed feeling very insecure and lacking in self-esteem. Moreover, Mr. O. was concerned about his explosive anger which, at times, he found difficult to control. He felt that despite receiving support from friends there were issues which he could not talk to them about.

Relevant background information
Recently, he had broken a six month intermittent relationship with a 17 year old woman. The reason behind the break up was that his girlfriend began to see other men behind his back which had left Mr. O. feeling very hurt and angry.

Mr. O. was born in Ireland and comes from a catholic family. He described having an ‘unhappy’ childhood. His father was a very strict man who used to give him regular hidings whenever he did something wrong. Mr. O. had a close and open relationship with his mother but she would never stand against her husband’s wishes. Throughout his school days, Mr. O. and an older brother used to help their father in the family business. As a result, Mr. O. felt that he was not allowed to have a childhood. He also recalled how his parents had very tight control over his life to the extent of constantly telling him what to do, how and when leading to the feeling that he was treated like a ‘baby’ and not a person in his own right with views and feelings. This generated strong emotions of anger and frustration which he was unable to express for fear of the consequences. If he ever expressed his views, his father would regard it as disrespectful which resulted in punishment.

Formulation
The feelings of hurt and anger engendered in the recent relationship break up can be traced back to Mr. O.’s childhood experiences. As a child, there were many occasions
when he felt unfairly reprimanded by his father which generated feelings of hurt and anger. However, he was not allowed to express these feelings. It was too dangerous and threatening for him to express the anger he felt towards his father so it was pushed underground. Currently, such anger resurfaces in an uncontrollable way when a situation engenders similar feelings like in the recent relationship break up.

The therapeutic relationship
Previously, Mr. O. had been admitted to hospital against his will under Section 3 on the Mental Health Act at the same premises where psychological therapy took place. As a result, he did not trust mental health professionals including myself which I feel impinged greatly in the development of the therapeutic relationship. This was manifested in the client’s reluctance to facilitate personal information. For the majority of initial sessions, the client did not feel safe enough to disclose sensitive material. Therefore, I adopted a very supportive, non-directive approach whereby I worked with the material Mr. O. was willing to provide. Gradually the client begun to disclose information about his childhood experiences which led me to think that the client had started to trust me and felt that the therapeutic relationship was strong enough to contain him. I continued to adopt a sensitive and non-directive approach with Mr. O. in order to build on the trust we had started to establish.

Outcome
During therapy, Mr. O. talked about childhood memories which he had never disclosed to anybody in the past. This unleashed very powerful emotions which we continued to explore for the remaining of the therapy. The client made good use of the sessions and became more aware of the links between her childhood experiences and his current difficulties leading to a reduction in his outbursts of uncontrollable anger.
Summary of the third client study

Presenting problem
Ms. D. is a 36 year old woman who had been experiencing a long standing low mood. She had expressed feeling very insecure, inadequate and lacking in self-esteem. She explained that she had felt like this since her childhood and wanted to understand the underlying factors contributing to her difficulties.

Relevant background information
Ms. D. comes from a large family of nine. Her mother was married twice and Ms. D. is the youngest of four children from the first marriage. The client has also three half siblings, from her mother’s second marriage. She was born prematurely so she had to be taken away from her mother’s side and put in an incubator for two months. Subsequently, when she was six months old, her father left them and her mother re-married soon after. Her mother had a new child from the new husband and spent most of her time with the new-born which led Ms. D. to feel ‘pushed aside’ and rejected by her. Ms. D. never met her natural father and described her step-father as distant and dictatorial. He had a very unpredictable, volatile temper so the children were frightened of him. She stated that she could not remember much of her childhood and that the memories she had were not happy ones. There is one particular incident she recalled vividly. She was five years old and at that time she used to follow her mother everywhere ‘clinging to her apron’. She was almost like her shadow. However, one day her mother told her to “stop clinging to her apron and go off to the shop on her own”. From that day, Ms. D. decided that she would never rely on her mother or anybody else again.

Formulation
Throughout Ms. D.’s history a pattern of loss, abandonment and feelings of being rejected and ‘pushed aside’ seems to emerge. The client’s first experience of abandonment reverts back to when she was taken away from her mother’s side as a new-born to be put in an incubator. Shortly afterwards, her natural father left her and
there was the birth of another child who was preferred by the mother over her so the client felt rejected and 'pushed aside'. In addition, at the age of five, her mother stated that she wanted her to “stop clinging to her apron”. This was probably experienced by Ms. D. as the ultimate rejection by the person she most relied on and depended on. From that day, in order to prevent being abandoned she decided not to depend on anyone again. It would seem that the client’s needs for dependency and unconditional love were repressed and pushed underground. Currently, this seems to give rise to an internal conflict. On the one hand, Ms. D. unconsciously wants a relationship in which she can be dependent and rely on the other person but on the other hand, she wants to avoid getting close to anybody because of her fear of being abandoned.

The therapeutic relationship

Such internal conflict was also manifested in the therapeutic relationship. The sessions with Ms. D. tended to fluctuate between being an account of the previous week’s events where I felt very distant from her to exploring her internal dynamics and feelings when I felt closer to the client. My interventions tended to make links between her current circumstances and past experiences or the therapeutic relationship. Interventions which made reference to the therapeutic relationship tended to be rejected by the client. It is possible that these interventions acknowledged the existence of a relationship between the client and I which may have triggered her fear of becoming reliant on me, thus, rejecting my interventions would symbolise rejecting any emotional involvement. Throughout therapy, there were times when I felt as if I was “banging my head against a wall”. However, I also felt warmth towards her which I feel was essential in establishing rapport.

Outcome

Throughout the therapeutic process, I got the impression that I could only reach a small part of the client because the rest was behind a big, thick wall. Nevertheless, towards the end of therapy, Ms. D. had shared more personal experiences and feelings and was able to make some links between her past experiences and her current difficulties.
Summary of the fourth client study

Presenting problem
Ms. P. is a 20 year old woman. She explained that her difficulties revolved around her eating habits. She had cut down on all fatty foods, although, she ate plenty of fruit and vegetables because they have little calorific value. She did regular exercise but did not employ any purging methods. She planned in advance exactly what she would eat at each mealtime because she feared that once she started eating she would not be able to stop. However, such rigidity left her feeling unsatisfied resulting in frustration because she wanted more but she did not allow herself to have it.

Relevant background information
Ms. P. is the eldest of two, her brother is three years younger. When the client was born, her mother dedicated all her attention to her. However, when her brother was born, she had to share her mother’s attention and love with him. Her relationship with her mother fluctuated from periods when they were close to periods when they were constantly disagreeing. Ms. P. viewed herself as a ‘daddy’s girl’ and felt very close to her father. However, since her parents divorce when she was twelve, she has been unable to spend as much time as she would like with her father resulting in some distancing in their relationship. Despite the difficulties with her parents, she constantly sought their approval in everything she did. Ms. P. did well at school and intended to go to university. However, three weeks into her course she felt very homesick and missed her mother so she decided that she did not want to be away from home and quitted her course so she went back home.

Formulation
In the client’s current and past experiences, a theme of dependency versus independence appears to begin to emerge. Since the birth of her brother, it is possible that Ms. P. felt that her mother no longer loved her and that she no longer gave her enough attention and love. The experience of her mother’s lack of attention and love, in other words, of ‘nourishment’, seems to be reflected in her eating difficulties. The
intake of food can represent the ‘nourishment’ which Ms. P. wants from her mother and her wish to be dependent on her mother the same way a new-born is dependent on its mother. However, she fears becoming overdependent on and engulfed by the relationship with her mother in a way that her sense of self would be obliterated. In order to prevent becoming overdependent she restricts the amount of food/‘nourishment’ she takes and maintains rigid boundaries by way of planning what and when she eats which keep her in control. This, in turn, leaves her unsatisfied and wanting more ‘nourishment’ which seems to set a vicious circle.

Her inability to be independent seems to be reflected in the fact that she was unable to live home in order to complete a university course. It is at this time that the conflict between being dependent and becoming separate from mother came to the fore which coincide with the onset of the client’s difficulties.

The therapeutic relationship
In the first session, it became apparent that Ms. P.’s reason for seeking help was that her mother had requested it. In addition, she was adamant to find out what my opinion was on whether she needed psychological therapy. It seemed that the client was relating to me as she did with her parents whereby she would follow whatever action I suggested in an attempt to gain my approval. Following my interpretation of the situation, we were able to discuss what the client’s own needs were establishing a sound therapeutic relationship.

At times, Ms. P. continued to relate to me as she did with her mother in terms of seeking my approval and striving to comply with the expectations she thought I had of her. However, she was very motivated to change and welcomed my interventions pointing out her ways of relating. I felt that the therapeutic relationship provided the client with a model of a relationship whereby there can be intimacy between two people at the same time as maintaining a degree of separateness and respectfulness that allows them to remain two distinct individuals.
Outcome

During therapy, Ms. P.'s relationship with her mother was explored. We also discussed the connection between food and her wish for 'nourishment' from her mother which resulted in a lessening of her preoccupation with food. Ms. P. made good use of the sessions and reported becoming more aware of the underlying factors contributing to her eating difficulties. Her motivation to change led her to strive towards becoming more her own person and relying less on other people's approval in particular her mother's.
A discussion of process issues derived from three process reports

The present paper is a discussion of process issues derived from three process reports, one from each year of the course. The themes below were selected in order to create a picture of the process of my development as a practitioner. These include self-awareness, awareness of the impact of the therapist’s interventions on the therapeutic process and awareness of the client’s issues.

Quotations from the process reports will employed to illustrate the themes. In order to maintain confidentiality, I will only refer to my own commentaries in the reports and the name of the client will be substituted by ‘the client’, in brackets.

Self-awareness is a theme that appears throughout the three years. Through reading the process reports, I was able to distinguish two aspects within the broad concept of self-awareness. Firstly, the degree of knowledge about one’s own feelings and personal issues which are engendered in the session. Secondly, the degree of knowledge about one’s own motivations and aims when making a particular intervention. These two aspects seem to broadly fall into a distinction between emotional and cognitive awareness.

Throughout my training, evidence of awareness of the reasons behind a particular intervention and the desired aim of it has been consistent. Initially, it was slightly more prominent, perhaps because, as a first year trainee, I felt I needed to justify and validate my actions. However, this subsided with time.

"The aim of the intervention below was to reflect on the process the client had recounted" (Process report from the first year).

As the training progressed and the confidence in my own abilities increased, I focused on other areas of my practice. One of those areas was the degree to which I was aware of my own feelings engendered by the client’s material. Early on in my training, I
realised that I paid little attention to how I felt in the sessions. This is reflected in the fact that in my first process report there was hardly any mention of my own feelings in the session. On the whole, my focus was to try to make sense of the client's material by employing intellectual knowledge to the detriment of emotional knowledge (what I mean by emotional knowledge is the use of the therapist's feelings to help him/her to make sense of what happens in the session). My tendency was to devote all my attention to what the client was saying.

Due to my emphasis on the client's material, there was little space for my self in the therapeutic process. As Casement (1985) suggests, a therapist has to discover how to be psychologically intimate with a client yet separate. The use of supervision, personal therapy and experiential workshops increased my ability to separate my self from the client's and reflect on my own feelings during therapy. Evidence of this can be found in later process reports:

"Working with (the client) has been very challenging, she has very strong defences in place which meant that at times I felt very frustrated and disskilled" (Process report from the second year)

"In the session, as I became aware of my stuckness, I dropped the subject and I began to feel more in tune with the client" (Process report from the third year)

Instances from the process reports suggest that my level of self-awareness has increased throughout my training which has encouraged me to think about my own strengths and limitations.

Another issue that was highlighted by reading through the process reports was the impact of the therapist's interventions on the therapeutic process. In psychological therapy, there is a lot going on both at an overt and a covert level so it is likely that therapists will miss something. Having a written transcript of a therapy session has
provided me with the opportunity to look at the interaction between client and therapist in a more detailed manner. As a result, I have been able to become more aware and comment on the particular impact that my interventions had on the client, the therapeutic relationship and the progress of the session.

"The client goes on to clarify to me what she was trying to say. I felt that my intervention affected the rapport with the client and broke the flow of the session" (Process report from the third year)

"From this point on, we no longer seem to focus on the client's inner world but rather on what has been happening at work. The beginning of this switch seems to coincide with my intervention below which means that perhaps my comment encouraged such switch" (Process report from the third year)

On the whole, such awareness has been developed on hindsight when analysing the transcripts. However, as the training progressed, sensitivity to the effect that my interventions have on the therapeutic process has increased resulting in greater insight within the session. This has allowed me to gain a better understanding of the client’s issues and offer more appropriate interventions. Evidence of awareness of the impact of my interventions is restricted in the second year process report. The reason for this might be that the second year report is verbatim whereby the content of the session is based on my recollections of it rather than on the transcription of a recording. The content of the verbatim process report is likely to be affected by memory biases. Due to these, probably many of the subtleties and specific words of the interaction between therapist and client are missed, thus, it is difficult to comment on them.

Awareness of the impact that my interventions had on the client, the therapeutic relationship and the progress of the session has provided me with a tool to evaluate their appropriateness:
"His response seems to dismiss my interpretation entirely which leads me to say that the timing was probably not appropriate" (Process report from the first year)

"The way (the client) acknowledges by intervention with a 'yeah' would lead me to incline towards the idea that my intervention reflected accurately the client's material" (Process report from the third year)

For me, two valuable aspects of writing up process reports have been firstly, to become aware of the importance of issues such as tone of voice, timing and wording of my interventions because of the effect that they have on the therapeutic process. Secondly, to employ the client's reaction to an intervention as a tool to evaluate it's appropriateness, accuracy and timing.

Finally, evidence on the level of awareness of the client's issues has varied across the three years depending on whether the session presented was from the beginning, middle or end of the therapy, the theoretical framework and my professional development.

In the first process report, the session transcribed was the second which meant that my formulation about the client's difficulties was at a preliminary stage. Also being on my first year, my ability to become aware of the client's issues at an earlier stage of the assessment was rudimentary. Nevertheless, there is evidence of my awareness of the client's issues:

"I got the impression that (the client) wanted to run away from his feelings both psychologically and physically" (Process report from the first year)

In the second process report, comments on the client's issues are much more abundant. The theoretical framework throughout the year was psychoanalytic which meant that I saw a small number of clients for long-term therapy. As a result, I found
that there was more space for me to reflect on my client's difficulties and how they affected the therapeutic process. In addition, during supervision more time was available to discuss each client resulting in more a in-depth understanding of their difficulties. This is reflected on the existing evidence throughout the process report:

"(The client) seems to project that aspect of herself onto others but then she feels persecuted by it" (Process report from the second year)

In the last process report, awareness of the client's difficulties is maintained.

"I got the impression that her patterns of thinking and being in relation to work are somewhat entrenched but her thought process in the session showed that she is beginning to challenge those patterns" (Process report from the third year)

However, as awareness and comments on other issues of the therapeutic process increased, statements related to client's issues appear to be less than in the second year. This is not to say that my level of awareness decreased but rather that the analysis of the transcript broadened to other areas of the therapeutic process providing a more comprehensive piece of work. As my training progressed, I had become more aware of the different aspects involved in the therapeutic process, thus, my comments reflect such broadening of my awareness.

An issue related to awareness of the client's issues is the extent to which the therapist actually shares such knowledge with the client. Reading the process reports, I noticed that there was a clear progress in this matter. Gradually, as a became more confident as a practitioner and more trusting in my own abilities, I was able to share more readily my hypothesis with the client in order to check them:

"It is possible that the client fears she would become like her mother and all the implications that would follow from that. In the following intervention, I
express such hypothesis” (Process report from the second year)

“This was my hypothesis which I shared with the client in the following intervention. The client appears to confirm my hypothesis and goes on to explore another aspect of the connection between her self-worth and achieving” (Process report from the third year)

Initially, I had a strong feeling that I had to get it right. Therefore, if I was unsure about my understanding of the client’s issues I would not feel confident in sharing it with the client. Later on, I feel that the sessions with my clients have become more open and transparent and I am more confident about my abilities as a competent practitioner resulting in an increased ability to be aware of and accept my fallibility.

In conclusion, the themes above seem to illustrate that my development as a practitioner is not a straight forward linear progress but rather a process with peaks and troths. I believe that the troths have been as important as the peaks in order to learn about both my strengths and limitations. Throughout the training, the growing sense of self-confidence has played an important role in allowing me to make use of my therapy mishaps in a constructive way.
References

Research Dossier
Introduction to the research dossier

This section contains the research projects conducted during the three years of training. The first study is a literature review of the disciples of family therapy and group therapy as distinct but also similar modes of intervention. The second project is a qualitative piece of research which focuses on the process of adaptation among international students. Finally, the third year research was also qualitative and explored therapists' accounts of the factors which in their experience contributed or hindered to effective cross-cultural therapy with international students.
Group therapy and family therapy: A comparative study

ABSTRACT

The use of group and family therapy as distinct modes of psychological intervention is well documented. The present paper reviews the existing literature on both disciplines and explores the similarities and differences between group therapy and family therapy in terms of their historical background, theoretical assumptions and the treatment context in which they are employed. In addition, implications for practice and research will be considered.
The present literature review explores the similarities and differences between group therapy and family therapy in terms of their historical background, theoretical assumptions and the treatment context in which they are employed. Furthermore, implications for practice and research will be taken into account.

A central aspect of the nature of counselling psychology is the emphasis on developing a scientist-practitioner model (Woolfe, 1996). The model is based around the belief that an integral part of the role of counselling psychologists in to continually research the process and outcome of their work. The use of scientific methods provides a base for forming and informing the profession, for establishing effective interventions and for evaluating the practice of counselling psychologists. Barkham (1990) sees current research as characterised by a combination of searching for specificity, that is, which methods work with which clients and under what circumstances, and focusing on how interventions work.

However, the scientist-practitioner model encompasses not only research and practice but also theory. It is an integrated approach that recognises the interdependence of theory, practice and research. Therefore, the connection between science and practice which is crucial to counselling psychologists, cannot be achieved without an understanding of the theoretical concepts that underpin the different modalities of treatment they employ. These include, among others, group therapy and family therapy. As a result, looking at the theoretical foundations of group therapy and family therapy and the implications for practice provides the first step towards the important link between science and practice.

**Historical overview**

Group therapy was pioneered by Joseph Pratt who in 1905 held weekly group meetings with tuberculosis patients (Nelson-Jones, 1982; Aveling & Dryden, 1988). Before World War II, a number of psychiatrists including Adler and Moreno employed group methods (Yalom, 1975). However, it was during the war that the use of group therapy became widespread mainly due to an inability to meet the demands
of one to one ratio in traditional forms of therapy (Nelson-Jones, 1982). According to Yalom (1975), the application during the 1950s of group therapy to a wide range of emotional difficulties such as neurosis, chronic psychosis, eating disorders and addictions, in a wide variety of settings including outpatient clinics, psychiatric hospital wards and day centres, and using a number of theoretical approaches was a crucial development in therapeutic practice.

Family therapy started in the late 1940s and 1950s in an attempt to find more effective treatment methods than the standard psychoanalytic treatment techniques for psychiatric disorders (Bowen, 1966). Barker (1986) explains how Freud, whose influence had been considerable, conceptualised individual’s emotional problems as a result of unsatisfactory childhood interactions with their parents. Thus, in order to ensure recovery, psychiatrists often moved psychiatric patients away from the possible negative effects of the family environment. However, Barker continues, researchers concerned with the study of schizophrenic patients and their families found a high incidence of seriously problematic family relationships and agreed on the importance of involving the family in the treatment of schizophrenic patients.

Therefore, the family gradually began to be considered as the unit of treatment and family therapy emerged as a new approach. Initially, family therapy was concerned with schizophrenic patients and their families but soon it began to be applied to other psychiatric disorders (Bowen, 1966; Barker, 1986). In general, family therapy deals with difficulties that are conceptualised in familial relationship terms, for example, marital problems, parent-child separation difficulties or when the individual’s symptoms seem to be the outcome of emotional conflict within the family (Harre & Lamb, 1983).

In fact, group therapy and family therapy emerged in a climate where psychoanalysis had been the predominant form of treatment for decades (Hines, 1988) which in its one to one form, it was no longer able to meet the demands of the time. Thus, group and family forms of therapy emerged as a response to specific practical demands.
Despite their common origins, however, group and family therapy developed as two distinct disciplines. Essential differences arose in the theoretical concepts used by members of each respective discipline (Hines, 1988).

**Theoretical perspectives**

Existing theoretical approaches to group therapy include analytic group psychotherapies, interpersonal group therapy, Gestalt group therapy, psychodrama group therapy and cognitive-behavioural group therapy. On the whole, group therapy seems to draw upon the body of knowledge that derives from individual therapy. Thus, there is an analytic, a Gestalt and a cognitive-behavioural approach to individual treatment. Manor (1994) points out that in the United States some group therapists have integrated concepts from systems theory into their practice and have progressed towards a systems approach to group therapy. An outline of the theoretical approaches to group therapy would entail taking into account all the theoretical models of individual therapy which is beyond the scope of the present review. Hence, for a detailed account of specific approaches to group therapy see, for example, Long (1988), McKenzie (1992) and Avelin & Dryden (1988). The assumption underpinning group therapy is that the group setting offers individuals a therapeutic context in which their personal, interpersonal and social relationships can be explored and modified, if necessary. The focus of group therapy is on the individual’s needs and not necessarily on the group’s needs as a whole (Yalom, 1985; Corey & Corey, 1987; Manor, 1994).

Within family therapy, key models include the structural approach (Minuchin, 1974; Minuchin & Fishman, 1981), the strategic approach (Madanes, 1981; Papp, 1983) and the symbolic-experiential approach (Whitaker & Keith, 1981). Barker (1986) suggests that despite the sharp divide between schools of thought within family therapy, an integration and assimilation into one common body of knowledge is occurring. Concepts that are shared by most approaches to family therapy derive from general systems theory. Systems theory is now considered to be the central theoretical foundation of family therapy (Merkel & Searight, 1992; Irving & Williams, 1995).
The assumption underlying family therapy is that the family is a system. Individuals are considered to be components of that system who are interdependent and play a particular role in the maintenance of the family system. Therefore, the focus of family therapy is on the whole system.

Due to the differing assumptions that underpin group and family therapy, their respective treatment goals are different too. The goal of group therapy is to improve the functioning of the individual with the help of other group members (Becvar, 1982). Therefore, the group is regarded as the context in which each individual pursues his/her own goals (Yalom, 1985; Corey & Corey, 1987). The emphasis of the therapeutic process is to promote self-awareness, self-understanding and responsibility for oneself (Hines, 1988). The aim of family therapy, however, is to improve the group’s functioning as a whole. The difficulties of the identified client are viewed as a problem of the family system. Therefore, the emphasis of the therapeutic process is on treating the whole system where individual change is though of as secondary (Becvar, 1982; Ritter et. al., 1987).

In view of the significant influence of general systems theory on both group therapy and family therapy, some of its key assumptions will be outlined. Merkel and Searight (1992) list the ideas which are prominent in the field. The group or the family are regarded as a system that consists of interacting elements (subsystems), the whole of which is greater than the sum of its parts. Moreover, the system itself is part of a larger system (suprasystem). For example, if the family is the system, parents and siblings would be the subsystems and the extended family or the community would be the suprasystem. The components of the system are interdependent which creates patterns or structures. Interactions in the system tend towards the maintenance of a steady state or homeostasis. As a result, Bowen (1966) explains, change in one part of the system generates compensatory change in other parts of the system. This is a flexible and reciprocal mechanism. However, when the flexibility of the system is lost, i.e. it becomes fixed and rigid in a particular pattern, the functioning of one or more members is impaired. Bowen suggests that at this point families tend to seek
help. Barnes and Cooklin (1994) conceptualise the family's problems in terms of "incongruent adaptation" whereby the family attempts to adapt to a problem or new situation in ways that were successful in earlier circumstances but are no longer appropriate in the current situation. In terms of flexibility, the family becomes fixed in a particular way of adapting to a problem or new situation. Skynner (1987) points out that understanding the family as a system has led practitioners to become more aware of the difficulties in changing individuals separately from their family context when they still remain in close contact and therefore deeply influenced by it. Moreover, practitioners have also realised that appropriately designed interventions can affect the whole family which may lead to new patterns of behaviour.

Manor (1994) puts forward the advantages of a systems approach to group therapy. He believes that systems theory allows the practitioner to understand the individual in relation to the group and other systems such as marriage, family and friends. Thus, all are taken into account when change is considered. Furthermore, systems approach to group therapy can address issues around interpersonal and social learning as well as personal transformation, hence, it is employed by group therapists from different theoretical backgrounds. As a result, Manor suggests that systems theory has the potential to integrate other group approaches and to link group therapy to family therapy. However, he adds, more research is needed to validate his observations.

In recent years, there has been a growing concern about the almost exclusive reliance upon system theory to understand and treat the family (Irving & Williams, 1995). A number of limitations have been identified by Merkel and Searight (1992). Family systems theory is deemed weak in terms of internal coherence and consistency, i.e. different versions of family therapy use basic theoretical concepts in different ways. They continue to say that, perhaps its greatest limitation is the lack of ability to make predictions because it does not say where change will occur and how it occurs. Furthermore, systems theory specifies that the components of a system are interdependently related. However, it does not identify and explain the processes involved in the development, change and maintenance of their dynamics (Irving &
Williams, 1995). The individual is viewed as one of the elements that composes the whole (Merkel & Searight, 1992). Therefore, as Schwartz (1987) notes, differences in subjective experience, cognitive style, motivation and personal values tend to be ignored. Systems theory assumes that the family forms integral part of a suprasystem, therefore, the study of the family needs to be accompanied by an understanding of the larger system in which it exists (Farmer, 1970).

In practice, family therapy tends to conceptualise and treat a problem within the family context which leads to underestimate the influence of wider political, economic, social and cultural forces (James & McIntyre, 1983; Hare-Mustin, 1987; Koch-Hatten, 1987). In addition, individuals within the system are interdependent, in this way, actions of all participants affect one another. This, in turn, assumes that there are no protagonists and victims but that both enter into an interaction and complement each other. These assumptions are particularly problematic when one member of the family is being abused by the sexual, physical or economic power of another. In any interaction, family members do not have equal freedom to choose whether they participate or not. The degree of choice and the consequences of trying to give up certain family dynamics will be different for different family members according to their relative power within the system (Barnes & Cooklin, 1994).

**Treatment context**

Following the comparison between group and family therapy in terms of their historical and theoretical context, the treatment context now will be considered. Both group therapy and family therapy regard the group as the focus of treatment and also as the foundation for change (Hines, 1988). According to Yalom (1985), the individual who is a member of a group does not exist in a vacuum, rather he/she interrelates with other members. Therefore, both modalities of treatment focus on the interpersonal processes that develop within the group, i.e. the stranger group or the family (Hines, 1988; Weiss et. al., 1988). This implies that the therapist needs to design and target interventions that are going to use and create interpersonal dynamics which promote therapeutic change (Trotzer, 1988).
Furthermore, stranger group dynamics are related to family dynamics in that, as Yalom (1985) stated, most participants in group therapy have a "highly unsatisfactory experience in their primary family" (p. 15) which they bring to the group (Burrows, 1981; Yalom, 1985; Skynner, 1987; Trotzer, 1988). The implications for therapy are, firstly, that each member manifests their own family patterns in the group which will influence their behaviour and experience in the group and also the group's development and the therapeutic process (Trotzer, 1988). Secondly, the majority of problems and issues raised by individuals in group therapy derive from family issues (Hines, 1988; Trotzer, 1988). Due to the impact of family dynamics in the stranger group, Trotzer (1988) suggests that family theory can provide the therapist with a useful framework as a means of understanding certain group dynamics, particularly as members begin to negotiate and establish norms, and certain problems addressed by the group so interventions that are more focused and realistic can be designed.

Within the group context in which group and family therapy take place, group therapy focuses on the "stranger group" which is made up of individuals that had not met before (Behr, 1988). Family therapy targets the family. The term "family group" will refer to the number of family members that take part in the therapeutic process. Basic similarities, in terms of group processes, are shared by the stranger group and the family group but also essential differences emerge from the very nature of each group (Tallman, 1970; Becvar, 1982; Behr, 1988; Hines, 1988; Weiss et. al., 1988; Cooklin, 1990). Some of these basic similarities will be described and explained below.

Clearly, the family is a small group (Tallman, 1970; Becvar, 1982), therefore, small group research would be applicable to the study of the family (Tallman, 1970). However, Colangelo and Doherty (1988) point out that most studies of group dynamics employ ad hoc groups in the laboratory or more transitory work groups which do not match the longevity and complexity of families. Thus, small group theory needs to be adapted and modified in order to be directly relevant to the study of the family. A number of authors (Bales & Slater, 1955; Zelditch, 1955; Brown, 1988) agree that a common feature of group life, including the family is the differentiation
of roles, although the differentiation of roles within the family tends to be more clearly defined than in small groups (Brown, 1988). Roles are based on the expectations about behaviour and performance which accompany certain positions. They fulfil two functions, firstly, roles imply a division of labour which facilitates the achievement of the group’s goals. Secondly, they help to bring order to the group’s existence (Brown, 1988). Thus, if roles become blurred, role conflict may arise (Katz & Kahn, 1978) which may result in problems for the individual and the group (Brown, 1988).

Role development plays an important part in group therapy (Yalom, 1975). Bogdanoff and Elbaum (1976) found that roles are particularly crucial during the initial stages of group development because the order and structure they promote reduces the individual’s anxiety. However, they continue to say, if roles become rigid the potential of the stranger group to enable individual growth diminishes. Bogdanoff and Elbaum suggest a number of signs of rigidity which include “lack of competition for playing new roles, group stagnation, labelling and stereotyping interpersonal relationships and increased dependency on the therapist to do something” (1976, p.248). At the other side of the continuum there is role disorganisation whereby individuals do not know how to behave so they get lost in a pool of ambiguity and confusion. As a result, role disorganisation is also considered counterproductive for the therapeutic process. Bagnadoff and Elbaum suggest that successful group therapy can be thought of as the achievement of role fluidity which implies enough flexibility in order to avoid rigidity but not too much so disorganisation can be prevented.

Various authors (Parsons & Bales, 1955; Zelditch, 1955; Farmer, 1970; Goode, 1982) argue that the allocation of roles in the family is predominantly by sex where fathers tend to adopt instrumental roles and mothers perform expressive functions. According to Brown (1988), the above findings imply a number of questionable assumptions. Firstly, there is no doubt that role differentiation does occur in families but it does not have to coincide with the two principal parents or even that different roles have to be allocated to different members of the family. Secondly, it is assumed that instrumental
and emotional roles are mutually exclusive. Slater (1955) found that this was not the case, he suggests that the same individual can fulfil various roles the same role can be fulfilled by different individuals.

Parsons & Bales (1955) argue that families that have a specific division of roles tended to be cohesive and effective. Research carried out by McGregor et. al. (1964), Stabenau et. al. (1965), Westley and Epstein (1970), and Lewis et. al. (1976) showed a connection between the degree of parental role differentiation and the degree of the children's emotional health. Parents of the healthiest children established a balance between separateness and overlap whereby parental functions were shared at the same time that roles were clearly defined which prevented role confusion. Families that showed less differentiation produced fewer healthy children and any degree of separateness was achieved through role stereotyping, i.e. rigid differences in sexual roles. Finally, blurred roles and unclear identities prevailed in families that produced the least healthy children, where characteristically there was scapegoating, evasion of responsibility and blaming. From the above findings one could say that similarly to the stranger group, the family is more effective with a degree of flexibility in terms of role development.

Although Bales and Slater (1955) stated that families and other small groups have different sets of norms, norms are established in both the stranger group (Corey & Corey, 1992) and the family group (Barker, 1986). Thus, the existence of norms can be considered as a further area of similarity for both groups. Brown (1988) defines norms as “a scale of values which define a range of acceptable (and unacceptable) attitudes and behaviours for members of a social unit” (p. 42). The function of norms, Brown continues, is to bring order and predictability to the individual’s environment because they act as frames of reference through which the world can be construed. As a result, norms are particularly useful in novel situations like, for example, the therapeutic setting, because they provide guidelines for appropriate behaviour, when a person does not know how to behave or what is expected of him/her. Norms also regulate and co-ordinate the groups activities.
Finally, Tallman (1970) believes that another area of similarity between a small group and families is that both operate as a problem solving unit. He adapted concepts derived from group problem solving theory and research to the family problem solving behaviour. It was hypothesised that, similarly to the small group, the optimal structure for family problem solving requires both open channels of communication and centralisation of authority. Open channels of communication encourages the generation of many ideas and the opportunity to critically evaluate such ideas. Centralisation of authority enables the co-ordination of the group’s activities towards the solution of the problem.

As mentioned before, despite the similarities between the stranger group and the family group, there are also essential differences. Such differences will be explored below. One of the major distinctions made is that the stranger group is created for the purpose of therapy (Levine, 1979; Corey & Corey, 1992). Thus, it has no history to begin with and will dissipate following treatment. In contrast, the family group has a history prior to therapy and will have a future after therapy. This is not to imply that the group will not have its own history. The stranger group creates its own history throughout the therapeutic process (Trotzer, 1988; Corey & Corey, 1992), whereas the family enters therapy with a long standing common history. Such difference has a number of ramifications for different group aspects and for the therapeutic processes of group and family therapy (Becvar, 1982).

In terms of group aspects, contrary to the stranger group, most of the family’s formative processes have been completed (Shaw, 1976), therefore a structure, patterns of interaction and a shared mythology have already been established (Weiss et. al., 1988). As a result, part of the focus of family therapy may be to deal with problematic pre-established family dynamics. One might say that certain forms of group therapy also focus on family dynamics. However, the emphasis is placed more on the individual rather than the group as a whole. Concerning structure, in the stranger group, members are regarded to have equal power and responsibility thus, the therapist treats each individual similarly (Becvar, 1982; Hines, 1988). The family
group, however, is intrinsically hierarchical where different family roles, i.e. parent, spouse, child and sibling have unequal status. The therapist, in this case, must be aware of it and be able to relate to family members according to their status, role and developmental stage within the family (Becvar, 1982; Hines, 1988).

The structure of the family group sets boundaries which determine who can or cannot take part in certain kinds of interaction. Boundaries exist between the family and society but also within the family (Skinner, 1987). A rigid structure within the family generates lack of communication and ability of honest evaluation (Handlon & Parloff, 1962). If the boundary between the family and society becomes rigid, a greater sense of cohesiveness within the family will develop which may give way to a weakening and blurring of boundaries (Behr, 1988). Bowen (1966) named such fusion of boundaries “undifferentiated ego mass” which he described as “a conglomerate emotional oneness” (p. 355). Minuchin (1974) employed the term “enmeshed families”. A number of authors (Bowen, 1966; Minuchin, 1974; Skynner, 1987; Behr, 1988) agree on the need for boundaries because of the negative effects that “undifferentiation” and “enmeshment” have in the functioning of the family. The negative effects of rigid boundaries have also been documented. Therefore, optimal functioning seems to rely on the ability of the family to create a balance between undifferentiation and differentiation.

Regarding mythology, in the stranger group, members bring their own mythology to therapy. Individual value systems are quickly revealed because they are not shared by every member (Handlon & Parloff 1962). Due to the diversity in ways of perceiving and behaving, individuals come to realise the theirs is not the only way of construing the world which leads them to re-examine it and learn new ways of being (Handlon & Parloff, 1962; Skynner, 1987). On the other hand, in the family group, members share the same mythology which, throughout time, supports certain ways of construing the world and behaving. The accepted family mythology can become part of the identity of family members which, in turn, perpetuates the existing mythology. Such mutually reinforcing circle generates stability and great resistance to change (Handlon &
Parloff, 1962). The family therapist does not count with the aid of the stranger group diversity in order to bring change. Therefore, his/her task of exploring and questioning the family’s mythology is made more difficult. One might argue that family members are able to examine and question the family mythology when they get involved in other groups. However, as Bowen (1966) suggests families that undergo therapy have lost their flexibility and remain in a steady state which does not promote change. Therefore, even though the individual might begin to question the family dynamics, if he/she still forms an integral part of the system, its established power structure and pattern of interaction may force the individual to ‘fit in’ (Weiss et. al., 1988).

The implications of the factor of history for the therapeutic processes of group and family therapy will now be addresed. The stranger group is formed for the purpose of therapy so before any group therapy begins the practitioner’s role is to select a group (Levine, 1979; Corey & Corey, 1992). A balance of people who are similar and different would allow group members to have enough in common so they can identify with each other, at the same time as providing enough diversity so individuals experience a variety of responses to their feelings, thoughts and behaviour (Manor, 1994). All group members are involved in an intake interview with the therapist which means that individuals enter the group not knowing anybody else but the therapist. As a result, individuals will initially tend to address the therapist rather than other group members (Hines, 1988). However, the focus of the therapeutic process is on the interpersonal processes within the group. Therefore, the role of the practitioner is to facilitate interaction among group members (Yalom, 1985; Corey & Corey, 1987).

At the beginning, the therapist holds a central position in the group which manifests itself in his/her ability to influence considerably the early stages of group development including the establishment of norms. Norms increase the effectiveness of the group’s functioning (Corey & Corey, 1992). Therefore, as Corey and Corey (1992) suggest, the development of group norms at an early stage ensures that the therapeutic process runs without conflict and confusion. In contrast, the position of the family therapist is almost the contrary. He/she begins the therapeutic process from a peripheral position
in relation to the family group which has a long standing common history. This means
that the therapist needs to gradually work towards being accepted by and connect with
the family in order to bring change (Hines, 1988).

Group research carried out by Merei (1949) and Hollander (1958, 1970) seems
relevant in providing a better understanding about the ways in which the therapist can
gain the necessary legitimacy in order to exert any influence. Merei found that
individuals achieved the leadership role by initially adhering to the pre-existing norms
of the group and only occasionally suggesting minor changes. Gradually, the
individual is able to introduce more radical changes. From this, one can conclude that
at the beginning it is important for the therapist to observe and identify how the family
operates, once he/she has a clearer understanding of the family norms, new ideas can
gradually be introduced.

The sequence of initially conforming to the group’s norms and then introducing new
ideas is crucial to Hollander’s theory of leadership (Hollander, 1958; Hollander &
Julian, 1970). Hollander points out that during the early stages, a leader needs to build
up the approval of the group members which will give him/her the legitimacy to
influence others. Hollander (1982) describes three sources that provide legitimacy to
the leader. Firstly, the way in which the individual has achieved such position. Being
elected by the group is a greater source of legitimacy rather than being appointed by
an external agent. Secondly, the leader’s degree of expertise to help the group in
achieving its goal, i.e. the more able someone is considered to be the more credit they
are given. Finally, the degree of identification with the group is also important. In
relation to the family therapist, the greatest source of legitimacy derives from his/her
expertise to help the family group attain its goal. Secondly, through empathy and
acceptance the practitioner can identify enough with the family in order to gain further
legitimacy.

Due to the fact that the stranger group is formed for the purpose of therapy, its
members typically meet just for the scheduled sessions (Becvar, 1982). Because
members of the stranger group are not connected to each other outside the therapeutic setting, they can experiment with new ways of behaving without direct consequences to their daily lives (Manor, 1994). Risks in the form of new ways of interacting which may be too disruptive in the family group can be taken in group therapy (Aveline & Dryden, 1988). Moreover, any intense emotions that the therapeutic process may generate tend to dissipate as group members interrelate to other people outside the group (Lieberman, Yalom & Miles, 1973). In addition to trying out new behaviours through direct interaction, learning in a stranger group context can also take place through vicarious learning. Members can learn new patterns while watching the interaction of others until they feel more ready to participate (Skynner, 1987).

In the family group, individuals are in continuous contact with each other, both in and out of therapy (Becvar, 1982). As Handlon and Parloff (1962) state, one aspect of family interactions outside therapy is the possibility of acting against a member for the way he/she behaved in the session. As a result, members do not feel they can freely express what they feel or experiment with new behaviours for fear of reprisals. Thus, the therapist needs to be sensitive to family members' difficulties in talking honestly and frankly about certain family issues (Hines, 1988).

As well as the history element, another major difference between the stranger group and the family group is that the latter is the primary unit of socialisation and identity formation. Farmer (1970) describes socialisation as the process by which an individual is prepared to respond appropriately to the demands of his/her environment. It is a learning process that provides the individual with reference points to guide him/her in differentiating appropriate and inappropriate behaviour both within the family context and the larger society. An important part of learning, Farmer continues, is imitation whereby the child becomes aware of and copies actions and attitudes that manifest around him/her and internalises them. As the individual internalises the parent's belief system, it provides him/her with the means to evaluate and monitor his/her behaviour, in other words, an internal means of control (Goode, 1982) which
exerts pressure on the individual to conform to the norms, values and laws of the family and, in turn, of the broader society (Farmer, 1970).

The transmission of norms, role expectations, values and belief systems from parents to children and from generation to generation supports continuity and stability of the family and society. Farmer further suggests that the models family members can provide will be influenced by the culture and society they live in and vice versa.

The family interacts with society and as the family responds to external demands and is modified, similarly, the other institutions it interacts with are also modified. As a result, the family and society can be considered as interdependent, neither of them can survive without the other. Throughout the process of socialisation, the family ensures maintenance and perpetuation of both the family’s and the society’s standards (Farmer, 1970; Goode, 1982). The fact that the family is the primary unit of socialisation results in a greater potential for strong affectionate alliances than in any other group (Weigert & Hastings, 1977). Therefore, the level of emotional intensity that the family group brings to the therapeutic process is much higher than in the stranger group (Whitaker, Felder & Warkentin, 1965). This means that difficulties tend to be enacted in the family group at an earlier stage and with greater intensity than in the stranger group. As a result, initially, the family therapist needs to be more cautious and in control in order to pace enactment of problematic family interactions so emotional upheaval does not escalate too quickly and to a degree that the family cannot handle (Ritter et. al., 1988). In the stranger group, as the degree of shared history builds, the level of emotionality increases. Members move gradually towards a point where they feel they can take risks and are willing to open up so the therapist’s aim is to monitor and facilitate movement at the same time as allowing individuals to remain in control over what they disclose and when (Ritter et. al., 1988).

Conclusion
This review has attempted to look at the degree of difference and overlap between group therapy and family therapy. Both share a similar historical background and are
applied in a group context where interpersonal processes are emphasised. Such similarities allow a dialogue between the two disciplines whereby group theory can be a valuable resource for the practice of family therapy and vice versa, that is, family theory can be a useful resource for the application of group therapy. However, major differences in their theoretical assumptions and the nature of the group they each focus on highlight the uniqueness of these two modalities. To date, there has been little research aimed at comparing and contrasting group and family therapy, specially in terms of their processes (Hines, 1988; Becvar, 1982). Learning from the similarities and differences between them will contribute to the process of further enriching both forms of therapy as disciplines (Hines, 1988). The importance of process and outcome research is stressed by the scientist-practitioner model which provides counselling psychologists with the scientific foundation that will inform their decisions as to what modality of treatment is more suitable under particular circumstances, and will enhance their therapeutic skills.
REFERENCES


Becvar, D.S. (1982). The family is not a group- or is it?. *Journal for Specialists in Group Work*, 7, 88-95.


MATERIAL REDACTED AT REQUEST OF UNIVERSITY
Challenges and personal development: adaptation among international students

ABSTRACT

The usual portrayal of cross-cultural adaptation focuses on processes of recovery from culture shock and culture-related stress. Some exceptions to this view are presented by models that conceptualise cross-cultural adaptation as a source of both challenges and difficulties and opportunities for personal development. This study aimed to explore the experiences of international students in England, while permitting both problematic and personal growth aspects of adaptation to emerge.

Individual in-depth interviews were conducted with ten international students from various countries who were studying at the University of Surrey. The interviews were transcribed and subjected to thematic content analysis to discern common themes across the reported experiences, while also attending to important individual experiences.

The difficulties reported by the students were linked to cultural distance (which was also related to adjustment) and to their status of being 'on their own'. However, 'on their own' status was also linked to personal development which, for the majority of participants, was a salient part of their experience as international students. Experiences of support were linked to the nature of participants' relationships with university staff and other students. The study supports a model that is interactive in nature and that represents cross-cultural adaptation as including aspects of difficulty and personal development.

Key words: cross-cultural, adaptation, sojourner, international students.
INTRODUCTION

One of the most persistent notions in the literature on people abroad, including international students, concerns the course of their adaptations (Nash, 1991).

Particularly dominant in the existing literature on cross-cultural adaptation are models based on the concept of culture shock (Anderson, 1994). Culture shock was originally defined by Oberg (1954) as a medical condition describing feelings of disorientation following a person's exposure to a new culture which could develop into physical symptoms "precipitated by the anxiety that results from losing all our familiar signs and symbols of social intercourse" (p.1). In this view, culture shock is portrayed as an occupational pathology (Zapf, 1991) and it is the pivotal concept in the development of Oberg's (1960) four stages of adjustment that sojourners go through. They include: a honeymoon stage, followed by crisis, then a recovery stage and finally adjustment.

A more up-to-date variant of the culture shock recuperation model is based on the idea that adjustment reflects recovery from a personality or identity crisis rather than from a mental or physical disintegration (Anderson, 1994). As the sojourner comes into contact with the new culture, the familiar cues that provide reference points for their behaviour as well as their sense of identity are taken away leading to an identity crisis. Recovery is attained when individuals go through a series of stages whereby they incorporate both the new and the old selves. Anderson, cites Adler (1975) as the best proponent of this view. He viewed the process of adjustment as a "movement from a state of low self- and cultural awareness to a state of a high self- and cultural awareness" (p.15). Adler, described five stages: a contact phase followed by a disintegration phase, a reintegration phase, an autonomy phase and a final independence phase. Church (1982) points out that Adler's stages show strong resemblance to earlier conceptualisations of the process of adjustment. However, Adler introduces the idea that culture shock can provide the impetus for cultural learning, self-development and personal growth, thus, implying that exposure to a
new culture does not lead solely to negative consequences but it also has the potential for personal growth.

Stage models of sojourner adjustment, mentioned above, pose a number of problems. Firstly, the term ‘culture shock’ which underpins both models has been described as a vague and overgeneralised term that encompasses a number of different reactions to a host of different problems (Anderson, 1994) and as misleading because it masks the diversity of causes of the disorientation and the differences in emotional intensity that individuals experience (Furnham & Bochner, 1986). Furthermore, research (Byrnes, 1965; Lundstedt, 1963) has not found evidence of culture shock or crisis only a feeling of general irritation (Torbiorn, 1982).

Secondly, Church (1982) points out a number problems in connection to applying the models. They include issues such as: whether the order of the stages can be varied and whether the individual passes through all the stages or some individuals skip some stages. Moreover, they do not provide key indicators that set the parameters and conditions under which the models can be applied. Finally, the models remain descriptive in nature which means that they are inadequate to make predictions.

Furnham & Bochner (1982) state that the stage models of culture shock are related to the hypothesis of a U-curve of adjustment in which sojourners are thought to go through three stages: initial optimism followed by frustration and depression and ending in an ascent towards confidence and satisfaction. Gullahorn & Gullahorn (1963) developed this hypotheses further and proposed the W curve hypothesis, suggesting that sojourners often undergo and second U curve when they return to their home environments similar to that experienced abroad. Church (1982) in his review of the support for the U curve hypothesis concludes that it is inconclusive and overgeneralised. Nash (1991) addresses the difficulties of the U-curve hypothesis. The curve does not take into account those individuals who fail to adapt and/or they return home, furthermore, it does not apply to individuals who do not involve themselves
deeply in the new culture. Finally, he warns that it tells us nothing about how each
individual experiences being in a new culture.

A relatively recent conceptual framework for sojourner’s adjustment views the
process of adaptation as a learning process, whereby individuals must learn the
parameters of the new culture and the adequate socio-cultural skills to participate in it
(Church, 1982).

One implication of this view is that adjustment difficulties are not conceptualised as
pathological, but as a result of a lack of necessary cultural skills and knowledge
(Leong & Chou, 1996). Schild (1962) suggested that learning can occur through
observation, participation and explicit communication. However, there are
circumstances in which learning may fail to occur. Adverse consequences and
encounters may inhibit subsequent efforts (Bochner, 1972; Hull, 1978); also, when
deep-seated stereotypes exist or when the home and host cultures differ widely in
values and world-views. Moreover, the learning process model may be regarded as
somewhat simplistic in that as, Anderson (1994) points out, adapting involves more
that just making the unfamiliar familiar.

Anderson (1994) believes that individually, none of the models described above are
able to fully account for the process of cross-cultural adaptation. As a result, she
developed a model based on both the specific literature on cross-cultural adaptation
and the broader psychological adjustment literature from the fields of bereavement,
migration and critical life-events studies.

Anderson (1994) conceptualises sojourns as “a particular instance of a general set of
potentially stressful, sometimes critical events all beings undergo in the course of their
lives” (p. 301). The implications of this definition are firstly, that adaptation is
regarded as part of human development, therefore, cross-cultural adaptation resembles
other potentially stressful and disruptive transitions such as starting college,
retirement, having a first child, diagnosis of a chronic illness and so on. Secondly, it implies that cross-cultural adaptation is not pathological per se.

Anderson (1994) explains that there are six general principles applying to cross-cultural adaptation that flow from the proposed model. They are as follows: cross-cultural adaptation involves adjustment (1), it implies learning (2), it implies a stranger-host relationship (3), it is cyclical, continuous, interactive (4), it is relative (5) and it implies personal development (6).

[Insert Figure 1 here]

The model, as seen in Figure 1, suggests that human adjustment takes place along three dimensions: affective/emotive, cognitive/perceptual and behavioural. It addresses the assumption that the sole outcome of adjustment is adaptation by providing a set of alternative possible outcomes, namely, returners, escapers, beavers, time savers, adjusters and participators. The model also attempts to provide a dynamic perspective into the process of adjustment by representing a recurring and linear process, however, it does not mention factors that may affect the process of adaptation and remains primarily descriptive. It provides useful information on the various aspects that form part of the process of adaptation and draws on a variety of psychological theories and concepts adding to its richness, however, is not adequate as a framework for making predictions.

In keeping with the idea that cross-cultural adaptation is a particular instance of the many potentially stressful life events individuals may go through with the potential for both negative consequences and personal growth, Schlossberg (1981) (Figure 2) has developed a model for human adaptation which includes factors that affect the process. She explains that the model provides a context in which questions about the differences between individuals and the same person across time and what determines whether a person deteriorates or grows can be explained. Moreover, it provides a framework in which transitions of all kinds can be analysed.
Hopson (1981) argues that Schlossberg has developed a most valuable set of transition variables which will help to analyse any transition and to make sense of all aspects of the transitional experiences which may prove particularly useful in therapeutic settings. Indeed, Schlossberg proposes that her model provides therapists and clients with “a framework for analysing the difficulties an individual is having with a particular transition, a cognitive map for understanding one’s reactions to life events and a perspective on adaptation to transitions” (p. 49).

Most of the present day cross-cultural literature has an emphasis on the negative consequences of adaptation and focuses primarily on identifying adjustment problems (Anderson, 1994; Church, 1982). In 1975, Adler viewed cross-cultural adaptation as having the potential for both disintegration and personal development, later on, Schlossberg (1981) and Anderson (1994) developed models that were consistent with such hypothesis. Therefore, the aim of the present study is to explore the experiences that international students have had during their stay in England focusing both on the problematic and personal growth aspects of such experiences. In order to achieve such aim, the present study will endeavour to answer the following research questions:

- What kind of difficulties international students experienced during their stay in England.
- In what ways international students changed as a result of their experiences in a different culture.
- To what extent the experience of staying in England has been a positive and valuable one.

The ideological framework in which the present research process will develop is influenced not only by the existing literature but also by the status of the researcher as international student. From the perspective of traditional psychological research which encourages objectivity and detachment from the part of the researcher, the similarities
between the observer and the observed risk accusations of bias (Coyle, 1996). However, as Coyle (1996) argues such similarities may provide the researcher with the potential for ‘insider’ knowledge to enrich the research process. This point will be taken up in the overview.

METHOD

Participants
The eligibility criteria for the study was everyone who was an overseas student who had come to England for the first time primarily to study at the University of Surrey. Posters giving information about the research and contact numbers were displayed all around the university campus. Overseas students were approached personally by the researcher and given flyers with the same information as the posters. Furthermore, at the end of each interview students were asked to inform other friends about the study.

A total of 10 overseas students agreed to take part. However, due to technical problems, 2 of those interviews were unusable. In the first one, the recording equipment failed to record the second part of the interview. Advice from a technician was sought. He informed the researcher that higher quality tapes would be better and proceeded to supply one. Following the second interview, it was found that the given tape had not been a blank one and the recorded equipment was unable to record the interview over the existing sounds leading to an unintelligible mix of sounds.

Research instruments
In order to gather basic demographic information, a brief self-completion questionnaire was designed (Appendix 1).

The emphasis of the present study is on the participants’ own subjective experiences and accounts on their experiences of living and studying in England. A way of
gathering detailed and personal data which is also concerned with subjective meaning is conducting face-to-face interviews (McLeod, 1994). Therefore, a semi-structured interview consisting of open-ended questions (Appendix 2) was employed to gather the data. The existing literature was consulted in order to ensure that the interview schedule encompasses relevant topics for the study. The questions were divided into five sections: general information, pre-arrival to the country, during the stay in England, the return and questions about therapy.

In the general information section, the issues covered included: previous experience of living away from home, sources of funding and attendance at English courses. In the pre-arrival section questions were asked about the decision process of coming to England to study, sources of information, nature of preparations and expectations. The during the stay section included: difficulties students had experienced such as language, financial, academic, relationships with staff and other students; also there are questions about the most valuable and difficult aspects their experience. In the return section, participants were asked about their plans for the future and in the final section the topic of support was covered. Due to limitations of space, this paper focuses upon the data elicited by the section on during the stay.

**Procedure**

The overseas students who volunteered to take part in the study were requested to complete a consent form (Appendix 3) which included information about the project and they were advised that the material would remain confidential. In order to maintain confidentiality, participants' names have been replaced by pseudonyms. Any identifying information that may arise in the course of the study such as names of people or places has been changed.

Each interview lasted for approximately 75 minutes. All interviews were transcribed and subjected to thematic content analysis, using procedures consistent with those outlined by Krueger (1994). Following transcription of each interview, each transcript was read noting any key words or phrases that were considered of relevance or
significance to the research focus. These were then coded with a word or phrase which captured the essence of the content. These constituted the emergent themes. Repetition of emergent themes within transcripts and across transcripts was taken as indicative of their status as recurrent themes leading to a more consolidated list of themes. As the analysis unfolded, attention was paid to commonalties of experience as well as the range and diversity of responses. Numbers and percentages illustrating the frequency with which themes appeared in the transcripts will not be employed when reporting the findings.

The use of quantification in a small sample may be misleading firstly, by giving the impression that the findings could be generalised to the larger population. Secondly, there are no pre-defined criteria determining the extent to which themes must recur before they merit citation (Krueger, 1994) and quantification may undervalue the significance of the themes that are identified. Adjectival phrases such as: “The majority of the participants”, “Few of the participants”, “One interviewee” will be employed instead. A specific and detailed discussion of the results will be provided in the analysis section of the paper whereby the data will be presented and analysed in specific components. An overall perspective of the findings will be discussed in the overview section.

In terms of evaluating the research, traditional criteria such as validity and reliability which have evolved for the assessment of quantitative research are inappropriate for the present study because they are based on the notions of objectivity and detachment which assume that the researcher and the researched are independent (Henwood & Pidgeon, 1992). Alternative criteria for evaluating qualitative research are internal coherence, transparency and persuasiveness (Smith, 1996). In this study, interpretations will be backed up by presenting actual material from the raw data in an attempt to make the analytic process as transparent as possible allowing the reader to question the analysis themselves and assess its persuasiveness.
In the sections where quotations are presented, empty square brackets indicate where material has been omitted and classificatory material that has been added is written within square brackets.

ANALYSIS

Demographic information
The participants were eight overseas students (3 men and 5 women) who had come to England for the first time primarily to study. Three were undergraduate and 5 were postgraduate students. The ethnic groups represented were Indian (n=3), Black-Caribbean (n=1), Chinese (n=1), Bangladeshi (n=1), Malay (n=1) and Nepalese (n=1). Participants’ mean age was 28 years (range 21-39, SD=6.9). Six participants were single and two were married with children. The mean length of time the interviewees had been in England was 2.6 years.

The analysis, presented below, focuses upon those themes relevant in understanding the experiences that international students go through when they come to England to study. The main body of the interviewees’ material focuses on their experiences during their stay in England, therefore, the analysis will concentrate on this aspect of the sojourner’s experiences. As seen in Figure 3 the material is comprised of a number of themes and subthemes which will be examined below.

[Insert Figure 3 here]

During the stay
This section begins with the presentation of the theme of the “on your own” status of international students and how this may be linked both to some of the difficulties and the personal development that the participants experienced during their stay in England. Following this, the analysis will focus on the theme of cultural distance and
its possible connection to the interviewees' difficulties and adjustment. Finally, the issue of support and the role of relationships will be examined.

"On your own" status, difficulties and personal development

Throughout the interviews, the students status of being on their own was reflected in the way they regularly employed words such as “on my own”, “by myself” and “away from home”.

One of the implications for international students of being away from home is that they have left their families and other established sources of support behind. The majority of interviewees felt that what they missed most during their stay in England was their families and being on their own had been difficult: “the basic thing is that we have to do everything ourselves, that’s the most difficult part” (a Sri Lankan student). On the other hand, for many the “on your own” status had also been the most valuable aspect of their experience. One student expressed very clearly such duality: “[The most valuable aspect of the experience was] living alone, even if, on the other hand, I find it a bit lonely on my own [] I think the loneliness is the hardest to live with probably”(a Caribbean student).

Moreover, being away from their families had given the students the opportunity to find out more about themselves: “I think I have learned more about myself being away from home than I would if I’d stayed at home”( a Malaysian student). Indeed, many of the participants implied a connection between the fact that they have been on their own, away from home and a process of personal development. For example: “I’m being more responsible now, that’s one of the things I have learned because I have been alone in this country”(a Mauritian student). A Thai student said: “I learned a lot living alone, living so far away from home, you have to manage the time, money, everything you need to do by yourself [] I have to do many things by myself, I’ve grown up”.
In view of the above evidence, the status of these international students as being on their own appears to be a contributing factor not only to the process of personal development that the majority of participants experienced but also to their difficulties. Although, the fact that overseas students are by themselves is a prominent factor underpinning the interviewees’ difficulties and personal development, it should not be implied that it is the only one. A few students mentioned other factors that contributed to their personal development, in particular, exposure to other people from different backgrounds. For instance, having asked a Malaysian student in what ways she felt she had changed, she responded: “More open-minded, I would think because just the fact that you meet so many people from so many cultures, from so many backgrounds, that you tend to be more open-minded and less judgmental of people”.

An exploration of the kind of difficulties the participants encountered during their stay in this country and other factors, in addition to the “on your own” status, that contributed to those difficulties will be presented below.

Cultural distance, difficulties and adjustment

The participants in this study are overseas students that come from different parts of the world and different cultural backgrounds. This was reflected during the interviews in the way students spoke about similarities and differences between their own country and England. Few interviewees spoke about similarities in terms of the political system, the educational system and level of development of the country but all made references to differences. Such differences are: religious beliefs, lifestyle, nature of family relationships and friendships, sources of recreation, food, humour, weather, academic system and individualistic versus collectivist mentality. This theme is called “cultural distance” which is defined by Opereza et. al. (1991) as the degree to which the home country is different from the host culture. One might argue that the weather is not part of culture and strictly speaking probably it is not. However, it can be viewed as part of the framework within which culture is shaped, therefore, it will be included in this section.
The awareness and experience of cultural distance underpinned some of the problems overseas students encountered. For example one student compared the educational system of his country with England and explained that he had less time to do his work here which he found difficult and resulted in changes: "In many ways because the problem is time, to do everything, I need time so when I was home, the method I studied was quite different [] after I came here I had to change it" (a Sri Lankan student). For another student from Mauritius environmental differences were a problem which affected his well-being: "In England, I don't like the houses, they are very small houses. It's different in Mauritius, everybody has their own place, their own house and this is horrible if you come from a different country [] you don't feel good, you feel frustrated, it's very crowded". Schlossberg (1981) points out the importance of the physical setting which includes the weather, neighbourhood, living arrangements and location. She argues that these factors can contribute to stress and sense of well-being and therefore may play a role in adaptation to transitions. Finally, another example that illustrates the link between cultural distance and difficulties is put forward by a Malaysian Muslim student who mentioned different ways of socialising between her and English people which made it difficult for her to socialise with English students: "people from my culture and religious background would find it difficult to socialise with many English students, not because we don't want to but because there are differences in social norms".

The nature of the difficulties that interviewees came across while they have been in England varied from individual to individual. Some of these difficulties were experienced by only one or very few participants. Nevertheless, they will be mentioned because they seemed particularly poignant to each one of them. The purpose of doing this is to show that even though some problems were shared by some interviewees, their experiences remain somewhat diverse and individual. The difficulties international students experienced included: relationships with university staff, in-group versus out-group, homesickness, practice of religion, financial, discrimination, finding sources of recreation and communication.
Relationships with staff

On the whole, the overseas students in the present study did not report difficulties in relating to university staff; this will be explored in greater depth in the “support and relationships” section below, however, one participant from Mauritius had very strong views about university staff and the way he had been treated by them: “It’s just the way people are arrogant in this university [] they are useless and arrogant. As an overseas student I spend plenty of money to be at this university and you don’t get any decent treatment, they just don’t treat you very nice”. He felt that lecturers were not helpful: “they just don’t care” but in his opinion a way in which this could be improved would be if “they could just say that if you have any problems just come and see me, welcoming people, to be available”. In this way, he explained, the student would feel more comfortable in asking for help from someone who is willing to offer it which would improve the relationship between students and lecturers.

Discrimination

Most participants did report experiences of prejudice outside the university. The more overt forms of discrimination entailed the use of derogatory names or racist remarks: “there was a gang and they were shouting at me, [] they were using the words that they use to call Asians” (a Sri Lankan student). Another student recounted: “when my parents were here, we went to Windsor and we were walking and there were a couple of young chaps in a car shouting racists remarks at us” (a Malaysian student). However, some students spoke about prejudice taking a more unspecifiable form: “sometimes it’ll be based on hunches like you feel it’s discrimination [] personally in front of my face no but you feel the usual things like people talking, nothing obvious because I don’t think it’s a norm for people here to show discrimination” (a Malaysian student). The way some students coped with it was to ignore it and tell themselves: “I may be different but that doesn’t mean that I’m less than you are” (a Mauritian student).
Financial difficulties

With regards to the financial situation of overseas students, the majority of interviewees are sponsored to study in England either by their own government or by the British government and a few rely on their parents. Most overseas students felt that their financial needs were met. However, some reported difficulties. In order to overcome such problems, one student’s family was able to supplement her scholarship but for the rest, it meant implementing restrictions which limited the extent of their experience in England: “Money doesn’t allow me much, I wanted to go to Scotland and other parts of England but I haven’t been travelling much, I haven’t experienced life in pubs, things like that. Good for bare survival but apart from that I can’t afford it” (a Nepalese student). Most students enter this country with either a restriction or a prohibition on taking employment implemented by the Home Office and they are not eligible for any state financial aid programmes. This means that when overseas students face financial difficulties, they have limited resources to deal with the situation (Khoo et. al., 1994). However, this was not specified by the interviewees.

Homesickness

As mentioned in the previous section, most students missed their families a lot. However for one participant from Thailand, being homesick nearly meant giving up the course to go back home: “I came from home last week, I came back from my country last week and I’m feeling very homesick [] Last week it was a terrible week [] when I came here I thought “Oh! it’s a problem, I want to go back””. The disappointment that this would have caused him and his parents, in addition to the support he received from his friends were strong factors that prevented him from leaving. For the majority of overseas students, coming to England to study is a unique opportunity (“only a few people have an opportunity like this”), and the primary aim of their stay is to gain a British qualification so as Livingstone (1960) explains returning home having failed to get a degree would be too shameful to bear. As a result, overseas students are under immense internal and external pressure to stay and succeed despite the difficulties they may experience (Sen, 1970).
Finding sources of recreation

A difficulty that was mentioned by a few participants is finding sources of recreation. In some cases, the problem is related to the lack of facilities: "There is no much recreation, there is only pubs, discos, and cinemas in this country, that has been very difficult for me[] like in Mauritius, we have sea, mountains, diving, camping, whatever, but here there isn’t much recreation" (a Mauritian student). The first thing that springs to mind when one reads this quotation is that England does also have sea and mountains where one can go diving and camping, although perhaps not as readily available as in Mauritius. It is possible that the difficulty of finding sources of recreation may be related to accessibility rather than lack of facilities per se. However, this possibility was not explored by this student.

In other cases, the problem of recreation was linked to differences in ways of socialising. The following quotation illustrates how major differences in social norms and socialising can give rise to difficulties in social interaction: "One of the best ways of making friends with the English is being able to socialise in pubs and go to bars and things [] but just because of the principle that it’s not a normal thing for me to actually go to pubs or bars, therefore, I don’t. [] We have different ways of socialising [] we socialise more at an interpersonal level than a large social group" (a Malaysian student). In order to overcome some of those difficulties, this student has learned to identify people who would have similar interests to her, "something that doesn’t involve drinks and intense socialising" such as going for a picnic, inviting friends to lunch or dinner at your place, exploring the countryside or doing sports. Church (1982) examines research findings that relate national origin to social interaction and general adjustment. He reports that Canadians and West Europeans are consistently found to be more socially involved with nationals and have fewer adjustment difficulties; students from the Far East are least involved socially and report the greatest number of adjustment difficulties. Indians, Black Americans, Latin Americans and Middle Easterners seemed to fall in-between the two extremes. However, he warns that these results apply to international students in the United States and it is not possible to determine to what extent these results would be true for
other host countries. Nevertheless, the results reported by Church (1982) seem to illustrate the link between cultural distance, social involvement and adjustment difficulties.

Practising religion

For one overseas student, practising her religion had been the most difficult aspect of living in a different culture: “There are four main religions in Malaysia and you are free to practise any of them but Islam is the main religion so it’s easy for you to perform religious activities or to be comfortable with whatever you wear, whatever you practise but being in a different culture where your ethnic group, your religious group is a minority then that’s a difficult part” (a Malaysian student). A way in which she was able to overcome some of these difficulties was by “finding out more about the appropriate places to practise”. Another factor that appears to have also helped is her reported experience of English people as tolerant of different religious beliefs.

In-group versus out-group

The above interviewee mentions being in a different culture where your ethnic group is a minority. This leads to the difficulty named “in-group versus out-group”. A few participants made a direct reference to feeling different: “sometimes it would be nice to be able to do things without feeling that you are different from them” (a Malaysian student) and even outsiders: “when you are in a social milieu environment, when there is a line, even though you are used to that, you still feel a line and you can’t feel fully, really feel confident in it, you still doubt on how to behave” (a Nepalese student). These quotations imply the existence of some kind of relationship between sojourners and nationals which Gudykunst & Hammer (1987) have described as a stranger-host relationship and Cohen-Emerique (1984) conceptualises as an insider versus outsider relationship.

There were also some references to international students “cliquing together”. Church (1982) describes the function of such enclaves as providing psychological security, self-esteem and a sense of belonging. They also serve, he continues, as reference
groups with whom the new environment can be discussed, compared and interpreted. On the other hand, this division between international students and host students may restrict interactions between them which can reinforce the sojourner's sense of alienation (Kang, 1972). One interviewee explains: "when I moved to England I wasn't going to get caught in the trap that a lot of students get caught in, spending most of their time with people from their country [] and you don't meet anyone else and then you find yourself totally isolated" (a Caribbean student).

Thomas & Althen (1989) also warn that one should never assume that all fellow nationals get along just because they are away from home. Indeed a Sri Lankan student remarked: "Because were are in another country, we shouldn't show the other people that we have problems [] nobody knows those things [] why should I tell them, inside us we know we have problems". For this student, being away from home meant that individual differences among his fellow nationals became more apparent. As Coyle (1996) suggests, it should not be assumed that shared characteristics, in this case of nationality, are not overridden by potentially more significant differences, for example world-views.

Communication

The university requires a suitable level of competence in the English language that will enable overseas students to complete their studies. In addition, some international students come from English-speaking countries. Yet, there was one theme that all participants talked about which was the difficulties in communication: "I think because we are international students, there are cases when it's difficult to communicate" (a Malaysian student). In particular, they mentioned verbal communication: "Another difficulty is the language [] the most difficult thing is speaking" (a Thai student). Related to this was the sense of being understood or rather the lack of it: "people couldn't understand me, often they had problems with my accent" (an Indian student). As these quotations indicate, communicating involves two parties, one who is trying to express a message and the other one who is trying to make sense of it. Within this process, most international students are employing a
language that is not their mother tongue which has implications for the way they express themselves, pronunciation and ability to understand others.

The way students have coped when they do not understand is to ask the person either to repeat it or to explain the meaning of a particular word. Reading in English and watching TV also seemed to help the student’s communication skills: “I had to process more vocabulary to actually express myself so I decided to read more so I was trying to read more and trying to watch TV a bit more, watched all the soaps and see how people expressed themselves” (a Mauritian student). However, if communicating is a two way process, efforts to improve the situation would need to come from all parties involved. In terms of being understood, some participants mentioned “a tendency of international students to understand other international students, they tend to be more sensitive to the pronunciation, to the language” (a Malaysian student) and “the expectation that if we didn’t understand each other at least we would try to understand” (a Mauritian student).

The link between the difficulties reported by the participants and the process of adjustment will be considered below. As seen in the above material, the majority of participants learned new ways to contend with the challenges that the experiences of living and studying in a new culture and environment posed. According to Coelho (1962), problem solving in any new situation entails first being aware of the parameters of the situation then devising responses to problems encountered and finally, internalising the responses. Thus, the processes of learning and adjustment are interrelated. One of the interviewees, a Sri Lankan student, explains in broad terms such process from his own experience: “the first day you realise what you have to do, the second day we are doing that so you get used to it so then it’s o.k”. On the whole, the interviews are riddled with phrases such as “I realised that...”, “get used to”, “I’ve learned that...” which seem to denote the aforementioned processes of becoming aware and learning as part of adjustment.
Another aspect of adjustment noted by the interviewees was the fact that this process took time: "I had to change my lifestyle, you can't change things like that in one week, but now it's o.k" (a Sri Lankan student). The quotation also makes reference to the way in which this particular student reacted to a challenge. Anderson (1994) broadly speaks of four ways of reacting to a new situation: by changing the environment, by changing oneself, by doing nothing at all or by walking away. The above quotation seems to be an example of changing oneself, as is the following one: "I learned to go about things the way I'm supposed to, I suppose these things are not within your control to have them changed, therefore I have learned myself how to adapt to the situation, it makes life easier" (a Malaysian student).

Two participants expressed their views on adaptation in a different way. A Nepalese student did not believe that one could ever fully adapt to a new culture: "you are born and brought up in a different culture, this part of the world has a different culture, you can adjust to some degree if your adaptability is good but you can adapt 70% or so but 100% is not possible unless you start right from childhood". Yet, the second participant, a Malaysian student, conceptualised adaptation as becoming totally familiar with the new environment: "I would really like to feel at home here". These quotations provide evidence for the idea that the final stage in attaining competence in another culture is defined by each individual; thus, each individual's definition of fitting will be different as his or her adjustment will be unique and personal (Coe, 1972; White, 1974).

Support and Relationships

When overseas students come to England for the first time, they leave behind their support networks: "being a student, away from home, away from a support network, family network" (a Malaysian student). One of their tasks is to re-establish sources of support in their new environment. Brammer & Abrego (1981) list abundant research about the importance of a support network in a transition. A Sri Lankan student makes this point very clear: "if I don't have any friends or anybody then I won't survive". They also explain the importance of identifying one's needs and then seeking specific
people that will fulfil such needs. Evidence for such concept is found throughout all
the interviews. Overseas students in the present study turned to different people
according to the help they were seeking: "It depends what kind of support I need, if
my father for some reason can't send me money for a short period of time, then we
use each other's money with my sister, she borrows money from me and I borrow
money from her, if I have, say, need to talk about anything academic then my personal
tutor and we talk about anything with friends so we have people to talk" (a Sri
Lankan student). Another student, from Nepal, explains: "Academically, if I need
help I go to talk to individual teachers, they always give me some advice and it
worked, emotionally, whatever I talk to my friends, you can exchange ideas, that can
help. The union also whenever I need specific information.". Having established that
these international students have different support systems, the specific sources and
nature of their support will now be explored. The three major sources of support
described by the majority of participant were: lecturers, friends and family.

The relationship with staff was partly dealt with earlier in relation to the difficulties
reported by one participant. Below, relationships with staff with be discussed in the
context of support. With regards to lecturers, students have described them as
"helpful", "friendly" and "nice". Some interviewees explained that what had helped
them in their relationship with university staff was: "the way they accommodate you
[]. Everytime you need help, everytime you want to know something they are always
there, they always want to help. Like one of them said to me that they appreciate when
the student comes round and asks him questions" (a Mauritian student). It appears
that being welcoming and available are two important aspects students look for in
seeking support from teachers and personal tutors.

The majority of interviewees turned to family and friends for emotional support,
although, for most overseas students the first source of support were friends: "I've
got a really best friend so I would go to her first and then if this thing is really
bothering me and upsetting me I might talk to my family" (a Mauritian student). The
main concern that some international students mentioned in connection with talking to
their families if they needed support was that they did not want to worry them unnecessarily. It is also possible that the accessibility of the sources may affect whom students would turn to first for emotional support. Overseas students have left their family network in their country of origin which means that they are not as readily available as friends in England may be.

In terms of friends, the majority of participants had few very close friends whom they turned to for support. When asked about their reasons for going to them specifically a theme of “sameness” emerged: “we share the same, more or less have the same experience and we may see things in the same way, that’s probably why” (a Mauritian student). Moreover, a sense of being understood was also mentioned by some students: “my closest friends tend to understand so you are able to expose your fears and feelings to someone that can understand where you are coming from” (a Malaysian student). The nature of the support they received ranged from advice and reassurance to just being with someone who listens and is nonjudgemental. The above material provides evidence for Brammer & Abrego’s (1981) argument that people often expect all their support to come from a few people; however, this may render their support systems incomplete and inadequate. They suggest that many people develop certain kinds of support such as friendships but they neglect other sources of support. In their work, they have found it useful to urge people to expand their support network to include people whom you can feel close to, who can give information or who will challenge our thinking.

All participants in the study were asked if they had made use of the counselling services at the university. Except one, nobody had. Most of the interviewees felt that the difficulties they had experienced were not serious enough to seek therapy and if they needed someone to talk to they would turn to their friends: “I don’t think the problems I’ve had are worth me talking to [a counsellor] and if I needed to speak to someone I would speak to my friends” (a Caribbean student). An issue that was brought up by a few students was one of trust and the fact that they did not feel they could disclose information to a stranger: “I don’t think I would be that willing to be
that trusting with a stranger” (a Caribbean student). A Malaysian student added: “I imagine it would be difficult for me to disclose to a person that I hadn’t established rapport”. The one student that had made use of the counselling services at the university had been referred by the GP whom he had gone to see for sleeping tablets. During the assessment, it emerged that the student’s father had died recently so it was suggested to him that he could go to see someone to talk about it. He found therapy very helpful because “you had someone to talk with and they would guide you” (a Mauritian student).

OVERVIEW

There are a number of methodological issues that need to be considered in connection with the findings of the present study. Firstly, the degree to which the results can be generalised to the population. The limitations of the sample deem it difficult to generalise the findings. The sample that took part in the research was small and very heterogeneous particularly in terms of nationality, thus, the data cannot provide insights into the adjustment of particular national groups. Moreover, it is difficult to ascertain the parameters of the population of international students who have come to this country for the first time to study, thus, it is not possible to verify whether the sample is representative. A study that included a larger sample from a single national group may yield results more relevant to a specific population.

Secondly, the research was conducted at a single point in time during the sojourn which means that the participant’s material was, in the main, retrospective and therefore subject to memory effects. A longitudinal study whereby interviews are carried out at several points across the sojourn may limit some of those difficulties and also may elicit richer, in-depth material into the processes of adaptation to transition.
Thirdly, the interviews were conducted in English which is not the mother language for neither the researcher nor the participants. This may have restricted the interviewees’ ability to recount their experiences as accurately and richly as they may have done using their mother tongue. On the other hand, English was the common language between researcher and participants which made communication possible in the first place. Therefore, the limitations posed by the use of a second or third language as a means of communication appear difficult to surmount in the present study.

Finally, the role that the researcher’s status as an international student may have played in the research process will be taken into account. Coyle (1996) points out the advantages and pitfalls of the ‘insider’s’ position. As an ‘insider’ the researcher may be more familiar with the research topic and be able to bring his/her knowledge to the analytic process, thus, avoiding some of the mistakes that a less knowledgeable researcher might make. Furthermore, Breakwell (1995) has documented how participant’s willingness to answer honestly and openly increases with an interviewer who they think is similar to themselves. On the other hand, Coyle continues, the researcher may be blinded by the similarities and fail to see potentially significant differences. The implications for the present study are twofold. On the one hand, the researcher’s status as an international student may have encouraged the participants to engage in the research in an authentic and constructive manner and added a specialised ‘insider’ knowledge to the analysis. On the other hand, there is the risk that the researcher might overestimate the similarities between the researcher and the participants which might result in failure to identify potentially relevant issues and/or making gross assumptions about the material. In order to avoid such difficulties, the research process has been checked by another researcher who has provided an ‘outsider’s’ perspective.

Having discussed some of the methodological considerations of the present study, an overall discussion of the findings will follow.
As mentioned in the introduction, the existing literature of cultural adaptation seems to have a somewhat negative view of the process of adaptation focusing specially on the difficulties that sojourners experience. The present study was carried out in an attempt to explore both the problematic and personal growth potential of cross-cultural adaptation. The findings corroborate the view that the experiences reported by international students entailed both difficulties and personal development. This seems consistent with the views put forward by Adler (1975), Schlossberg (1981) and Anderson (1994).

The results also indicate the interactive nature of the various aspects of the experiences reported by the students whereby the nature of difficulties encountered by the participants appeared to be influenced by the degree of cultural distance between their home environment and the host environment and the fact that students were on their own which in turn also influenced their personal development. Adjustment was linked to cultural distance and support was linked to relationships. Such findings seem to be consistent with the interactive model proposed by Schlossberg (1981) which emphasises the differences of the pre-transition and post-transition environments in relation to the individual’s perceptions of the transition, support and individual characteristics.

It seems apparent that appropriate and comprehensive models for describing and explaining the process of adaptation are scarce, thus, future research may need to concentrate in developing models that concentrate on the dynamics and processes involved in adaptation. Moreover, research on international students should be extended to include systematic exploration of existing models of human transition and more studies comparing the adjustment process of particular national groups are needed. Longitudinal research is recommended to compare differences in adjustment within individuals and to evaluate the effectiveness of services provided to international students.
As counselling psychologists working in a variety of settings which may include university counselling services, the present study has a number of implications for practice. The model proposed by Schlossberg (1981) can offer counselling psychologists a framework to draw on, which may assist them in designing pertinent and appropriate interventions. Moreover, as Gould (1981) states, the transition period is a vulnerable state, thus, awareness of the difficulties that international students encounter in a different culture is important. Counselling psychologists working with international students face a number of challenges which are inherit in cross-cultural psychotherapeutic practice (Okorocha, 1997), thus, any recommendations for practise would need to take such challenges into account. Specific recommendations derived from this study and the literature on the challenges that cross-cultural therapy poses include the following:

**Awareness and sensitivity to other cultures**
The results suggest that cultural distance may be a contributing factor to the difficulties reported by the participants. Thus, when working with culturally different clients, awareness and sensitivity to other cultures would be important therapist’s assets. In order for therapists to broaden their knowledge of other cultures, Okorocha (1997) suggests reading books, specific training or even asking the client, although being cautious not to allow curiosity about the client’s culture to interfere with the therapeutic process. Therapists that depend entirely on their own internalised value assumptions become as Pedersen (1988) defines, “encapsulated”. He explains encapsulation as a process in which professionals rely on stereotypes in making decisions about people from different cultural groups, ignore cultural differences among clients and define reality according to one set of cultural assumptions.

**Acknowledge communication difficulties**
One difficulty reported by all the participants in the present study was communication, in particular, verbal communication. The therapeutic process relies on verbal and non-verbal communication and the therapist depends on the client’s ability to express verbally their feelings, motivations and so forth. However, this may
pose limitations when therapy is conducted in the client’s non-native language. Furthermore, Gonzalez-Reigosa (1976) found that the client’s emotional experience and expression may be restricted in a non-native tongue. Differences between international students and therapist in the interpretation of non-verbal communication may lead to misinterpretations. In order to avoid such misinterpretations it is important to clarify verbal and non-verbal issues and avoid the use of jargon and idioms which international students may find difficult to understand.

**Treat the client as an individual**

The findings illustrate that international students are not a homogeneous group and each individual has a unique set of experiences which they will bring to therapy. Stereotyping the client as “cross-cultural” may prevent the therapist from viewing him/her as an individual within a culture which may hinder the development of rapport (Draguns, 1976). Cultural differences imply that therapist and international students do not share the same set of assumptions about the therapeutic process. International students may be unfamiliar with the therapeutic process, thus, Hare-Mustin et al. (1979) specify the importance of letting clients know about the procedures and goals of therapy.

**Use of a flexible approach**

An extension of treating international students as individuals is the recommendation to fit the approach to their individual needs. The assumptions implicit within the theoretical approaches that psychologists are trained on and work with need to be clarified. Such models have been developed by white, middle class practitioners enmeshed in western cultural values. Within the white western culture, the internal self and the independent individual are given overriding importance, thus, psychological therapy is aimed at self-centredness, self-exploration, self-disclosure and self-determination (D’Ardenne & Mahtani, 1996). On the other hand, these goals may not be suitable for overseas students from cultures where the interdependent self is more important, that is, cultures that put the family and other social unit above the individual, and interdependency is considered not only healthy but necessary (Casas
& Vasquez, 1996). Moreover, western models provide a specific conception of positive mental health which may be subject to cultural differences. The interpretation of the client’s behaviour in terms of the therapist’s values rather than those of the client’s can result in erroneous assessment and diagnosis and potentially ineffective interventions, thus, Casas & Vasquez (1996) specify that what is considered “acceptable” behaviour must be evaluated and understood according to the situation, the cultural background and the time in which the behaviour is observed.

Practising across cultures requires flexibility in adapting therapeutic approaches, formats and interventions that are congruent with the value systems of diverse ethnic groups. As Draguns (1996) indicates, a basic component of the therapeutic experience that remains constant across cultures in a trustful and open relationship, thus, the client/therapist relationship may be more important than technique. Although, as Church (1982) points out, conceptions of a good therapeutic relationship may not be culturally universal, therefore, a constant questioning of one’s own assumptions and the assumptions made by the approaches counselling psychologists work with is necessary.

**Training and research**

In order to work effectively with clients from diverse cultures, specific multicultural training that emphasises differences in the behaviour of individuals who seek help as well as differences in perceptions of mental health, is necessary (Wright et. al., 1989). Casas & Vasquez (1996) point out that without specific training, practitioners may fail to appreciate the role that culture plays in psychological development and functioning. In addition, they may concentrate solely on the presenting problem, failing to evaluate it within an appropriate socio-cultural context. Moreover, generating research plays an important role in bridging the gap between theory and practice, in assessing psychologists’ interventions with international students and in encouraging further understanding of clients from different cultures.
REFERENCES


APPENDIX 1

BACKGROUND INFORMATION

The following are some general questions about you (such as your age, education and nationality). The information that you give will not be used to identify you in any way as this research is completely confidential. Please tick or write in the appropriate answer.

1. Are you?
   Male  ___
   Female  ___

2. How old are you?  ____ years

3. What is your legal marital status?
   Single  ___
   Married  ___
   Divorced/Separated  ___
   Other (please specify:______________)

4. a) Do you have any children?
   Yes____ (go to part b)   No____(go to question 5)
   b) How many children do you have?  ____

5. What is your nationality?_______________

6. What is your country of residence?_________

7. Which of the ethnic groups listed below would you say you belong to?
   White  ____
   Black - Caribbean  ____
   Black - African  ____
   Black - Other  ____
   Indian  ____
Pakistani __________________________
Bangladeshi ________________________
Chinese ____________________________
Other (please specify: ____________)  

8. What is your current occupation? ______________

9. What course are you currently undertaking at the university?

__________________________________________

10. Is your course?

Undergraduate ___
Postgraduate ___

11. What year are you in? ___

12. How long have you been in England for? _____________

13. a) Have you taken any official exams that assess your level of English?

Yes__ (go to part b)    No__ (go to question 14)

b) What exam was that? __________________________
What were the results? __________________________

14. a) How would you rate your level of spoken English?

Extremely good ___
Very good ___
Quite good ___
Not very good ___
Not good at all ___

b) How would you rate your level of written English?
<table>
<thead>
<tr>
<th>Rating</th>
<th>Score</th>
</tr>
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<tr>
<td>Very good</td>
<td></td>
</tr>
<tr>
<td>Quite good</td>
<td></td>
</tr>
<tr>
<td>Not very good</td>
<td></td>
</tr>
<tr>
<td>Not good at all</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 2

Interview schedule

GENERAL INFORMATION

- Before coming to this country, have you ever moved from the parental home to a different town/city/area?
  If Yes: Where?
    When?
    For how long?
    How much of a change was this for you?
      What makes you say that?
    What were your reactions to the change?

- Before coming to this country, have you ever lived away from home, in another country?
  If yes: Where?
    When?
    For how long?
    How much of a change was this for you?
      What makes you say that?
    What were your reactions to the change?

- To what extent do you think that your experience of living away from home has prepared you for the move to England?
  If Yes: In what ways?
  If No: What makes you say that?

If Not lived away:
- Do you think that if you had already lived away from home it would have prepared you for the move to England?
  If Yes: In what ways?
  If No: What makes you say that?

- Has anybody in your family studied or worked abroad?
  If Yes: Do you think it has helped you to prepare for the move to England?
    If Yes: In what ways?
    If No: What makes you say that?
  If No: To what extent do you think that if anybody in your family had been abroad before you, would have prepared you for the move to England?
    If Yes: In what ways?
    If No: What makes you say that?
-How do you fund your stay?
-To what extent does your funding meet your financial needs?
  If it does not: How do you cope with that?
  How does that make you feel?
-Have you attended any English courses provided by the University?
  If Yes: How helpful was it?
    What was helpful/unhelpful about it?
  If No: What has prevented you from attending?
    How helpful do you think it would have been?

PRE-ARRIVAL
Now I am going to ask you some questions about the time prior to arriving in this country, so if you can cast your memory back to that time.

-How was it first decided that you would come to England to study?
  (Prompt:-Whose idea was it?/ What made them/you decide to come to England to study)
  If not own idea: How did that make you feel?

  If own idea: How did your family members react to the idea of you coming to England?
    How did that make you feel?
      (-Prompts: Were there any conflicts in your family about you coming to England?/-To what extent were you able to discuss it openly at home before the decision was made?/-To what extent were you able to discuss it after the decision was made)

-How long was it from the time you knew you were coming to England to the time you actually arrived?
-Did it allow you to prepare yourself for the change?
-What, if anything, did you do to prepare yourself for the change?

-What expectations did you have?
  About the country
  About the people
  About the course
  About the experience of a different culture

-Did you have enough information about what to expect?
-What were your sources of information?
-To what extent was the information you had helpful?
In what ways?
-What did you want to achieve from your stay?
-Which, would you say you have achieved?
-How does that make you feel?
-What about the others, do you think you will achieve them?
-What makes you say that?
-How does that make you feel?

-Looking back, what, if anything, could you have done prior to your arrival which would have made it easier for you to adapt to life in England?

DURING THE STAY
Now I want you to think about the time you arrived to England and "Could you tell me in your own words what happened during the first weeks.... "
-How did you feel?
-What were your first impressions about?
  the country
  the university
  the people
-What gave you that impression?
-Have they changed?
-In what ways?
-What do you think has contributed to such change / the lack of it?

-What kind of difficulties have you experienced during your stay in England?
  Language
  Financial
  Academic
  Relationships with university staff
  Relationships with host students
  Relationships with fellow nationals

Prompts for the above:
-Have you experienced difficulties in.....?
If Yes: How does it make you feel?
  What is the nature of such difficulties?
  What factors, do you think, have contributed to your difficulties?
  In what ways?
  What, if anything, have you done to overcome such difficulties?
  How has that helped?
  What, if anything, could others have done to improve the situation?
  How would that help?
If No: What do you think has helped you to avoid difficulties in....?
How has that helped?
-Have you experienced prejudice? What I mean by prejudice is discrimination against you due to race or status as international student.
-What has been the nature of the prejudice?
-Could you give me some examples?
-How does it make you feel?

-What have you learned, if anything, from your experience in a different culture?

-To what extent do you think have changed as a result of your experience?
-In what ways?

-What do you think it has been the most valuable aspect of your experience?
-Why?

-What have been the most difficult things about adapting to a different culture?
-Why?

THE RETURN

Now changing the subject to something else,

-Do you go back home to visit?
-How often?
-In what ways do visits home affect you?
(Prompts: Do they help you? How?/Are they unhelpful? How?)
-What do you most miss from home?
-Why?

-What are your plans when you finish your studies?
If staying:
-How do you feel about staying?
-What are your reasons for staying?
-Do you have any reservations about staying?
If Yes: What are they?
If No: What makes you say that?
-Do you intend to do anything to overcome these reservations?
If Yes: What do you intend to do?
   How would that help?
If No: What makes you say that?
If going back:
- How do you think you will feel when it is time to go back home?
- Do you have any reservations about going back?
- What are they?
- Do you intend to do anything to overcome these reservations?
- How would that help?
- How do you anticipate you will feel when you are back home?
- What do you think you will miss about your experience in England?
- Why?
- What do you think you will be glad to leave behind?
- Why?

- Looking back on your experience of living and studying in England, if one of your friends in (country of origin) was thinking of coming here to study, what advice would you give them? (Prompt: to help them overcome the difficulties you have faced?)

QUESTIONS ABOUT THERAPY
As you know I am currently undertaking a postgraduate course in Psychotherapeutic and Counselling Psychology and I am interested in issues around counselling. To begin then,

- Have you ever made use of the counselling services at the university?
  If Yes: Would you like to tell me a bit about that?
    (Prompts: reasons, how long and how often)
    Before you began, what were you hoping that you would be able to achieve through counselling?
    Did you find counselling helpful?
    If Yes: What was it about it that you found most helpful?
      Is there anything the counsellor could have done to make it more helpful?
      What could they have done?
      How do you think that might have helped?
  If No: What makes you say that?
  Were cultural issues talked about in counselling?
  If Yes: How helpful did you find it?
    What do you think the counsellor’s attitude towards cultural issues was?
    What makes you say that?
  Do you think you achieved the aims that you talked about earlier?
  If Yes: Do you think this was due to the counselling or other factors?
    What other factors?
If No Counselling:

- Have you ever considered going to the counselling services?
  **If Yes:** What made you think of considering counselling?
    - Why, in the end, did you decide not to?
  **If No:** Why, do you think, you have not considered counselling?
    - Can you think of anything which would have made you consider seeking counselling?

- Who do you turn for emotional support if you need it?
  - How easy is it for you to contact them when you need it?
    - How does that make you feel?
  - Why do you turn to that particular person/group/organisation?
  - What kind of difficulties would you turn to them for?
  - What have they said or done that you found helpful?
  - What, if anything, have they said or done that has been unhelpful?

- To what extent does the nature of the support you receive meet your needs?
  **If it does:** In what ways?
  **If it does not:** What makes you say that?
    - How does that make you feel?
    - What would you need to feel appropriately supported?
      - How would that help?

**STANDARD PROMPTS**
- Anything else?
- Could you tell me some more about that?
- What makes you say that?
- In what ways?
- How does that make you feel?
- What happened then?
The aim of this research is to explore how international students adapt to living and studying in England. In order to address these issues, you will be asked to take part in an informal interview about your experiences of studying and living in England.

The interview will be recorded on audio-tape so that, in writing up the research, I can cite people’s experiences directly. Naturally, to protect confidentiality, I will not quote any identifying information such as names and departments. In making the transcriptions, therefore, your name will be replaced by a letter, and I will not record the names of other people or places that may arise in the interview. Once transcribed, the audio-tape recordings will be erased.

If you have any questions so far or feel you would like further information about this research, please ask the researcher before reading on.

Please read the following paragraph and, if you are in agreement, sign where indicated.

I agree that the purposes of this research and what my participation in it would entail has been clearly explained to me in a manner that I understand. I therefore, consent to be interviewed about my experiences of living and studying in England. I also consent to an audio-tape being make of this discussion, and to all or parts of this recording being transcribed for the purposes of research.

Signed ........................................... Date .........................

On behalf of those involved with this research project, I undertake that, in respect of the audio-tapes made with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Signed ........................................... Date .........................
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
FIGURE 3: THEMES AND SUBTHEMES (INCLUDING LINKS) OF PARTICIPANTS' EXPERIENCES DURING THEIR STAY IN ENGLAND.

Difficulties
- Relationships
- Discrimination
- Communication
- Ingroup versus outgroup
- Homesickness
- Practise of religion
- Financial
- Finding sources of recreation

"On your own" Status

Personal Development

Adjustment

During the Stay

Cultural Distance

Similarities
- Political System
- Educational System
- Food
- Level of Development
- Religious Beliefs
- Lifestyle
- Relationships
- Recreation
- Food
- Humour
- Weather
- Academic System
- Individualism versus
- Collectism

Differences

Sources
- Nature
- Accessibility

Support
- Staff
- Relationships

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Factors that facilitate or hinder effective cross-cultural therapy with international students: therapists’ accounts of practice

ABSTRACT

The existing literature on cross-cultural practice focuses primarily on identifying the difficulties that various sojourner groups experience as a result of leaving their home country and the implications for their psychological well-being. However, more research that investigates the therapeutic process itself and what is effective about cross-cultural therapy is necessary. Therefore, the aim of the present paper is to elicit information from therapists who work with international students about factors which, in their experience, facilitated or hindered effective cross-cultural practice with this client group. A total of nine interviews were carried out with therapists who work at University Counselling Services in the London area. Interviews were transcribed and subjected to Interpretative Phenomenological Analysis. It was found that strategies that contributed to effective cross-cultural therapy included not making assumptions about the similarities or differences between the therapist and the client and becoming aware of the therapist’s own agenda. The participants reported a number of potential barriers to effective cross-cultural therapy. These encompassed: the degree of cultural distance between the therapist and the client, language, lack of trust and credibility in the therapist and the image of the counselling services being portrayed to international students. In the light of such findings, some recommendations for the development of future practice are offered.

Key Words: cross-cultural, strategies, potential barriers, effective cross-cultural practice.
INTRODUCTION

Counselling psychologists work in a variety of settings which may include university counselling services. Within such settings, counselling psychologists are likely to work with students from a variety of cultural backgrounds. Research that explores issues involved in working with international students in a therapeutic context will provide an increased understanding into the practice of counselling psychology in a cross-cultural context.

Terms such as 'culture' and 'cross-cultural therapy' will appear throughout. Thus, a discussion of the meaning of such concepts seems pertinent in setting the parameters of the present study. Vontress (Jackson, 1987) refers to cross-cultural therapy as the interaction between a therapist and a client that are culturally different. Whether therapy is considered cross-cultural depends on real and perceived cultural differences and similarities between therapist and client within the therapeutic relationship. Since 'cultural differences' are necessarily discussed in the cross-cultural literature, what is meant by 'culture' will inevitably affect the definition of cross-cultural practice.

Many definitions of culture exist (Kroeber & Kluckhohn, 1952) which could be grouped in two broad categories depending on whether they reflect a universal (etic) or specific (emic) view of culture. Those definitions of culture which include variables such as sex, age, sexual orientation, religious beliefs, ethnicity, race and socio-economic status are considered as an etic perspective (Fukuyama, 1990). As a result, an etic approach to cross-cultural therapy includes not only ethnically different clients but also clients that belong to a different culture to that of their therapist because of other variables such as class, sexual orientation and gender (Atkinson, Morten & Sue, 1989). Common themes have been identified among minority groups as a result of "being different" from the western, white, male, middle-class, heterosexual, able-bodied and youth-based dominant culture. These include: experiences of discrimination, prejudice or neglect (Brislin, 1981; Dworkin & Gutierrez, 1989), identity development, self-esteem, need for validation of personal
experiences and need for empowerment (Mangolis & Rungta, 1986). The etic approach to cross-cultural therapy seems to emphasise the issue that therapists are both similar and different to their clients in myriad ways in which culture is one of many. In this way, therapists can be mindful of the impact that variables such as gender, sexual orientation, class and disability, as well as culture, have on the therapeutic relationship rather than being blinded by the more obvious differences such as race and ethnicity. In addition, an etic approach to cross-cultural therapy can mean that the field of cross-cultural therapy can benefit from the broad and rich existing literature in other disciplines such as gay and lesbian affirmative therapy, feminist therapy and therapy for the disabled. In contrast, more purist definitions of culture or emic perspectives focus solely on aspects of race and ethnicity. Therefore, an emic approach to cross-cultural practice is based on notions and experiences specific to each ethnic group and deals with characteristics, values and techniques for working with visibly ethnic minority groups. Therapeutic strategies and interventions are tailored to the needs of particular cultural groups. Those holding this view would consider a wider definition of culture to dilute the importance of racial and ethnic issues in the therapeutic relationship. Furthermore, assumptions may be made about the applicability of general concepts across cultures. The emic approach would seem to reduce the risk of underplaying the impact of race and ethnicity and viewing culturally different clients as a homogeneous group. In view of the lack of consensus about the concept of culture, it is not surprising that the question of what exactly constitutes cross-cultural therapy is still being debated in professional circles (Stills, 1990).

A substantial US literature has developed in the last two decades offering recommendations for therapeutic practice with culturally diverse clients (Vontress, 1969; Sue & Sue, 1990; Pedersen, 1991; Pedersen et. al., 1996). In recent years, the UK literature in cross-cultural therapy is also beginning to develop (D’Ardenne & Mahatani, 1989; Eleftheriadou, 1994; Lago & Thomson, 1996). However, the existing literature on cross-cultural practice focuses primarily on identifying the difficulties that various sojourner groups including international students and refugees experience
as a result of leaving their home country and the implications for their psychological well-being (Church, 1982; Anderson, 1992). A review conducted by Ponterotto and Casas (1991) of all the racial/ethnic minority research that was published in the major counselling psychology journals in the US between 1983 and 1988, concluded that one of the criticisms of the existing cross-cultural literature is that there has tended to be a lack of theoretical frameworks to guide and give meaning to both research and clinical endeavours. Casas and Vasquez (1996) believe that, in the absence of such a framework, it is difficult to determine the importance or relevance of much of the information available in the literature in relation to the therapeutic process. In an attempt to provide such a framework, they proposed a theoretical model which presents categorical variables along a continuum. At one end of the continuum are categories which are more covert and distal to the therapeutic process. These include selected therapist variables which are then further broken down into personal/sociocultural and professional variables which include biological, cultural, cognitive, behavioural, training and life experience aspects. Further along the continuum there are the selected client variables which include personal, sociocultural and life experience variables. At the other end of the continuum are those categories which are more proximal and integral to the therapeutic process which are selected therapy process variables. These encompass the client’s expectations and preferences for therapist, the client’s attitudes toward the therapeutic process and therapist, credibility, rapport, the setting, the therapist’s level of sensitivity to personal and professional biases, the therapist’s degree of understanding of the client’s expectations and cultural background and the therapist’s ability to select appropriate interventions.

The model provides a multifactorial and comprehensive view of the variables that are likely to affect the therapeutic process. It may be useful as a tool to contextualise existing literature and future research in terms of its relevance to the therapeutic process. However, it does not explain how the various variables may interact with each other nor the implications of such interactions for the therapeutic process. The model remains primarily descriptive and thus, is not adequate for making predictions. In order to create more adequate models, research that focuses on process and
explores what actually happens within therapy are necessary (Pedersen, 1991). Historically, process research has developed as a distinct area of investigation when interest moved away from discovering whether therapy was effective towards discovering what is effective about the psychotherapeutic encounter (Wilson & Barkham, 1994). In an attempt to explore what makes cross-cultural therapy with international students effective, research that explores key factors which facilitate or hinder the therapeutic process will provide further understanding on ways to enhance effectiveness. Thus, the aim of the present study is to elicit from therapists who work with international students information about factors which, in their experience, facilitated or hindered effective cross-cultural practice with this client group. In order to achieve such aim, the present study will endeavour to answer the following research questions:

- What strategies contribute to effective cross-cultural therapy.
- Which potential barriers hinder effective cross-cultural therapy.

METHOD

Participants
The eligibility criteria for the study was everyone who was a therapist working at University Counselling Services in the London area and were either Chartered Clinical/Counselling psychologists, registered on the United Kingdom Counsel for Psychotherapists (UKCP) or accredited by the British Association of Counsellors (BAC). Experience of working therapeutically with international students was also part of the criteria.

Individuals were recruited by writing to Heads of University Counselling Services who then were able to inform other staff members of their Counselling Services about the study. The initial letters (Appendix 1) were followed-up by telephone calls in an attempt to establish personal contact with potential participants and increase the response rate. Nine participants volunteered to take part. With a small sample
generalisation of the findings to the wider population proves difficult. However, qualitative research has different conceptions about sampling than quantitative research. The aim of most qualitative research projects, including the present study, is to explore a small sample in detail from which claims about that particular group can be made (Flowers et. al., 1997).

**Procedure**

The emphasis of the present study is on therapists' own subjective experiences and accounts of their professional practice with clients from other cultures. A way of gathering detailed and personal data which is also concerned with subjective meaning is conducting face-to-face interviews (McLeod, 1994). Therefore, interviews were employed to gather the data. All the participants were interviewed at the University Counselling Services where they worked. Informed consent to participate in the study was gained by providing the interviewees with information in advance on the aims of the study, what it involved, ways of ensuring confidentiality and what will be done with the data. Once the participants understood and were in agreement with the purposes of the research and what their participation entailed, they were asked to sign a consent form (Appendix 2). In order to ensure confidentiality, participants' names have been replaced by pseudonyms. Any identifying information that may arise in the course of the study such as names of people or places has been changed. Additionally, participants were asked to complete a demographic information sheet (Appendix 3). A semi-structured interview was then administered consisting of open-ended questions (Appendix 4). The existing literature was consulted in order to ensure that the interview schedule encompassed relevant topics for the study. The main areas included in the interview were: strategies that the participants employed which they felt contributed to effective cross-cultural practice, potential barriers to effective cross-cultural therapy, examples of both sensitive and inadequate practice, the issue of cultural matching between therapist and client, training and specific skills and knowledge of cross-cultural therapists. Due to the limitations of space, the present paper focuses on the topics of strategies and potential barriers to effective cross-
cultural therapy. Interviews lasted between 1 and 2 hours and were tape-recorded. All interviews were transcribed verbatim.

Analysis
The data was qualitatively analysed using Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith et. al., 1997). This approach is considered the most appropriate because of its emphasis on individuals’ personal experiences. The aim of IPA is to explore the participant’s view of the world and adopt, as far as possible, an ‘insider’s perspective’ (Conrad, 1987).

This form of qualitative methodology is concerned with the individual’s accounts of an object or event and the meanings individuals ascribe to them as opposed to an objective account of the object or event itself. IPA also considers that such meanings can only be arrived at through a process of interpretation. Thus, IPA recognises that research is a dynamic process whereby access to the participants’ accounts is dependant on, and complicated by, the researcher’s own interpretative framework (Smith, 1996). In view of the impact that the researcher’s world view has on the process of interpretation, an acknowledgement of the researcher’s speaking position is required. The researcher’s status as a psychologist with training and experience in psychotherapeutic work, familiarity with existing work relevant to the research topic and the researcher’s position as an international student are factors that may affect the interpretative framework brought to bear on the analysis. Accounts of what each respondent thinks or believes about the topic under investigation are subject to memory distortions and recall biases (Rubin, 1996) because they are shaped by the context in which these accounts are produced (Potter & Wetherell, 1991). Therefore, it is difficult to justify considering such accounts as true representations of the facts. Nevertheless, it is recognised that individuals’ accounts bare some relationship with the actuality of events, although no claims will be made to the nature of such relationship.
Following transcription, each transcript was read noting down anything considered by the researcher as relevant or significant about the participant's response. These comments were attempts at summarising the data, making connections between different aspects of the data and making initial interpretations. These were then coded with a word or phrase which captured the essence of the content giving rise to emergent theme titles. Repetition of emergent themes within transcripts and across transcripts was taken as indicative of their status as recurrent themes leading to a more consolidated list of themes. At the same time, due attention was paid to the range and diversity of responses and experiences.

Themes connecting to other themes were grouped together to create major themes. Quotations from the transcripts which exemplify each theme and sub-theme as well as the links between them were noted. Repeated reading of the transcripts and reference to the relevant literature informed and supported the interpretative process.

Numbers illustrating the frequency with which themes occurred will not be employed when reporting the findings. The use of quantification in a small sample may be misleading firstly, by giving the impression that the findings could be generalised to the larger population. Secondly, there are no pre-defined criteria determining the extent to which themes must recur before they merit citation (Krueger, 1994), and quantification may undervalue the significance of the themes that are identified. Adjectival phrases such as: “The majority of participants”, “Few of the participants”, “Some participants” will be employed instead. A specific detailed discussion of the results will be provided in the analysis section of the paper whereby the data will be presented and analysed in specific components. An overall perspective of the findings will be discussed in the overview section.

In terms of evaluating the research, traditional criteria such as validity and reliability which have evolved for the assessment of quantitative research are inappropriate for the present study because they are based on notions of objectivity and detachment which assume that researcher and researched are independent (Henwood & Pidgeon,
1992). Alternative criteria for evaluating qualitative research are internal coherence, transparency and persuasiveness (Smith, 1996). In this study, interpretations will be backed up by presenting actual material from the raw data in an attempt to make the analytic process as transparent as possible allowing the reader to question the analysis themselves and assess its persuasiveness.

In the sections where quotations are presented, empty square brackets indicate where material has been omitted and classificatory material that has been added is written within square brackets.

ANALYSIS

Demographic information
The participants in the present study were six white females and three white males with a mean age of 46 years (range 34-55, SD= 6.7). They were all therapists working at University Counselling Services in the London area. Seven therapists were BAC accredited counsellors, one was a UKCP registered psychotherapist and one was both BAC accredited and UKCP registered. They had worked with international students for a mean duration of 8 years (range 1-23, SD= 7.0). In terms of theoretical orientation, one participant was predominantly cognitive-behavioural, two psychodynamic, two psychodynamic and humanistic, three humanistic and one integrative, although it was not specified which particular approaches were being integrated.

Strategies which contribute to effective cross-cultural therapy
One of the themes that emerged from the data concerned the strategies the interviewees said they employed which they believed contributed to effective cross-cultural therapy. Within such a broad category, the majority of participants described employing various strategies which were clustered under the subtheme of ‘not making assumptions’. The participants referred to assumptions about the client’s beliefs and values due to their membership to a particular culture and assumptions about both the
perceived similarities and differences between the therapist and the client. In order not to make assumptions, the therapists in the present study focused around the concepts of gaining an insider’s perspective into the client’s world view and acquiring knowledge of the client’s specific culture. These subthemes will now be discussed in turn.

The majority of participants reported employing the strategy of gaining an insider’s perspective into their client’s world view. The aims of such understanding identified by some interviewees are: to get a better sense of the client’s difficulties which would then influence the treatment plan, to create a space where the complexity of the individual can be heard, to develop greater empathy and not to make assumptions. Such practice is in accordance with Ibrahim’s (1985) argument that an understanding of the client’s world view is one of the key elements in enhancing effectiveness in cross-cultural therapy. The need to gain an insider’s perspective into the client’s world view seems to stem from two premises. Firstly, the idea stated by some participants that the therapist’s background is different from the client’s background. Therefore, the therapist does not necessarily understand things in the same way that the client does, resulting in a need to ask questions and clarify the client’s point of view and the meaning they attribute to their experiences in order to understand their world view: “I don’t necessarily understand things in the same way that the other person does in that what I need to do is hear their point of view and what it means to them” (Keith). As a result, acknowledging and respecting difference in an explicit manner and without putting a value judgement on it is another strategy described by these therapists: “Just acknowledge difference and diversity and that I might be asking questions because I want to understand my client’s world” (Darren). Jan reported acknowledging and being aware of one’s own culture as a pre-requisite to acknowledging and respecting difference: “I think that until you are actually aware that you have a culture then I don’t see how you can begin to accept that other people see things differently and don’t actually value the same things you value”. For her, being part of the dominant, white, English culture was seen as making it difficult for the individual to be aware of
the impact of his/her culture. Therefore, it is important to make a conscious effort to make visible a cultural context that may be rendered invisible.

For one participant, the need to acknowledge difference was about accepting that cultural differences exist between client and therapist in terms of attitudes and beliefs and that they have an impact on the therapeutic relationship. She reported her experience of being at a conference where people argued for ignoring the colour of a client because it does not make a difference, which she disagreed with. The term “colour blindness” coined by Sue & Sue (1990) seems to encapsulate the essence of the viewpoint opposed by this participant. The basic concept underlying “colour blindness” is a liberal humanistic focus on the supposed universal “humanity” of all people. Whilst originally the aim was to reduce prejudice within therapy, such a stance may serve to deny the existence of differences that arise from membership of different racial groups. As some participants in the present study suggested, excluding race or culture from the therapeutic process and ignoring difference may create barriers to effective cross-cultural therapy (Sue & Sue, 1985).

The second premise underlying the need to gain an understanding of the individual’s world view is the experience that the majority of interviewees reported of noticing substantial individual differences within cultures. The majority of participants in this study believed that clients from the same culture come from different walks of life and different backgrounds so it is important to understand their particular world. “Wanting to understand not only what the culture is but what it means to them because it does mean very different things, it can mean very different things and there is so much individual differences between people of the same culture...”(Keith).

All but one of the interviewees placed great emphasis on the individual and on understanding both “where they are coming from” (Susan) and “their personal meaning of what they are telling” (Darren) when working with international students. Jan and Darren regarded identifying the client’s cultural norms as a useful technique in gaining an understanding of the client’s world: “trying to understand what it
means to that student, "a useful technique has been to ask them what it would feel in their culture" (Jan). In particular, they found it helpful to ask the client what would happen if they were feeling like that back home, how serious it would be, how people would respond to them and what it would mean. Participants reported focusing not only on the individual’s experience and the meaning attached to their current reality but also on the individual’s experience and the meaning attached to their socio-political and cultural context. Both internal and external realities are taken into consideration through the eyes of the client and their particular experience of those realities: “I want to understand my client’s world and their personal meaning of the socio-political context they come from” (Darren). As Ibrahim (1985) suggests, it is imperative to understand the client’s specific world view. However, this world view then needs to be placed in the context of the client’s primary subculture and how his or her values relate to the majority culture. The participants in the present study seemed to focus on the individual’s experience of his/her internal and external realities to the extent that the socio-political and cultural contexts are also personalised. This highly individualised emphasis may be partly explicable by the fact that the theoretical stance of the majority of participants entails a large humanistic component. The humanistic approach emphasises the phenomenological world of the client. As the interviewees suggested, in an attempt to apprehend the client’s internal frame of reference, therapists concern themselves mainly with the client’s subjective world (Corey, 1991). However, therapists may then undermine the impact that socio-political and historical developments have on individuals of a particular racial or cultural group. These findings seem to be in line with Sue & Sue’s (1990) argument that, at times, therapists tend to focus on the individual and universal aspects of their clients to the detriment of the group aspect which may hinder effective cross-cultural practice. They advocate that the therapist needs to recognise three aspects of each client. Firstly, the individual aspect which makes each client unique and unlike others. Secondly, the group aspect acts as a reference framework which may incorporate family, race, ethnicity, gender, religion and sexual orientation. Finally, the universal aspect which emphasises those common aspects that we all share as human beings.
For the majority of participants, part of acknowledging the student’s external reality and avoiding making assumptions was to gain some knowledge of the specific culture they come from. Such findings corroborate the view of other authors (Sue & Zane, 1987; Sue & Sue, 1990; Khoo et al, 1994; Okorocha, 1997). The means by which cultural knowledge was said to be acquired varied across the interviewees. Dan stated that it is the therapist’s responsibility to have knowledge of the client’s culture rather than asking the client. According to him, “the therapists can then make tentative connections in therapy between the client’s experience and his/her cultural background.” He believed that talking to someone who has some understanding will prove less disrupting and encourage a quicker development of rapport. However, Sue & Zane (1987) warn that therapists assume that cultural knowledge enables them to understand clients more accurately, although the application and relevance of such knowledge cannot be assumed because of individual differences among members of a particular ethnic group. For a few participants, a combination of learning about the client’s specific culture through books and movies and through asking the client was preferred: “Understanding about other cultures and check out with the student what is important from their culture” (Jan). It was felt that some prior broad knowledge of the client’s culture would reduce the risk of offending the client in any way and provide the therapist with some understanding of the client’s background. Furthermore, asking the client about their subjective experience of their culture would address the issue of individual differences within cultures. For some participants, using the client as the sole source of information was favoured. This was linked to the idea that there are individual differences within cultures. Thus, as Susan pointed out “I try to find out from the client for example, the differences in schooling and education to give me a better understanding of where they come from [] and because I don’t want to make any assumptions about people” (Cadieux & Wehrly, 1986). However, it may be seen as unfair to place the responsibility of educating the therapist on the client. As some participants have already stated, a combination of having some prior knowledge of specific cultures and asking the client would seem to provide a balanced approach whereby the therapist does not rely on the client for their education and individual differences are taken into account by adapting the therapist’s knowledge to each
individual client in the light of their particular experiences. Thus far, the responsibility for acquiring knowledge of a client's specific culture seems to be placed on individual therapists, although, one might argue that employers and training courses also need to share that responsibility.

One therapist believed culture specific knowledge to be not only unnecessary but also a potential barrier to cross-cultural therapy. He felt that such knowledge could increase the risk of employing stereotypes by entering the therapeutic process with pre-conceived ideas about a particular client: "I think sometimes you can believe you know, 'Oh, there is an Asian woman coming through the door and it's going to be like this'. It doesn't work like that" (Keith).

Other strategies which, according to the majority of interviewees, contributed to effective cross-cultural therapy clustered around the subtheme 'awareness of the therapist's own agenda'. The need for the therapist to be aware of his/her own assumptions, values and biases is in accordance with the view stated in the existing literature (Vontress, 1971; Cadieux & Wehrly, 1986; Holiman & Lauver, 1987; Coronado & Peake, 1992; Eleftheriadou, 1994; Khoo et al, 1994; Lago & Thomson, 1996; Du Plock, 1997.). As mentioned above, participants stated that the main strategy for effective cross-cultural therapy was not to make assumptions. Therefore, they said to employ a number of means which have already been discussed in order to prevent making assumptions. However, they also acknowledged that despite their efforts, therapists in this study are working from their own particular frame of reference which may result in some assumptions being made: "I don't want to make assumptions about people but it's very easy to make assumptions from where you are coming from" (Susan). Thus, some participants stated the importance of being aware of one's own stance and the implications of such a stance on the therapeutic relationship. Self-questioning and challenging were advocated by some who also suggested the need for a forum in which assumptions can be challenged which may include individual therapy and supervision: "I specifically sought out and chose a supervisor who identifies in ways that are very different to ways I identify myself in
order to help me become more conscious of what I'm not conscious of in terms of assumptions and stereotypes” (Jannette). Other participants experienced peer supervision as having the potential to challenge and reduce the risk of making assumptions: “Actually, being from different ethnic backgrounds means that in the group we are challenging and learning and exchanging so that very stereotypical assumptions are not allowed to develop too tightly” (Alice). However, not all the therapists in the present study were part of an ethnically diverse setting which would seem to place the responsibility on each individual therapist to set up structures where their own agenda can be explored and challenged. In the words of Jannette: “It’s actually taking responsibility for that level of awareness in myself and my own willingness to be challenged”.

A lack of awareness about the stereotypes and prejudices that therapists may hold in connection to certain races and cultures was regarded by few participants as a barrier to effective cross-cultural therapy. They argued that most people hold prejudices to a greater or lesser extent and that not acknowledging them has a detrimental effect on the therapeutic process. One interviewee explained that a lack of self-awareness impinged on her ability to be sensitive to the client’s reality: “I think that we are all these things [racists, heterosexists, homophobics] to a greater or lesser extent and that not acknowledging those realities [] is a big barrier for me because it removes me from that necessary sensitivity to the here-and-now of the person who is in front of me” (Jannette). In order to address such a barrier, the use of supervision and personal therapy was advocated. Other potential barriers to effective cross-cultural therapy reported by the participants in the present study will be considered below under the theme named ‘potential barriers to effective cross-cultural therapy’.

One might argue that many of the strategies described by the therapists in this study are not exclusive to cross-cultural practice. Indeed, few participants believed that their practice with international students was similar to their practice with other students: “Those [strategies] are kind of constant for me whoever I’m working with whether is cross-gender or sexual orientation []. It’s what I would consider good practice with
whoever I’m working with” (Jannette). Others viewed cross-cultural therapy as similar but also as requiring something extra such as specific cultural knowledge, acknowledgement and awareness of the client’s status as an international student and the implications of such status. The interviewees’ accounts on what cross-cultural therapy entails seemed to reflect a dichotomy. On the one hand, it is suggested that cross-cultural practice is another branch of therapeutic work but on the other hand, it is argued that although international students are culturally different from the therapist, they are also human beings. In the words of Susan: “You’ve got to tread that line between being aware that there are differences and realise that there is a common humanity”. The therapists in the present study seemed to be echoing the dichotomy present in the cross-cultural literature between epic and emic approaches to cross-cultural therapy. The implications of such dichotomy will be discussed further in the overview.

Potential barriers to effective cross-cultural therapy
The majority of participants talked about the possible detrimental effects of ‘cultural distance’ for effective cross-cultural therapy. Cultural distance was defined by Opereza et. al. (1991) as the degree to which the international student’s home culture is different from the host culture. The interviewees’ accounts suggest that cultural distance has an impact both prior to and during the therapeutic process. The findings suggest that before any therapeutic contact is made, international students’ cultural background will exert its influence by shaping their views on therapy and the meaning attached to seeking therapy. The experience of some of the therapists in this study has been that many international students do not know what therapy is about and tend to ask for practical advice: “If there is confusion is that they think that you are going to advice them on what to do” (Avril). The way in which this has been addressed is by explaining to the client what the role of the therapist is, making explicit what the therapist is able to offer and clarifying that therapy is not about practical advice. In addition, as some therapists in this study pointed out, in some cultures, therapy may be seen to be for people who are “mad” and therefore it is not regarded as appropriate for their difficulties. Indeed, a study conducted by the researcher in which
international students were interviewed about their experiences of living and studying in England showed that participants felt that the difficulties they had experienced were not serious enough to seek therapy and if they needed someone to talk to they would turn to friends (Gascon, 1997).

Another way in which cultural distance was identified by some therapists in this study to be a potential barrier to effective cross-cultural therapy is that the students’ cultural values and sense of what is appropriate may be in direct conflict with the therapy values. In particular, a few participants mentioned the clients’ expectation that the therapist is the expert and will be giving them advice and the therapists’ expectation for the client to be open and share their innermost feelings with them. As Susan explained: “There is a barrier there to begin with because in our culture we’ve grown up with the tradition of expressing ourselves with our problems [ ] so if you get somebody from a culture where that isn’t part of their way of being [ ] it’s very hard to sit there with the same expectations and hope that they will open up and trust you with their most inner feelings”. These findings are in line with the results of the study carried out by the researcher which has been mentioned above where international students did not feel they could trust a stranger enough to disclose personal information (Gascon, 1997). However, the conflicts between the client’s cultural values and the therapy values do not stop there. Keith and Alice mentioned the cultural biases implicit in the theoretical frameworks employed by therapists: “I do think that the body of psychoanalytic knowledge is broadening but I think we need to understand that it is quite culture bound and therefore would have some limitations” (Alice). The theoretical models that therapists are trained in and work with have been developed by white, middle class practitioners embedded in western cultural values. Within white western culture, the internal self and the independent individual are given overriding importance (Sampson, 1989). Thus, psychological therapy is aimed at self-centredness, self-exploration, self-disclosure and self-determination (D’Ardenne & Mahtani, 1996). On the other hand, these goals may not be suitable for overseas students from cultures where the interdependent self is more important, that is, cultures that put the family and other social units above the individual, and
interdependency is considered not only healthy but necessary (Casas & Vasquez, 1996).

With reference to the meaning that international students attribute to seeking therapy, many participants were aware that a number of students feel that undergoing therapy is a stigma. The interviewees’ experience was that many international students are sponsored by their countries or a company to attend an English university which was said to put the student under a lot of pressure to do well. As a result, acknowledging any kind of problem can prove difficult for them. As Darren suggested: “It must be a catch 22 for them, to come and allow themselves to be vulnerable in terms of owning up to something that is troubling them within a context where they are supposed to come and perform”. In the experience of one participant this meant that some international students tend to seek help only when the situation becomes intolerable and they are in crisis. It would seem that therapy then may be more about crisis management rather than exploration and growth. Few participants commented that for some international students seeking therapy is not just difficult but a shaming experience whereby they feel that they are letting their fellow nationals and their country down. Thus, it is hard for the therapy to progress because the student feels that he/she should not be there in the first place: “Some international students are very anxious about being in counselling because of what it means to them and they feel that in some way they are loosing face by being there so it can be very hard to work with them” (Jan).

The above indicates that barriers to cross-cultural practice exist even before any contact is made. Once therapy begins, some of the interviewees’ views as to the extent to which cultural distance plays a central role in therapy varied. Keith and Jan advocated that the centrality of cultural distance in therapy depends on the degree of distance. Therefore, a big cultural distance between therapist and client may be an impediment to effective cross-cultural therapy: “If you’ve got a very big cultural difference then that adds a bigger barrier” (Keith). It is suggested by Jan that if this is the case, then cultural distance needs to be explicitly acknowledged, otherwise, the
client may drop out of therapy or the therapeutic process may become sterile by fostering an atmosphere of hidden agendas and non-openness. However, two participants argued that acknowledging differences is not enough and highlight the importance of the way in which those differences are acknowledged in order to create a safe and open environment: "How you go about making something explicit is very, very important so the environment may stay safe enough in which difficulties can be clarified" (Jannette). These therapists, identified the following aspects that need to be taken into consideration when making big cultural differences explicit: relevance to the material that is being brought up by the client, level of rapport, timing and wording of the intervention.

Keith believed that if the level of cultural distance is small then culture plays an equal role to other factors that come into play in the therapeutic relationship: "The smaller the cultural difference then all the other factors will come into play".

The majority of participants identified language as another potential barrier to effective cross-cultural therapy. Due to restrictions of space and extensive consideration in the existing literature of language as a potential barrier to effective cross-cultural therapy, other, possibly less well documented potential barriers will be focused upon below.

Jan and Susan described a lack of trust and credibility in the therapist as a potential barrier. Sue and Zane (1987) describe credibility as the client’s perception of the therapist as an effective and trustworthy helper. Two factors identified by these therapists as contributing to such lack of trust and credibility were firstly, the students’ expectation that because the therapist is from a different culture to them they will not understand. As a result, the client does not believe that the therapist will be able to help them which may be reflected in an inability to establish a therapeutic alliance: "[In what ways is the students’ anticipation that you are not going to understand a barrier?] Because you don't have an immediate therapeutic alliance, there isn’t an assumption on their part that you are going to be able to help them"
"Therapeutic alliance" or "working alliance" refers to an explicit or implicit agreement between therapist and client to engage in therapy (Clarkson, 1995) which would mean that if a therapeutic alliance is not established, therapy will not proceed. The second factor contributing to a lack of trust and credibility in the therapists was the therapists’ position as being part of and separate from the university institution. International students may perceive the therapist to be a member of the teaching staff who will be assessing them, thus finding it difficult to trust him/her: "It does feel quite hard with some students to accept that we are not actually part of the teaching team [J]. They see it that we are the institution and they are the student" (Jan). As these therapists stated, despite the message given to the students that the therapist’s role does not involve assessing and that information about the client will not be disclosed to anybody outside the counselling services without their consent, Jan pointed out the difficulty of overcoming this barrier because therapists are actually members of staff. Both participants hoped that time and the actual experience of therapy would be sufficient to address these barriers. However, Sue and Zane (1987) argue that therapists can play a greater role in increasing their credibility through their actions in therapy rather than hoping that with time clients will come to believe in them. In view of the important role that developing credibility plays when working with international students, its relevance will be discussed further in the overview.

Another potential barrier reported by a few participants was the image of the counselling service that they felt was being portrayed to international students. For these therapists, having a team of predominantly white therapists was disadvantageous: "I do think that if a service seems to have a very homogeneous profile in terms of the staff, I think that presents a barrier" (Alice). Jannette believed that the reason for such a disadvantage was that therapists in a particular service may be perceived as all being the same and holding a uniform set of beliefs about culturally different clients which may give the impression of not being a culturally sensitive, accessible service. For one interviewee, even making the consulting rooms "user-friendly for the students" (Avril) was important. She had in her room various objects, posters and cards which portrayed people and art from other cultures.
However, the implications of having an all white team go beyond the international students' perceptions of the service. It reflects a concern expressed by Avril about the lack of cultural diversity in the profession as a whole. She believed that the majority of therapy courses do not offer any funding leading to a large section of the population being excluded from access to the therapeutic professions: "You hardly see any black people in counselling courses because they can't afford it. There are no bursaries available so a lot of people that may make good counsellors are excluded" (Avril). Despite the availability of some part-time courses, the lack of cultural diversity in the profession is still evident. In this way, a white, middle class culture within therapy seems to be perpetuated with the risk of the whole profession becoming 'encapsulated' whereby therapists depend entirely on one set of cultural assumptions. Pedersen (1988) explains encapsulation as a process in which professionals rely on stereotypes in making decisions about culturally diverse clients, ignore cultural differences among clients and define reality according to their own internalised value assumptions.

OVERVIEW

The limitations of the sample in the present study make it difficult to generalise from the findings. The sample chosen was very specific and likely to have particular biases. For example, the participants' experience of cross-cultural therapy focused on international students. Cross-cultural therapists working with other populations such as refugees may have provided different experiences. Furthermore, they were all based in London which is a culturally diverse city. Therefore, it is possible that cultural differences may be regarded by the interviewees as the norm. A study that includes therapists from various geographical areas would help address such bias. Despite the dominance of white therapists in the profession, had the participants in the present study represented other ethnic backgrounds, there might also have been differences in the results. Despite these limitations, the present paper identifies key factors that impact on the therapeutic process with international students, providing a
better understanding of the variables that are likely to facilitate or hinder effective cross-cultural therapy. The study focuses on therapists' perspective on what contributes to effective cross-cultural therapy. Thus, future research may want to ask the same questions and evaluate effective cross-cultural therapy from the perspective of culturally diverse service users in the UK.

The findings on the participants' views of what cross-cultural therapy entails appear to reflect the etic and emic approaches to cross-cultural therapy. On the one hand, some of the strategies reported by the interviewees such as not making assumptions and being aware of the therapist's own agenda indicated little difference between cross-cultural therapy and therapy with other client groups. On the other hand, strategies such as acquiring specific knowledge of the client's culture, being aware of one's own cultural background and having respect for other cultures seem to indicate that cross-cultural therapy is different from mainstream therapy. As previously discussed, it seems that both approaches have their merits and drawbacks. Ideally, as some participants in this study have suggested a balance between the etic and emic approaches would be desired. Fukuyama (1990) and Draguns (1996) postulate that taking a universal approach to cross-cultural therapy does not eliminate the need to move towards a more culture-specific approach. The discipline of cross-cultural therapy can be enriched by the cross-fertilisation with disciplines that deal with other minority groups, whilst ensuring that such knowledge is modified in order to render it pertinent to specific cultural groups.

The participants in the present study identified several potential barriers to effective cross-cultural therapy which included discrepancies between the client's cultural values and the therapy values, the image portrayed by the counselling services to the students and lack of trust and credibility in the therapist. Such findings seem to corroborate Sue and Zane's (1987) view on the importance of developing credibility in order for therapy to proceed and be successful. Acquiring specific knowledge of the client's culture was suggested by some of the participants as a strategy for effective cross-cultural therapy. This was also identified by Sue and Zane as one of
the means by which therapists can anticipate problems in the development of credibility and therefore increase the effectiveness of therapy. They apply the concept of credibility in relation to therapists. However, such concept seems to be also relevant to Counselling Services as a whole. Ascribed and achieved credibility of Counselling Services appear to be important considerations if international students are to contemplate Counselling Services as a viable source of support in the first place. For example, participants’ experiences of international students believing that Counselling Services are for “mad” people and that seeking therapy is a shaming experience may mean a low ascribed credibility. A lack of cultural diversity in the Counselling Services may mean a low achieved credibility.

It was also found that the client’s attitudes toward the therapeutic process and the therapist, the establishment of credibility and rapport, the organisational setting in which therapy takes place, the therapist’s level of sensitivity to personal and professional biases, the therapist’s degree of understanding of the client’s expectations and cultural background and the therapist’s ability to respect the client’s culture play an important role in enhancing the effectiveness of cross-cultural therapy. The findings suggest that such variables are influenced and shaped by the therapist’s own personal, professional and socio-cultural background as well as the client’s personal and socio-cultural background. These results point towards the interactive nature of the variables that affect the therapeutic process with international students rather than the linear process described by Casas and Vasquez (1996). It seems that appropriate and comprehensive models for describing and explaining the process of cross-cultural therapy are scarce. Thus, future research may need to concentrate on developing models that are truly cross-cultural in their conceptualisation and focus on the dynamics and processes involved in practising with culturally diverse populations.

The present study has a number of implications for counselling psychologist working in a variety of settings which may include university counselling services.
Beliefs and attitudes of cross-culturally effective therapists

The findings illustrate that not making assumptions about the similarities or the differences between therapist and client is a priority in order to practice cross-cultural therapy effectively. In this way, therapists are able to give adequate consideration to the unique set of experiences that each individual brings to therapy. However, sensitivity to the impact of their socio-political context is also necessary in order to maintain a holistic approach to the individual. Being aware of the therapists’ own values, attitudes and assumptions and how these are likely to affect minority clients was also seen as an essential component for effective cross-cultural therapy. Therapists are then likely to be in a better position to acknowledge and respect cultural diversity.

Knowledge of cross-culturally effective therapists

The results point out the importance of having some prior knowledge of the historical background, traditions and values of the client’s culture at the same time as asking the client for their particular perspective on their culture. In this way, the therapist is able to have a better understanding of the client’s background and develop rapport more quickly whilst adapting such knowledge so its applicability is relevant to the individual client. Individual therapists may be able to acquire the necessary knowledge through reading books and attending workshops and conferences. Employers and training courses also have the responsibility of providing opportunities for therapists to acquire knowledge pertinent to their work with international students, perhaps, through lectures and experiential workshops. The use of video and discussions with international students themselves may be useful teaching tools.

Therapists are likely to form part of a particular organisational setting such as the University Counselling Services. Thus, knowledge of the impact that institutional barriers have on limiting the accessibility of Counselling Services to international students would also be important.
Skills of cross-culturally effective therapists

The specific knowledge that therapists acquire would then need to be translated into particular interventions which are pertinent to the individual’s cultural background and congruent with their cultural value system. The findings suggest that this is perhaps the area of cross-cultural therapy which may need further development. Training courses need to be aware that knowledge is necessary but not sufficient in providing cross-cultural therapists with the therapeutic tools they require. The use of culturally pertinent theoretical models in conjunction with practical experience of working with culturally diverse clients while in training may fill part of the gap.
REFERENCES


APPENDIX 1

Letter to potential participants

Dear

I am currently in my final year of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. Research is an important element of the course and it is your participation in my research project that I am contacting you about. I am also aware that you will have received several other requests for help in research projects and appreciate your time to consider this one.

The aims of this exploratory study are to investigate a number of issues concerning the practice of cross-cultural therapy with international students. Thus, participants will be practitioners who have experience of working with international students at University Counselling Services. Studies investigating the role of the therapist in therapy with international students as well as the therapeutic process itself are crucial in identifying and gaining further understanding about the key factors which facilitate or hinder effective psychological therapy with international students. In this study, I am hoping to elicit therapist’s accounts on particular examples of both appropriate and inappropriate professional practices with international students and to explore therapist’s views on what factors may facilitate or hinder the therapeutic process with international students. With your participation it is hoped that this research will be published and help in clarifying issues in this area. Copies of the final study will be available to those who agree to take part.

At this preliminary stage, the research will involve seeking information from Chartered clinical or counselling psychologists, UKCP registered psychotherapists and BAC accredited counsellors who have experience in working with students from another culture at University Counselling Services. I will be conducting audio-taped in-depth individual interviews consisting of mainly open-ended questions. It is envisaged that the interview will be no longer than an hour and whilst this method is somewhat time consuming, it is anticipated that will provide rich and varied data. All data collected will be treated in the strictest of confidence and anonymity will be maintained.

I will be contacting you by telephone in the very near future. If you or other therapists working at the Counselling Services can spare one hour and agree to be interviewed, a time and venue convenient to you will be arranged. In the meantime, if you have any questions, do not hesitate to get in touch through any of the above contact sources.

Thank you for your consideration, I look forward to speaking to you.

Yours sincerely,

Maria Gascon
Counselling Psychologist in Training.
APPENDIX 2

RESEARCH CONSENT FORM

The aim of this research is to explore therapists' views on what constitutes both effective and inappropriate cross-cultural therapy with international students. In order to address this issues, you will be asked to take part in an informal interview about your experiences of working with international students.

The interview will be recorded on audio-tape so that, in writing up the research, I can cite people's experiences directly. Naturally, to protect confidentiality, I will not quote any identifying information such as names of people or institutions. In making the transcriptions, your name will be replaced by a pseudonym, and I will not record the names of people or places that may arise in the interview. Once transcribed, the audio-tape recordings will be erased.

If you have any questions so far or feel you would like further information about this research, please ask the researcher before reading on.

Please, read the following paragraph and, if you are in agreement, sign where indicated.

I agree that the purposes of this research and what my participation in it would entail has been clearly explained to me in a manner that I understand. I therefore, consent to be interviewed about my experiences of working with international students. I also consent to an audio-tape being made of this discussion, and to all or parts of the recording being transcribed for the purposes of research.

Signed .................................................. Date .........................

On behalf of those involved with this research project, I undertake that, in respect of the audio-tapes make with the above participant, professional confidentiality will be ensured, and that any use of audio-tapes or transcribed material from audio-tapes will be for the purposes of research only. The anonymity of the above participant will be protected.

Signed .................................................. Date .........................
APPENDIX 3

BACKGROUND INFORMATION

The following are some general questions about you (such as your age, education and ethnicity). The information that you give will not be used to identify you in any way as this research is completely confidential. Please tick or write in the appropriate answer.

1. Are you?
   Male ___
   Female ___

2. How old are you? _____ years old.

3. What is your current occupation? ______________

4. Which of the ethnic groups listed below would you say you belong to?
   White ___
   Black-Caribbean ___
   Black-African ___
   Black-Other ___
   Indian ___
   Pakistani ___
   Bangladeshi ___
   Chinese ___
   Other (please specify: ______________)

5. Are you? (Tick more than one if necessary)
   Chartered clinical psychologist ___
Chartered counselling psychologist ___
UKCP registered psychotherapist ___
BAC accredited counsellor ___
Other (please specify:_________________) 

6. Years of practice following qualification ______

7. What theoretical orientation you predominantly adhere to in your practice?
   Psychodynamic ___
   Cognitive-behavioural ___
   Humanistic ___
   Other (please specify:_________________)

8. How long have you been working with international students for?
   ____________
APPENDIX 4

Interview schedule

1. In your own experience, what strategies, if any, have you employed which have contributed to effective cross-cultural therapy with international students?

Prompts:
Awareness and sensitivity to other cultures.
Sensitivity to personal and professional biases and stereotypes.
Learning from the client.
Selecting appropriate approaches and interventions.
Be explicit about cultural differences.
Modify communication style.

- In what ways do you feel it would contribute to effective cross-cultural therapy?

If no strategies:
- What makes you say that?

2. What, in your experience, would you consider to be potential barriers to effective cross-cultural therapy with international students?

Prompts:
Language
Generalisations and stereotypes
Strict adherence to western theoretical approaches
Erroneous assumptions

- In what way is that a barrier to effective cross-cultural therapy?
- How could you address such barrier?
- To what extent do those barriers affect the therapeutic process?
- To what extent could therapists avoid such barriers? If yes: In what ways?/ If no: What makes you say that?

If no barriers:
What makes you say that?

3. Could you think of any incidents which would reflect biased, inadequate or inappropriate cross-cultural practice? (Sources of particular examples can include reports from colleagues or clients or from your own practice).

If incident:
- What in particular makes you think of this incident as reflecting biased, inadequate or inappropriate cross-cultural practice?
- What makes you say that?

**If no incident:**
- Do you think that there is any particular reason for that?

4. Could you think of incidents that reflect particular sensitivity to clients from other cultures? (Sources of particular examples can include reports from colleagues or clients or from your own practice).

**If incident:**
- What, in particular, makes you think of this incident as reflecting sensitivity to international students?
- What makes you say that?

**If no incident:**
- Do you think that there are any particular reasons for that?

5. If guidelines for appropriate cross-cultural therapy were being drawn up, what would you include in them?

- In what ways would that aid the development of appropriate cross-cultural therapy?

6. To what extent do you feel that a client-therapist match in terms of culture is necessary for effective therapy with international students?

**If yes:** What makes you say that?
**If no:** What makes you say that?

7. To what extent do you think cultural distance affects the therapeutic process?

**If yes:** In what ways?
**If no:** What makes you say that?

8. What skills would cross-cultural therapists need in order to practice effectively with international students?
9. What knowledge would cross-cultural therapists need in order to practice effectively with international students?

10. To what extent do you feel that your training was adequate to equip you to work with international students?
If yes: In what ways has your training addressed issues of cross-cultural therapy? issues on cross-cultural practice with international students?  
-What has been the most valuable aspect of your training in connection to cross-cultural practice with international students?  
-What makes you say that?

If no: What makes you say that?  
-How would you like the training to change?  
-What would you like training programmes to include in order to equip therapists to work with international students? In what ways would that be helpful?

11. What theoretical approach, if any, would you consider most appropriate when working with international students?  
-What makes you say that?

12. We’ve come to the end of the
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