A Portfolio of Academic, Therapeutic Practice, & Research Work

Including an investigation of mental health professionals' attitudes towards asylum seekers

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To help others... you have to know what they need, and the only way to find out what they need is for them to tell you. And they won’t tell you unless they think you will listen... carefully. And the way to convince them that you will listen carefully is to listen carefully (Nyberg 1971\textsuperscript{1}).

FROM UNDERGRADUATE TO COUNSELLING PSYCHOLOGIST

This portfolio represents my professional and personal development as a counselling psychologist. I decided that I wanted to be a counselling psychologist while I was an undergraduate.

At this time I was working as an outreach worker, on a drugs project for a children's charity. The ethos of this project was harm reduction and psychoeducation, but I realised how much the children would benefit from a safe space to talk. This concurred with the developmental psychology I was learning, I therefore linked Bowlby's (1988) attachment theory with the benefits of individual psychotherapy. I thought that if children developed best when they have a secure base from which to explore their external world, clients might develop best when they have a secure base from which to explore their internal world. This thought about a secure base has remained with me throughout my training and has resulted in my placing great emphasis on creating a contained, boundaried, and safe therapeutic space for my clients, presented throughout this portfolio.

This outreach work was also my first exposure to really vulnerable client populations, and I desperately wanted to help them. With hindsight I believe that, as Jung (1946) theorised, I had unconsciously identified with my archetype of the divine healer. As a naive undergraduate I probably did want to be able to heal everybody. These earlier ideas, although utopian and unrealistic, have served as the vision and the driver to achieve my goal. I still want to work with vulnerable clients, especially children, and after completing two placements working with them I am pursuing job offers in this area of work.

In my final undergraduate year I was really enthused by social and cultural psychology. I recognised that people's cultural backgrounds would have an enduring and significant impact on their identity, internal processes and relationships within
their external worlds. I felt that if I was really attempting to study and understand the individual I needed also to have a sound knowledge of culture and cultural effects. I acknowledged Ridley’s (1995) criticism that most psychological theories of development were based on ‘the middle class, white Anglo-Saxon male’, so I decided that I needed to widen my exposure to other cultures and life perspectives whilst maintaining my interest in children and childhood.

I consequently completed a masters of science in social anthropology of children and child development at Brunei, with a research focus on the development of children in a Romanian orphanage. I spent six months working and living in a Romanian orphanage as an aid worker. This really impacted upon my professional and personal life. I had learned to speak Romanian so I was asked to do some one-to-one work with the children about their emotional affect. During this I learnt the importance of physical and psychological boundaries, use of personal space, such as using the same room, and the real need for sharing and support linked with appropriate confidentiality. I also discovered that these children benefited from having specific individual attention and a personal physical nurturing touch, of which they were extremely deprived. Bowlby (1969) in his work with attachment and loss illustrated the effects of such emotional deprivation on personal development and was supported by Flavel (1985) in his work on cognitive development towards a sense of confidence and self-esteem. The children I worked with at that time were also HIV positive, which for some had developed into AIDS, so that their entire existence was brief and fairly brutal. This experience also illustrated to me the durability and basic strength of human nature – its propensity for survival and self-healing even when given the most limited of opportunities to thrive.

I realise that my listening to the Romanian children in the orphanage and providing them with the opportunity to talk about themselves was a very limited therapeutic relationship. However, I recognise that I was providing them with emotional responses, similar to those of Roger’s (1951) core conditions unconditional positive
regard, empathy and congruence, which I believe helped to support their developing sense of self and added some strength to their coping within their situation.

It was here that I also experienced the need for effective, well-organised teamwork. The needs were so great and various that the most effective interventions were made by ongoing and systematic co-ordinated effort. I learnt the importance of real team commitment because without it the work with the clients really suffered and the team fell apart. This has parallels with my work as part of multidisciplinary teams such as the community mental health teams. I have worked in these contexts for two of my placements, and have forged and needed strong links with other agencies, particularly social services.

The therapeutic approach that places great emphasis on the supporting systems for therapeutic change is systemic work. The rationale behind systemic work is that for change to be maintained within the individual, it needs to be supported by similar development and change within the client’s environmental systems – family, friends and significant others. I believe this approach has great and lasting benefit for therapeutic change.

I also learnt a lot about myself. I learnt that I could cope with harrowing material if I had emotional distance from it. I struggled with working and living within the most extreme poverty and realised that I needed to look after myself in order to be there for others. Further, I realised that unlike social relationships, working relationships needed consistent boundaries if the client and I were to feel really comfortable.

I also realised, much to my detriment, that I made assumptions about the Romanian orphans and people on the basis of generalised stereotypes. Furthermore, I failed to consider the impact of the power imbalance within my professional relationships both with the children and their carers. This can be worrying in any context but especially within a therapeutic relationship.
My first essay within the academic dossier ‘Me: Ideal and normal, you: Weird and other - A discussion’ explores this very issue. I wrote this paper in order to facilitate my own and others’ thoughts on how clients can feel discriminated against by therapy. It also presents various arguments and theories on discrimination prevention. I feel that this is a very important issue because, as counselling psychologists, we are unable to truly offer clients positive regard or help if our attitudes are consciously or unconsciously prejudiced towards them. Furthermore, we are unable to form positive therapeutic relationships with clients towards whom we have unconscious negative attitudes.

Forming a secure and positive therapeutic relationship has been the focus of most of my reparative client work. This emphasis can be seen in my second essay within the academic dossier, ‘The therapeutic relationship: How it can assist efforts to work integratively’, and my final clinical paper within the therapeutic practice dossier, ‘Towards a personal therapeutic framework’. Both of these essays reflect my development into an integrative practitioner. The therapeutic relationship is both the context and content of my therapeutic encounters.

The therapeutic relationship is the context of the therapy because it contains all of the therapeutic interventions and dialogues. It is the content of the therapy because the experience of a positive and non-neurotic relationship can be reparative for so many clients. When reflecting upon the importance of the therapeutic relationship I often consider the work of Lambert (1983), who reasons that because neurotic relationships and interactions help to form troubled lives, new non-neurotic therapeutic relationships are needed to change troubled lives. He also asserts that relationships are vital because early relationships cause the background factors to the presenting problem, interpersonal relationships cause the vulnerability factors, and relationships based on conflict are often the maintaining factors. Therefore, a healthy therapeutic relationship is needed to change the maladaptive thoughts internalised through earlier relationships.
The therapeutic relationship enables me to incorporate various therapeutic approaches into my client work, including reflection and use of unconscious communications. I have found working with the unconscious the most challenging and rewarding of my professional and personal development. I feel it was personally challenging because I needed self-insight to determine whether my counter transference was reactive, stemming from the clients' issues or proactive and caused by my own issues. The ways I have used transferential communications are discussed in detail in my third essay within the academic dossier, 'In praise of transference and counter transference' and my final clinical paper, 'Towards a personal therapeutic framework'.

In order to reflect upon my own personal issues I needed to be aware of them. My personal therapy and supervision helped me to have deeper self-awareness and aided my personal development. For instance, through my experiences as a client I know I can feel guilty about my interactions with family and friends because of a belief that I am responsible for their emotions and experiences. Professionally, I often feel that I am letting clients down because I am simply 'not good enough' and this makes me feel very guilty. I need to continue to explore these feelings of inadequacy both personally and within supervision to see if they are a response to the clients' projections, and therefore reactive counter transference, or whether they stem from my own insecurities and are proactive counter transference. Casement (1985) suggests that the more reflective and experienced the therapist the more advanced their internal supervisor. I believe I am beginning to develop an internal supervisor through internalising my external supervision, which is enabling me to listen to implicit as well as explicit client feedback. I believe this is illustrated in my process report presented in the attachment to this portfolio.

I met a lot of 'would-be asylum seekers' amongst the dispossessed and much vilified Romany population whilst working in Romania and was shocked by their plight and poverty. I realised they were 'stateless' people struggling desperately to find a home and become recognised members of society. They were searching for a sense of
belonging that they could not have in their own country. I sometimes feel that this can be likened to searching and needing a more appropriate parent. The asylum seekers also felt profound rejection, as no state really wanted them. Further, in their desperation law abiding people were forced to affiliate themselves with criminals whose business was 'people smuggling'. This interest in the plight of asylum seekers has continued and developed across the three years of my doctoral training.

In this portfolio are three research projects exploring attitudes towards asylum seekers, who I believe are a very stigmatised group within British society. This stigma also exists within mental health professional cultures and has worrying implications for practice which I have explored in my first year literature review, 'Refugees: Victims or survivors? A review of the literature', and third year report, 'A study of mental health professionals' attitudes towards asylum seekers'.

This literature review highlighted dichotomies that exist within attitudes towards asylum seekers. In psychological literature asylum seekers are described as damaged victims incapable of change or survivors. Within political literature asylum seekers are portrayed as either deserving or frauds. Within societal literature such as media reports the attitude is expressed that asylum seekers can be labelled as non-deserving criminals or damaged victims. Asylum seekers describe themselves in their self-reports as either victims or survivors. Unfortunately there seems to be little middle ground within any of these polarised attitudes.

In order to look at this problem in greater depth, and to test the possible validity of the stereotypes, I undertook a qualitative research study in my second year, exploring asylum seekers own stories. I interviewed 13 asylum seekers and discovered that they expressed attitudes about themselves in relation to others with the implicit assumption that they were deserving survivors. No one presented as a victim; they did talk about being unfairly treated by others but none had lost hope or developed an external locus of control. The stories explored here did not concur with the reported self-reports critiqued in the literature review, which expressed attitudes of both survivor and
critiqued in the literature review, which expressed attitudes of both survivor and victim identities. The participants in my second year study were much more hopeful. As relationships with professional support systems figured greatly in this research, I decided to explore professionals’ attitudes towards asylum seekers.

My final piece of research was a quantitative study exploring attitudes in relevant professions using a structured survey design. A gratifying 249 mental health professionals took part in this research that explored their attitudes towards asylum seekers’ human rights, psychological problems, professional intervention, control and neediness. These were validated by exploratory factor analysis. The results found that attitudes altered depending on a variety of independent variables. Prior contact with asylum seekers, personal motivation, positive attitudes towards specialist training and being a woman were associated with more positive and hopeful attitudes towards professional intervention with asylum seekers and more supportive attitudes towards their human rights. Organisational motivation, no prior contact, and lack of interest in specialist training were associated with greater reluctance to work with asylum seekers and more negative attitudes concerning their human rights. Perhaps because these participants had a tendency to stereotype asylum seekers into one general category.

I found this research very useful while working in my third year early intervention placement in a North London primary school. During this time I worked with children of asylum seekers and, because I was conscious of the danger of stereotyping, I was able to avoid repeating this pattern. Consequently, I really engaged with the children and worked with all of their material rather than simply focusing on their experiences of seeking asylum.

This research seems particularly relevant during a period of increasing political interest in asylum seekers, and the increasing social animosity towards people who are for the most part from Moslem communities. This is perhaps exacerbated by the terrorist action of September 11th, 2001. I believe that my research points to the fact
that asylum seekers are condemned by most people, either for being potential terrorists or criminals, or because they are damaged victims beyond help and service capacities. This seems to me to have very worrying implications for therapeutic practice because they are perhaps stereotyped before they even enter the consulting room.

I believe that this portfolio represents my development as a trainee counselling psychologist. I now feel I have focus to my therapeutic practice and research. I believe that development as a practitioner is a continual process and that I am equipped to continue on this developmental journey and encounter the next steep learning curve, that of a newly-qualified counselling psychologist.
References
Academic Dossier
Academic Dossier

We are born of relationship, nurtured in relationship, and educated in relationship. We represent every biological and social relationship of our forebears, as we interact and exist in a consensual domain called society (Cottone, 19882).

This dossier contains a selection of papers and reports, principally focusing on the therapeutic relationship, submitted over the duration of the course. A ‘Context of Counselling’ extended essay considers the importance of taking differences between client and therapist into account in the therapeutic relationship. An ‘Advanced Theory and Therapy’ paper examines the role of unconscious transference communication within the therapeutic relationship, and a ‘Workshops’ paper outlines my rationale for integrative therapeutic practice - the therapeutic relationship. Finally, in order to illustrate a variety of written academic work, a psychopathology report has been selected for presentation, this focuses on a client with borderline personality disorder.

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This paper is intended to facilitate thought on how clients can sometimes come out of therapy feeling discriminated against rather than helped. It also presents various arguments and theories on discrimination prevention. Preventative strategies seem to be based on either therapist reflection or matching client and therapist. The latter is usually based on shared experience and is intended to prevent feelings of prejudice as both people could be considered to be 'in the same boat'. Therapist reflection promotes the therapist thinking about their differences to the client and any stereotypical attitudes they may have formed about these differences. The hope is that through considering stereotypical attitudes the therapist will be able to limit their prejudice or at least to recognise it. The viewpoints presented in this paper are not definitive or exhaustive. Indeed I am sure there are many more ways in which clients can feel discriminated against. Similarly, further arguments either supporting or criticising 'matching' therapist to client could be made.

Personally, I think assumptions on sameness can be deceptive. Oguntokun (1998) discovered that large aspects of a person's life might be ignored when working on the assumption of a shared experience. Furthermore, prevention of prejudice through deconstructing stereotypical beliefs assumes that these beliefs can be recognised. In reality it is difficult for therapists to isolate and analyse objectively concepts, based on their own life experiences, which they take for granted.

As counselling psychologists we need to explore the assumptions about our clients on which we base our therapeutic interventions if we wish to claim, as Wilkinson and Campell write: “to be able to apply various therapeutic interventions based on various theoretical stances to any particular client group” (1997: 5). Some of these assumptions may be generated by stereotypical beliefs and damage our clients rather than help them. No one is neutral. Burr (1995) explains that, all humans are 'the social', no individual can be disassociated from their society as they are
simultaneously part of society and an individual. Clients' social and historical experiences should be held in mind when trying to understand them. Any psychological therapist or researcher attempting to understand another's narrative must appreciate how difficult it is to escape from his or her own social and historical context. Clients could feel alienated by therapists' assumptions based on their own world view. It is important that therapists recognise that clients' social and historical values and experiences are not deviant, but may be just different from their own.

**Discrimination because of race and religion**

People of colour often experience prejudice. They are sometimes represented as an out group, a minority, and therefore deviant. Even though on a world population basis white is the ethnic minority (Dyer, 1997). Many white people would not consider white to be an ethnicity as it is commonly represented as the norm. People are not only devalued on the basis of race in everyday social and political life. They may also experience prejudice within the therapeutic relationship.

Palmer and Laungani write: “There is among some politicians a belief, shared by many others in the country, that when people migrate to Britain they ought to jettison their cultural baggage” (1999: 45). On some level therapists may have internalised this thought pattern and consciously or unconsciously encourage conformity with the dominant culture even within the therapeutic relationship. This assimilationist policy does not take into account cultural impact on identity. Indeed, even if therapists are trying to be culturally aware they may, as Roach (1999) asserts, also be bringing cultural stereotyping into their formulations of the client’s presenting problems. Littlewood and Lipsedge (1982) have examined the higher incidence of stress and associated mental illness in certain cultures. They have offered a very valuable explanation that has implications for all counselling psychologists of a majority culture. This is that they may be actively discriminating against clients from a different culture by over diagnosing them as seriously ill. This misdiagnosis may simply stem from the fact that they have no adequate frame of reference from which to judge. Therefore, therapists are more likely to represent their clients’ behaviour as
deviant or sick. Indeed, it is hard to construct a culturally appropriate frame of reference because cultural experience will be different for every client. Therefore, therapists' assumptions would be ineffectual and a defence against the unknown. Collins (1990) believes that because of this lack of awareness ethnic minorities and black people's behaviour was more likely to be pathologised than those of white ethnicity.

Indeed most psychological tests are based on Western standardisations so non-whites may be represented as psychologically unhealthy when they are not, it is simply cultural bias in the questions. Ridley (1995) found black people to be over represented in mental hospital populations. Furthermore, Ridley also found Afro-Caribbean and Asians have a much greater chance of being labelled schizophrenic and are often hospitalised for longer periods than their white counterparts. This is sometimes because mental health workers believe their ethnic clients' thoughts to be irrational, whereas they might actually be culturally rational.

Furthermore, Palmer and Laungani (1999) found British women in therapy often describe emotions first and only mention physical symptoms when questioned; with Pakistani women it is usually the other way round. This portrays their attitude to therapy. Pakistani women tend to expect the medical model, in which the therapist is perceived as an expert. They assume the therapist will automatically understand them, and cure them with direct intervention, without them having to divulge everything in the assessment. Consequently, they may be disappointed and confused by some approaches to psychotherapy.

Discrimination does not only occur in therapeutic formulations and assessments. It can occur in attitudes and expectations affecting the counter transference. All clients have assumptions and expectations of the therapeutic process before they start which may stay with them to a certain extent throughout the process. Clients from a different culture to the counselling psychologist will also have expectations of the psychologist's culture and vice versa, which will impact upon therapeutic outcome.
Lorion and Parron (1985) theorise that more ethnic clients drop out of therapy early or have trouble forming therapeutic relationships because of the therapist’s expectations (transferred onto their clients) about the poor outcome of therapy with ethnic clients. This unfortunately perhaps rings true for me with my first black client. At the beginning, I stated in supervision I thought that she would be reticent to engage as she was only in therapy on her doctor’s recommendation. This proved to be completely false. She was the most consistent of my early clients. I was displaying a common misperception and defence (Lorion and Parron, 1985) that she had medicalised her problem, when in fact that was my problem, not hers.

Discrimination may also be manifested by the very nature of therapy because often clients may not have a Western notion of boundaries. Therefore, certain client behaviour should not always be seen as, for example, pushing boundaries, lack of psychological mindedness (Coltart, 1988) or trying to gain power. Instead it may be more useful to evaluate these behaviours as culturally relative. Hassan (1994) found that strict therapeutic boundaries were experienced by survivors of the Holocaust as reminiscent of strict boundaries in the camps, so resistance to them would seem contextually reasonable and not deviant.

The implications for practice of alienating the client because of differences in culture or religion could be failure to engage, misdiagnosis and a perpetuation of the presenting problems. In order to combat this d’Ardenne and Mahtani (1989) advocate transcultural counselling based on sensitivity both to difference and therapist assumptions of the difference. Leininger (1985) has referred to transcultural counselling as using cultural knowledge and skills creatively to help people live and survive satisfactorily in a diverse and changing world. Palmer and Laungani (1999) promote multicultural counselling psychology based on therapist flexibility.

However, Pederson (1985) found black people responded more favourably to black therapists and he therefore supports the notion of matching the client to the therapist.
on the basis of race or religion. Pederson believes that black people may actively seek black therapists as a result of having been persecuted all their lives. Sue and Sue (1990) suggest that this is because black clients fear that discussing their problems may further confirm negative stereotypes concerning their race and its identity within society. Furthermore, black people do not want to be treated as another white client by a 'colour blind' psychotherapist (Grant, 1994). The 'colour blind' therapist may often be defending against their own fear of their racist tendencies.

Palmer and Laungani (1999) state that if matching referral was to be suggested, the client should have full say in the process to avoid blatant discrimination by assumption. As this is a consumer nation and the client is a consumer of therapy they should therefore be aware of all the choices. Matching is, however, somewhat problematic as it may be hard to assess on what basis to assume sameness. Furthermore, some clients may find it difficult to express negative material about their own identity when their therapist appears to share that identity. However, there are also disadvantages with transcultural and multicultural counselling. These approaches require the counselling psychologist to recognise assumptions by deconstructing all their beliefs. This may be deeply problematic for someone unused to questioning all of their reality principles even their use of language.

**Silenced by language**

Language represents and constructs reality. Therefore language used in a therapeutic relationship may represent or indeed construct the client as deviant by being culturally loaded.

Clients may feel vulnerable and unsure when they first arrive for therapy and therefore could feel very insulted if the therapist pronounces their name wrongly. Henley (1979) states that this is particularly true for transcultural clients who have a different naming system. These clients often give their last name as their family name to fit into Western naming structure when in fact it is their personal name. If this is unrecognised by the therapist it could serve to highlight cultural differences. Thereby
rendering the client silent or more defensive and alienated from the therapeutic relationship before it even begins.

Truax and Carkhuff (1967) note that for psychotherapy to be effective each party must grasp the other’s meaning. This can sometimes prove difficult when they have different native languages (d’Ardenne et al., 1989). Therapists tend to adjust language style with clients on the basis of their experience of life, such as, situationally-specific language codes. But if the therapist is not really aware of cultural experience how can they do this? d’Ardenne et al. (1989) suggest constantly requesting validation for communication style and message conveyance. Henley (1979) recommends taking the lead from the client on gaze and other non-verbal cues to achieve non-verbal congruence. Furthermore, she endorses learning specific cultural rules on greeting, speaking volume, gaze and etiquette relevant to each client to help them feel accepted and unconditional positive regard. If time keeping values differ, Henley (1979) suggests explaining the need for them to avoid alienation.

The use of an interpreter is another context where the client can be hindered from engaging. The interpreter may not translate verbatim and alter the meaning of the words so the therapist receives a picture of a different reality from the one the client is trying to construct. Gaze between interpreter and therapist may further serve to make the client feel the third person in the relationship. Furthermore, issues surrounding confidentiality and speaking in front of two people may make the client feel as though therapy is not designed to support them. It is often difficult to find interpreters, as they are not given high priority for National Health Service (NHS) spending. Whilst working with a Turkish woman I needed to use an interpreter. My department provided me with a Turkish male interpreter. During the first session I realised that having a male interpreter was culturally and therapeutically inappropriate for my client. Her presenting issue concerned her physically abusive and absent husband. She was very uncomfortable talking about this in front of a Turkish male because she felt he would unfavourably judge her. The therapy seemed much more containing in the second session when I employed a female interpreter.
Even when the therapist and client appear to speak the same language the client could still feel their voice unheard. Colloquialisms and lifestyle specific terms could cause misrepresentation, lack of therapeutic rapport and confusion on both sides, damaging the working alliance.

As the Laplander has over 20 words for snow, so do Hindi speakers have separate words for each different family relation (d’Ardenne et al., 1989). This could be because of ‘the family’s’ cultural importance within Indian society. If a therapist fails to acknowledge this they may misdiagnose the client as over dependent. Indeed, as the Laplander has many words for snow so do the English have many words for emotional states. However in Ghana three words describe all unpleasant emotions, which would make it hard for a non-native speaker to understand the depth of the client’s experience and emotional affect.

The language that the therapist uses can isolate the client because of class issues. Each class, culture or province has its own accent indeed its own recognised forms of communicating. Failure to adequately understand the client can cause errors and inappropriate interventions (Kearney, 1996). Bernstein (1971) believed lower social economic status (SES) people use restricted code and higher SES people use elaborated codes. The therapist perhaps needs to recognise this and work appropriately. However, it should be noted that the very terminology elaborated and restricted seems to be value laden and may serve to other and alienate people. Furthermore, if language both represents and constructs reality (Burr, 1995), people hearing these terms may act them out. Theory may construct reality, not vice versa. Therapists do not listen with a neutral ear and clients do not speak in a neutral voice: neutrality is not generally a human characteristic. Therefore, assumptions may be made on both parts, which prevents empathy and unconditional positive regard. This hinders the therapeutic relationship as the client may not feel heard and the therapist may feel silenced.
Gender as a construction of the other

Internalisation of the child ego state begins when babies lying in their cots receive gender dependent attributions. These begin to develop a socially acceptable identity for the individual (Ernst and Gowling, 1994). Identity and self-perception issues are occasionally cited as the presenting problems.

Gilligan (1982) theorises that women have an interconnected view of the world. They therefore value relationships with people above task fulfilment. This view of women has been embodied in our cultural patterns. Society perceives women as requiring emotional closeness above all else. Goodwin expressed this view when she wrote: “We see women as nourishment... embodied in the symbol of the ideal mother who is paraded before us in so many commercials, cooking, washing, caring, touching, immaculate babies, loving and radiantly happy, whereas men are popularly thought of as detached, focused and traditionally ‘bad’ at relationships” (1990: 6). These stereotypes may serve to ‘other’ people who do not conform to socially acceptable stereotypes. Indeed, perhaps because men are expected to be detached and resilient they are under represented in those seeking psychotherapy.

Perhaps because issues are often gender related people frequently seek same sex therapists. This is the reasoning behind organisations such as the Women’s Therapy Centre. However, matching according to gender denies difference in other aspects of identity.

Chaplin (1988) claims that women can be distanced from patriarchal society because they do not conform to the hierarchical model that is exemplified in the business world. Some feminist therapists want to move from hierarchical rhythms to equarhythms. Equarhythms are based on equalising all aspects of experiences therefore balancing the natural and commercial domains. Feminist counselling attempts to train people to value ‘feminine’ values as much as ‘masculine’ ones. Perhaps this language constructs an ‘us and them’ reality. Feminist counselling attempts to help people to become less rigidly hierarchical in their thinking.
Furthermore, it recognises the integration of the internal psychological world with the social and material worlds. As one of the main aims of feminist counselling is to empower, the roles of client and therapist are viewed as different but not with a power imbalance. In keeping with the theoretical underpinnings both roles are recognised for their own value and interconnectedness. One role would not exist without the other so a hierarchy would be unrealistic and forced. Most mainstream psychology is based on a male Anglocentric experience yet feminist counselling tries to concentrate on mothering. How will this approach fit in? Chaplin (1988) views feminist therapy as a journey for the client. But perhaps it is also part of the journey for counselling psychology. Only by experience will counselling psychologists begin to accept and believe in feminist counselling, and its ability to give women, ‘the other’, an empowered voice. Furthermore, feminist counselling recognises the damage stereotyping can do, especially within families. Feminist systemic therapy tries to focus on the roles people are assigned within their families and the ensuing scripts. It not only recognises how therapy can ‘other’ the client, but literally aims to work with ‘the other’ on their experiences of being made to feel different in any part of their life.

**Constructing otherness on the basis of sexuality**

Davies and Neal (1996) proposed Gay Affirmative Therapy to help gay people when their presenting problem is related to their sexuality. Coyle (1993) found that most gay men’s sense of wellbeing was similar to people who had suffered massive trauma, perhaps because they face prejudice and lack of support from all around them. However, Kitzinger (1987) feels that gay affirmative therapy categorises and oppresses lesbians by constructing lesbian women’s problems as similar to those of gay men. Furthermore, Hitchings (1994) feels that the move from historic pathological models of therapy with the homosexual person to gay affirmative therapy has left a gap that needs to be filled. Perhaps this gap is the tendency to discriminate, unconsciously or consciously. Hitchings (1994) suggests real deliberation when working with gay clients. He recommends Coleman’s (1981) model as an aid because therapists’ tolerance is not the same as acceptance. In order to prevent being rejected in some way some gay clients may prefer gay psychotherapists. However, Hitchings believes: “There is a particular potential advantage for gay men and lesbian women in
working with a heterosexual psychotherapist since it is less likely that particular prejudices, that perhaps could be fostered by the gay/lesbian subculture, would go unnoticed or be actively colluded with” (1994: 120). This seems to be actively encouraging working with ‘the other’ so the seduction of sameness and assumptions will not occur.

However, Rochlin (1982) argues that a gay psychotherapist can be more empathic towards a gay client. He believes this increased empathy stems from their ability to provide a role model, which hitherto may have been absent, and genuinely understand lifestyle specific experiences. Discussions such as these raise the question of psychotherapist self-disclosure. Malyon believes: “If the clinician is gay, it is often of therapeutic value to reveal this early in the treatment process in order to help assure the client that the details of his homosexual feelings will be understood and accepted by the therapist” (1982: 63). This seems to be once again trying to eliminate the concept of ‘other’ within the therapeutic relationship. However, it could also be seen as further discrimination as heterosexual psychotherapists would not regularly need to address this issue. Obviously, it is not only in sexuality that people differ, assuming sameness on the basis of shared sexual preference may be the biggest assumption of them all. I doubt very much that heterosexual psychotherapists would assume sameness with a heterosexual patient. This could be an example of the minority being categorised as similar on the basis of one aspect of their life style choices and experiences. However, these debates are purely academic if the client does not know their therapist’s sexuality.

Indeed, there are those who advocate that group therapy is more beneficial for gay clients. Coleman (1985) theorises that this is because of feelings of isolation that exist in the coming out stage of identity formation. Hitchings writes: “Working in a group provides a gay/lesbian client with an opportunity to be with others in an intimate but non-sexual way, and to own their homosexuality in a comparatively safe setting” (1994: 122). Ownership in a secure setting may be a real benefit of therapy. This may provide clients with the chance to feel comfortable in their own skin before
they experience prejudice from other members in society. Yalom (1975) advocates mixed groups. He believes the main aims of such therapy are for gay clients to no longer find their sexual preferences problematic and for heterosexual clients to really explore their homophobia. This seems to me to be actively mixing ‘others’ to benefit each group. Therefore people are literally working with difference to facilitate their own self-development. However, one disadvantage appears to be an imbalance in the required ownership of one’s identity. The heterosexual clients are confronting their prejudices against another but not about themselves. The gay group members would need to be well adjusted and able to own their identity. Otherwise they perhaps would not be able to cope with the prejudice attitudes being explored by the other members. Therefore, the gay members would perhaps not find it such a safe environment and consequently may benefit less from the group in terms of self-development. This group method could be an example of how the majority use discrimination to enhance their own self-image with little regard for how the process impacts on or isolates the minority.

**Discrimination on the premise of class and politics**

Kearney believes: “Acceptance of social inequalities is, according to present day Marxists, ‘part of the air we breathe’ to the extent that, like goldfish living in a bowl, the last thing we would recognise as being all around us is the water” (1996: 20).

As with most of life, class and poverty are relative. But this does not mean that the experience of class and poverty is any less real for those dealing with them. Kearney (1996) recommends that assumptions should not be made about class beliefs. But at the same time she does not advocate simply ignoring the class dimension. Ignoring class dynamics could result in unrealistic therapy goals. Indeed the very structure of therapy could be constructed as class biased. Most lower Socio Economic Status (SES) people may need to access primary care therapy as they cannot afford private counselling (Kearney, 1996). Their therapy tends to be short term with a problem solving mentality rather than in depth analysis spanning several years. In this way people are discriminated against before they start the therapeutic work. How ethical
Conclusion

It is recognised that the situations described in this paper are not the only ways in which people are constructed as the other: trauma, illness, disability and age, indeed any life experience or identity can have the same effect. Counselling psychologists are participants, not observers of prejudice. If counselling psychology is prejudiced against the client through lack of knowledge or ideology developed in training, it will not be able to provide an adequate context for therapeutic change. Furthermore, it will actively perpetuate the silencing of ‘the other’ in today’s cultural climate. This is obviously a very negative implication for practice. However, Strawbridge and Woolfe (1996) believe that the very fact that this is being recognised as an aspect of counselling psychology is testament to the fact that the counselling psychologist is a reflective practitioner. Perhaps as scientific practitioners we need to concentrate on exploring how we could be discriminating against our clients. Unconscious discrimination is hard to recognise in ourselves, therefore it is only through reflection and discussion that it can be prevented. Hopefully, I have become slightly more self-aware of my discriminatory defences after writing this paper.
References


IN PRAISE OF TRANSFERENCE AND COUNTER TRANSFERENCE

Unconscious motivation and energies have been the working material of psychodynamic theorists and therapists since Freud first began work on his definitions of the unconscious. This essay\(^3\) celebrates psychoanalytical work with the unconscious and in particular the use of transference and counter transference as this is especially relevant to all modern day psychoanalysis and counselling psychology. Andersen and Glassman (2000) found that the recognition of these unconscious processes pervade most of modern psychological theory from social perception, cognition and emotional development.

Transference and counter transference – aspects and interactions

Freud described the transference situation as: “A whole series of psychological experiences are revived, not as belonging to the past, but as applying to the physician at the present moment” (1905: 48). Within the therapeutic relationship this means that the client responds to their therapist in the present as though they had the characteristics of a significant person from their past. Obviously, this has an impact upon both the therapeutic relationship and the therapist. The therapist unconsciously responds through their counter transference. Clarkson summarised counter transference as: “Counter transference is nowadays divided between what the psychotherapist brings - what can be termed proactive counter transference (really pathological psychotherapist transference onto the patient) - and that to which the psychotherapist reacts in the patient often termed reactive or inductive counter transference” (1995: 89).

These unconscious communications, transference and counter transference, are important aspects of the therapeutic relationships, perhaps even the most important. Indeed, Bateman and Holmes wrote: “The hall mark of psychoanalysis is the use of

\(^3\) Where used, all clients’ names have been changed in order to protect anonymity, and potentially identifying details, such as place names, professional roles etc., have been disguised to protect client confidentiality.
transference and counter transference as a guide to understanding the inner world of the client” (1995: 95). Transference messages are not exclusive to therapeutic contexts and occur in all everyday interactions. But because of the nature of the therapeutic situation they have a profound and powerful effect on the therapeutic process. Transference messages can construct the space in which therapist and client can discover psychologically unhealthy repetitive patterns. Furthermore, Freud (1912) and Clarkson (1995) theorise that more appropriate interactions and ideas can be practised within the transference context. Therefore, the transference can be both context and content of therapy.

It is important to remember that the transference affects both client and therapist. The therapist does not listen with a neutral ear. Bion wrote: “when two people get together they make a relationship whether they like it or not, this applies to all encounters including psychoanalysis” (1962: 93). Interpersonal therapeutic approaches are also likely to describe transference in terms of a two-person interaction with contributions from both analyst and patient. Therefore two people’s unconscious processes are present and impacting upon and constructing the therapeutic relationship.

**The roots of transference**

Klein (1952) theorises that transference originates in the super ego. She believed that early introjections, unconscious memories and early experiences of primary object relations construct the superego. Primary object relations are caused by early fears. The first of these is the death instinct, which manifests fear of annihilation, the primordial cause of persecutory anxiety. Klein (1952) advocates that in order to cope with these fears the infant splits their world into two forces, those that persecute which are perceived as bad (the bad breast) and those that nurture and protect and are experienced as good (the good breast). This splitting results in idealisation of the good objects to protect the child from bad objects and the infant functions in the paranoid schizoid position. A patient may be interpreted as still operating in the paranoid schizoid position if their transference seems very split into positive and
negative phenomena. Klein (1952) theorised that the infant forms early object relations and the super ego through introjecting and projecting their emotions on to the mother’s breasts. The ego’s growing capacity for introjection and projection leads to aggressive impulses, which are directed by the infant towards the bad breast. This causes the depressive position as the infant fears their aggression towards the bad objects may harm their idealised good objects. The anxiety and guilt about harming the good object fuel the Oedipus complex, which, according to Klein (1952) sets in soon after the depressive position. Klein also believed that the pressure of these early anxieties results in repetition compulsion, which is eventually introjected into the therapeutic relationship through the transference between patient and analyst. This is illustrated in the following case example.

Ms. A was an articulate 27-year-old female solicitor who had developed binge eating as a coping strategy. Her mother had died from breast cancer when Ms. A was 12. Her father remarried 18 months later to a woman Ms. A reported hating. This situation seemed to have realised Ms. A’s unconscious splitting as an infant. She experienced a lot of guilt about her mother’s death. It was as though she felt her aggressive impulses towards her mother’s bad breast had literally killed off her mother, who became her idealised wholly good object. Therefore someone Ms. A perceived as a bad object had replaced Ms. A’s idealised good object. I felt that she unconsciously communicated her split feelings towards me within the therapeutic relationship.

Occasionally, I would feel overwhelmed by the desire to rescue my client and be everything to her and at other times I would feel she hated me for letting her down. I felt her hatred the most when we discussed her feelings about endings, such as her mother’s death and the ending of therapy. I tried to work with these split feelings and interpret them to Ms. A. I was also very aware that the ending of therapy might make Ms. A feel she had once again lost a good object. I therefore tried to work towards the ending within therapy to minimise the feelings of abandonment and loss for this
client. Further, I used supervision to monitor this client’s attachment to me to help prevent her over idealising me, which would have made the ending even harder.

Jacoby (1984) believes that the main cause of transference is the primal relationship, which corresponds with Freud’s (1912) ideas of repetition compulsion. This certainly seemed to be the case in the above example.

Jacoby (1984) also believes that the main cause of counter transference is the patient’s, and sometimes a neurotic analyst’s, primal relationships. Therefore, Clarkson (1995) believes the counter transference may stem from the therapist’s pathological objects and could be proactive (stemming from the therapist) rather than reactive.

Money-Kyrle (1955) formulates that analysts’ reactive counter transference originates from their introjected and projected identification with their patient. He explains that as the patient speaks the analyst identifies with them and having comprehended the analyst will then re-project and interpret. However, the most potentially destructive part of this process is the projective phase where the patient represents to the analyst an immature or ill part of themselves or their damaged objects. Jung (1946) believed that the analyst’s unconscious plays an equal part to that of the patient’s in creating their common unconscious, which he termed participation mystique. This both manifests and holds the transference messages. Jung (1946) also theorised that analyst counter transference occurring within the common unconscious is created by the seduction of their archetypes especially those of the divine healer. Thus the analyst’s healer meets and wants to fulfil the patient’s need for help, creating the opportunity for a mutually rewarding therapeutic outcome.

**Communications through the transference**

Freud (1912) theorised that repetition compulsion indicates the nature of early relations. This need for repetition may result in the patient unconsciously acting as
though the analyst had the same characteristic as an early significant relationship. Consequently the past is brought into the present within the context of the therapeutic relationship. The significant early relationship may be with an object or person depending on where the patient is fixated. If the patient suffered severe trauma at or under one year of age it is likely that their super ego will still be in the paranoid schizoid position and they will project I-it transference. Whereas Jacoby (1984) theorised that if they are in some way acting in the depressive position they may be in the I-thou unconscious communications. Often this move from paranoid schizoid to depressive position is a primary therapeutic goal, which can be achieved through interpreting the transference and practising I-thou interactions in the therapeutic space.

Whilst running a parenting group I focused, where appropriate, on the type of projections the clients projected onto me as indicators of the type of relationships they may have with their children. With one particular couple this proved very fruitful. Mr. and Mrs. K used to make me feel objectified. After the group I would literally feel as though I was only there to serve a purpose and had failed at even that. They definitely seemed to respond to me as an 'it'. After some containing supervision I was able to use this to inform my assessment of their family life. It became clear that they felt that their son who had attention deficit hyperactive disorder had a specific role in the family which he could not achieve. They were therefore very angry with him and were unable to feel anything more than resentment towards him. Obviously this had serious implications for the appropriateness of their parenting. My supervisor and I referred the family to social services and they were treated by several agencies concurrently. They were also offered family therapy as well as parenting group sessions. The reason for this was that we felt we needed to have direct therapeutic contact with their son as well as them, in order to adequately meet the needs of the whole family. In this way the communications through the transference directly informed my practice. Furthermore, attending to the transference on a one-to-one basis, helped me to work ethically with an awareness of professional issues and responsibilities.
Listening to the transference also helps acquire important client information and develop a picture of the client's history. Detrick (1989) theorised that transference can communicate at which developmental stage the patient is functioning in. Further, Livingston Smith (1999) described transference and counter transference as signals. I believe they are signals, signals of the patient's inner world. The common unconscious and perhaps the strength of the working alliance are also signified in the transference. Indeed, it could be said that transference and counter transference are the most important aspects of the therapeutic relationship because they not only communicate about and into this relationship but also contain it. Hence their importance in psychoanalytical supervision.

In some of my clinical work the transference has initially been the only source of information about my client's internal world. Ms. U, is a 37-year-old white woman with mild to moderate learning disabilities. Her expressive communication skills are good, but she has some deficiencies in receptive communication skills. However, she was initially unable to verbalise her affect.

While in the room with Ms. U I would often feel like leaving. I felt it was a waste of time to attempt psychotherapy with an adult with learning disabilities. This was because I questioned the level of personal insight of which she was capable. This continued for several weeks until I literally had to stop myself from reducing the therapy to an informal chat. I even considered shortening the length of the sessions. I started to justify this to myself because of her seemingly short attention span. I realised that I had not generalised these feelings to any of my other clients with learning disabilities. I began to wonder if these feelings were specific to Ms. U. I started again to take a developmental history. Between Ms. U's verbal communications and the information in her file I discovered she had been sent to a hospital to live at the age of two. Furthermore, since her mother's death when she was 12 not one member of her family had visited her. She had basically been abandoned for 25 years. I believe she had unconsciously communicated this to me. I
had felt like abandoning her and giving up on her as her family has done. She had unconsciously shown me how she had been treated by early significant attachments.

Obviously, I did not shorten the sessions or reduce them to informal chats. Ms. U did manage to explore her emotions in the sessions, at first through crying and then through discussion. She showed deeper personal insight than I would have imagined. This relationship successfully taught me not to assume all of my therapeutic ideas are logical or in the client’s best interests. Abandoning her would certainly not have been in her best interests as it would have been fulfilling her psychologically damaging repetition compulsion as theorised by Freud (1912).

Racker (1982) believed counter transference could indicate the analyst’s world view. He advocates this because the analysis of the therapist’s interpretations and their counter transference can indicate at which stage the analyst is at in their development of appropriate self-awareness. Counter transference can also indicate appropriate levels of self-awareness and awareness of the patient’s presented material. This is opposed to neurotic counter transference that communicates that the analyst still has unrecognised damaged objects. In the above clinical example I internally interpreted my counter transference to discontinue therapy with this client as rational professional judgement. I believe this was a defence against my real suspicion that I was actually prejudiced against adults with learning disabilities. Prejudice often stems from fear of difference. I was perhaps confused and afraid of my client’s world as I thought it was alien to me. I hid behind the façade of expertise to cover up for my naïve and ego centric world view, which exposed my lack of self-awareness in relation to this client group.

**Working with transference**

Psychoanalysis has not always regarded transference as beneficial to the therapeutic process. Indeed, Breuer and Freud (1895) cited in Bateman and Holmes first described them as a hindrance to analysis and “contaminating influences” (1995: 96). Freud (1912) later modified this to describing them as hard to
manage. This was certainly the case in the example of my counter transference to Ms. U. Freud wrote; "It cannot be disputed that controlling the phenomenon of transference presents the psychoanalyst with the greatest difficulties" (1912: 2). I believe this is the case and Freud’s theoretical change does not illustrate an early mistake but an appreciation of the complexities of the transference relationship between analyst and patient. The psychotherapist’s transference is a very real yet difficult aspect of the therapeutic relationship. If the therapist does not listen to their internal supervisor (Casement, 1985) and monitor their bias this can detract from the patient’s agenda. It is not only the therapist’s proactive counter transference, which can threaten the therapeutic relationship but also their reactive counter transference. The therapist’s complementary reactive counter transference can stem from the therapist internalising their client’s projection and accepting it as reality. Thus, the therapist can communicate his or her own issues within the therapeutic relationship through proactive counter transference. The client may then unconsciously identify with these and internalise them as well as communicating them back to the therapist as reactive transference. This may result in the therapist interpreting the client’s reactive transference as proactive (Clarkson, 1995), which would result in the therapist treating their own issues within the therapeutic relationship and silencing the voice of the patient.

These negative affects of the transferential relationship may also signify its importance within psychotherapy. Powerful tools and therapeutic spaces can never be truly safe or free from ambiguity otherwise they would not have such positive effects when interpreted appropriately. Psychoanalysis is hard work and challenging for both analyst and patient and the therapeutic relationship can never be treated lightly.

Freud (1912) had some ideas on how to minimise destructive transferential communications, the main one being analysis for the analyst. To Freud analysis was not just a way of ensuring appropriate interpretations it also disclosed fitness to practice for the therapist. Freud (1912) thought if the analyst cannot himself be analysed he cannot analyse others because he will have too many defences and
unresolved issues and his counter transference would stem from his own issues and defensives rather than that of the patient. Benowitz Eigner (1986) also emphasised self-awareness to understand patient transference and analysts' reactions to the projections. She wrote a thoughtful and provocative article illustrating the safe containment of transferred rage, which can be expressed creatively by the analyst and put to good use. Benowitz Eigner described a creative containment strategy when she made a particular dish to eat, which resembled male genitalia, which helped her act out the projected rage of her male patient. Money-Kyrle (1955) believed that analysts can learn a lot about their patients through their own reactions to their projections.

My own experience of working as a trainee counselling psychologist has been significantly influenced by my knowledge of the transference and counter transference process. This is illustrated by the following case study. Mrs. S, a 26-year-old religious Indian lady of upper caste origins married to a lower caste Indian man, kept telling me about her perfect parents. However, she seemed to me to have a very low self-opinion and reported being stigmatised by her family for her marriage. She left him two years into the marriage because she felt persecuted by him. After several sessions she became persecutory towards me and I felt she might be trying to make me feel similar to the way her husband made her feel. I decided not to name this straightaway but explore it further during the sessions. This proved to be the right decision, because as I thought about this more and experienced more feelings of persecution and inadequacy I realised it felt more like parental criticism than that of a husband. I then became concerned that this might be my own issues rather than her unconscious communication. On further reflection I decided to risk the interpretation that the first time she felt persecuted was at the hands of her parents which may have made her rush into an unsuitable marriage in order to escape from them and perhaps also to rebel against them. Her reaction was to cry and to agree with what I interpreted. This seemed to imply that this had been a correct interpretation and effective use of transference and counter transference. I felt my client and my professional development had benefited from this experience.
Since then I have used the concepts of transference and counter transference extensively in working within my therapeutic relationships. I have also spent some time in therapy myself in order to increase my personal development and to work on improving my self-awareness. The latter is not only useful in itself, but as discussed above, is fundamental to ensuring the appropriate analysis of reactive counter transference within therapy.

Personal therapy is an ongoing process and is one which I believe will continue to develop and contain me, inform my practice, help to avoid contaminating the therapeutic process and ultimately benefit my clients.
References
THE THERAPEUTIC RELATIONSHIP: HOW IT CAN ASSIST EFFORTS TO WORK INTEGRATIVELY.

The English verb 'to integrate' derives from the Latin 'integre'. The direct translation of this is 'to make whole, to renew'. This implies a process of bringing together, to form something new, suggesting that integration is not just a combination process but a creative process. Clarkson (1995) has brought many diverse theories on the therapeutic relationship together and summarised five types of therapeutic relationships: developmentally needed/reparative, transferential, person-person/real, regressive, and transpersonal. Clarkson's (1995) model advocates that in order for the integration process to be effective there must be a clear method and rationale. But how do we as counselling psychologists choose a method for integration? Clarkson (1998) suggests that we should incorporate academic psychology with clinical practice. Indeed, the conscious use of academic psychology to enhance practical counselling skills perhaps differentiates counselling psychologists from counsellors.

Counselling psychologists' ability to integrate theoretical research and practice and act as scientist practitioners is perhaps our defining feature, our professional foundation on which we can build further recognition and value. This essay will explore my rationale and method for integrating different theoretical approaches and how my experiences in supervision and personal therapy influence my clinical practice.

From the beginning of my training I found that focusing on the therapeutic relationship and working alliance, as conceptualised by Gelso and Carter (1985), enabled me to begin to construct a rationale for integration. With hindsight, I would argue that this was because it helped me attune to my internal supervisor, as theorised by Casement (1985) and really consider the reasoning behind my interventions.

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4 Where clinical material is used for illustrative purposes, identifying information has been altered and pseudonyms used to ensure confidentiality and anonymity.
Working within the therapeutic relationship in the first year of the course enabled me to integrate humanistic and psychodynamic theoretical concepts whilst working in a primary care setting. During the second year, I found that again by focusing on the therapeutic relationship I was able to apply knowledge gained from working with adults in primary care to children and adolescents in a Child and Adolescent Mental Health Service (CAMHS). In this context my focus on the therapeutic relationship also helped me to begin to think about working systemically. My third year placements were in two very different contexts with very challenging client populations. One context was a Community Mental Health Team (CMHT) for adults with learning disabilities and the other was in a North London Primary school. In both cases considering the therapeutic relationship enabled me to bring together all of my clinical experience and theoretical knowledge and to adapt my way of being with clients to fit with their specific individual needs.

In my first year, I was impressed at how effective the experience of a positive therapeutic relationship can be for therapeutic change. Lambert (1983) attributes this effectiveness to the fact that the therapeutic relationship is very different from any other relationship. I experienced this as both the therapist in my own clinical practice and as the client during my personal therapy. Arnkoff (1983) believes the therapeutic relationship can contain the client, the therapist, the therapeutic techniques and processes at the same time as being the agent for therapeutic change. In the first year I also had my first experience of supervision. Clarkson (1995; 1998) suggests incorporating our own clinical, personal therapy and supervisory experiences to rationalise our own integrative agendas. I found both my own supervisory and therapeutic relationship (as the client) safe and contained because of consistent boundaries and frame. I therefore tried to incorporate aspects of these relationships into my own way of being with clients. I found that when appropriately managed the therapeutic relationship provides a reflective space for the therapist and limits the impact of external processes on the transference. Clarkson (1995) believes a consequence of this is that the therapist can be more certain that they are working with and interpreting proactive transference and reactive counter transference rather than proactive counter transference and reactive transference. I also attempted to
mirror the psychological secure base my supervisor provided for me in my therapeutic relationships with clients, and incorporated concepts from Bowlby's (1988) attachment theory into my understanding and use of the therapeutic relationship.

Focusing on frame and boundaries within the therapeutic process resulted in my reflecting on my own impact on the therapeutic outcome. As Langs (1979) suggests I therefore began to consider my use of self. Langs (1979) and Casement (1985) believe this is important as integration is not just about integrating different approaches when working with clients but also integrating the different ways of being as a therapist while remaining congruent. If congruence and consistency are not achieved the client may experience the therapeutic relationship as disjointed and chaotic. These disjointed interactions may mirror the client’s external relationships and therefore distress rather than help them. The importance of remaining congruent while drawing on an ever-broadening theoretical knowledge and way of working is perhaps most usefully illustrated in a clinical example.

During my third year placement in a North London Primary school a nine-year-old male client was referred for facial twitches. During our assessment sessions I used the therapeutic relationship as a model. This enabled me to focus on my client’s specific needs and I was therefore able to integrate a number of seemingly appropriate techniques, such as using Rogers’ (1951) humanistic skills to establish a working alliance. As the work progressed, it became apparent that my client was profoundly anxious about his and his family’s relationship with the outside world. His appraisal of his family’s need of protection was based on his having witnessed his father being beaten by men with baseball bats in his own home. I therefore decided to use Padesky’s (1994) schema focused approach with him because he held the core belief that the outside world was unfair and that he needed to protect his family from it.

It also became apparent to me that this client and his family would be best contained in a developmentally needed/reparative relationship - reparative of both early relationships and recent relationships with professionals. It was important to involve...
his parents because their interpretations of the facts surrounding their experiences seemed to be adding weight to, if not causing his core beliefs about the issue of who was responsible for protecting them. I therefore decided to ask the parents to attend a session with me as part of my assessment. I discussed this with my client to ensure that he did not feel that I was attacking his privacy or invading his therapeutic space. To help this I gave his parents a separate time so he retained his individual space with me and I could maintain boundaries already developed and operationalised. The whole family then agreed to attend sessions together as well as continuing my individual sessions with my client. I, therefore, had to integrate systemic therapy (Jones, 1993) into my schema focused work. My rationale for this was that as a child he was dependent on his family system and that if therapeutic change were to take place and be maintained for him internally it also needed to take place externally within his family system.

In these systemic sessions we managed to increase the transparency of communication within the family. This supported my client to realise that people do have some control over their experiences and even when victimised they can survive in the same way as his father survived an attack. I also organised a meeting between the school head mistress and the parents to discuss supportive strategies the school could adopt. During these meetings I tried to be supportive to both family and school systems whilst facilitating implementation of my recommendations. I hope that his experience with me has also helped him and his family to experience a positive therapeutic relationship. I tried to remain consistent with my use of self whether seeing him individually or together with his family. Over the course of the therapy it became appropriate and mutually empowering to move from a reparative into a collaborative relationship with the parents in the family sessions. I integrated techniques from systemic and schema focused therapy within this relationship.

Focusing on the therapeutic relationship when working with children helps to integrate my way of being and with my therapeutic skills enabling me to make them understandable to the children. As a model for doing this I have used Vygotsky's
(1976) model of a Zone of Proximal Development (ZPD). Vygotsky (1976) believed that humans are innately social so children learn best through interaction pitched just above the child’s lone functioning level. These interactions start by being interpersonal but through consistent exposure the child internalises the interactions and they become intrapersonal. Models of learning by Vygotskyian internalisation can be easily applied to therapy. The therapist can be seen as facilitating client change by pitching therapeutic intervention and interpretation at a level the client may not reach alone but can do so with therapeutic guidance. This can be considered as similar to Clarkson’s (1995) ideas on the developmentally needed/reparative relationship.

Clearly, with each of their clients therapists need to pitch their interventions at the right level. Kroesse, Dagnan, and Loumidis (1997) suggest that this is particularly pertinent when working with special populations such as adults with learning disabilities. During my third year placement, I constantly had to rely on my ability to form a strong therapeutic relationship with the clients in order to help them feel valued within the therapy. This was particularly true when explicit verbal communications were not always possible. Within these relationships I often had to rely on unconscious communication to give me insight into the client’s way of being in the world. Kroesse, Dagnan, and Loumidis (1997) found that this client group can be conceptualised as encompassing both adult and child characteristics. Waitman, and Conboy-Hill (1992) support this and found that adults with learning disabilities are both children who cannot grow up and adults who have had to cope with a lot of adverse life situations. Therefore, when working with this client group, I tried to integrate what I had learnt from working with adults in my first year and children and adolescents in my second and third year. Working with this client group really highlighted the importance of integrating theory into practice, using the theory to inform my practice as well testing the applicability of the theory to address the client’s needs, in the manner of the scientist-practitioner. Often the reasons for referral would bear no resemblance to the client’s real point of maximum pain as conceptualised by Hinshelwood (1994). I, therefore, had to draw on my theoretical
knowledge to really assess the client’s situation and my knowledge of systems to understand what the referral process mirrored in the client’s life.

Mr. T, for instance, was referred for anxiety and profound fear of his neighbourhood youths, who had never attacked him. The referral suggested he was very childlike and a victim who needed constant babying. Indeed, in the sessions with him my counter transference was that I was in the room with an adolescent rather than a 55-year-old man. However, I monitored this and attempted to respond to him as an adult and this seemed to cause an early and marked shift within the client. During only the second session he disclosed an incident that occurred four years previously involving inappropriate sexual behaviour in front of and advances towards his 13-year-old niece. It seemed to me that his fear of boys was due to his unconscious belief that he is a “very bad man” because of his sexual desire for his adolescent niece and he will be discovered and punished by everyone, especially adolescent boys. I feel his anxiety was a defence against his knowledge that he could be a perpetrator. It seemed as though it was easier for him to live as a victim of scary adolescent boys rather than the source of adolescents’ fear. This is seemingly mirrored by the systems treatment of him. Having formulated this I presented it to my supervisor and on her suggestion we held a risk assessment meeting. This was not only about the risk to him and others, but also the risk of therapy and the increased awareness of his issues as these could be far too overwhelming and damaging for him. Theoretical knowledge informed my awareness of ethical practice with this client. When this was applied within the therapeutic relationship it became a guide as to the way the therapeutic encounter should progress with this client.

Integration can be an extremely difficult approach to achieve. Sometimes I feel as though I have a sense of being able to really work with a variety of clients using a variety of different theoretical approaches. There are also times when I feel as though my attempts at integration are a compensatory strategy for my incomplete knowledge of any one pure approach. During these times my attempts at integration feels like a thinly disguised veil of incompetence, which results in the scientist being lost in my
professional identity as a scientist-practitioner. However, so far, with internal (Casement, 1985) and external supervision, I have continued on my way towards working with my key focus of maintaining the therapeutic relationship.

In conclusion, over the three years I have used the therapeutic relationship as the basis for integrative working. I have attempted to integrate theories, previous clinical experience, supervision and my sense of self into my clinical practice. Obviously, as an integrative practitioner, I am still in my infancy but with ongoing experience and further supervision I will continue to build on the foundations of my counselling psychology training.
References
DIAGNOSTIC REPORT FOR MISS SIEGEL

Possible diagnoses in the case of Miss Siegel

Substance related disorders (F10, ICD 10)

DSM IV defines substance abuse as, ‘a maladaptive pattern leading to clinically significant impairment or distress’. It is important to consider this diagnosis in relation to Miss Siegel due to her persistent contact, either through using or supplying, drugs from the age of thirteen.

Miss Siegel’s grades fell dramatically in the seventh grade when she was ‘spending time with peers who were experimenting with drugs and alcohol’. However, it is not completely clear from the report whether her work suffered because of a lack of interest in school life and a preference to be with peers, or a fixation with drugs and substance abuse. At the age of 14, Miss Siegel appears to have experienced a sense of depersonalisation, and derealisation, vivid hallucinations and paranoia. The report does not clarify whether she was abusing hallucinogens or amphetamines at that time. More recently, Miss Siegel has suffered episodes of psychological disturbance caused by stressful interpersonal events rather than substance use suggesting that a diagnosis of a substance related disorder is not appropriate in this case.

Mood disorders (F32, ICD 10) (296.3X, DSM IV)

Major depressive disorder, recurrent

It is important to consider depression as a possible diagnosis because the report describes Miss Siegel as having extremely low moods from the age of 16 especially when she is alone. Furthermore, during her first hospitalisation she showed vegetative signs of depression, insomnia and lack of appetite. During her latest

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Miss Siegel is a pseudonym. Further it should be acknowledged that this report pertains to a fictitious client presentation.
therapy sessions she continued to present signs of depression although the specific symptoms are not specified. Further clinical assessment would be useful when considering this diagnosis.

Client presentations should be considered holistically rather than looking at separate components and fitting them to fragmented diagnoses. Miss Siegel’s symptomatology may meet some of these criteria but her presentation is more accurately and diagnostically substantiated through reference to the criterion for borderline personality disorder (BPD).

Dissociative disorders

Depersonalisation disorder 300.6 (DSM IV) F48.1 (ICD 10)

It is important to consider this diagnosis because of Miss Siegel’s episodes of feeling unreal and her consequential reality testing behaviour in the form of self-harming.

Criteria 300.6 A is met because the report indicates that Miss Siegel’s experiences recurrent experiences of feeling detachment from her body. However, another explanation could be her history of sexual abuse (Doyle, 1994) rather than a depersonalisation disorder.

300.6 B is met as the report suggests that during such episodes her reality testing remains intact although maladaptive, such as, incidents of cutting herself to feel pain in order to feel real.

The criteria relating to impaired functioning as a result of clinically significant distress and the exclusion criteria, do not seem to have been met by the description of Miss Siegel’s experiences in this report.
ICD 10 concludes that this diagnosis should not be used as a main or single diagnosis when the syndrome arises in the presence of other mental disorders. Therefore, this is rejected as a diagnosis for Miss Siegel because it is does not explain all of her symptomology and is therefore unlikely to be her principle disorder.

**Schizophrenia (295. 90, DSM IV) (F20.6, ICD 10)**

It is important to consider this diagnosis because Miss Siegel has experienced dissociative symptoms and her performance on the Rorschach Thematic Apperception Test is similar to those seen in people diagnosed with schizophrenia. However, hallucinations are the only criterion met out of five (two criteria make for a diagnosis) and these were not sufficiently prevalent to accept a diagnosis of schizophrenia.

**Sexual and gender identity disorders**

**Sexual masochism (302.83 DSM IV) (F65.5 DCR-10, ICD 10)**

The above diagnosis is included in this report because Miss Siegel has had numerous sexual experiences over a period of at least six months in which her sexual partner has inflicted pain on her such as punching her in the face. Nevertheless, her experiences do not meet the criteria for this diagnosis as specified in either the DSM IV or ICD 10. Miss Siegel does not report fantasising about violent sexual acts, also sadomasochistic activity is not Miss Siegel’s most important source of stimulation, nor is it necessary for sexual gratification (referring to F65.5 C in ICD 10). It is on these grounds that the diagnosis of sexual masochism is rejected.

**Sexual sadism (302.84, DSM IV) (F65.5 DCR-10, ICD 10)**

This diagnosis is considered because Miss Siegel has had numerous sexual experiences over a period of at least six months in which she has inflicted pain on her partner during sex such as biting during fellatio. However, the diagnosis of sexual masochism is rejected because it seems that her engagement in these behaviours is not caused by sexual fetishism but her inability to refuse anyone anything. This seems to
be indicative of a fear of abandonment and perhaps another disorder such as Borderline Personality Disorder.

Furthermore, Doyle (1994) formulates that children who have experienced sexual abuse can often develop a resigned and despairing acceptance that they will continue to suffer in this way. Miss Siegel may have responded as thus to her stepbrother’s abuse and have become unable to maintain any personal boundaries and felt unworthy of positive treatment. She may have come to accept and expect abuse as a defence to normalise the trauma and therefore engages in sadistic and masochistic sexual behaviour. It could be argued that this is because of unnecessary and psychologically unhealthy guilt associated with these sexually abusive experiences.

**Personality disorders**

**Histrionic personality disorder** 301.50 (DSM IV) F60.4 (ICD 10)

It is important to consider this diagnosis because of the patient’s excessive emotionality and attention seeking behaviour, illustrated by her efforts to form ‘special’ attachments to hospital staff. However, as this behaviour does not seem to stem from a need to be the centre of attention the above diagnosis may be rejected.

**Borderline personality disorder (BDP) 301.83 (DSM IV) F60.31 DCR 10 (ICD 10)**

It is important to consider this diagnosis because it seems to comprehensively relate to Miss Siegel’s experiences and explains her maladaptive behaviours.

DSM IV criterion 1 relates to frantic avoidance of real or imagined abandonment. Miss Siegel’s has behaved in this fashion since her biological father left the family home and became unavailable to his six-year-old daughter.
Her disclosure that she had possession of drugs during her hospitalisation appears to have been an attempt to prevent discharge. She may have developed an idealised attachment to the staff and dependence on the hospital structure, and may have experienced the possibility of discharge as further abandonment. This hypothesis seems to be supported by her depersonalised experience following disclosure, when she cut herself. The fact that the self-harming was visible led the staff to believe it was an attempt to malingering. Alternatively, since Miss Siegel had access to drugs, this behaviour may have been drug induced rather than a symptom of borderline personality disorder. Although neither of these explanations is mutually exclusive, further drug testing would clarify the cause of these dissociative experiences.

DSM IV criterion 2 states that the person must have a pattern of unstable and intense interpersonal relationships characterised by alternating extremes of idealising and devaluation. From the report these relational patterns seem applicable to most of her relationships beginning with her father and, most recently with hospital staff and fellow patients. The report hints that this pattern of idealising and devaluing has occurred with her previous boyfriends although further information would be useful to make a complete assessment of her attachment styles.

Whether criterion 3 is met is questionable. Criterion 3 pertains to identity disturbance with a markedly and persistently unstable self-image or sense of self. It is not clear from this report whether this identity instability is characteristic of Miss Siegel. She is described as taking part in sexual behaviour that is not congruent with her sense of ideal self and consequently experiences intense feelings of guilt. Furthermore, her ‘acting out behaviours’ including her sexual activities, drug taking and self-harming and dissociative episodes, may also relate to her fragile sense of self. Although this offers support for criterion 3 further assessment interviews are required.

Criterion 4 seems met by Miss Siegel becoming impulsively involved in risky drug taking behaviours at the age of 13; this pattern has been repeated continuously throughout her life span. She is also described as impulsively engaging in potentially
damaging sexual practices. However, this behaviour could once again be explained by a massive fear of abandonment and rejection.

Criterion 5 pertaining to recurrent suicidal or self-mutilating behaviour is definitely present in the report. Miss Siegel is described as regularly using self-mutilation as a form of reality testing to reaffirm her sense of realness. This behaviour started when she was 13 whilst under the influence of drugs. Miss Siegel was 15 when she first self-harmed during a non-drug induced dissociative state. Similarly, when an idealised and falsely romanticised relationship ended she used self-harming as a maladaptive coping mechanism. Miss Siegel also threatened suicide possibly because her experience of being rejected and abandoned, left her feeling devalued. This is a pattern that is continuously repeated in her past and present day functioning.

Criterion 6 is described as an “affective instability due to a marked reactivity of mood”. This criterion is confirmed by Miss Siegel’s extreme mood swings between anger and depression during her hospital admission procedures.

Criterion 7 is characterised by “chronic feelings of emptiness”. This criterion also appears to have been met. By the time the patient was 16 years of age she could not tolerate being alone. During her first hospitalisation her emotions appear to have oscillated between outbursts of anger and feelings of emptiness and depression. Furthermore, feelings of emptiness were prevalent during her eighth and most recent hospitalisation.

DSM IV criterion 8 is pertinent, “intense anger and difficulty controlling this anger”. This was most recently displayed during Miss Siegel’s eighth hospital admission whilst undergoing routine arrival procedures.

DSM IV criterion 9 relates to “transient, stress related paranoid ideation or severe dissociative symptoms”. This appears to be present within Miss Siegel, who was
reported as having extreme dissociative reactions to abandonment, either real or imagined. Feelings of dissociation could be her maladaptive defence against the pain of these abandonments.

DSM IV specifies that five out of the nine criteria need to be met in order to give this diagnosis. Miss Siegel meets eight of these criteria and therefore this diagnosis is strongly recommended. Furthermore, most of her maladaptive behaviours and motivation seen throughout her life story seem to be explained by this diagnosis. I would suggest, therefore, that Borderline Personality Disorder is Miss Siegel's principle psychological diagnosis.

**Emotionally unstable personality disorder, borderline type F60.3 (ICD 10)**

This diagnosis is also accepted as pertaining to Miss Siegel, although it is perceived as secondary to Borderline Personality Disorder. This diagnosis is accepted Miss meets four of the additional criteria. These criteria relate to Miss Siegel's tendency to form intense and emotional relationships leading to emotional crises, her excessive efforts to avoid abandonment, her use of self-harm as a coping mechanism, her fear of being alone and her sense of pervasive emptiness.

**Further clinical assessment and intervention**

Although the Rorschach Thematic Apperception Test was administered when Miss Siegel was in eighth grade, this report strongly recommends that it is administered again in order to test her tendency for 'primitive splitting'. This is a characteristic of BPD, which can result in the patient splitting her world into good and bad categories with no middle ground. Her results at 13 could also have been influenced by drug use, so it is important to re-test her as an adult during a drug-free period.

This report will end by emphasising the importance of a thorough clinical therapeutic assessment with both Miss Siegel and her family, as this will greatly benefit accurate diagnosis, formulation and treatment planning. Furthermore, with full family co-
operation and support her treatment plan is more likely to be effective. Miss Siegel’s behaviour is indicative with Johnson’s (1994) characterisation of an abandoned child. Miss Siegel’s avoids the reality of her abandonment by fantasising about her father’s return and resenting her stepfather’s presence. Moreover, because she wants to prevent further abandonment she does not seem capable of refusing anyone anything even if it is to her detriment. Perhaps most worryingly, she was unable to refuse or prevent her stepbrother abusing her. Johnson (1994) advocates that systemic family therapy has the best prognosis for ‘abandoned child ego states’ since the therapy helps to strengthen attachments and feelings of self-worth. Although her stepfather may refuse to attend therapy with Miss Siegel, I feel she would greatly benefit from her mother’s support throughout the therapeutic process.

Miss Siegel may also benefit from dialectical behaviour therapy (DBT). This is a broad-based cognitive-behavioural treatment developed specifically for BPD. Linehan, Armstrong, Suarez, Allmon and Heard (1991) found that this was the first treatment, via controlled trials, to be effective with this disorder. Linehan (1993) found that the most effective DBT is a combination of individual psychotherapy and skills training. When working with clients with BPD skills training is useful in the areas of: psychosocial skills, core mindfulness skills, interpersonal effectiveness skills, emotion regulation skills, dialectical strategies, and problem solving strategies. However, this training should take place within a positive therapeutic relationship not as a replacement. Clarkson (1995) believes that the experience of a positive therapeutic relationship is vital in all psychotherapy with any client.

Professional issues are always important considerations within any therapeutic encounter. Some areas requiring therapist reflection when working with BPD are, splitting within the therapeutic relationship, reactive counter transference to extreme and polarised client emotions, boundaries and guilt. Due to the practical constraints of this report only the latter two areas are considered. Miss Siegel has a history of trying to form special attachments with staff and may therefore benefit from a contained and very boundaried relationship. She may be very adept at pushing the
boundaries so this requires internal supervision (Casement, 1985) on behalf of the therapist. Further, Miss Siegel is reported as often feeling guilty; this may be an important unconscious communication within the therapeutic relationship. The therapist needs to reflect on this communication and work with it to avoid overreacting. Over identifying with the client’s feelings of guilt is a risk when therapeutically engaging with clients that self-harm.

Diagnosis can be beneficial to professionals in treatment planning, explaining certain behaviours and gaining deeper insight into the internal worlds of clients. Diagnosis can also be liberating to clients by offering an explanation to them and allowing them support from hitherto inaccessible sources, such as community mental health teams, or in patient care. However, diagnoses should not become all encompassing to the clients identity and needs. There is a risk that professionals can stereotype certain client populations by offering a generic and overly structured therapy purely based on the diagnosis. To try and prevent diagnostic processes being traumatic to the client and family post diagnostic therapy is essential. This can help prevent stigmatisation within the family, and the client hiding behind the diagnostic label and losing sight of themselves as an individual. Further, care should be taken when diagnosing complex disorders such as BPD to ensure accuracy. Some of the issues surrounding diagnosis have been highlighted in this report and it is therefore recommended that a thorough and holistic approach is adopted, so that clients’ (like Miss Siegel) individuality are not lost among the diagnostic criteria.
References

American Psychiatric Association. (1994). *Diagnostic criteria from DSM-IV.*


Therapeutic Practice
Dossier
Therapeutic Practice Dossier

Chartered Counselling Psychologists are trained to work psychotherapeutically with clients with a broad range of psychological difficulties and disorders. They work in a variety of settings including primary care, community mental health teams, and social services (Wilkinson and Campbell, 1997).

This dossier illustrates my training as a counselling psychologist over four year long placements. It contains a short description of each of my placements in a variety of settings with diverse client populations presenting a broad range of psychological difficulties and disorders. These also present my roles as a psychologist within the National Health Service (NHS) and educational systems. An extended essay that reflects upon my integration of theory, research and therapeutic practice within the therapeutic relationship is included. Due to the nature of this work, client names, initials and any identifying information have been altered to preserve confidentiality.

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My first year-long placement was in primary care. Counselling psychology services had been available in this surgery since 1994. Since then this service had grown to offer group therapy as well as individual psychotherapy.

At the surgery there were 13 doctors who all referred patients to the counselling service. There was also one psychiatrist and a large chiropody and dentistry department as well as five district nurses and seven health visitors.

The patient group for the psychology department was local people registered at the surgery, who were referred by their GP. At the time of writing this, there was a two month waiting list, but everyone was seen for their initial assessment within three weeks. The clients were treated with a mainly psychodynamic approach in short-term therapy, around eight sessions. I offered clients between 4-12 sessions of individual psychotherapy depending on their presenting problems.

I worked at this placement for two days per week. Over the course of the year, I worked with 17 clients individually and four clients jointly with my supervisor. My weekly supervision was integrative as my supervisor was a counselling psychologist and integrative psychotherapist.
SECOND YEAR CHILD AND ADOLESCENT MENTAL HEALTH SERVICE
PLACEMENT

My second year-long placement was at a Child and Adolescent Mental Health Service (CAMHS) in which I worked as part of a multidisciplinary team. The multidisciplinary team consisted of psychotherapists, counselling psychologists, clinical psychologists, educational psychologists, social workers, primary health care workers, GPs, family therapists and community psychiatric nurses.

Children and families were referred to this service through primary care, hospitals, schools, social services and the police; no self-referrals were accepted. Once a referral had been received it was taken to an intake meeting where a treatment plan was decided; whether to treat it as an emergency and be seen within two weeks or whether to put it onto the waiting list. The waiting list was around six months.

The client groups were mainly children, adolescents and their families. The infants who were under five years old were treated in a psychodynamic therapeutic playgroup. Children aged five and over were treated in family, individual or group therapy. All initial assessments were completed with a parent or carer present in order to comply with the ethics of working with minors. Subsequent therapy was contracted on an individual or family basis.

Children and their families were offered individual and/or group therapy on either a long- or short-term basis. The work was carried out by either one therapist or by different teams. I worked integratively, but with a psychodynamic and systemic focus offering long term, therapeutic intervention. While at this placement I worked with three adolescents individually, one family and six therapeutic dyads, the young client and a parent. I saw all of these clients for the full year. I also co-ran the psychodynamic therapeutic playgroup for the full year and a ten-week parenting group. My weekly supervision was principally psychodynamic and systemic.
THIRD YEAR EARLY INTERVENTION PLACEMENT

This was a paid placement with a London council health education team. I worked as a counselling psychologist in training with the counselling psychology service in a primary school. I helped run a one-day-a-week counselling psychology programme for a primary school.

Teachers referred the clients. I worked with six children on an individual psychotherapy basis, I saw them fortnightly from September-April. Furthermore, I also ran groups to help children involved in bullying and those with identity issues. I also worked with one family and one mother and child dyad. Moreover, I ran an open door lunchtime, the rationale for this was that any of my clients could come and talk to me in private during their lunch hours. I felt this was particularly useful given that I only saw some children fortnightly and they sometimes needed to see me more urgently.

As this was a pilot project I was involved in a core group assessing and evaluating this venture. I was also an integral part of devising a future strategy and a protocol for its implementation.
THIRD YEAR COMMUNITY MENTAL HEALTH TEAM PLACEMENT

This paid placement was within a learning disability community mental health team for one day a week for a year. I was the only counselling psychologist in training among clinical psychologists, trainee clinical psychologists and assistant psychologists hoping to become clinical psychologists. In the beginning, this occasionally presented me with issues of credibility. However, this gave me good practice in interpersonal and diplomacy skills required to form alliances and working relationships within somewhat hostile cultures within the NHS structure, which I am sure will be of benefit later in my professional development.

Other disciplines present on this team were; psychiatry, clinical psychologists, care managers, speech and language therapy, social workers, key workers and community outreach workers. The psychology department was based across three sites we had departmental meetings fortnightly.

I worked with three clients on a weekly basis for one year. With one of these clients and their parents I undertook some short-term systemic family therapy. I was also greatly involved in care staff training. This training focused on increasing client empathy. My work was integrative but with a cognitive behavioural and systemic focus, this was mirrored in my supervision.
TOWARDS A PERSONAL THERAPEUTIC FRAMEWORK

Introduction

The intention of this paper is to present a personal statement about my development thus far as an integrative counselling psychologist and to present my own approach to clinical practice. In order to do this, I will combine my experience of practice with elements of my learning, theory, training, supervision, and research. I have not only tried to use different therapeutic approaches in my clinical practice, but also to incorporate population specific skills acquired during my work with children, adolescents, and adults with learning disabilities. Examples of my integrative approach with certain clients7 will also be given in this paper.

I am not suggesting that integration is the only way of working therapeutically, neither am I implying that development as an integrative practitioner is a clearly defined process. Indeed, I constantly find it difficult to decide whether I am working within an integrative or eclectic paradigm. Norcross and Grencavage (1990) summarise the differences between these two approaches. They state that eclecticism is “a technical process and focuses on applying different parts of theoretical approaches to form a selected collection, which is the sum of its parts” (1990: 2). They also believe that integration is: “a theoretical process combining many different approaches to create a new therapeutic approach, which is more than the sum of its parts” (1990:3). I recognise both of these processes in my work. Furthermore, I also feel that it is possible to work with approaches that are really incommensurable, such as behavioural techniques and unconscious processes. It is inappropriate to compare these two paradigms, as they are very different but equally valid in the proper context. I would never say that I ‘integrate’ these two approaches, as I believe this would be theoretically and epistemologically impossible. I prefer to describe my work as client focused and ‘incorporating’ rather than integrating, in that I keep a range of

7 In order to protect client confidentiality all potentially identifying client information has been disguised to preserve client anonymity. Disguised titles are used for adult clients, pseudonyms are used for clients under the age of 18 throughout.
approaches and techniques in mind and use those that I feel are pertinent for the client’s individual needs. Theoretical knowledge is vital in this approach because, without a clear rationale to govern the choice of therapeutic approaches this way of working might simply be a method for disguising incomplete knowledge.

Furthermore, I recognise the importance of empirical research to practice and the need for counselling psychologists to be scientist-practitioners as well as practitioners. Clarkson advocates that counselling psychologists’ unique strength derives from our “emphasis on the systemic application of distinctively psychological understanding, based on empirical research of the client and the counselling process, to the practice of psychological counselling” (1998: 3). Understanding the most current research about the therapeutic approaches, which are most appropriate with certain clients in specific situations, helps counselling psychologists to be clinically accountable for their work, which is both a professional and ethical requirement.

The humanistic perspective

I find the client centred approach extremely useful. By focusing on providing the Rogerian (1951) therapeutic elements of ‘empathy, unconditional positive regard and congruence’ I am able to begin to engage clients in a safe therapeutic relationship. Developmental ideas can be applied to this approach as the core conditions parallel Bowlby’s (1988) conceptualisation of the ‘secure base’ (the space a primary caregiver provides for their child to explore his/her environment). If this secure base is not provided appropriately, children can develop complex problems with their attachment to their primary care giver. Similarly, Rogers’ (1951) core conditions are designed to provide the client with a compensatory and reparative therapeutic secure base. The therapy can help the client feel valued within an atmosphere of unconditional positive regard. This can be internalised by the client in the same way that a child can internalise the ‘glint in their primary carer’s eye’ (Meins, 1997).
Mr. J, a 55 year-old man with a moderate learning disability was referred due to problems with managing his anxiety. His fear of the neighbourhood boys was preventing him from leaving his house. In order to try and lessen his anxiety about the therapeutic encounter with me, I tried in the first three sessions to create a safe and understanding environment for him by being empathic, congruent and portraying unconditional positive regard. This latter core condition is vital when working with adults with learning disabilities: Kroese, Dagnan, and Loumidis (1997) found that adults with learning disabilities often report feeling infantilised. I constantly tried to convey that I had understood him by using humanistic skills such as summarising and paraphrasing without being judgmental or patronising.

This experience of an interaction in which he felt respected seemed to have a dramatic effect on Mr. J. At the end of our second session he tearfully told me that 5 years ago he had attempted to coerce his 13-year-old niece into masturbating him. She had fled in great distress and his family had been very punitive towards him, stopping his access to therapeutic support. This had resulted, amongst other things, in his feeling very ashamed whenever he encountered adolescent boys. I formulated that this was because he unconsciously feared that these teenage boys might punish him for his inappropriate sexual desires. To summarise, my expression of the person-centred core conditions empowered Mr. J to break his self-imposed silence and voice the reasons for his anxieties.

This client work also raised child protection issues. After Mr. J’s disclosure I held a professionals’ meeting to discuss Mr. J’s risk to other adolescents. Although no incidents had been reported over the last seven years, we still felt it was important to provide Mr. J with security and containment. This was particularly relevant with the commencement of therapy, which might bring these issues to the fore. A care manager was assigned to Mr. J who could both run continuous risk assessments and increase his level of support. This is an example of the tension between maintaining confidentiality as an empathic therapist and being part of a healthcare service with a responsibility surpassing the therapeutic dyad. However, I felt I managed this
appropriately as I engaged well with Mr. J while following the local vulnerable adults policy.

The humanistic perspective was my first experience of the therapeutic relationship as both context and content of therapy. It is the ‘context’ of therapy because it provides the pre-condition for therapeutic change; as well as the ‘content’ of therapy because an experience of a positive therapeutic relationship with these core conditions can empower client self-actualisation (Rogers, 1951).

The therapeutic relationship has been a defining feature of my clinical practice, as is evidenced in my supervisors’ reports and I have always been commended for my ability to form appropriate therapeutic relationships. This emphasis towards the therapeutic relationship as a key aspect of any therapy has continued throughout the duration of the course and across the three main therapeutic paradigms.

However, this emphasis is both advantageous and problematic, as the therapist’s role associated with the therapeutic relationship differs between paradigms. Within the person-centred relationship the therapist is ideally relationally positioned alongside their client. Within psychodynamic therapeutic relationships the therapist is ideally ‘slightly standing back’, thereby allowing the client to project onto them. Finally, the cognitive behavioural approach really encourages a collaborative and educational therapeutic relationship, although this is also underpinned by the client-centred core conditions. In all of these paradigms the therapeutic relationship provides a contained context for therapeutic change.

The psychodynamic perspective

Bateman and Holmes wrote: “The hallmark of psychoanalysis is the use of transference and counter transference as a guide to understanding the inner world of the client” (1995: 95). I have found working with transference the most difficult and rewarding challenge thus far in my development as an integrative practitioner.
Transference is the clients’ unconscious communication; counter transference is the therapists’ unconscious communication. Although the term ‘counter’ implies it is reactive this is not always the case. The therapist can communicate his or her own issues within the therapeutic relationship through proactive counter transference. The client may then unconsciously identify with these and internalise them as well as communicating them back to the therapist as reactive transference. Clarkson (1995) believes this may result in the therapist interpreting the client’s reactive transference as proactive, which may result in the therapist treating his/her own issues within the therapeutic relationship. Jacoby (1984) explains that this is because patients and neurotic therapists can recreate characteristics of past primal relationships within the common unconscious of the therapeutic relationship.

Similar issues exist with projection. Money-Kyrle (1956) describes patient-to-therapist projection as the client speaking, then the analyst identifying with the client speaking and, after introspectively comprehending, re-projecting and interpreting. However, the most potentially destructive part of this process is the projective phase where the patient represents to the analyst an immature or ill part of themselves or their damaged objects. The analyst may then interpret their own damaged objects to the client and the therapy will then focus somewhat on the therapist’s issues rather than the client’s. These transferenceal messages are not exclusive to therapeutic contexts but occur in all everyday interactions. However, because of the ‘nature of the therapeutic setting’ they have a profound effect on the therapeutic process. The practical consequence of these issues is that I have needed to develop personal insight into my own unconscious processes.

In order to create a containing therapeutic relationship for unconscious communication I have tried to incorporate my experience of safe therapeutic settings within personal therapy and supervision into my own clinical practice. My therapist and my supervisors paid great attention to the frame and consistent boundaries, and consequently, they always presented a congruent use of self. This resulted in my feeling safe enough for self-exploration in therapy and for critical analysis of my
clinical work in supervision. By attempting to mirror this in my work with clients, (Detrick, 1989) I feel I enable the clients to feel safe enough for self-exploration within our therapeutic relationship.

Further, I have learnt much from focusing on maintaining the frame within a therapeutic relationship (Langs, 1979). I try to explore clients' reasons for breaking the frame to see whether it is perhaps symbolic of resistance, a sense of being overwhelmed, or anger towards me that may or may not be deserved. I feel that within this context the exploration of negative emotions is incredibly useful.

Also, due to my focus on the frame and my use of self as an aspect of that frame (Langs, 1979), I have decided that in the main I will refrain from self-disclosure during my clinical work. Casement (1985) wonders for whose benefit therapists do self-disclose; - their own or their clients. Whenever asked a direct question about myself I try to understand why that particular question is important to the client rather than to simply answer it. This is particularly problematic when working with children because they ask a lot of questions. Towards the end of the day one of my ten-year-old female clients asked me where I lived. We had just been talking about her feelings concerning her imposed exodus from Jamaica and my first reaction was that she wanted to know how I felt about my home. I stopped myself from just answering her question and asked instead what it was about where I lived that was important? She became quite cross, perhaps understandably, as normal social etiquette is to answer people politely rather than question their motivation. She retorted that she wanted to know if I lived near. I replied, “near to you?” She then explained that she wanted to be able to come over for tea and perhaps stay the night occasionally whenever her mother became exceptionally ‘low’. This clearly opened up a whole other focus in our therapeutic relationship that would have been lost if I had simply answered her question. After this I also reflected on how answering her first question might have intimated that we had a special friendship, which would raise her hopes that I would take her home with me. I was pleased with the way I had handled her
question, and it reinforced my resolve to be very careful about personal self-disclosure.

The following case presentation, Ms. S, is an example of how I have found integrating humanistic and psychodynamic approaches to be helpful. I feel that by providing this client a secure base and offering her unconditional positive regard, empathy and congruence, she was able to use the therapeutic relationship to explore her experiences. Further, by offering her some insight into their cause (psychodynamic interpretations) therapy empowered Ms. S to take better care of herself.

Ms. S was a very articulate 27 year old female solicitor who had developed binge eating as a defence against verbally expressing her emotions to her family or ex-partner. Her mother, whom Ms. S remembers as ‘very good’, had died from breast cancer when Ms. S was 12 years of age. Her father remarried 18 months later to a woman Ms. S reported ‘hating’. I used Klein’s (1946) notion of splitting of the good and bad breast to help with my formulation. I felt that she was consciously and unconsciously communicating her split feelings towards me. Sometimes I would feel overwhelmed by the desire to rescue my client and be everything to her, whilst at other times I would feel she ‘hated’ me for letting her down. I felt her hatred the most when we discussed her feelings about endings, such as her mother’s death and the ending of therapy.

Kleinian object relations theory (1952) was also pivotal in the development of my understanding Ms S who had lost her good object at the crucial latency period of development and had not replaced it since. I postulated that, as an adult, Ms. S was attempting to recreate an internal good object using food, and at the same time punishing her body because she constantly worried that it would betray her and that she too would die of breast cancer. After much supervision, I interpreted this to Ms. S. This seemed to have a positive effect and she began to talk about feeling split off from her body as though her real self were only her head. Ceasing binge eating was
not instantaneous, but in the therapy she did manage a break-through. She reported reminding herself about the reasons why she wanted to binge the next time she had the urge and booked herself in for a massage instead. By the end of therapy, Ms. S felt more positive about herself, and she reported feeling that there was less of a discrepancy between her ideal self and actual self. Further, she could more truly be her own good object.

I believe this case illustrates that much pathology is developed in childhood and that typically our current issues and problems are a product of repetition compulsion, Freud (1912). I have consequently sought to integrate developmental psychology with clinical practice. However, I also keep in mind Weisskopf-Joelson (1955) criticism of psychotherapy’s focus on developmental causes for all adult pathologies. Weisskopf-Joelson wrote “Although traditional psychotherapy has insisted that therapeutic practices have to be based on findings on aetiology, it is possible that certain factors might cause neuroses during childhood and that entirely different factors might relieve neuroses during adulthood” (1955: 130). By keeping this in mind, I remain open about the source of adults’ maximum point of pain (Hinshelwood, 1994).

The cognitive behavioural perspective (CBT)
The basic principle underlying this approach is that people are distressed not so much by events as by the meanings they attribute to them. Cognitive behavioural approaches advocate that these meanings can be maladaptive and changed by logical challenge. Initially, I had some concerns about this approach, such as, feeling that it ignored the unconscious, and cast the therapist in the role of educator rather than ‘skilled helper’. Binder (1993) criticised this paradigm because the therapeutic relationship can become lost in a prescribed approach to treatment. However, with increased exposure to this therapeutic approach I discovered that my criticisms of it were somewhat naïve. Although, I still believe that ignoring unconscious influences is a disadvantage, I have also found many benefits by incorporating this approach into my clinical practice.
Recent cognitive behavioural theory places more emphasis on the therapeutic relationship. Teyber (1992) considers that it is the therapist’s skill in constructing an atmosphere of ‘openness of exchange’ which allows the client to challenge their core beliefs. Further, Teyber (1992) and Overholser and Silverman (1998) found that openness of exchange results in the client feeling able to express their negative emotions and, contrary to their first belief, discover that they are tolerable and not dangerous. Moreover, Rudd and Joiner (1997) specifically designed the ‘Therapeutic Belief System’ to enable the therapist to have a framework for openly attending to the relationship within the cognitive behavioural therapeutic process. This enables the therapist and client to incorporate readily accessible peripheral cognitive structures such as automatic thoughts, related assumptions, and compensatory strategies as well as core schemas and tacit beliefs.

Safran (1990) incorporated CBT, developmental, schema focused, and relational factors to conceptualise his interpersonal approach. Safran (1990) theorised that early interactions with significant others results in the development of interpersonal schema. Interpersonal schemas govern how infants explore their world. These schemas develop into internal working models and a program for maintaining relatedness, a cognitive interpersonal cycle that repeats throughout the life span. This theory has influenced my practical work and my conviction about the importance of the therapeutic relationship. If we develop in relation to one another, interpersonally, then we can only change intra personally in relation to one another. This concept has formed the basis of my personal integrative framework.

**Systemic approaches**

The aim of systemic therapy is to increase transparency of communication and empathy within the family system and other relevant human systems (Jones, 1993). This was extremely effective in the following client presentation.
Justin, a ten-year-old schoolboy, was referred because he had been suffering from facial twitches and headaches for 18 months. I initially saw him for individual sessions. His historic narrative focused on his 5 year old memory of witnessing his father being savagely attacked in his own home by four men wielding baseball bats. I formulated this case using Klein’s (1952) concepts to explain the root of his anxiety.

Klein (1952) theorised that early introjections, unconscious memories and early experiences of primary object relations construct the super ego. Primary object relations are caused by early fears, of which Justin had many. The first fear is the death instinct and at 5 years of age Justin had literally feared for his own and his father’s lives. He had a pronounced fear of annihilation, which is the primordial cause of persecutory anxiety. Consequently, Justin was continually anxious that he and his family were being persecuted. I hypothesised that his anxiety was expressed through his body, by his facial twitches and headaches.

During my formulation, I also had to consider child protection issues in accordance with the 1989 Children’s Act. I had to reflect upon, and assess, whether the assault witnessed by Justin was retaliation for something his parents had done, and was Justin, consequently, at risk. After completing a thorough assessment it seemed that this was not the case; the assault seemed to be a political and racist attack typical of the area of Northern Ireland in which they had lived.

As his presenting problems were so ingrained in family experiences and actions I decided to work systemically with the family, thereby integrating family therapy. I continued with the individual sessions and saw the family together at different times so that there was no break in the frame of the individual sessions. My aim was that Justin should not, once again, feel his space had been invaded, although I did realise that it might be difficult for him to voice his negative feelings towards a therapist who also knew his family.
At the beginning, both Justin and his family found it very difficult to trust me and to use the sessions. They were eventually able to do so because I tried to provide a safe space within which they could work by communicating Roger’s (1951) core conditions, thereby integrating the psychodynamic and humanistic paradigms. The parents seemed to mirror this by the provision of a safe space in their home environment. They stopped going out to the pub so frequently and, when they did, they asked a loved and trusted grandparent to stay with the children rather than to hire a babysitter.

I employed circular questioning during which Justin communicated his understandably mistrustful and fearful view of the world stemming from his core belief that he and his family were under siege. Justin often reported that his parents were very anxious, when really they felt quite calm. It also transpired during the sessions that Justin felt that he had to protect his family, because he thought his parents were overwhelmed. This resulted in separation anxiety because of a fear of what might happen to them in his absence, and therefore constant school refusal. During circular questioning the parents realised that situations they concealed from the children to protect them actually made the children more fearful because they distorted their perceptions of what was happening. His parents thought that the children were far less aware than they really were.

As the parents’ empathy increased, they encouraged the children to talk about their feelings rather than dismiss them and they tried to explain situations, such as family arguments, instead of trying to conceal them. Furthermore, during therapy the parents explored their own roles in the incidents presented, which they managed to communicate to their children. This increased the transparency of communication within the family challenged Justin’s core belief that his family were passive victims of a violent world.

The result was that Justin perceived his parents as survivors capable of protecting both their children and themselves. He therefore seemed to fear annihilation less and
was able to allow himself to relax rather than constantly to be on guard. His core belief about the world as dangerous was challenged by awareness that his parents had influence over some of their experiences, and even when they did not, they survived. He seemed to feel safe and have a more age appropriate self-concept, which was helped by his parents’ increased empathy towards him. The family were all very positive about this piece of therapeutic work.

Towards a personal integrative framework

As previously mentioned I rely on the following common factors; the therapeutic relationship, therapeutic frame, therapist’s use of self and contextual factors (Frank, 1978) to provide a framework. I therefore try to maintain congruent common factors across all of the three perspectives.

I always attend first to constructing a strong therapeutic relationship. For this reason, I prefer not to take notes in the session as I feel this creates a physical barrier and emphasises a power imbalance between the note taking professional and the client. I always try to maintain a congruent and consistent frame, paying attention to any breaks, regardless of the therapeutic paradigm I am working with. This has posed problems in my work with adults with learning disabilities as some practitioners engage in therapeutic work in the clients’ homes. I prefer not to do this because I feel that it would project a very mixed message to engage in a therapeutic rather than a social relationship with a client while sitting in the clients’ living rooms.

Another common factor in my practice is my use of self. I try to present a congruent use of self with each client in all therapeutic and professional settings. My use of self may alter between clients depending on the focus of our work, but I try not to confuse my clients with an inconsistent use of self within our therapeutic relationship. This is particularly difficult in meetings with both professionals and the client, as there is often a conditioning to respond to the other professionals as a peer group, which would, I feel, isolate rather than support the client.
Another way I monitor my use of self is through really considering my use of touch. On the whole I try to avoid touch as I feel it can send confused messages to the client and in some occasions give them more issues to deal with. For example, if I were to take, when offered, the hand of a young client struggling with their home life, they may see no reason why I would not keep hold of their hand and lead them to my home and, thus, help them to physically escape their difficulties. When reflecting upon this topic I mainly consider both Yalom’s (1985) and Casement’s (1985) writings.

Contextual factors such as confidentiality and boundaries are the final common factor to which I am bound; these are ethically and therapeutically vital for a positive outcome. The common factors could be described as the foundations to my ‘integrative house’ (Hollanders, 2000), into which I invite different approaches. This metaphor fits my personal philosophy about human needs for safe internal or external spaces. Hopefully my therapeutic relationship provides a safe house from which clients can begin their exploration. I try not to be agoraphobically bound to my house’s foundations (Hollanders, 2000) but, rather, to constantly bear them in mind, as a form of internal supervisor (Casement, 1985).

However, I also try to work with significant epistemological and pragmatic difference as well as commonalities between the approaches. As mentioned in the introduction, I believe that in certain cases significantly different approaches can be borne in mind simultaneously.

While therapeutically engaging with Ms. A, a 36 years old learning disabled female she began self harming by scratching her arms. As a short term crisis intervention I devised a behavioural chart to reward days when she did not self harm, I also considered my counter transference. My counter transference was mainly guilt and fear that I was not being a ‘good enough’ therapist. After thinking about it in supervision I felt that this was reactive counter transference and could therefore inform me of some of Ms A’s reasons for self-harming. These seemed to be based upon her desire to prevent further abandonment because she was ‘not a valid or good
enough person'. Once we had implemented the behavioural chart as part of her routine with care staff, we began to explore her feelings and reasoning behind her self-harming, and I used my counter transference as a guide to my therapeutic interventions.

This is not to suggest that I integrated these two approaches, rather that I held the impact of unconscious communications in mind while (temporarily) working behaviourally. This was important to adequately meet this client’s needs and to respond to her communication of distress through self-harming on both an explicit and implicit level. The behavioural chart responded explicitly to her self-harming behaviour, and talking about the reasons for it and listening to her transferential messages responded implicitly to the cause of this distress. Further, the behavioural technique was designed to ensure that the care staff team were involved as they would have to continue the approach with her, thereby strengthening her care system’s support and empathy.

As the above example illustrates, I believe that the psychodynamic approach can be slightly altered to work with any of the client groups of which I have had experience. When working with children in my second year psychodynamic placement, I often tried to work with both parent and child. My rationale for this was that children are dependent on their support systems. If changes were to be permanent, they also had to occur within the child’s family or home environment. This therapeutic rationale has some parallels to systemic family therapy, which is why I attempt to integrate them. I would never make explicit the feelings a child was evoking in me but instead use my counter transference to inform my interventions. I would, however, make transference interpretations to the parent of the way they were making me, or perhaps their child, feel. Schema focused and humanistic core conditions and developmental theory can also be integrated with psychodynamic therapy as following example illustrates.
The presented main concern in relation to Benjamin (9 years old) was his continued use of a dummy. His father felt that Benjamin had 'seen too much for his age'. This appeared to be based on his parents' volatile and somewhat abusive turbulent relationship. Benjamin's alcoholic mother was mostly absent because her visits were erratic and unreliable. However, these topics were rarely discussed between father and son for fear of upsetting each other.

These factors initially caused me some concern as to whether Benjamin's care was appropriate or whether his living situations contravened the Children's Act 1989. However, his father seemed very careful never to leave Benjamin alone with his mother. Because of her alcohol abuse he arranged for his mother to visit Benjamin at his maternal grandmother's house. His care may have been retrospectively questionable at the time of his parent's separation but it currently seemed appropriate and his father certainly tried very hard to look after his son well. I did, however, continue to reflect upon the extent to which Benjamin received appropriate care. Whilst so doing I incorporated Samuels' (1993) theory that children can have mothers or fathers of any sex, as it is appropriate parenting that is important rather than cultural perceptions of what constitutes 'mothering' or 'fathering'.

I formulated that Benjamin's dummy was a transitional object representing his need for comfort to help him cope with separation from his mother. It may have also symbolised a plea for help that he felt unable to voice. He could not cope with his parents' separation and acrimonious behaviour, or seeing his mother under the influence of alcohol.

I incorporated Vygotskian developmental concepts (1976) into this clinical work. Vygotsky believed that humans are innately social and consequently children learn best through interaction pitched just above the child's lone functioning level. I tried to facilitate client change by pitching therapeutic intervention and interpretation at a level Benjamin and his father might not have reached alone but could achieve with
therapeutic guidance. I also took care not to over-emphasise my role so that neither client would feel rejected or abandoned when the therapy ended.

I also encouraged increased transparency of communication between father and son. One of the issues they needed to talk about was that Benjamin constantly feared abandonment by his father. Johnson (1994) wrote that abandoned children spend their lives trying to prevent what has already happened (their abandonment). His father attributed Benjamin’s constant need for reassurance as stemming from ‘babyish’ behaviour rather than a real fear of abandonment. I therefore tried to help Benjamin and his father to explore this element of their relationship. This is presented in the following dialogue of a session between myself, Benjamin, his father.

| Benjamin: Sometimes at night I cry because I am worried about you, Mummy or Granny dying |  |
| Client’s Father: *I think that’s normal when I was little I used to do the same, I don’t think that’s it anything you should worry about I’m sure we’ve all done it and I think most of your friends cry about that as well its something most children worry about.* |  |
| Benjamin: mmmmm (smiles) |  |
| Therapist: *I’m wondering how you’re feeling about it now having told Daddy, Benjamin* |  |
| Benjamin: Fine (pause) |  |
| Therapist: *and I’m also wondering how your feeling about what Benjamin has told you.* |  |
| Client’s Father: *I’m glad he has said if it was worrying him. But I don’t think he needs to because I’m sure it’s normal to do that when you are little.* |  |

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*Benjamin is presented in standard font, his father in italics and myself in bold.*
These interventions are based on systemic principles of gaining another family member’s reaction to what has just been presented. However, I was not sure that Benjamin really felt ‘fine’ because his father was very quick to reassure and normalise and as Casement (1985) advocates reassurance never reassures or contains. Therefore, I tried to explore this interaction further.

| Therapist: | I notice that you are very quick to reassure Benjamin that its normal and that everything’s fine, |
| Client’s Father: | I think he was worried about telling me because it is sometimes hard to admit your feelings. |
| Therapist: | Yes and I think it is hard for Benjamin to talk about his fear of abandonment and perhaps hard for you as well because then you both have to engage with your past relationships and feelings regarding Benjamin’s mummy and all that has happened. |
| Client’s Father: | yeah maybe (laughs) mmm |

This response suggests there is some truth to my interpretation. This interpretation is based on naming the taboo scripts within their relationship so that real exploration and openness of exchange can begin. My intention was to use this to decrease insecurities within the attachment. Indeed, after one year of therapy, Benjamin no longer used a comforter and emotional conversations, trust and empathy between father and son had greatly increased.

In my infant status as an integrative practitioner I relied on external supervision for evaluating my work. However, I have since begun to internalise supervision and started to use the same criteria for self-evaluation. I have also become somewhat more adept at listening to client feedback, both conscious and unconscious, and this has proved vital for evaluating my work. I now feel I am a competent autonomous
practitioner with a much clearer personal framework and approach to therapeutic practice upon which I can continue to build as my experience and personal and professional development progress.
References


Research
Dossier
Research Dossier

_We were upset being an asylum seeker, you’re stigmatised; you’re poor; you’re nothing. Even though we had come from good homes. Nobody would trust you; nobody would lend you money (Muna⁹)._

Three research reports are included in this dossier, one from each year of the course. Together, they constitute a research programme that investigates attitudes towards asylum seekers.

The initial paper is a review of attitudes towards asylum seekers as expressed in psychological, political, and societal literature and in asylum seekers self reports as presented within psychological works. Using an Interpretative Phenomenological Approach (IPA), the second report analyses the themes generated from interviews with asylum seekers focusing on the asylum seekers own stories about and attitudes towards their experiences. Finally, the last report builds on the previous research projects and explores mental health professionals’ attitudes towards asylum seekers and their implications for practice.

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⁹ Muna was an asylum seeker from Bosnia, presented in: Weine, S. (1999). *When history is a nightmare lives and memories of ethnic cleansing in Bosnia-Herzegovina*. London: Rutgers University Press.
ASYLUM SEEKERS: VICTIMS OR SURVIVORS? A REVIEW OF THE LITERATURE

Abstract

This literature explores psychological attitudes towards asylum seekers. Political and media attitudes towards this population are also explored. These are compared to psychological attitudes in order to try and understand the perceptions of society and its member cultures towards this vulnerable population. Asylum seekers' self-reports\textsuperscript{10} are also explored to ascertain if these have any impact on the attitudes of others.

This review is felt to be timely given the ever-increasing controversy around the topic of immigration. Furthermore, psychological attitudes appear to be more judgmental than perhaps one would hope. Asylum seekers are now being refused treatment from some National Health Service (NHS) mental health settings on the grounds that they are too damaged. This attitude corresponds to the common societal attitude, often expressed in the media, that asylum seekers are damaged victims. Another common societal attitude, expressed in the media, towards asylum seekers is that they are criminals. These two views are obviously polarised. Also, polarised attitudes towards asylum seekers exist in the psychological and political attitudes. Psychological literature describes asylum seekers as either damaged victims or survivors. Political literature treats asylum seekers as deserving versus non-deserving. Such dichotomous thinking is perhaps damaging to an already vulnerable population. The asylum seekers self-reports reported in psychological literature, correlates exactly with the professional opinion. Reasons for this are explored in this report.

\textit{Key Words: Asylum Seekers, psychological, political, societal, attitudes, self-reports.}

\textsuperscript{10} As reported in psychological literature.
Use of Self as Researcher

[I have chosen to devote the research element of this course to the study of attitudes towards asylum seekers because of a deep personal conviction that this vulnerable client group is not sufficiently supported by British psychological, political and social systems.

I first encountered 'would be' asylum seekers while working in a Romania. Their desperation to leave their troubled circumstances was all consuming for these people and I witnessed them deciding to take ever-increasing risks to immigrate. They were often exploited by criminals who promised them safe and effective passage to Britain in return for extortionate sums of money; some even paid with their lives. Their expectations of their new life were also completely exaggerated and would, I feared, lead only to disappointment.

Having returned from Romania I came into contact both professionally and personally with asylum seekers in Britain and realised that even on a safe arrival their plight was far from over. On the contrary, it was just beginning. They were, as I feared, completely disappointed with their new situations. Although relieved to be out of danger from political violence or poverty, their political and economic struggles were immense. Even more concerning, their reception in this country was at best ambivalent, and at worst hostile. Society seems to have very extreme and dichotomous views towards asylum seekers, who are often judged collectively rather than individually. Attitudes towards asylum seekers are tantamount to cultural prejudice. Yet these people no longer have a culture they escaped prejudice in their original country only to find it in their new country. They have escaped prejudice in their countries of origin only to find it again in their new countries. The asylum seekers I have met tell me that they find it hard to cope with the prejudice because it is everywhere and they have no supportive culture to call their own, within which they could feel accepted. I have seen how this can affect even the strongest and most brilliant of minds.
While finishing my 'masters' degree in anthropology I made friends with a very clever student from Ghana. While most of us enjoyed our graduation he fretted about his impending return. His life would again be in danger and the avenue of escape through a university transfer would no longer be open to him. Despite having invented a new training shoe and published a book he still cannot gain asylum. He feels stateless and at the mercy of friends and employers. He is unwilling to seek any social benefits because he feels that as a PhD he should be self-sufficient.

Asylum seekers have to grapple with prejudice, immigration systems, and political policies, medical and social systems and antagonistic social attitudes. Unfortunately, the attitudes of the caring professions, as presented in this literature review, are also less than helpful.

Through my early professional contacts and personal friendships I have formed my own attitudes about asylum seekers and their treatment within this country. I realise that my convictions could have a disproportionate impact on my research and will therefore try to reflect upon this throughout this review.]
Introduction

The aim of this review is to evaluate recent psychological literature on asylum seekers. Cole's definition of asylum seekers was adopted whilst reviewing the literature: "person who has left their country due to well founded fear of persecution" (1992: 3). [I realise that the employment of this definition may be indicative of some of my non-judgmental attitudes towards asylum seekers. I feel very strongly that economic asylum seekers are no less genuine than victims of torture, and consequently deserve a fair and unbiased hearing.]

This review could be constructed as similar to empirical work because it does not simply concentrate on expert opinion. This is important because as Harris (2002) suggests, mental health professionals are part of society, therefore attitudes towards asylum seekers associated with societal and political cultural patterns may well be present in their consulting rooms. This obviously has implications for counselling psychology practice. Accordingly, this review presents psychological literature on asylum seekers, followed by political literature, media articles and, finally, self-reports. Asylum seekers' self-reports have been included because it is important to acknowledge the other's voice whilst representing them (Livia, 1996). Asylum seekers are 'other' to those who have no experience of their predicament (Wilkinson and Kitzinger, 1996); they will be silenced if their own voices are not acknowledged.

This review evaluates all of these attitudinal representations in the light of both their similarities and differences, and the implications they have for counselling psychology practice.
Societal attitudes, expressed and reinforced within media articles, may influence psychological attitudes and both of these may in turn impact on the identity of asylum seekers. It is also to be hoped that the asylum seekers’ own stories may have an impact on the attitudes of the media and the experts.

Indeed attitudes may have the power to help or hinder the therapeutic process because they can be seen as the architects of the social constructs of reality. How one reacts to an event will correspond with how one feels about it and this in turn depends on existing attitudes. From a theoretical point of view the model that best explains this is the ‘three component model’ of attitudes (Eagly and Chaiken, 1993). According to this model, an attitude is a combination of three conceptually distinguishable reactions to a certain object (Eagly and Chaiken, 1993; Zanna and Rempel, 1988). These reactions are specified as affective, cognitive, and behavioural. Affective reactions refer to feelings or emotions associated with an attitude object, cognitive reactions refer to beliefs or thought about an attitude object and behavioural reactions refer to past behaviours or behavioural intentions with respect to an attitude object.

Griffin (1996), Basoglu (1992), Weine (1999) and Cole, Espin and Rothblum (1992) imply that personal interest with regard to the client group being represented should be stated, as this will highlight possible bias when constructing and presenting the material. Possible bias in this review could stem from a firm political belief that asylum seekers should initially be offered real help before their authenticity has been evaluated, instead of withholding financial and practical help until a permanent visa has been granted (as is currently the case). The attitudes expressed in some current theories of asylum seekers as victims are also a cause for concern. My own feeling after meeting with asylum seekers, and extensive reading for this review, is that they are survivors, not victims.
A dichotomy appears to exist within current psychological literature. On one side of the dichotomy asylum seekers are presented as victims suffering with post traumatic stress disorder (PTSD), traumatisations, culture shock and learned helplessness; they are described as resistant to engage and somatizing. However, on the other side of the dichotomy asylum seekers are described as survivors, resilient and capable. The purpose of this review is not to discuss which is the more accurate representation, as both can be criticised.

Asylum seekers as suffering victims

Within the literature PTSD and a sense of bereavement are often associated with asylum seekers, (Shepherd, 1992). PTSD is classified in DSM IV (2000: 209) as an anxiety disorder sometimes occurring after a very traumatic event. Perhaps typically within this side of the dichotomy McNally (1992) describes PTSD as a very common reaction to asylum seekers ‘trauma of displacement’. Lunde and Ortman (1992) believe attitudes towards asylum seekers are based on the premise that they may feel as though they are constantly reliving painful and disturbing memories. They write that asylum seekers may experience events as recurring through illusions, hallucinations and disassociative flashback experiences. Further, Van der Veer (1998: 4) devised a list of typical experiences for asylum seekers, all of which he believes result in post traumatic stress: uprooting, political repression, detention, torture, other kinds of violence, the disappearance of relatives, separation and loss, hardships exile, and culture shock. Basoglu (1992) extends this idea that most asylum seekers have PTSD by suggesting that this is not a sufficient diagnosis. He argues that a more appropriate diagnosis is ‘on going traumatic stress disorder’ because they are still experiencing traumas whilst trying to accommodate to their new lives. This attitude further pathologises asylum seekers lives and experiences. Papadopolous (2001) believes that this description of asylum seekers perhaps reinforces stereotypical attitudes of asylum seekers as ‘damaged victims’. She claims that if therapists hold the attitude that asylum seekers are likely to be suffering with some form of PTSD or
shock, they can overly focus on their asylum seeker clients’ traumas and ignore other
important aspects of their experiences. However, PTSD is not always pathologised
within psychological literature. Davidson, Hughes, Blazer and George wrote: “many
people with PTSD do not clearly understand that their symptoms are in fact a fairly
normal reaction to a very abnormal event” (1989: 713). Davidson et al. (1989) found
that people with PTSD may suffer from among other symptoms flashbacks, memory
loss and survivor guilt, which greatly concerns them as they feel this is extremely
abnormal.

Van der Veer (1998) writes that culture shock can be described as loss. It is a loss of
love and respect of family relationships. It is also a loss of social status, familiarity of
environment and social situations. Similarly, Eisenbruch likens culture shock to
bereavement: “Because it is also a form of loss, culture shock and cultural uprooting
can be compared with the way people cope with bereavement - with denial, anger,
depression and acceptance” (1989: 5).

The psychological literature also tends to describe asylum seekers as helpless and
‘needy’. Keane, Albano and Blake (1992) construct the therapist as the expert and the
asylum seeker as a very demanding and difficult client. Keane et al. (1992) believe
that asylum seekers often exist in a state of learned helplessness and external locus of
control, resulting in their inability to benefit from short term therapy. Scarry (1985)
states that asylum seekers are frequently too traumatised to be capable of change, and
goes as far as to describe them as resistant to professional intervention. Basoglu and
Mineka wrote: “Victims lose control over their treatment and consequently can
sometimes no longer manage their own stress levels and behaviour” (1992: 189).

Of course it could be argued that refugees may internalise a forced external locus of
control and learn helplessness because of their loss of control over their environment
resulting from torture, forced exile, disappearance of their family or inability to obtain
permanent asylum in a new country. However, as a professional attitude it seems to
be over generalised and damaging to therapeutic outcome. Not all asylum seekers

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will be needy and some will benefit from therapy. If this stereotypical attitude is widely believed therapists will become reluctant to engage therapeutically with asylum seekers (Scarry, 1985). The following quote of an anonymous mental health aid worker presented by Weine illustrates that Bosnian refugees are not only seen as resistant but can be represented as difficult: “I have worked with refugees all over the world, but I have never seen a group behave like this.... The refugees know they must wait, that the process takes time and they accept all this. But these Bosnians do not want to accept any of that. It’s like they experience everything as a personal insult to which they defiantly protest” (1999: 75). However, Roberson (1992) argues that it is not surprising that this population sometimes appear resistant as they have usually suffered an incredible sense of betrayal and are therefore understandably paranoid and untrusting around people, especially professionals or those they perceive as having power. Often people in power originally sanctioned their maltreatment. Having portrayed this more empathic and positive attitude towards asylum seekers Roberson (1992) also expresses the somewhat negative attitude that asylum seekers are unable to verbalise their problems. He advocates that rather than accept their psychological problems some refugees and survivors of torture self-present as medically ill. Yee (1992) agrees with this attitude as she describes elderly refugees as somatizing because they cannot accept that their mental health has been affected by physical experience.

At the extreme end of the description of asylum seekers as victims they are described as being so damaged they have been dehumanised. This has very negative implications for practice because it suggests that asylum seekers may be beyond help. Krystal wrote: “trauma causes a paralysed, overwhelmed state of immobilisation. Clients can block the ability to feel emotions and pain which leads to major inhibitions of other mental functions” (1988: 142).

However, the psychological literature quoted below contradicts this victim construction. This literature is based on the formulation that asylum seekers must
have a tremendous strength and capacity for survival to have been able to escape from terrifying situations.

Asylum seekers as survivors

Bylund argues that asylum seekers have "immense capacity" for survival both physically and mentally (1992: 53). Indeed, Vestí and Kastrup (1992), designed insight therapy on the basis that, with therapeutic help to understand their experiences, asylum seekers could rebuild their self-esteem, take control of their new lives and develop an internal locus of control. Further, Rousseau, Said, Gagne and Bibeau (1998) found that adolescent asylum seekers were able to show signs of resilience if they could make sense of what was happening to them. Basoglu (1992) found that female asylum seekers could become resilient and even empowered if they could make sense of their new roles and feel that they could impact on their environment. Both Rousseau et al. (1998) and Basoglu (1992) suggest that the understanding of new situations could help asylum seekers feel more positive, resilient and therefore perhaps self-empowered. Stiles, Gibbons, Lie, Sand and Krull (1998) also found, among refugees in Norway, that absence of uncertainty led to a more positive perception of their new environment and their self-images. Moreover, Van der Veer (1998) asserts that asylum seekers have both the willingness to engage and the capacity to change with adequate professional intervention. It would seem that some psychologists believe that if asylum seekers can accommodate new information and gain insight into their situation, they can find the inner strength to respond positively because they have once again assimilated an internal locus of control. However, Herbst (1992) argues that even these attitudes reinforce the idea that asylum seekers have to recover. He believes the contrary: some asylum seekers are simply survivors and do not feel as though they have been damaged or need to recover.

However, Palmer and Laungani (1999) believe that all of these psychological attitudes towards asylum seekers judge something that is culturally appropriate as pathological; none of them sufficiently consider cultural backgrounds. For instance, they found that some refugee women brought their families to counselling sessions. They believe that
therapists tend to view this as helpless, needy and indicative of over dependency, whereas Palmer et al. (1999) believe they were involving their families to help implement life style changes suggested in the therapy. Basoglu (1992) also suggests that families rather than individuals may present for therapy because asylum seekers' secure bases have been exterminated. They may be trying to recreate a secure base by totally involving what is left of their separated family.

The attitude that asylum seekers are somatizing could stem from different cultural backgrounds. Palmer and Laungani (1999) found that British women in therapy often describe emotions first and only mention physical symptoms when questioned, and that with Pakistani women the opposite is true. This really portrays an attitude towards therapy. Pakistani women tend to believe in the medical model, believing the therapist to be an expert who will automatically understand them without their having to divulge all, and who will cure them by direct intervention. They may consequently be disappointed and confused by some of the psychotherapeutic approaches.

Finally, perceiving asylum seekers as difficult could result from their appraisal using common stereotypes such as those presented by current politics. Asylum Aid (1999) believe that current political attitudes are somewhat unaccepting especially with the adoption of a 'hard but fair' approach to asylum seekers' human rights. It would seem that the political attitude is that some asylum seekers are real 'victims' and others are malingerers. Nowhere within political literature are asylum seekers described as 'real survivors'. Wilkinson and Kitzinger (1996) term this type of stereotyping as 'othering' and assuming sameness on the basis of one characteristic, which is, in this case, being an asylum seeker.

[I am aware that the existence of the dichotomy within psychological literature correlates with my own thoughts about attitudes towards asylum seekers, as I feel that attitudes towards this client group are often very polarised and judgmental. Therefore, it is possible that I actively sought literature that illustrated this point. However, the fact that I undertook as full a literature search as possible and
considered literature from other areas suggests that these dichotomous and polarised attitudes are a true representation of the expressed attitudes towards asylum seekers.

Political literature

Cuny (1979) found that asylum seekers are moved to the bottom of the socio-economic scale. He attributes this fate to political, social, and economic policies. Joly and Cohen (1989) found that this disadvantaged situation had in fact worsened. They believe the situation has become even more difficult for asylum seekers because of the European Commission’s (1987) decision to create an ad hoc group to develop preventative strategies against people abusing rights to asylum. Harris (2002) believes that, since 1987, political attitudes towards asylum seekers have become semi-hysterical in their suspicion, and now have little regard for the Geneva Convention developed to protect those seeking asylum.

Within political literature there seems to be two polarised attitudes towards asylum seekers, deserving or non-deserving. Asylum Aid (1999) criticises current political attitudes as being antagonistic, especially the adoption of a ‘hard but fair’ approach to asylum seekers’ human rights. Blunkett reported that he wanted to construct a “tough and tender system” which “welcomes real refugees, encourages legal foreign workers, and deals swiftly with false asylum claims” (2001: 4). It would seem that the political hope is that by distinguishing between deserving and non-deserving asylum seekers Britain will be able to fulfil moral obligations to help real ‘victims’ and avoid being cheated by false claimants. This perhaps sets the political climate of the day that asylum seekers are ‘real’ or ‘frauds’. This does not correlate with asylum seekers’ own stories or psychological literature, and is therefore perhaps indicative of the fact that political attitudes are formed proactively rather than by listening and reacting. The attitudes of the politicians may be based more on their own political agendas than responses to the actual immigration situation. At the very least these stereotypical attitudes make Britain a reluctant host.
Harris (2002) questions the ability to categorise asylum seekers accurately, arguing that this attempt to label simply constructs a culture of disbelief. It is unlikely that any human can be truly neutral and listen with a purely objective ear. Injustice must often prevail. Harris (2002) suggests that this injustice perhaps stems from society’s perpetuation of the dismissive trend towards asylum seekers’ needs. Asylum Aid (1995; 1999) similarly argue that this ‘tough and tender’ approach ingrains a guilty until proven innocent attitude into all policies concerning asylum seekers. This culture of disbelief has perhaps worsened since the terrorist action of September 11th, 2001, asylum seekers are not only suspected of fraud, they are sometimes even suspected of being potential terrorists.

[I did not deliberately seek harsh political attitudes in my literature selection. Nor did I consciously search for humanistic critiques of these policies but I am aware that many of the policies presented and the critiques I used emphasise my point that political cultures are suspicious rather than supportive of asylum seekers. However, after reflecting upon this I undertook another search and could not find any critiques that presented Britain as anything like a welcoming host towards this population.]

**Societal literature/media articles**

Polarised attitudes exist in the media as well as in psychological and political literature. The presentations of asylum seekers within the media range from criminals to victims, and they are occasionally presented as survivors. The media constructs readers’ everyday thinking by presenting facts subjectively, loaded with their own particular political bias. It is therefore important to evaluate how asylum seekers are presented in the press as this will impact upon society’s attitude towards them. Further, Harris (2002) writes that psychological attitudes will be influenced by society’s attitudes because professionals are necessarily a part of society.

This chapter considers articles from: The Guardian (Bright and Wazir, 2000: 6; Carvel, 2002: 6), The Observer (Burke, Bright, Thompson and Gitting, 2000: 8), The
Big Issue (Naidoo, 2000: 6; Ghouri 2000: 4) and The Evening Standard (Whitney, 2000: 1; Smith and Birkett, 2000: 1; Adamson and Sawer, 2002: 1). This is not a full cross section of media articles but a representative sample given the practical constraints of this literature review, which includes literature from four large areas: psychological, political, media and self-reports.

Asylum seekers as criminals

The Evening Standard printed an article by Whitney quoting Roger Davies (a stipendiary magistrate at the Horseferry Road Court) as saying to a Romanian mother: “we don’t like people begging with children in this country, you are living on the generosity of the British public…. I have said it before and I’ll say it again the British people are fed up with people like you” (2000: 1). The attitude expressed here is that asylum seekers are equivalent to parasites. What may strike the reader is that Whitney herself seems to construct this as a positive and accurate attitude, because she continues by presenting another asylum seeker who allegedly attacked a lady outside Harrods for refusing to give her any change. Whitney also reports yet another deviant case without counterbalancing it with positive narrative, therefore painting a very biased picture: “a 25-year-old gypsy who threw 67-year-old Lady Joy Berry to the ground and threatened to slit her throat, as did her four-year-old son, after demanding money outside Harrods” (2000: 1). She appears to be endorsing the attitude that asylum seekers are akin to beggars and socially undesirable characters.

The Evening Standard also printed an article one year later by Adamson and Sawer (2002: 1) reporting the inferno at an asylum detention centre. They reported that Group 4 security officers had dismissed claims that the asylum seekers were protesting over a sick woman being handcuffed to a bench. Group 4, instead, claimed that they were just rioting, as prisoners will do if given a chance. This article did refer to the centre as a ‘jail’, and asylum seekers as ‘inmates’, thereby suggesting that it was appropriate to perceive asylum seeker detainees as imprisoned criminals. They also reported the quality of life available to the asylum seekers inside the detention
centre, implicitly expressing the attitude that asylum seekers were not only like criminals but were also ungrateful detainees.

**Asylum seekers as victims**

The Guardian published an article by Bright and Wazir (2000) presenting asylum seekers as victims of commercial greed. They noted that it is estimated that the Government pays £150.00 per asylum seeker per week to private companies like 'Clearsprings', yet immigrants are placed in condemned buildings unfit for human habitation. They followed this up with another article in which they disclosed information about 'Clearsprings' director presenting him as the deviant criminal. Bright and Wazir quote King as saying: “There is nothing in my business or personal past that I would not worry about... sorry, there is nothing in my business or personal past that I would worry about” (2000: 6). This article expressed the attitude that asylum seekers are victims who, having escaped persecution, find their safe haven difficult and abusive.

The Big Issue published an article by Ghouri (2000) also expressing the attitude asylum seekers are victimised by British systems. She asserts that Kosovan children are victims to British political inhumanity because they and their families are being forced to return to Kosovo. Ghouri wrote: “These children and their families have been betrayed. It’s not like they came here in the back of articulated lorries. We invited them here because they were the sickest and neediest in the camps. They are still sick and needy”. She reiterates this by quoting The Refugee Council’s opinion: “sick and vulnerable Kosovans are being kicked out of Britain in breach of UN guidelines” (2000: 4).

The Evening Standard ran an article by Smith and Birkett (2000) about the tragedy of 58 Chinese youths dying in a lorry in Dover. This article expressed the attitude that asylum seekers are not only victims of their countries’ problems but also victims of those unscrupulous enough to profit from other people’s desperation. They wrote about the crime of human trafficking, which exploits and harms so many asylum
seekers. The Observer published an article by Burke, Bright, Thompson and Gitting (2000) expressing this attitude. They stated that the authorities are blaming the human traffickers, the only criminals in the case. In this case asylum seekers are being sympathised with rather than criminalised for attempting to illegally enter this country, perhaps because they died trying.

The Guardian recently ran an article by Carvel (2002) expressing the attitude that asylum seekers were even being victimised by the caring professions. This article reported that NHS services refused treatment for asylum seekers on the grounds that they are too traumatised and damaged. This may be an example of the dangers of holding generalised polarised attitudes. Asylum seekers are commonly presented as victims both in the psychological literature and media articles; this stereotype may now be being considered as fact with very negative implications for practice. Indeed, this article likens psychologists' attitudes as tantamount to racism.

Asylum seekers as survivors

This is the rarest attitude towards asylum seekers, however, Herbst (1992) suggests it is the most authentic. The Big Issue published an article by Naidoo (2000), which described a Bosnian asylum seeker as a 'hero' of the Bosnian concentration camps. He wrote “After several months in therapy Pervanic swiftly mastered English and went on to study for a degree in management studies.... He is responsible for setting up ‘Association of Concentration Camp Survivors” (2000: 6). Here the attitude is being expressed that the asylum seeker can be a crusader. Further, this article did not present the asylum seeker as a passive victim but as someone capable of fighting for his or her rights.

[Although I found some of these articles quite shocking in their condemnation of asylum seekers I have tried to present a fair synopsis of media attitudes towards asylum seekers. The media aims to elicit strong responses and report shocking facts so these articles may well be representative of attitudes towards asylum seekers in the media. However, it may also be true that I noticed and reported on these articles]
because they elicited a strong reaction in me, which may well have influenced the selection process.]

So these are some of the host’s attitudes, but what about the asylum seekers’ own attitudes? These may affect the media and political views, if not by complementing them, by opposing them. Hopefully, asylum seekers’ own attitudes may affect psychological attitudes.

Asylum seekers’ reported self representations

This section focuses on asylum seekers’ experiences as reportedly described by those who have lived through them. However, as these stories were all reported in psychological or medical publications they could have been manipulated by those presenting them, in order to make them more acceptable to the majority or to illustrate the author’s point. It should be noted that the psychologists whose attitudes were evaluated earlier did not present these stories. This was deliberate in order to avoid simply exploring the same experts’ attitudes twice, firstly under the guise of expert opinion and then through the asylum seekers’ voices they chose to present.

These attitudes did seem to echo the polarised attitudes expressed in the psychological literature; the asylum seekers all described themselves as either victims or survivors with no real compromise between these two attitudes.

Asylum seekers as victims

Many asylum seekers as represented in the literature seemed to describe themselves as victims with a sense of helplessness. Light (1992: 299) presents Mama Maquin (a Bosnian refugee) as interpreting her forced exile as confirmation of women’s victimisation and helplessness:

Women are not worth anything, the woman is only to stay in the
Continuing this theme of helplessness, Weine (1999: 65) presents H (also a survivor of Bosnian concentration camps) as feeling powerless to help his fellow countrymen since he has survived and 'escaped' to Britain:

*It's still happening and there is nothing I can do. I can't be happy as long as other people are suffering over there.*

Weine (1999) also reports that asylum seekers not only feel as though they are victims, they feel as though they are damaged victims. Weine (1999) believes they take on the guilt that should belong to the torturers. In order to illustrate this point Weine (1999: 26) quotes R, a Bosnian refugee, as saying:

*The only ones who are not responsible for what happened are children and animals. Every one else is responsible. Really.*

Within these reported self-reports the asylum seekers who described themselves as damaged victims had all experienced torture. Furthermore, from this literature it would seem that those who have experienced torture often feel more guilt and shame about sexual violence and attacks on their sexuality than other forms of trauma. Friedman (1992) believes that guilt is a common consequence of rape. He writes that sexual attacks are prevalent especially in Muslim countries as the religion prohibits the execution of virgins. Women are, apparently, routinely raped so as not to break any religious laws if they are executed. Friedman (1992: 71) reports D’s interpretation of her flashbacks as proof that women sometimes hold the attitude that their torture was their own sin:

*the fact that I can relive the event without shutting my eyes and that I can smell the room and feel the pain at anytime is because my punishment must stay to remind me of my sins, when I am*
worthy of forgiveness and I have learnt what it is to be pure
again the punishment will leave me.

Bowen, Carscadden, Beigle and Fleming (1992) write that Cambodian girls are
responsible for their family’s good name to such an extent that if they are raped they
identify themselves as their attacker’s wife as does the rest of the community. What
are the consequences of these scripts in making sense of sexual torture? How can
women rename torturers as their husbands? According to Friedman (1992) the only
way they can make sense of it is to never speak about it, deny it to themselves and
others or face shame. She believes this has negative implications for the their
engagement in therapeutic relationships.

Weine (1999: 202) presented a diary extract of Nadia, an eighteen-year-old Bosnian
woman living in Britain, describing how she feels and lives after her brutal
experiences:

When you awaken from a nightmare, you do not bounce out of bed
to greet the new day. You sit up slowly, put your feet on the floor,
and pause while you slowly rub your palm across your forehead.
You stand up tentatively, and you may sit back down for a few
more minutes before trying again to get up. Should you trust the day?
You are not sure.

Chester (1992: 211) echoes the extreme psychological attitude that asylum seekers
have been dehumanised by their experiences. To illustrate this she reports an extract
from A’s oral history:

Then he took his gun and shot my sister in the head. I am not a
human anymore. I never cried for my sister. They crushed my
soul, I feel like a bird without wings.
Another commonly presented attitude is asylum seekers’ feeling of disconnection and disassociation. Thompson (1992: 130) co-wrote her article with Sieng (a Khmer refugee) who said:

> Our life in the U.S. is like a small boat floating in the middle of the ocean.
> We have no destination and no hope. I am looking for a new life, but my home is still in my heart and mind.

In some cases this disconnected attitude apparently remains over time. Siegel (1992: 108) remembers saying to her husband after living in the USA for fifty years: “This is a great country of yours”. Apparently Siegel (1992) loved America like her own but never really felt connected.

Weine (1999: 53) expresses the attitude that disassociation occurs as a consequence of PTSD, in particular the re-experiencing of traumatic events. To make this point he describes S’s memory:

> The worst event was when I watched one young man as they castrated him. Right now in this room I can hear his cries and his prayers to be killed. Every night it wakes me... It gives me nightmares and makes sleep almost impossible when I speak about that even though my eyes are open I see all those images in front of me.

Sieng and Thompson (1992: 130) also present a Yiddish woman’s disassociated attitude towards her world. She apparently said: “Ich weiss nit uf wesser welt ich bin” (I do not know in which world I am).

**Asylum seekers as survivors**

However, some people represented as not merely victims of these experiences but as survivors who became inspired to empower themselves. The ‘Intifada’ are a group of
Israelis who self-formed to fight back and protect their loved ones. Bylund (1992: 63) presents their song as an illustration of their newfound self-empowerment:

They seized our children
They burned down our homes
They left us to the desert
To waste lands without soil

Children murdered by Famine
Anxiety our food
So come sister come
Let's act
Let's use our time

Furthermore, Weine (1999: 60) presents H's inspirational attitudes:

I said to myself, whatever my destiny, whatever God decides will happen. You can kill me but you cannot break my spirit.
I started feeling superior to those criminals whose bestiality toward innocent, unarmed people was shameful. Something in me helped me preserve my dignity, helped me remain human.

Further, Muna presented by Roberson (1992: 39) summarised her feelings:

However people see me or treat me, I know who I am, I was loved and can love. I still feel I am kind and worth knowing.

[While collecting these self reports I was aware of a desire to present both sides of asylum seekers reported self identity. Within the literature there was far more space allocated to victim like attitudes of asylum seekers; only a few asylum seekers were
reported as having survivor attitudes. Perhaps the ratio in this review does not reflect the distribution of these two attitudes in the literature. I realise that I wanted to present the attitudes of survival because I did not want this voice to be lost. Perhaps I am also pushing for this voice and self identity to be heard and acknowledged.

Implications for practice

The aim of this review was to evaluate psychological attitudes towards asylum seekers. The review identified similarities between the attitudes towards asylum seekers of the psychological, political, media and reported self-reports literature. All sources displayed polarised attitudes towards asylum seekers as victims versus survivors. The attitude that asylum seekers could be categorised into deserving and non-deserving was prevalent in the political literature; this attitude seemed to be more extreme in the media, which expressed the view that some asylum seekers could be categorised as criminals. These polarised attitudes are illustrated in Figure 1.
Deserving Survivors

Non-deserving Damaged Victims

Criminals

Figure 1: A Diagram Representing the Polarised Attitudes Explored in this Literature Review

As this diagram illustrates the attitude that asylum seekers can be categorised as either deserving but damaged victims or deserving survivors is expressed in psychological, political, societal/media literature and in asylum seekers own reports. Further, the attitude that asylum seekers are damaged victims to such an extent that the victim identity is all consuming is expressed within psychological literature. The attitude
that asylum seekers can also be categorised as non-deserving criminals is present within political literature about this vulnerable population. Perhaps vulnerable would be a more empathic and hopeful description than damaged for asylum seekers.

As they stand these attitudes all seem to be quite extreme, an effect compounded by their polarisation. The fact that there is such a dichotomy seems to result in each individual attitude taking on a less helpful meaning. These polarised attitudes all seem to have implications for practice.

Eagly and Chaiken (1983) found that attitudes were composed of feelings, thoughts, and past experiences or behaviour. The popular press aims at eliciting strong affective and cognitive reactions and therefore perhaps influences even professionals’ attitudes towards the subject matter, classifying asylum seekers as victims. This is worrying because psychological services are now refusing mental health treatment for asylum seekers because they believe them to be beyond their services’ capabilities, as described by Carvel’s (2002) article, discussed in the media section of this report. Psychological services, in this case at least, are generalising, which is worrying given that psychology is based on the study of the individual and emphasises human as opposed to collective differences. Clinical prognoses of the asylum seekers as too damaged may be based on prejudiced stereotypes, which has very negative implications for practice. Further evidence for this was expressed by Scarry (1985) and Basoglu (1992) who hold the opinion that some counselling psychologists and psychiatrists felt that refugees were typically resistant clients who were ambivalent if not possibly bordering on the ungrateful in their approach to therapy.

The asylum seekers’ self-reports included illustrations both of victim-like attitudes and attitudes of empowerment and survival. These exactly correlate with the psychological literature. Another reason why asylum seekers self-reports may correlate with psychological literature, is the impact that professionals’ opinion may have had on the asylum seekers. A vast amount of the psychological literature describes asylum seekers as traumatised and helpless, thus interpreting them as
victims. If people hear themselves described as victims they may internalise this attitude and consequently act as helpless and out of control. If, on the contrary, they are constructed as survivors they may internalise a more empowering and helpful attitude. Herbst (1992) advocates this view as she asserts that language helps asylum seekers to find hope and empowerment in their memories through telling, reorganising and re-constructing their story. This enables them to alter their victim identity. Perhaps for asylum seekers to be commonly perceived as 'survivors' psychology needs to construct them as such both in the literature and within clinical practice.

Asylum seekers also held attitudes of separateness, from others, from their environment and even from themselves, which psychological theories tend to represent as disassociation and disconnectedness. The asylum seekers presented in this report associated flashbacks and reliving the traumatic experiences as 'being between worlds' or karma punishing them. These attitudes may stem from religious beliefs. However, psychological attitudes seem to ignore this interpretation and attribute the re-experiencing of traumatic events to suffering with PTSD, thereby adding weight to the attitude that asylum seekers are suffering victims. This seems to be a very detached expert attitude that does not really consider people's cultural and religious values. Bourdieu (1991) believes that psychological attitudes often ignore cultural diversity because they are trying to be objective. Perhaps recognising the subjectivity is more ethical, as we should let subjectivity also guide our practice by considering the nature of clients' self-representations.

Psychological attitudes have a direct impact on therapeutic outcome. Danieli (1980) and Bustos (1989) theorised that therapists' attitudes can lead to the therapist's issues being attended to in the therapy rather than those of the client. Danieli (1980) believes that the therapist's attitudes that asylum seekers experiences are too traumatic to address can lead to a 'conspiracy of silence'. The therapist unconsciously directs the client to avoid this topic with their proactive counter transference, which supports the client's view that their experiences are too much for
anyone to handle and should be denied and avoided. Lira, Becker and Castillo (1990) believe that this denial can cause splitting, which can hinder positive therapeutic change. Conversely, Papadopolous (2001) believes that therapists can be so concerned about falling into the trap of a ‘conspiracy of silence’ they focus too much on the traumatic events, She calls this ‘the phase of devastating events’. This also has negative implications for therapeutic change because the client remains ‘stuck’.

However, psychological attitudes can also promote psychological healing. Therapies such as ‘Testimonio’ and ‘Oral History’ (Mollica and Caspi-Yavin, 1992) are based on the survivors telling their story and together with the therapist reorganising and re-framing their memories of self and events to find empowerment where before there was only destruction. The therapist records the story and then presents it to the client. Together they collaboratively co-construct new meanings.

Mollica et al. (1992) also point out that oral history and testimony depend on accurate recall by the client, which is not always possible. They base this on the fact that retelling their traumatic stories may cause the refugee high emotional arousal and a re-experiencing of the events. In order to help refugee’s memory recall they suggest first gaining their trust. This seems to me to be tantamount to attending to the therapeutic relationship (Clarkson, 1995).

Vesti and Kastrup (1992) also believe that a supportive therapeutic relationship is a pre-requisite for insight therapy. Insight therapy works on the premise that the problems presented may concern five spheres of functioning; psychological, somatic, social, legal and spiritual. The psychological sphere may correspond with this client group’s feelings of helplessness, guilt, and disassociation. The somatic sphere may correspond with their apparent tendency to perceive themselves as having medical rather than psychological problems and the physical acting out of their emotions. The social sphere may be indicative of their attitude that they have lost their community and therefore some aspects of their identity. The legal sphere may be a result of their perceived victimisation when they try and access political and social support in their
host countries. The religious sphere may correspond with self-representations of guilt and a sense that they have been punished for earlier sin, karma. Vesti and Kastrup believe that all of these spheres are integrated because people are simultaneously individuals as well as social beings. Being aware of the interplay of these spheres may help awareness of client issues as long as the spheres are based on the clients’ attitudes as well as psychological attitudes.

Conclusion and suggestions for future research

The review identified a dichotomy in attitudes towards asylum seekers in the psychological, political, media and reported self-reports literature. All sources displayed polarised attitudes towards asylum seekers as victims versus survivors. The attitude that asylum seekers could be categorised into deserving and non-deserving was prevalent in the political literature; this attitude seemed to be more extreme in the media, which expressed the view that some asylum seekers could be categorised as criminals.

One limitation of this review is the fact that it includes asylum seekers’ attitudes only as reported by professionals, not asylum seekers’ own voices from face-to-face interviews.

To some, representing the other is assuming but not understanding the attitudes of others and is, therefore, unethical: “No one should ever ‘speak for’ or assume another’s voice... it becomes a form of colonisation” (Sinister Wisdom Collective, 1990: 4). However, Livia (1996) asserts that it is important to continue researching and reviewing all topics not just the ones that researchers have experienced first hand, otherwise social psychology will become too limited. MacMillan (1996) believes that research on vulnerable populations should always include the population’s own voice.
If it is the victim's/survivor's mind that is damaged it is within the realm of psychology to heal. In order to heal perhaps psychology needs to have more compassionate and ethical attitudes towards asylum seekers. I suggest that using asylum seekers' own stories as a guide is the most ethical way of constructing micro theories based on lived experiences rather than assumptions. Therefore, I intend to interview asylum seekers about their experiences and let them tell me their stories in my next research project.

[Having completed this literature review I am even more determined to continue my research emphasis on the plight of the asylum seeker. The literature about asylum seekers seems polarised and judgmental, and helpful and positive attitudes are lost. Asylum seekers do seem to be unfairly thought of and as a population seem to have few human rights. The rights of the asylum seeker were never mentioned in any of the literature. I realise that my own attitude towards asylum seekers is that they are people who need individual attention and support, who should not be pre-judged or categorised. However, through continued and consistent reflection of my use of self in my research I will try to limit my bias within my research.]
References


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Appendices

A. Notes for contributors to Counselling Psychology Review
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
ASYLUM SEEKERS' STORIES

Abstract

Asylum Aid (1999) believes that asylum seekers tend to be represented as either victims or frauds. Papadopoulos (2001) believes that the majority of psychological literature constructs asylum seekers as 'traumatised victims' because most research involves NHS service users. From the available research it is difficult to draw meaningful conclusions about the experiences of relatively well functioning asylum seekers. To date this appears to be the first study that attempts to understand this group of asylum seekers. In-depth interviews were conducted with 13 adult asylum seekers who had been in the UK for at least one year. Participants were asked about their life stories, issues concerning life-changing events, coping strategies and external support and influences. The participants' personal narratives were analysed using interpretative phenomenological analysis.

The analysis yielded three themes: comparison with others, finding a voice in UK systems, and relating to others. The first theme had three sub-themes concerning the subject of their comparisons: in the beginning, lost selves, and rebuilding their lives. From the second theme two distinct sub-themes emerged: silenced even in crisis, and heard and supported. The final theme concerned relating to family, and relating to social networks. All of the themes pertain to the emphasis of asylum seekers on present and future relationships rather than dwelling on past traumatic events. The asylum seekers in this study presented as hopeful rather than hopeless. Papadopolous (2001) believes this is an identity with which they are not often associated.

Keywords: Asylum seekers, personal narratives, relatedness, hopeful
Introduction

It would seem that, for political and economic reasons such as the current 'tough and tender' political approach (Blunkett, 2001), asylum seekers' voices are seldom heard in a way that communicates their resilience and determination to survive against the odds. Furthermore, Asylum Aid (1999) advocates that their cause as people with human rights deserving an appropriate place in our society is also often ignored. This study attempts to present asylum seekers' own voices and stories about their experiences by listening to them as individuals with something important to say. This seems to be vital because they are currently categorised and stereotyped within British culture.

Let me briefly explain what I mean by this. In society at large there seems to be a dichotomy between those who view asylum seekers as deviants and criminals and those who perceive them as powerless victims needing charity. The British press often follows the political climate of the day and denounces asylum seekers as criminals and deviant others to be avoided (The Evening Standard, Whitney, 2000) or as victims needing charity (The Observer, Burke, Bright, Thompson and Gitting, 2000). The Evening Standard published an article by Whitney quoting Roger Davies (a stipendiary magistrate at the Horseferry Road Court) as saying: “we don’t like people begging with children in this country” to a 21-year-old Romanian mother. Whitney continues by further quoting Davies: “you are living on the generosity of the British public…. I have said it before and I’ll say it again the British people are fed up with people like you” (2000: 1). This article suggests that asylum seekers are not acceptable to Britain. Rarely are they portrayed as survivors of yet another man made disaster (The Big Issue, Naidoo, 2000). However, Herbst (1992) believes they are survivors above all else.

11 The ‘tough and tender system’ advocates welcoming real refugees, encouraging legal foreign workers, and dealing swiftly with false asylum claims.
On the other extreme of this dichotomy, we find the more sympathetic attitude that asylum seekers are suffering and irrecoverably damaged people. However, these ‘asylum seekers as victims attitudes’ often seem associated with little trust in their capacity for survival and recovery. The Big Issue published an article by Ghouri (2000: 4) who constantly refers to asylum seekers from Kosovo as “sick and vulnerable”. This view is also somewhat compounded by the psychological literature. For instance, Van der Veer (1998) concentrates on their tendencies to suffer from depression. Shepherd (1992) and Lunde and Ortman (1992) similarly concentrate on pathology by writing about those asylum seekers with post traumatic stress disorder. Keane, Albano and Blake (1992) theorise that asylum seekers often exist in a state of learned helplessness and have even lost the ability to self-contain. Horowitz (1976) and Amati (1976) theorise that asylum seekers internalise their traumatic experiences to such an extent that they begin to blame themselves. Weine, for instance, believes that asylum seekers take on the guilt that properly belongs to their persecutors, and quotes a Bosnian refugee as saying: “The only ones who are not responsible for what happened are children and animals. Every one else is responsible” (1999: 26). Krystal (1988) even believes that asylum seekers’ traumas can be so damaging that they have been literally “dehumanised”. Obviously, traumatisation, shock, pathological helplessness, and self-blame may occasionally be psychological consequences of the asylum seeker experience. Nevertheless, Papadopoulos (2001) believes these psychological problems certainly seem to be over represented in current psychological literature about asylum seekers.

Fortunately, not all of the literature on asylum seekers paints such a bleak picture. Rousseau, Said, Gagne and Bibeau (1998) found that adolescent asylum seekers were able to shows signs of resilience if they had insight into their situation. This hypothesis forms the basis of so-called insight therapy (Vesti and Kastrup, 1992) which was specifically designed to facilitate the promotion of understanding and personal control over difficult events and processes, such as immigration. Underlying resilience and coping skills may also better reflect the asylum seeker’s own point of view. Bylund reports that researching the ‘intifada’ has led her to hypothesise that: “empowerment can rise out of the ashes of despair” (1992: 63).
It is important that counselling psychology promotes a view of asylum seekers, which includes an awareness of the asylum seekers' own self-perceptions. Roberson (1992), advocates that stigmatisation really pertains to the phenomenology of asylum seekers. Stigmatisation is not only described in relation to how they felt they were treated by their persecutors, but also how they were treated by their host countries. Muna presented by Roberson (1992: 39) said: “We were upset being a refugee, you’re stigmatised; you’re poor; you’re nothing. Even though we had come from good homes. Nobody would trust you; nobody would lend you money”. Oguntokun (1999) promoted understanding black African refugee women through researching their experiences using face-to-face interviewing. Her research influenced this study, as it sought to understand and promote the refugees’ voices. Both studies are trying to hear the silenced voices within society.

However, in order to try and build on Oguntokun’s (1999) research this study recruited both male and female participants from any cultural background. Further, this study did not only focus on the psychological and social consequences of war and immigrant experiences. It also attempted to understand what the asylum seekers themselves felt was the most important focus of their experiences.

In brief, it seems to me that to better understand and help asylum seekers we need to enrich our view of their situation by considering their resilience, capacity to ‘rebuild’ their lives, and desire for relatedness. True, not to hold a partial view of others, especially ‘different others’, is not easy. Livia (1996) believes that the only way to avoid this is to never assume another’s voice. However, this may result in limited research topics, with some populations being totally absent in psychological literature. Russell (1992) argues that it is better to research others and, at the same time be aware of one’s own impact and interpretative frameworks, for instance by constantly questioning one’s inclusion criteria and aims. For this reason I have made my political stance as clear as possible. I should also add that my motivation to research in this area stems from working and living with asylum seekers and victims of political persecution in Romania for one year.
The aim of this study is to offer an in depth description and exploration (with some comparison to current media and psychological literature) of participants’ ‘stories’ gained through face-to-face interviewing.

Method

Participants

Attempts were made to recruit asylum seekers who had been living in the UK for a minimum of one year, were over 18 years old, and relatively fluent in English. Thirteen participants were recruited by contacting specialist charities, social services, ‘asylum seeker’ specialist teams and by ‘snowballing’ from those who volunteered through these channels. Organisations were contacted by letter, and meetings arranged to discuss the aims and objectives of this research before asking permission to approach their service users.

Thirty asylum seekers were finally contacted, 17 via letter and 13 directly. It is interesting that only those 13 directly approached consented to participate in this study (implications for the validity of the results will be addressed later in the report). The 13 participants were seven adult males and six adult females. Participants mean age was 30 years (range 19-44 years; SD 7.33). Nine were waiting for their visas and four had received permanent visas and had asylum granted. However, no one had yet been granted British citizenship. The mean length of stay thus far in the UK was three years (range 1-8 years; SD 2.65).

Information to participants

Care was taken to convey to participants that the research would be based on their description of life as an asylum seeker. Information was made available in advance of the interview to enable prospective volunteers to appreciate the nature of the study and make an informed decision regarding participation. This information was communicated in plain and simple language to reduce the possibility of
misunderstanding, and in a manner hopefully perceived as friendly and non-threatening.

All of the participants met with me at the pre-arranged interview time two days after the first contact. The time gap between consent and interview was intended to relieve any pressure to participate or any feeling that participants would be subject to interrogation. Contact details of non-fee paying specialist support services for asylum seekers were also distributed at our first meetings, regardless of whether or not they chose to participate in the study.

Interview Schedule

Interviews were semi-structured in order to give both respondent and interviewer some focus as well as a degree of flexibility. The interview schedule was piloted for clarity and coherency with staff at a homeless centre. Two advocates at the homeless centre who were ex-asylum seekers agreed to be interviewed. This was deemed appropriate because they had been British citizens for eight years and felt sufficiently adjusted to be able to offer feedback on the interview process as well as discuss their experiences as asylum seekers. They both offered the feedback that pre-planned prompts should be available, hence their inclusion in Questions 1 and 2 of the schedule (see Appendix A).

During the actual interviews, care was taken to build a positive rapport with the participants, whilst asking open questions and probing interesting areas with prompts. In brief, a sensitive method of interviewing was used that Coyle & Wright (1996) and Coyle (1998) based upon an interactional style derived from counselling psychology. The interview took place in the interviewees’ homes or in private consulting rooms, and began with demographic questions and questions about length of time in the UK and immigrant status. This was followed by questions about how they came to be in the UK and their initial experience of living here. The next area of interest was their perception of themselves and possible changes as a result of becoming an asylum seeker. They were then asked to assess if they had found anything particularly useful
or difficult. If they had they were encouraged to explore what they had found supportive or effective coping mechanisms and what they had found to be unsupportive and perhaps distressing (see Appendix A). Interviews always ended with a debriefing question and the interviewer took sufficient time to ensure that nobody was left in a distressed state and the interview ended appropriately grounded. The interviews lasted between 25 minutes and 1.5 hours. All were audio recorded with the participants’ permission and transcribed verbatim. Tapes were then destroyed as pre-arranged to protect participant confidentiality. To protect anonymity pseudonyms have been used throughout this report.

**Analytic Strategy**

The transcripts were analysed using ‘Interpretative Phenomenological Analysis’ (IPA) (Smith, 1996). Flowers, Smith, Sheeran and Beail, (1997) have used IPA to analyse qualitative data on a range of topics related to health and well being. Further, Smith (1995) writes that there is a natural fit between semi-structured interviewing and qualitative analysis, particularly IPA. Smith (1995) attributes this to the facilitative nature and flexibility of the interviews that tends to produce a corpus of detailed material on the experiences of the respondents. This is important when adopting a phenomenological perspective (Giorgi, 1995) and a symbolic interactionist position (Denzin, 1995). It pertains to IPA’s stance that it does not claim that the participants are describing a reality but, rather, that they are describing what they perceive and experience as reality. Although IPA is concerned with what the individual thinks and believes in relation to the subject being investigated, it simultaneously recognises that the interpretation of the responses is dynamic and intrinsically linked with the researcher’s frameworks and engagement in the analytical procedure. The assumption is that it is not possible to be entirely objective. Smith, Jarman, and Osborn (1999) believe interpretations are subjective, it is not claimed that the thoughts of an individual are transparent within verbal reports, although the analysis is undertaken with the assumption that meaningful interpretations can be made about those thoughts. Indeed, Smith (1995) developed IPA to provide a systematic framework to analyse participants’ experiences, cognitions and meaning making, as
well as the interaction between the researcher's interpretative framework and the participants' narrative.

The subjective nature of IPA could make it difficult to evaluate its results, which is why Smith et al. (1999) recommend clarity about the analytic process. The initial process of the analysis involved reading each of the thirteen transcripts in turn, several times. The most detailed and lengthy interview (see Appendix B for a transcript of interview 1) was then re-read in depth whilst making notes in the left-hand margin about anything that appeared to be particularly pertinent or revelatory about the research topic. This procedure was then repeated with all transcripts. Interview 1 was then worked through again and emerging themes were noted in the right hand margin. These included summaries of content, connections between different aspects of the transcripts and initial tentative interpretations. Again, this was then repeated for all of the transcripts paying particular attention to commonalities and anomalies with interview 1. This early iterative coding process was kept at quite a broad level. These codes were then grouped together and notes were taken as to why the researcher felt the groupings were meaningful. The clusters of codes for each individual transcript were then analysed to see if any collective patterns emerged, to produce shared themes. The data was then re-worked to produce a complete corpus of data for each shared theme, although care was taken at this stage not to lose the participant and keep the themes grounded in the data. Patterns, connections and tensions between the data were analysed to produce superordinate themes from the shared themes. Due to the high degree of subjectivity, a second party (supervisor) also cross-checked the themes. The superordinate themes were then related back to the participants and any that could not be associated with all thirteen either by affirmation or contradiction were rejected. Any superordinate themes that could have been based on the questioning during the interview process were also rejected. The themes were then ordered in such a fashion as to produce a coherent and logical research narrative.

Elliot, Fischer and Rennie (1999) also suggest grounding interpretations in examples to add to the transparency of the analysis. Therefore in this paper interpretations are
corroborated by extracts from the data set in an attempt to permit the reader to assess the appropriateness of the analysis.

**Results**

All 13 participants emphasised the extreme life changes they had experienced since fleeing their country and becoming asylum seekers. In speaking about their experiences as asylum seekers, three distinct themes emerged: 1) social comparison with other selves; 2) finding a voice in the UK systems; and 3) relating to others. The first theme relates to the participants’ tendency to define their progress in rebuilding their lives in relation to other people’s lives, or their memories of previous selves and projection of self in the future. The second theme pertains to their descriptions of successful and unsuccessful ways to communicate their needs. The third theme is based on their positive and negative perceptions of their relationships with family and social networks.

**Social comparison with other selves**

*I mean being British is better than being a refugee. (Ms L)*

All of the 13 participants reported a need to start again and rebuild their lives. They used social comparisons as indicators of their progress on this journey. This display of determination does not really concur with Basoglu and Mineka’s belief that “Victims lose control over their treatment and consequently can sometimes no longer manage their own stress levels and behaviour” (1992: 189). As participants described their struggle to ‘start again’ they compared themselves with other people and with themselves both in the past and as projected into the future. Three sub-themes illustrate their journey in starting again: i) in the beginning; ii) lost selves; and iii) rebuilding their lives.

12 Participants’ names and identifying information has been altered to preserve their anonymity.
i) In the beginning

This sub theme relates to the beginning of their stories. The participants’ stories did not commence with a description of their traumatic events, but with a description of their lives before the problems began. A common theme was describing their original ‘good fortunes’ and how everything changed.

Nobody would come here if they were not desperate especially I am telling you I know my people Iraq you know before Iraq was a very good country and we are very very you know educated people we don’t need to go out we are very our country is very rich and we have a thing there we have a houses very nice houses we have our education our schools are very good so why would we go out we don’t need to go out but you can’t live there anymore it’s just a very bad situation you are terrified. (Ms N)

In this extract Ms. N compared her lifestyle in Britain unfavourably with her pre-war lifestyle in Iraq. Ms. N also articulates the desperation that forced her to become an asylum seeker. The identity of asylum seeker is never described as a positive life choice but as a necessity for survival.

I did have money I was in a very good job a good situation I am struggling here to make my life the same but it is not easy here as life is very expensive. It is not easy for a single person to do it is hard. My husband was jewellery and I used to work in Saudi Airline there. Of course after the war they all run away all of them there is no airline anymore they just close it down. I had a good job yeah my son was in a private nursery and then I came here no job and had to put my son in a nursery that wasn’t suitable but it was the only thing I could put him in. (Ms M)

Just before the war everything is you know in position, and everyone knows that then we were out of position and for that I am here at this time. (Mr B)

The participants’ stories seemed to imply that they felt they were not just starting again but that they had suffered a major set back from which they were struggling to
recover. It was as though their narrative communicated that their position had not just been altered but that it had deteriorated to such an extent that they could not help but think about 'the good old days'.

ii) Lost selves

All 13 of the participants used comparisons between their current selves and their past identities to further communicate their shift in social status.

*In our country we were respected professionals we had our own building company our own construction company so we had we were wealthy because you know that’s life. It makes it hard you know to have everything and then you know you have to study everything from the beginning you know and umm even if you are a professional architect not being able to work like that it’s really hard.* (Ms F)

*If I had a chance I would have been something in my country. I studied English and I studied law. So with two universities finished I would have been something. I would have been a solicitor when I had finished the English degree. My husband has an economy degree finished and he is a cab driver now.* (Ms L)

Stories such as these seemed to illustrate a move down Maslow’s triangle. The participants had reached the top but had now fallen to the lowest position in the hierarchy of human needs (Maslow, 1970).

iii) Rebuilding their lives

Without exception the participants’ main preoccupation was rebuilding their lives. One way they communicated this was by comparing their present, retrospective and projected future selves. In particular it seems that the ability to study is perceived as an indicator and facilitator of progress back up the social and professional ladder.
Because I study here but we can't really study in Iran because they shut the schools and I don't know there was school but high risk. But now I study here to get job, nice house maybe if we had a nice house like in Iran I could make a friend and show her my house, I don't want to take anyone to my house now because it is not so good it is err embarrassing and my parents they also will not show anyone our house because they think it makes us look dirty and too poor. (Ms IG)

Ms IG reports that all of her hope is in education. She seems to consider education as a key to a professional and social life. This seems to be because through education she will get a job and earn money and improve her standard of living. Implicit in this extract is the idea that she is embarrassed rather than relieved about her current lifestyle.

I learning English, going to college and university. Because when I was a child, yes, I didn't go to school in my country so when I came in England I started to study, so I'm happy. I have changed. But a year, did you know, in my country I no learn 5 years, 6 years you know. I come here and learn English and go in school and do fine I think. (Mr K)

No you could never go out or study now I can study and will soon have my NVQ level 2 carpentry I know it's bad to say but I am best in my class I want to be best and do something with my life I should be somebody I am still alive. I don't want vouchers I want to live like everybody else in this country and pay taxes, pay for house and pay my food and living as it is my life and my responsibility not somebody else's I want to live like free. (Mr N)

These extracts present a determination to rebuild their lives. This resonates with Bylund's (1992) description of asylum seekers’ aims to fulfil personal potential despite the adversities encountered. The participants never focused on their traumatic events, instead they communicated their determination, a determination to survive and
re-build their lives so they were at least as good if not better than they had been before.

Finding a voice in the UK systems

This second theme relates to participants’ communicating their needs. The participants’ perceptions of how much services listen to them seemed quite split and ranged from absolute condemnation to absolute idealisation. This dichotomy could be the participants’ reaction to society’s tendency to categorise them as victims or frauds as discussed in the introduction. When systems label them as frauds they may ignore and silence them so that the asylum seekers feel persecuted and punished without reason. When the systems listen to them they may be treating asylum seekers as completely dependent victims. Therefore this theme had two opposing sub-themes: silenced even in crisis, versus heard and supported.

i) Silenced even in crisis

Twelve out of 13 participants reported feeling ignored and silenced into submission by UK systems.

*I can’t do anything about it that’s it you can’t say anything about it, you are homeless that’s it you have to accept whatever we will give you. Nobody will hear your voice, who’s going to hear your voice? (Ms N)*

The participants reported feeling hopeless about their future possibilities when they felt their voice was not being heard. This resonates with Basoglu and Minneka’s (1992) hypothesis that asylum seekers are forced to submit to a sense of learned helplessness.

*The way that they treat you in the Home Office does make you feel like you’re not human, like you’re rubbish. Not nice at all, It really affects me. It did upset me because it was like they did not pay attention to us but of course we had to queue up but in the way that they treat you, the way that they treat you*.
way that they speak to you. It's not right. I can't explain it to you. It made me feel cheap; it made me feel like I was nothing. (Ms L)

In Ms L’s case she had fled from persecution and being politically stigmatised as unworthy of life on the grounds of religion and then experienced similar treatment where she came for asylum by those in power. Ms L felt she was ignored because the immigration system perceived her as unworthy of notice to the extent that she struggled with and almost internalised this sense of worthlessness. Another collective theme for all the participants was being ignored until a crisis forced their plight to be heard.

And then we learned we had to go to council we say [shrugs shoulders]. They didn't even consider to look at our case because they said now we already had a room. I took that hard, and it took them about one year and a half to start helping us, changing our accommodation and everything and that was only when err my son got burnt. We were very upset. But after a while like I said when we had that accident with our son the doctors and social services and um things started moving a little bit. (Ms F)

Only being heard when they are literally screaming seems to be a dangerous trend because they may be conditioned to use crisis as their voice. Fuller-Hahn (1992) believes that this may result in them relating to people in power from the victim position and finding it impossible to interact as adult equals. Other people are perceived as either victims or persecutors In fact nine participants also reported being silenced and being treated as less than human even when in crisis.

When I go to hospital with my mum they say first give me the paper she's allowed to stay in this country after that they give her a treatment. If she wasn’t, if she’s not allowed to stay in this country she cannot have the treatment. Until the Home Office make her come around and get the Home Office paper after that they can give her treatment but they must think she’s die from blindness or she get blind. I couldn’t take her to the hospital over the four
weeks I was waiting for the paper to come and take her to the hospital but you
know it's really bad, you see its matter its anyone's life; it's no matter of the
home office. Money or matter of the country or matter anything it matter that
somebody's is in one human who want to live. Its matter of somebody's life.
(Ms LP)

I couldn't sit at all on the chairs because I was full up I was nine months
pregnant so he saw me and took me straight away to the doctor to check me.
After she confirmed I'm pregnant you know nobody care they told them she's
full up she's full she's going to have the baby anytime and after that nothing
happened they just left me sitting on the chairs to talk nothing happened at all
nothing, it didn't make any difference that was really sad you know and maybe
dangerous. (Ms N)

Scary it was scary [to rely on help] maybe I shouldn't say this but especially for
refugees it is err they don't bother a lot, err they don't bother a lot. You know
my son his hearing wasn't OK since he was one and it took me two and a half
years to have him operated you know which I think if I was English they, I don't
think that would happen. (Ms F)

This seems to be a strong example of silencing and being ignored, being refused
medical care because of bureaucracy or culture, even when those in need are
especially vulnerable because they are elderly or children. This is an example of
politics and cultural context becoming more important than human life, a message
these participants had already heard in their country of origin. Ms F describes the
impact of this as having an extreme effect on her son's personality and development.

I can't find the right words but he [her son] was aggressive he was really yeah
aggressive I don't know because he couldn't hear, he couldn't hear he couldn't
speak he couldn't even if he would try to say something people wouldn't
understand him so he couldn't communicate he couldn't explain himself and
you know he was just blamed. He had to do something so that he could show
his angriness you know and if everything would be OK if the operation was done in time you know he wouldn't be like that. He became a very impatient person you know for three years and then after the operation I had to work hard with him to make him a bit how do I say softer? (Ms F)

In this case the child was perceived by his mother as being unable to develop an appropriate method of communication because his voice had been silenced at such an early age. Indeed five participants described incidences where fear of being ignored led to a personal tragedy.

At that time I was pregnant again and I decided to get a to have an abortion because of the situation because you know we didn't know whether they would re-house you, would they leave you there or you know there was too much pressure. It was really a big tragedy for us, I don't even want to think about that I want to forget that because you think we could have another child there [points to living room floor space in front of her] just if maybe a year later. Both of them [the children] they asking for a sister or a brother. (Ms F)

The sense of powerlessness in society and with their situation was reported as causing the deterioration of one couple’s relationship into violence.

You know I have a friend she had three big boys with her husband five of them in one room three years they stayed in one room. They started beating each other many many times I saw her with a black eye you know they start beating each other because they can't stand each other. You can imagine you are living five people in one tiny room. She started to be very upset she started to be very nervous she break down she was sleeping in hospital three months ago she was taking electric shocks and things because she was nervous down. They separate but they have nobody to sit and talk to them and make them together again, they don’t have to be separated after that they can work it out but nobody do that. (Ms N)
There is a direct wish expressed for counselling in the last extract. There is an obvious need for support. This opposes Scarry (1985) and Roberson’s (1992) perceptions of asylum seekers as resistant to engage with therapeutic intervention.

ii) Heard and supported

In contrast to the experiences of being silenced by social and medical services the participants also expressed feelings of being heard and greatly supported by these systems and specialist charities. Indeed the one participant who had had perhaps one of the most traumatic experiences describes the supportive psychological intervention he received.

*I think not so much of it [his experience of torture] because of great help I have had to me at medical foundation a lot of people have talked to me about my torture. They helped me with all things I saw a counsellor, I owe this country for everybody been so nice. I know, err he helped me to in my feeling and I think this is very important to me and err he helped me deal with err cold-blooded things. My feeling about my bloody country not good feelings they are very sick you know these people and I think that help with feeling is very important for me, I feel very relaxed now. (Mr T)*

Another participant not only felt heard by British systems, he also felt that they nurtured him.

*All the English are very kind. It was like being born again, when I was born by my parents were parents and then when I came to England it was like I was born again and England is my parents. That lady who gives out the vouchers is like a mother to me because every time I come here with a problem she makes time for me and is always kind. I have my blood parents but people here and England are like my parents for new life. In my country no one would be so helpful if not your own blood, blood is everything. She helped me find a house.*
For two nights I slept in hotel where everyone sleeps when they first come here but then they give me house near college. (Mr N)

Mr N seems to have replaced his family with English social systems; he reports feeling a strong connection and relationship to his social services because they listen to him and help meet his needs. This attitude seems to give him hope for his future as if he had been given a second chance and was 'born again'. It could be that Mr. N truly finds it very nurturing or that he is idealising the social workers as though they were his attachment figure now that he no longer has contact with his mother. This would meet his unconscious need to re-establish a merging with a good self-object, idealising transference (Kohut, 1971; Clarkson, 1995).

Relating to Others

This theme has two sub-themes: relating to family, and relating to social networks. In the first sub-theme participants described both a sense of loss and gain. In the second theme they described experiencing both acceptance and rejection.

i) Relating to family

When participants discussed their feelings relating to their family, often these were associated with loss and grief, but occasionally they felt relief and even hope. They had all escaped from communities and families that were literally torn apart, causing them grief and anger. One participant had literally lost contact with his family and presented as distraught about this.

It's a problem you see because every people from Kosovo, from Afghanistan, from everything said I no want to go back because from here but I have no sister, no brother, my family now is not in Kosovo. Not in Kosovo and last 3 months ago my family called me. I don't know where from, maybe one time and told me you know for me no go back. I don't know where my family are now, now I no call them because I lost my phone in the time. I lost my phone. I buy...
another number but I don’t know. Losing my phone for speaking to my family, I think I alone now. But last two month, three month I want paper coming from Home Office and saying why are you no going back, no in Misovisa but maybe in other city. But I don’t like this going in other city, my in my house living Serbia people and me and I go in other city. This is not my home or my people are gone, I don’t want to be there for this. (Mr K)

Mr K’s sentiments resonate with Yee’s (1992) hypothesis that cultural and family uprooting is a major life crisis to which asylum seekers have to accommodate. Indeed, eleven of the participants expressed distress at having lost familial support.

Parents also expressed grief at not being able to offer support to their families and fulfil their perceived caring and providing roles. This concurs with Palmer & Laungani’s (1999) research on the importance of family for migrants.

It’s hard to know what to do when first arrive, my child of one and a half year is very ill and I don’t know where to take her to hospital or doctor. I ask at hotel and they say I must register with GP. But I don’t know what register or GP is and I feel I must know because I am the father. But I come here as hotel tell me about here and ask the teacher what should do my daughter very ill and crying and my wife asking me what to do? The lady here find me doctor or GP and I take my daughter but hard as I am the father I must know what to do to look after future life of my childs and my family. In beginning was hard as I not know where to go to get food and the facilities in hotel not work really. My wife very crying because she not able to be like the mother she like to and she felt she was being a bad mother when my babies hungry. (Mr TA)

Mr. TA is describing feeling as though he has lost some of his identity as a father because the situation made him so helpless that he was not able to relate to his family as the provider and protector. Further, he describes his wife as feeling as though she was not able to relate to her children as their mother because she could not fulfill her
role as homemaker. This emphasises the importance of asylum seekers’ identity in relation to others; they became distressed if they were not able to maintain their roles within their families. Conversely, the participants with dependants also talked about the hope and support they experienced from their ability to care for their children.

*The only thing was that I was separated from my family and had no one here and I used to miss them a lot in the beginning. And then time passes by and you long to see your to see your family. And then my dad came here he had a heart attack once, twice and the second time he had it he was quite bad and I knew that if he died I wouldn’t be able to go and see him. That was bad. I didn’t think about that. But you have your life, you have to think about your children. Stand back. Because at that time otherwise I can’t think of any thing but my father but then I realised that I had to care for my children. (Ms L)*

*We know someone here not so much but I think for now is enough we have all the family is not bad I have fathers and two brothers one brothers just came before four months here. But he has his own problems and I have mine. As you can say life is life again. But what is important than looking for your brothers or your sisters or your father how much is more looking for your own family like kids where the kids until they have kids themselves. It’s not so bad have your main family and that one is more important. (Mr B)*

Ms. L and Mr. B describe feeling a sense of focus from their relationship with their children. Relationships with family or friends seem to give the participants a sense of purpose and hope. Duck, (1986) theorises that humans are innately social and these stories do indeed emphasise the importance of relationships with others; it is as though survival is possible if you do not feel alone.

ii) Relating to social networks

Perhaps because the participants were all grieving for their communities and families they seemed to place great emphasis on re-establishing a sense of belonging and
community here. Apparently, all thirteen participants attempted to develop new support networks, but five of them reported being sometimes thwarted because of prejudice.

*A racist area it is and the people from there they break their [her relations] windows, they swear at them, they fight with the children, they want to hurt them they all go to school, At school my niece and nephew they [fellow pupils] beat them up, scar in the mouth, in the face and the child is suffering. They come home and he cries, “I don’t want to go to school”. Says, “why, his mothers says why you no want”, he says, “because in the school they beat me up”. (Ms L P)*

Forced school refusal must be particularly distressing for asylum seekers considering the importance these participants place on education, as discussed in the earlier section ‘rebuilding their lives’. These participants fled persecution in their home countries so it must be very distressing to experience persecution in their new communities.

*So whatever we will do here as refugees we will still be foreigners. In my country you know who is your enemy the government is your enemy now I don’t know who is my enemy. I am forced to be scared. (Ms N)*

Ms. N describes being forced to be continuously scared and perhaps paranoid in Britain because of a ‘hidden enemy’. She describes her relationships within her new community as very precarious and potentially dangerous because of racism. Indeed, she likens the threat of racism to the political threats she experienced in her home country.

*Because I always say to them they [hostel cohabitants] are making too much mess and too much noise they don’t care where they are drinking and sometime*
Ms CP reports feeling confused by racists in her new home. In this extract she is describing being made to feel powerless by her relationship with the small community within her hostel. Whenever she complains to them about their unreasonable drinking they respond with racist remarks. This must be very hard to bear inside your own home.

Conversely, eight participants presented support networks where they felt very accepted almost as though they had found a new family. The women placed particular emphasis on constructing new friendships and developing women’s social support networks.

And then when we started to go to the homeless family centre it was much better because they had a big hall there with toys and things and it was really nice. We went twice a week and she was really enjoying it. And then I had a baby and a young child as well. But the most and the best thing was emotional side because you could make friends there. Well this way you would walk on the street and not know nobody not exchange a word or have a chat with somebody and then you go there and it’s like family it’s really like family. (Ms F)

I don’t know there were other ladies who used to come and when it was nice weather we used to go in the garden there and the children were playing. The only fun we had was there with other ladies and very rare the husbands used to come because it is not good for the husbands to be with the ladies in you know these dresses that cover you all up [makes a sign indicating women in Perda] they cannot relax with men around. (Ms L)
This corresponds with Hill Collins’ (1990) theory that women cope with trauma best when they construct a supportive network of women in similar situations. Hill Collins (1990) suggests that this is because women provide much needed social support to each other, which seems to be expressed in these stories.

**Discussion**

This study has yielded three themes (comparison with other selves, finding a voice in the UK systems; and relating to others) all of which are correlated to each other as they concern interactions and relationships. This correlation is appropriate, as most aspects of human experience are inter-related in some way. It is noteworthy that the participants all focused on these relationships rather than focusing on their traumatic events, which is often emphasised within psychological literature (Papadopolous, 2001). Furthermore, these interviewees did not focus on victim like aspects of their experience and identity, as was the case with the asylum seekers’ reported self-reports explored last year. All of the participants seemed to communicate an implicit attitude that they would and could survive. Therefore, these participants emphasised their identity as survivors, this is the attitude least expressed towards asylum seekers but corresponds the most with asylum seekers’ own stories.

The participants all seemed to report thinking about available social networks and communities as being important to them, perhaps this is because as Vygotsky (1961) found human contact is vital to a sense of wellbeing. There does appear to be a correlation between successful relationships in social networks and a feeling of being supported and a sense of being settled. This could be evidence for the need for a positive therapeutic relationship and secure working alliance (Gelso and Carter, 1994).

The participants in the study did seem to be mostly concerned with their intersubjective relationships. Vygotsky (1961) theorised that we only develop through relationships with significant attachment figures and those who influence our lives. He believed that development and accommodation of new life events is
relational and based on the zone of proximal development (ZPD). The ZPD is the relational space where the individual has the chance of acting ‘one head higher’ because of a facilitative relationship with another person. He likened this to a child learning through play with a significant attachment figure. However, this has direct implications for counselling psychology. The psychotherapist could be described as the key attachment figure helping the client to accommodate to new life events and develop personally by acting ‘one head higher’ than usual within the therapeutic relationship.

The participants in this study spoke out about themselves in relation to others and described relationships and interactions with others as the most influential on their sense of being. Therefore, perhaps the experience of a positive therapeutic relationship could be extremely beneficial. Rogers (1951) theorises that a successful therapeutic relationship offers the client unconditional positive regard, therefore Harris (2002) believes counselling psychologists need to be non-judgmental and treat all asylum seekers as ‘valid clients’ needing some support to rebuild their personal and professional lives.

Furthermore, professionals need to avoid over-emphasising asylum seekers’ ‘victim’ status so that they become perceived as an over demanding and damaged client group. Writing about work with this particular client group does seem to be either completely optimistic or pessimistic. It is as though professionals, such as Scarry (1985), decide on the outcome prognosis before they engage therapeutically. Counselling psychology needs to redress this imbalance. This study is not suggesting emphatic optimism or generalised pessimism concerning this client group but professional hopefulness and reserved judgement focusing on individuals rather than stereotypes.

Now, there is a possibility that participants focused on these inter-subjective themes presented here because of sample bias or their relationship with the researcher. During the interviews I did feel that I was impacting upon this study. Only those with whom I was initially able to develop a rapport consented to participate. However, I
feel that it was important to establish a rapport with participants to help them avoid associating the research process with difficult interrogations they had all experienced whilst either under arrest in their native countries or as part of the immigration process in the UK. Had the participants not established a positive rapport with me, painful associations with the interview process itself may have silenced their true perceptions and phenomenological accounts and prevented me from gaining an ‘insiders’ perspective on participants’ experiences, as recommended by Golsworthy and Coyle (1999), and ultimately be ethically and methodologically questionable.

Use of Self as Researcher

[The relationship between the participants and me did seem to become part of the research process, perhaps indicated by their attempts to relate to me during the interviews. Perhaps they tried to engage with me because I was giving them space to talk. I also gave them a contained space to present their emotions. When the participants became distressed I did not immediately try and distract them nor negate their emotions; instead I sat with them while they cried. This did have a profound effect on me because I was acutely aware that the interview was not part of a therapeutic process. This made it more difficult for me to ‘sit with’ the clients painful emotions rather than distract them because I was concerned about their ability to self contain after the interview, aware that I would not be meeting with them again.

However, I forced myself to remember that, just as we need to have a certain degree of trust in our clients, I also needed to trust these participants to control their own emotions. They were fully informed of the purpose of this study and after time for deliberation they chose to participate. If, therefore, they felt they needed to communicate their distress through tears I needed to listen and provide that space within the boundaries of this research process. This response to their tears seemed to work well as all the participants contained themselves after some time and all reported feeling better for having been listened to.
Their stories did affect me as they often spoke of very difficult experiences and emotions, further they told me their stories in order for me to report them, to get their message across. I now feel I have a professional responsibility to fulfil this research promise to them by presenting their stories. I am sure that this did affect my interpretation of the data. I wanted to communicate their resilience and strength and emphasised this aspect more than I would have done if I had had a different agenda.

Consciously or unconsciously, I may have ignored any data that might reinforce conventional stereotypes of asylum seekers as damaged victims or system cheats. However, the fact that I left each interview feeling even more strongly about asylum seekers' capacity for survival and desire to relate to others personally and professionally suggest that these were important communications from the participants that needed exploring and reporting. I certainly finished this research with even more of a conviction that asylum seekers need a 'fair hearing' and even more of a desire to challenge stereotypical negative attitudes towards them.
References


Harris, K. (2002). The importance of developing a ‘culture of belief’ amongst counselling psychologists working with asylum seekers. *Counselling Psychology Review*, 17, 1, 4-16.


Appendices
A. Interview Schedule
B. Interview 1
C. Notes for contributors to Counselling Psychology Review
D. Ethical approval notification
Interview Schedule

Introductory question

1) How/why did you get here?

Prompts

Self-concept (how altered if at all)
Feelings towards native country
Current functioning
Treatment from others
Future plans

2) How is it to be here?

Prompts

Events leading to immigration
Journey (Process)
Experiences on arrival
Legal situations

3) If you were to describe yourself (as an asylum seeker) to somebody who does not know anything what would you tell them?

4) What do you feel if anything at all has been the most helpful to you to get you through everything you have just described?
5) Conversely could you tell me about what has been the least useful or what has distressed you the most, if anything at all?

6) Could you tell me about what you enjoy doing most these days?

This is a debriefing question.
To start with Ms. N, how long have you been in England?

Six years

And when did you arrive?

I arrived on (names date)

And what was the reason for you coming here?

Umm I’m from Iraq and we have of course you know that we had a war and err life there it was really bad and err you have no security there. There’s always trouble with the government err I have my husband he’s from the Kurdish side as well my ex actually. We separated now because of this movement. Err we had lots of trouble as well with the government that’s why we had to leave. There is no future even for our kids there, there is nothing so we had to leave the country.

And how was it to be here when you first arrived?

Umm when I first arrived it was horrible actually, the hostel they took me from the airport to it was really horrible bad it was all the furniture inside it was damaged the windows was damaged and it was you know end of November it was freezing cold. The window was broken and I had a child with me and I was pregnant nine months. It was the room was horrible and err after that I went to the hospital I had my second baby and then I didn’t go back to the same hostel I just went I came to (names place) here I applied for a house here now. I came to a hotel here.

13 Pseudonyms are being used and other identifying details altered in order to protect participant anonymity
And what was that like?

Err it was better I would say it was much better but the first month I had a very bad room as well but after that they moved me to another room which was alright it was fine.

What were they like at the airport when you first arrived?

The first person who meet us she was a woman and she was very rude woman. After that we refused to talk to her because she was really shouting at us and she was rude. There was somebody else who came to talk to us they were alright actually because they saw my situation we were six people who applied we don’t know each other I had only my brother and my son was with me. But there were other people as well they put us altogether but one of the officers when he was passing he saw my situation because I couldn’t sit at all on the chairs because I was full up I was nine months pregnant so he saw me and he didn’t believe actually first time that I was pregnant because I am not allowed to travel on this time. He took me straight away to the doctor to check me I was surprised because the doctor she told them she’s full after that after the doctor she said that I wait seventeen hours in the airport just for meetings which was which was between five minutes talk they would leave us for five or six hours just sitting there, you don’t know anything you know you can’t talk to anybody, nobody answer your question just wait and see what is going to happen, which is real scary actually the situation because you don’t know what is going to. We came from a really scary country situation if you see a policeman you would be terrified so we were terrified actually at that time. After that after they had finished their interview they just send us to this hostel which I just told you about what happened.

What made you surprised when the doctor confirmed you were pregnant?

After she confirmed I’m pregnant you know nobody care they told them she’s full up she’s full she’s going to have the baby anytime and after that nothing happened they
just left me sitting on the chairs to talk nothing happened at all nothing. Just stayed everybody with me all of us we went out together didn’t make any difference.

Mmm

And that was really sad you know and maybe dangerous

And from what you know now having been here for six years has the situation improved?

No its very bad, its worse than before

Really

I see the people now you know they are coming they now of course they have changed even the payment for them there is no payment. They give them these vouchers now which is it’s a very err what do you call it insulted?

Mmm

Any shop you go into its very insulted because nobody on the staff they know what is this and if you give it to them you have to call the supervisor and the other staff and they will come and stand around to see what is happening and all the queue behind you they will keep looking at you know which is just pointing to you that you are a asylum seeker or you are a foreigner, which is they keeping looking at you and you are really ashamed in this situation, it’s not nice this situation.
So it’s embarrassing?

It’s very embarrassing. I saw this many many times you know I have my sister now she just came living with me 11 months ago, which she is receiving this vouchers it is a really embarrassing thing.

It’s like they take away your adult status

Yeah you just have to stand there like this until they call the supervisor and then another supervisor will come and he will look at it he will keep looking at you all the staff you know they come out they keep looking at you as though you know a different creature it’s just not nice and most of the shops they just don’t accept it even if they have you know they have them in the list they don’t accept it they say we don’t care we don’t want it.

So you have to look around to find shops

Certain shops yeah and even the certain shops they give you they give you a list which should you know they have the name of the shops most of them they refuse it. I have my sister with me this is 11 months I have her with me. I went to the council I have trouble with the council myself because I kept her with me because she’s not allowed to stay in London anymore, which is this is a new law nobody allowed to stay in London anymore you know she’s sick she had cancer err they said she can’t get medication anywhere in London if she’s not disabled she can’t do it.

So where do they want her to go?

Anywhere never know they are throwing them now Glasgow, Manchester anywhere. They just find accommodation they’ll send them there to hostels.

So location of other family members is not considered
No not at all. She has no plans she is just waiting this is eleven months she didn’t have any answer from the home office until now nothing at all. Now they start to do give answers for people who have been here in a short while which is one month or two months but when they start to do something they leave the people that came before she came before 11 months and now the people that came yesterday they will have the decision made next week, which doesn’t make any sense. No that’s their system that’s how they work when they have a new law they will leave the people that came before the law. She came 11 months ago and she don’t have an answer and I know lots of people they came last month and they have their decision now which is you know they will know what are they doing. You know I have a friend she had three big err two big all boys one of them is 18 and one of them is 15 and she has a seven year old child with her husband five of them in one room three years they stayed in one room.

Mmmm

They started beating each other many many times I saw her with a black eye you know they start beating each other because they can’t stand each other. You can imagine you are living five people in one tiny room. She started to be very upset she started to be very nervous she break down she was sleeping in hospital three months ago she was taking electric shocks and things because she was nervous down.

So she ended up in hospital and he ended up hitting her because of the living situation?

Exactly exactly and I have another friend they are nearly separated as well now because they have been living two years and a half in a hotel same room you know if you have one child in the same room you are sitting with them all the time and you are sleeping with them all the time you can’t do anything it drive you mad. So people keep fighting for small things because they are facing each other all the time they can’t even when they are upset go to another room they can’t do that.
So are you saying that you have found social services the least helpful since you have been here?

Definitely, you know social services here what they do they encourage couples to separate get out and that’s it go and find yourself a place, which is funny I find the social services here they act very funny. They encourage people to separate and there is nobody to sit and talk to them and make them together again, nothing like this. OK he hit her once it had to happen between any families fights grow but you don’t have to be separated after that they can work it out but nobody do that.

Do you feel it was worth coming here for these people and yourself because you came here to make things better.

I don’t feel that you know my marriage broke down as well because I had to come not with my husband because it is not easy to come here you have to pay lots of money as well and we separated well he stayed behind and more than a year and this year he find somebody else and he never came. It wasn’t easy for him to get out from the country it wasn’t easy for him to reach London as well which is hard. I was pregnant by him when I left Iraq and he was gone and he never came after that.

And you were waiting for him but he didn’t come?

Mmm even my decision we were waiting for my decision you know all European countries as soon as you have your decision even if it err not political asylum its just leave to remain there in the country you can apply for your family to join you. But here there is nothing like this only if you have a full refugee status, then you can ask for your family to join you.

So you were waiting to hear whether you could stay and then as soon as you know your husband was going to join you?

Yeah yeah my decision took two years three months
And were you expecting him to come?

After all this time no we separated after August. I was damaged I was totally damaged everybody here even they know I was depressed damaged until now on medication for depression tablets which was a horrible situation for me because there wasn’t any reason except I am far from him and he is far from me and men they can’t stay alone so.

And now you have depression

Yes (cries)

Take your time would you like to take a break or stop?

No no it’s fine

And how are you coping with the depression?

Sometimes no sometimes it is hard you know when you have kids here its very hard you know I am still suffering here I am alone here. I don’t miss my husband it’s gone you know but I am alone here with two kids which is err. I had a school here in (names area) for which is but they didn’t care I had a house here I lived in (names area) for three years everything I have is here my kids in school I couldn’t move them they refused totally to move to another area school. Every day I am coming here every morning I am coming here for which is hard you know for a single person to do all this by yourself so nothing is helping me to remove this depression.

And like your friends that separated who did not get any help or counselling have you not been able to get any counselling or help with your depression?
I had counselling before but I did not see it do any help because it’s just talk there is no action. I study the counselling now myself and I know it’s only talk somebody will sit in front of you and listen to you and feel sorry for you which doesn’t help me at all.

I can sit with my friend err I learn I study it myself so I know I learn it myself to start talking before I don’t talk about my problem my personal life with anybody but now I can talk to anybody.

So you’ve started to study counselling, what made you decide to do that?

Um I don’t know, I want to help myself to understand why I like this to understand what’s my problem. I want to help myself it’s not easy you know when you have the same situation everyday same hard things everyday it’s not easy. Sometimes I am OK, I am very good doing very well and sometimes I am very down.

And are you going to use your counselling to help others as well?

I should be able to continue in September to do more another course, which will help me to work as a counsellor.

What made you decide to come from Iraq without your husband?

It’s not easy to go all of you together or to travel all of you together because you have to buy passports false passports because they don’t give us Visas because we are Iraqis. You have to buy false passports to come all this way and it costs thousands of dollars pounds it costs a lot. So we decided I would come first as I was full with my son and then he would come later.

Could you tell me how it is to buy false passports?
It is difficult it is a terrifying situation as well because you don’t know what is going to happen you don’t know what if they’re going to cheat you because there is black market there is people that just cheat you they took the money and then they run away. And they give you maybe just passport to come in and when you look at it you will know if you are an airport officer and you viewing and you would know that this is a not good passport. So it was just luck for me, six years ago it was easier because they not check the passport as much where now it is very very difficult.

You must have been quite desperate to come here to go through all of that?

Nobody would come here if they were not desperate especially I am telling you I know my people Iraq, you know before Iraq was a very good country and we are very very you know educated people we don’t need to go out, we are very our country is very rich and we have a thing there we have a houses very nice houses we have our education our schools are very good so why would we go out we don’t need to go out but you can’t live there anymore. It’s just a very bad situation you are terrified from everybody there because if you sit with your friend there they might take a tape recorder for you and they just kill you for that reason. Anybody could kill you at anytime. I have a friend my cousins they just got killed like this they were sitting at home talking between each other and they killed them just talking about the government just for making a joke about the government. That’s it that’s a terrifying situation I mean you don’t know anytime we thought in the first war to leave the country which was in the early eighties we didn’t believe it was going to last for eight years now it would finish tomorrow or the day after we stayed. But when the second war start which was a shock for all the Iraqis which make me sad as well when I come here I see the people here believe that we wanted it, we were encouraging the government, which was all lies we did not want it. The news here is all lies we don’t encourage anything. We don’t have any reason you know to go to war. To leave the country if he don’t do all these things you know at anytime you could have a war.

And how do you feel about it all now?
If my country gets better definitely I will get back.

**If you were to describe yourself (as an asylum seeker here) to somebody who does not know anything what would you tell them?**

I would prefer to be there in my country because you know I’m telling you I was telling my children last week whatever they will do, my children don’t speak my language now, whatever they will do they will stay as a foreigner here. I was in the hospital with my daughter last week and a woman she told me ‘you bloody foreigners’ I was in the hospital and she well my daughter she want the TV as well because the TV was shared in the room and she just took the TV without asking her and put it inside her curtains and my daughter she asked the nurse to put it back she was looking at us and she said ‘bloody foreigners’. So whatever we will do here as refugees we will still be foreigners. This woman called my daughter ‘a cow’ in the hospital she saw my daughter, as a not English bastard and you will find like this everywhere.

**So as asylum seekers you will always be stigmatised?**

Yeah, and we came away from our country because we are stigmatised because my husband is a Kurd and you find it here. I find kids in the school they told us the same things, “you go back to your country why you are here”. They tell them this. I know it will get better you know not like the beginning the beginning is very hard really you know because of the language and because of the change of err you know style err lifestyle but its gets better when you get used to it when you start knowing the people one day when you have your own place you know and when they have flats or something then they will start settling but the problem here takes a very long time. It will get better well still they will have different problems but not like the beginning the beginning is really hard.

**What’s the hardest about the beginning?**
It’s hard you know if you have kids as well you know err I stayed I was trying to put my son in a nursery school, I went to the school I put his name he was 4 years 5 months I put his name down for the nursery school and they said no you should have put his name down when he was 2 and I said OK I just came to the country what do you mean I should come when he was two. They say I don’t know care where we are where you, you know we don’t have to give him a place because we don’t have a place he stayed without a place and I have to put him in a place which is for the homeless as well homeless people I put him in part time there which was err I don’t think in my country he was err in a private school.

Right

He went in private nursery it was really hard for me to put him in that place hard to do that.

So you had money in your country

I did have money I was in a very good job a good situation I am struggling here to make my life the same but it is not easy here as life is very expensive. It is not easy for a single person to do it is hard. My husband was jewellery and I used to work in Saudi Airline there. Of course after the war they all run away all of them there is no airline anymore they just close it down.

So you both had very good jobs

I had a good job yeah my son was in a private nursery and then I came here no job and had to put my son in a nursery that wasn’t suitable but it was the only thing I could put him in. Nobody accept him, state school they don’t accept because you have to put his name when he was two, which is err I went somewhere else they refuse Catholic schools refuse because we are Muslim they refuse us totally which is you have to wait until he is err big school they accept him in the term when he is five.
How did you find out about places that could help?

I was coming here they find me you know they told me everything about the area about where to go, here they help me a lot and there is another place as well here in (names area) which is they help us as well. There are two centres here which help me a lot. They do the same thing as well the same people that come here go there as well all of them.

How did you find out about the centres?

I was in the hotel actually and err I think maybe (names support worker) or somebody they used to come to the hotel and visit the hotel and see if there is any new families coming there to bring them here. So I start coming here first and then they told me about the other place they told me they had English courses and whatever so I start going there and I took an English course for a few months.

Your English is very good

It’s from my school you know I took courses there as well just after the third class the British Council in Iraq they gone away as well. There is no British council anymore there. The teacher here she told me this is only basic you don’t need the basic so I start they open a child care course and I start doing it and I did it and I took diploma in child care.

And do you use that now?

I do part time you know work err a crèche just a crèche for kids I come here sometimes and help as session worker because still I can’t work full time because of my kids its good yeah.
What do you feel if anything at all has been the most helpful to you to get you through everything you have just described?

When I finished my course when I could make something which was very difficult you know because it’s very difficult when I used to have a very small baby you know I mean she was just born and they had a drop in where they could take care of the baby as well my son in the nursery downstairs which was very good for me.

On the other hand could you tell me about what has been the least helpful for you?

Yeah I after the hotel I moved to a temporary flat which was very dirty as well and the council they refused to clean it even paint the wall which was very dirty he told me to paint it yourself. Err and it was full of cockroaches all the time even when I open the fridge cockroaches would come out, they come from the fridge. I couldn’t put anything any biscuit down the cockroaches they used to jump on it. I stayed in this flat for 2 years and a half.

How did you cope?

I can’t do anything, I have to. I called the council I talked to them the council she told me you shouldn’t talk anything you should be grateful you have a roof on your head, that’s what she told me. He came to the flat the housing officer once and he saw my daughter she was crawling on the floor my daughter’s knees was black you know her pyjama was black from the carpet and he says I can’t do anything for you. He said go and do it yourself. The last months before I leave the building they renew all the carpet but I stayed 2 years and a half on this dirty place and they moved me and they said to (names area), which is very far from where I lived and I did everything here and when I tried to refuse they said if you refuse that’s it we remove you from the list and you are not homeless anymore so you have to accept it I had to go there.

What’s it like?
I don’t like it there at all. I can’t move my kids’ school there or let them go out because they’re kids and the area is not suitable for kids at all. The flat is OK but the area is rough you know. It’s all drugs it is not for single woman to live there with little kids. Until now I’ve been there nearly three years I don’t let my kids go out not at all, they come home from school I lock them I can’t let them out. They should go out garden downstairs and play in front of the door, no, no way it’s not safe. This made me depressed if you come from a good place a clean place and you end up like this what you think? You came to make a good life to make a good life better but you came to this situation which is treat you like you are a dirt it’s not nice like you are a beggar. I felt like I am begging I was shy I never went to the council if they when they moved me from the hotel I was very annoyed the woman from the council she called the hotel manager and she told him how she look like? Because we have never seen her before. I came only the first day when I went there and they re-house me in this hotel and they never see me anymore. They just call to the council by phone and they told them the address to go to this flat. I never went there I never took anything from them because I feel shy to ask for anything. I would ask but like I told you when I told her there was things like this in my flat she said I should be grateful you have a roof on your head. I don’t ask until now because I don’t want to hear things like this because I am not a beggar. It’s hard for me to do it myself because I am not earning this much of money it’s hard for me to do it myself, I swear to God I pay lots of money for just painting the flat. Even my flat now they used to give people you know help but they don’t now, I ask them for a grant they refuse they used to give they still give but when I went there and ask them they refuse, I don’t know why. They just pick people and they give them and they refuse the others why is that I don’t know. They give people which they have husbands they have families and can manage themselves and I am a single mother with two children under 5 both of them was at that time and they refuse to give me the grant and I until my when just last year I finish to pay £1,000 they give it to me. It’s got worse now they give £10 and £25 vouchers a week to live on I don’t know for families but my sister take that. £10 is not enough for anything you can’t go anywhere a travel card is what £3.80 is not enough for anything.
**Before you came from Iraq did you think it was going to be this bad?**

No no not at all you know the picture we have it about England is totally different that they would treat us more better than this. I hear a lot about other European Countries which is they treat them much better.

**Do you regret coming here?**

No I don’t regret coming to England because especially the language was very easy for me I don’t regret you know I make a good thing for myself here as well you know it’s not I regret it but it’s still hard after 6 years for me it’s still hard. It’s not easy it should be very easy now. It’s very expensive there is not much help now my children err are I have my child he is depressed when you go to the GP and you have this system err only you have to go to GP you can’t go to specialist yourself and you have this system this is nearly one year and a half my child because he has a depression because of what happened to me and the separation of my husband and me. He have they call it alapeacia which is he is loosing hair from his head which is that is caused by stress. I ask for the sickness I told the GP what is this and he told me what stress a child like this he will have? I feel like my hand is just blocked because I can’t take him to a private doctor to have a look at him to know what is this what because this GP doesn’t know anything. You can’t go to the hospital and ask to see a specialist because then you have to go through the system through GP, which is up to him, and the system is not helping me. You have to go through the GP, the GP he will lie because the GP have limited of money to spend so he will won’t spend you to specialist because then he have to pay. He won’t it’s money it’s all related to money. It’s difficult to find a GP and then even when you find a GP it’s difficult to get help. GP’s very bad I was trying to remove myself from a GP to another GP and all the GPs same area they refuse because the law say that you can’t remove yourself from a GP to another GP in the same area, which is I don’t know what is this law?
Right

It's I don't know they put laws that are no not going to help the people. Like if you went and you had a fight with a GP what are you going to do then nobody is going to see you because you had a fight or something it's just you have to find a solution for the people.

Mmm

Nobody will hear your voice, who's going to hear your voice? It is hard I am not happy at all with my children my children education. I live in (names area) because I don't want to go the (names area) area my GP would send me to (names hospital) hospital which I would be treated very badly there I came from there to here I came to here in hospital because I know here they treat you as a human being in this hospital but there no you will stay five or six hours nobody will even talk to you because the money they just spend it on the other part of the area it's not like money in this part of the area. (names area) is very very posh area which is the same as (names area) but other area is very very bad. It's luck of which area you are put in I have people that have lived in same hotels as me they have flats on the river in (names area) and I am in (names area) it makes you upset it makes you angry. I can't do anything about it that's it you can't say anything about it, you are homeless that's it you have to accept whatever we will give you. People like this (points to centre) are the most helpful they will talk to you they will come down to your level and talk to you and they try to help you however they can they try to make the phone calls they try to argue the council for you but otherwise if you go to the council yourself nobody will they will shout at you.

When you say come down to your level is that how you are made to feel down?

Mmm it's hard I cried a lot but now I find it easier to talk about it before I cried a lot because of this but now I get stronger. Like me I came with a little bit of language can speak for myself but you find people here they do not know how to say yes or no
these people they I know the council and the people that work in the council if you went there and you don’t know what you are talking about you don’t know the law they will play ball with you believe me. They just shout at you they just tell you err whatever they will give you whatever they want people know they are sending them to hotel families to hotel with no kitchens no fridge no nothing and how do they expect you to talk I don’t know. They come here carrying all their pots all their bowls and food and they cook here. Families with babies with how would you put them like this? I know they have places they have lots of hotels here with kitchens to deal with housing problems I don’t know maybe they want to punishment, punishment the people people there they run away from bad situations they should I don’t know they should keep them carefully because these people they are upset already you just they are mad all of them they might do something wrong you know because if you treat a person who is upset already treat them bad as well he will do something bad as well. I don’t tell you everywhere you get bad treatment but if you are upset and don’t know the law don’t know what are you talking about they treat you bad. You have to be equal with them to talk to them know how to answer know whatever they are asking you then you they can’t play with you otherwise yes they will.

It seems to me you are becoming stronger and more able

I am not able until now when I used to go to the council it would be terrifying I don’t go now I am trying since I moved there I am trying to move from this area to come back every time I send them a letter they send me zero point I never get any point they don’t want. You have to play tricks you have to pay money to GPs to get false letters you have to play tricks on them and lie and then they will give you whatever you want.

So some GPs will sell false letters?

Yeah some will do that they will, they sell letters to asylum seekers saying they are depressed and that their housing is making it worse that they have this problem and this problem and they get points from the council and they will re house them quickly.
I see

And they don't care I have depression for more than 5 years now, my son he have it as well and they don't care they don't care because the GP which I have he doesn't do that, he doesn't know anything at all I don't know how he is a GP or how he is a doctor, I know more things than he know I don't know how he is there whatever you go he says I don't know what's this?

You've talked a lot about the harder things what about now what things do you enjoy?

Seeing my kids get an education and seeing them being treated better than I because I think when they grow up they will speak the language here they will be more stronger than me when I came. I hope they won't face the racists and these things just I hope that. I hope they will be good because still here its very scary you know I am telling you because I am in this area I am scared about my children that they will learn the drugs or because they are mixed with the other kids in that area its scary. I am worried police with dogs they are running kicking doors I am scared to answer the door. In my country you know who is your enemy the government is your enemy now I don't know who is my enemy. I am forced to be scared.

And perhaps forced into world that is not you?

Yes I don't do anything now I can't do anything about it I don't know how to play these tricks no I don't know, you have to be clever to play these tricks. They will put you into posh houses I am telling you just by luck by how you play it. I know people they nothing wrong with them and they put them into very good places. I don't know why families together with husbands I don't know why.
It must be hard for you without your husband?

It was very hard for me very bad until now it's not as hard to cope with as a single woman. I was crying all last week I was terrible it was horrible last week, my daughter I the hospital I am alone there I don’t know what to do. Somebody to bring me food I was eating her food because nobody can go outside and bring food to me I was eating her food because she did not eat not easy to be on your own and be a woman and I have my son it’s not easy. My son he is very very angry person. Since she came back from the hospital he is very hard with her because he think I was with her in a posh place, not hospital. He feel very jealous you know because of what happened to us she born he blame her for all that happened because she born on the first day when we arrive here so he blame her for all the changes in his life. He loves her now but he still upset all the time with her, he can’t he has to hit her all the time.

How does that feel for you?

For me it’s bad because I can’t settle him down I tried but I couldn’t. He is still angry still the same he is still upset. Because he see himself other people have perfect family perfect places and he have he don’t because I can’t afford to make it for him, I make it the best I can for him but I can’t I can’t afford it. It’s not easy.

I am aware that you have told me some hard things for you, how are you feeling now?

Same as usual I am always a bit sad about these things and I don’t know what to do.

Well is there anything we can do right now that might cheer you up a bit?

Not really

169
Could you tell me about what you enjoy doing most these days?

Being a mother to my children and seeing my friends.

How was it to talk to me?

OK

And how are you feeling now having talked to me?

OK fine

I am aware that you have talked about some very personal and painful issues and I was wondering if you want to talk about anything else before we end?

No I am fine I can talk about these things now

And that feels like personal progress to you?

Yes I am fine

OK great thank you very much.

Well thank you very much

Thank you
Dear Ms Atcheson

Refugees Talk Back (ACE/2001/03/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2001/03/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 14 June 2001
Date of expiry of approval by the Advisory Committee on Ethics: 13 June 2006

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Professor L J King, Chairman, ACE
    Mr R Draghi-Lorenz, Supervisor, Dept of Psychology
A STUDY OF MENTAL HEALTH PROFESSIONALS’ ATTITUDES TOWARDS ASYLUM SEEKERS

Abstract

Attitudes towards a client group may have a vital impact upon their treatment. Indeed, Carvel (2002) found that asylum seekers are being denied support from British so-called caring professions. This study explored 249 mental health professionals’ attitudes towards asylum seekers by administering a questionnaire measuring participants’ attitudes on five domains: human rights, psychological problems, professional intervention, control and neediness, which were confirmed with exploratory factor analysis. The results also showed significant differences on these attitudes depending on a variety of independent variables. Prior contact with asylum seekers, personal motivation, positive attitudes towards specialist training, and being a woman were associated with more positive and hopeful attitudes towards professional intervention with asylum seekers and more supportive attitudes towards their human rights. Organisational motivation, no prior contact, and lack of interest in specialist training were associated with more reluctance to work with asylum seekers and more negative attitudes concerning their human rights. Among the professionals with no prior contact with asylum seekers counselling psychologists and psychotherapists were found to be more sensitive towards asylum seekers’ human rights than clinical psychologists, advocates and social workers. It is suggested that the findings of this study have important training and practice implications for professionals working with asylum seekers, who may be influenced by social and political trends rather than maintaining an apolitical and non-judgmental attitude towards their clients.

Key words: asylum seekers; mental health professionals’ attitudes.
Introduction

Asylum Aid (1999) described British society’s general attitude towards asylum seekers as dismissive and ambivalent. They also critique current political attitudes as being antagonistic, especially the adoption of a ‘hard but fair’ approach to asylum seekers’ human rights. Blunkett reported that he wanted to construct a “tough and tender system” which “welcomes real refugees, encourages legal foreign workers, and deals swiftly with false asylum claims” (2001: 4). It would seem that the political hope is that by distinguishing between deserving and non-deserving asylum seekers Britain will be able to fulfil moral obligations to help real ‘victims’ and avoid being cheated by false claimants. However, Harris (2002) questions the ability to categorise asylum seekers accurately, arguing that this attempt to label simply constructs a culture of disbelief. It is unlikely that any human can be truly neutral and listen with a purely objective ear: injustice must often prevail. Harris (2002) suggests that this is perhaps in order to perpetuate society’s dismissal of asylum seekers’ needs. Asylum Aid (1995; 1999) similarly argues that this ‘tough and tender’ approach ingrains a ‘guilty until proven innocent’ attitude into all policies concerning asylum seekers. This culture of disbelief has perhaps worsened since the terrorist action of September 11th, 2001 as asylum seekers are not only suspected of fraud they are even sometimes suspected of being potential terrorists.

Harris (2002) suggests that since mental health professionals are a necessary part of our society these disbelieving attitudes may well be present in their consulting rooms. This obviously has worrying implications for practice: “Asylum seekers are being refused treatment by NHS psychologists on the grounds that they are too traumatised, too time consuming and have little grasp of the English language” (Carvel, 2002: 6).

Indeed, Papadopoulos (2001) advocates that concerns for practice exist even when professionals accept asylum seekers’ need for treatment. Papadopoulos (2001) found that some professionals have a tendency to overly focus on their asylum seeker clients’ traumatic events, and therefore overly perceive them as victims. She defines
this as 'the phase of devastating events' (Papadopoulos, 2001). This is obviously concerning because it may place asylum seekers 'between a rock and a hard place'. Even when they are not labelled as 'frauds' they risk being seen as too damaged to benefit from treatment. Even more concerning is the fact that these attitudes are indeed somewhat reflected in the relevant health literature.

Within current psychological literature there does seem to be a certain amount of victim construction associated with asylum seekers. Van der Veer (1998), for example, concentrates on asylum seekers' tendencies to suffer from depression and, as a result, describes them as a generally emotionally unstable population. Further, Shepherd (1992) and Lunde and Ortman (1992) similarly emphasise the risk of pathological developments by focusing on asylum seekers with post traumatic stress disorder. Moreover, Keane, Albano and Blake (1992) found that asylum seekers often exist in a state of learned helplessness and external locus of control, resulting in their inability to benefit from short term therapy. Scarry (1985) states that asylum seekers are frequently too traumatised to be capable of change, and goes as far as to describe them as resistant to professional intervention.

However, Bylund (1992) contradicts this victim construction with the theory that asylum seekers must be emotionally stable to have been able to escape from terrifying situations. Bylund reports findings indicating that asylum seekers have "immense capacity" for survival both physically and mentally (1992: 53). Rousseau, Said, Gagne and Bibeau (1998) similarly found that adolescent asylum seekers were able to show signs of resilience quickly, especially if they could gain some insight into their situation. Moreover, Van der Veer (1998) found that adult asylum seekers have both the willingness to engage and the capacity to change with adequate professional intervention. Indeed, Vesti and Kastrup (1992) designed insight therapy on the basis that, with therapeutic help to understand their experiences, asylum seekers could rebuild their self-esteem, take control of their new lives and develop an internal locus of control.
To summarise, two polarised attitudes seem to exist within the literature. Within the political literature asylum seekers are categorised as either deserving or non-deserving. Within the psychological literature asylum seekers are categorised as capable with an internal locus of control or victims incapable with an external locus of control. These two polarised attitudes also seem to overlap. Perhaps the most ideal humanistic attitude is deserving and capable. However, attitudes are commonly expressed within political literature suggesting that the asylum seekers that are non-deserving but capable are in fact in some way 'fraudulent' as they are attempting to cheat the UK's social systems for economic reasons. Another common public opinion is that asylum seekers are victims, deserving but incapable and very needy (Carvel, 2002). This attitude also exists within psychological literature. Along this polarisation there is a fourth attitude that is not often expressed, which is that asylum seekers are non-deserving and needy. These polarised attitudes are illustrated in Figure 1 overleaf.
These different views are not irreconcilable. For instance, Roberson (1992) argues that resistance to engage in therapy is indicative of the fact that asylum seekers have often suffered a lot of betrayal from people in power and should not be interpreted as typical of a deserving but incapable and needy client.

It is noteworthy that these polarised views are expressed in literature written by those professionals with an explicitly established interest in asylum seekers. Attitudes towards asylum seekers may be different within the general population of mental
heath professionals as several differing factors may play a role in shaping professionals’ attitudes.

McGuire (1995) believes that attitudes are formed through experience of the attitude object. Therefore, professionals who have had direct therapeutic contact or specialist training on working with asylum seekers may be more positive towards them. At the same time, it may also be true that those who seek to work therapeutically with asylum seekers have more positive attitudes from the outset. Either way, one would perhaps expect a positive association between ‘positive’ attitudes towards asylum seekers and amount of previous contact and motivation to work clinically with them.

Further, professional speciality may impact upon attitude. There may be a difference between practically trained professionals such as social workers and advocates, and professionals who focus on the internal processes and worlds of their clients, such as psychologists, psychotherapists and counsellors. Moreover, as counselling psychology primarily considers the therapeutic relationship rather than diagnostic categories (Woolfe, 1996) there may be a difference in attitudes between counselling psychology and clinical psychology professionals.

Other impacting factors may be age and gender. Trench (1999) suggests that older generations that experienced the Second World War will be more sympathetic towards refugees escaping war. Bylund (1992) found that gender impacts upon attitudes towards asylum seekers with females tending to be more supportive and empathic. She also found that females consider the asylum seekers and their family’s plight more sympathetically with less disbelief and cynicism than males (Bylund, 1992).

It is important to study attitudes because they can have a strong impact on professionals’ actions. According to the ‘three component model’ of attitudes (Eagly and Chaiken, 1993) an attitude is a combination of three conceptually distinguishable
reactions to a certain object (Eagly and Chaiken, 1993; Zanna and Rempel, 1988). These reactions are specified as affective, cognitive, and behavioural. Affective reactions refer to feelings or emotions associated with an attitude object; cognitive reactions refer to beliefs or thought about an attitude object and behavioural reactions refer to past behaviours or behavioural intentions with respect to an attitude object. The three-component model claims that the three defined components of attitudes are only moderately correlated. This model suggests that in order to understand attitudes towards an attitude object affect, cognition and behaviour towards the attitude object need to be examined.

The purpose of this study is to explore mental health professionals' attitudes towards asylum seekers and the impact of background and professional characteristics, such as motivation to work with asylum seekers, desire for formal training, and prior contact. In order to achieve this five hypotheses about professionals' attitudes and the factors that impact upon these will be explored.

1. It is expected that professionals who have had prior contact with asylum seekers will hold more positive attitudes towards asylum seekers in all five attitude domains: human rights, psychological problems, professional intervention, control and neediness.

2. It is expected that there will be a difference in attitudes in all five attitude domains between the participants on the grounds of professional speciality.

3. It is expected that participants who are personally motivated to work with asylum seekers will hold more positive attitudes in all five attitude domains towards this population.

4. It is expected that attitudes towards formal training in this area will impact upon professionals' attitudes in all five attitude domains towards asylum seekers.

5. It is expected that a gender difference will be found with females being more positive about asylum seekers in all of the five attitude domains.
Method

Sample

For this study, 660 professionals were approached to take part. A random sampling interval approach (Fife-Schaw, 2000) was used to select 400 (200 counselling and 200 clinical) chartered psychologists, from their current professional register. As asylum seekers are often treated in multidisciplinary teams, 200 questionnaires were also sent out to community mental health teams and welfare services departments. These were addressed to advocates, counsellors, psychotherapists, social workers and any other speciality therapists, such as speech therapists, who were contacted through the social services register. Of the 200 services contacted, 55 were known specialist asylum seeker services. Finally, 30 trainee counselling psychologists from the University of Surrey and 30 trainee clinical psychologists, on placement within the same mental health trust as the researcher, were also approached. Equal numbers of male and female professionals were approached. There were 249 completed questionnaires that were returned (38% response rate). Table 1 illustrates a complete summary of the participants' background information.

Although equal numbers of professional disciplines were approached, this balance was not represented in the sample. Only 31 (12.4%) chartered counselling psychologists responded, compared to 185 (55.4%) chartered clinical psychologists. Further, only 5 (2.0%) trainee clinical psychologists chose to take part in this study, although 27 (10.8%) trainee counselling psychologists participated. Moreover, only 2 (0.8%) psychotherapists, 8 (3.2%) counsellors, 12 (4.8%) social workers and 6 (2.4%) advocates completed the questionnaires out of a possible 200. Finally, 20 (8.0%) professionals who classified themselves as "other" participated. A large gender difference also existed within the participants with 177 (71.1%) females responding but only 72 (28.9%) males. This obviously has implications for sample representativeness, which will be discussed later in this research report.
## Table 1 Summary of Participants' Background Information

<table>
<thead>
<tr>
<th>Variable</th>
<th>Number of Participants</th>
<th>Response Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>249</td>
<td>38%</td>
</tr>
<tr>
<td>Number of Participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response Rate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>177 (71.1%)</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>72 (28.9)</td>
<td></td>
</tr>
<tr>
<td>Male Age (years): Mean</td>
<td>42.1</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>22 - 74</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>Female Age (years): Mean</td>
<td>46.2</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>21 - 65</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>9.8</td>
<td></td>
</tr>
<tr>
<td>Age (years): Mean</td>
<td>43.22</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>21.00 - 74.00</td>
<td></td>
</tr>
<tr>
<td>SD</td>
<td>10.34</td>
<td></td>
</tr>
<tr>
<td>Professional Speciality:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counselling Psychologists</td>
<td>31 (12.4%)</td>
<td></td>
</tr>
<tr>
<td>Clinical psychologists</td>
<td>138 (55.4%)</td>
<td></td>
</tr>
<tr>
<td>Trainee Counselling Psychologists</td>
<td>27 (10.8%)</td>
<td></td>
</tr>
<tr>
<td>Trainee Clinical Psychologists</td>
<td>5 (2.0)</td>
<td></td>
</tr>
<tr>
<td>Psychotherapists</td>
<td>2 (0.8%)</td>
<td></td>
</tr>
<tr>
<td>Counsellors</td>
<td>8 (3.2%)</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td>12 (4.8%)</td>
<td></td>
</tr>
<tr>
<td>Advocates</td>
<td>6 (2.4%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>20 (8.0%)</td>
<td></td>
</tr>
<tr>
<td>Overall Experience With Clients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Clients Seen</td>
<td>106 (42.6%)</td>
<td></td>
</tr>
<tr>
<td>1 - 100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>101 - 500</td>
<td>56 (22.5%)</td>
<td></td>
</tr>
<tr>
<td>501 - 1000</td>
<td>82 (32.9%)</td>
<td></td>
</tr>
<tr>
<td>Over 1000</td>
<td>05 (2%)</td>
<td></td>
</tr>
<tr>
<td>Overall experience with Asylum Seeker (AS) Clients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>111 (44.2%)</td>
<td></td>
</tr>
<tr>
<td>One to ten</td>
<td>91 (36.5%)</td>
<td></td>
</tr>
<tr>
<td>Eleven to fifty</td>
<td>30 (12%)</td>
<td></td>
</tr>
<tr>
<td>Over Fifty</td>
<td>17 (6.8%)</td>
<td></td>
</tr>
<tr>
<td>Any Contact with Asylum Seekers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>142 (57.00%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>102 (41.00%)</td>
<td></td>
</tr>
<tr>
<td>Training with Asylum Seeker Clients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23 (9.2%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>225 (90.4%)</td>
<td></td>
</tr>
<tr>
<td>Wish for training with Asylum Seeker Clients Participants' Response:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>67 (26.9%)</td>
<td></td>
</tr>
<tr>
<td>Possibly</td>
<td>112 (45.0%)</td>
<td></td>
</tr>
<tr>
<td>Not Sure</td>
<td>41 (16.5%)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>27 (10.8%)</td>
<td></td>
</tr>
<tr>
<td>Motivation to work with Asylum Seekers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organisational</td>
<td>57 (22.9%)</td>
<td></td>
</tr>
<tr>
<td>Personal</td>
<td>46 (18.5%)</td>
<td></td>
</tr>
</tbody>
</table>
Measures

It was deemed useful and appropriate for this study to offer a definition of asylum seekers in order to ensure a common understanding of the term for all participants. Therefore a definition constructed by the researcher using Harris’ (2002) global, non-judgmental, and apolitical conceptualisation of asylum seekers appeared on the top of the questionnaire on attitudes (see Appendix B). Asylum seekers were defined as: ‘Individuals seeking citizenship in the UK because they no longer feel able to stay in their home country’.

A short questionnaire was also used to ascertain demographic information (see Appendix C). This asked for details of participants’ gender, age, professional identity, number of clients they have worked with and number of asylum seekers they have worked with. It also asked for details of their personal contact with asylum seekers, formal training for working with asylum seekers, motivation to work with asylum seekers and, finally, desire to receive training in this area.

The questionnaire measuring professionals’ attitudes towards asylum seekers (see appendix B) was designed using Eagly and Chaiken’s (1993) conceptualisation of the ‘three component model’ (as briefly described in the introduction) as a theoretical base. Therefore, each dependent variable theme, (such as human rights), had at least three questions pertaining to it: one question about the participants’ feelings towards the attitude object (i.e. asylum seekers), one asking about their beliefs, and another asking about their behaviour (whether actual or possible) in regard to the attitude object.

The items were based on attitudes and categories of attitudes derived from a literature review and a previous qualitative study that investigated asylum seekers’ own experiences and narratives. Asylum seekers’ responses to these questions formed the basis for the development of five scales: human rights, psychological problems, professional interventions, sense of control, and neediness. Twenty nine questions were presented to respondents in Likert format with a 7-point scale ranging from
strongly agree (1) to strongly disagree (7). A Likert scale is the most popular scaling procedure in use today (Oppenheim, 1998), particularly when attempting to measure attitudes (Anastasi and Urbina, 1997).

Pilot work

The whole questionnaire was piloted (Oppenheim, 1998) at the researcher’s clinical placement and at a homeless family centre. These contexts seemed appropriate because there was at least one representative from each sample group present. The questionnaire was administered to two clinical psychologists, one counselling psychologist, two psychotherapists (one of whom is considered as a specialist with asylum seekers), one advocate, one counsellor, and one social worker (total N= 9). After completion, the pilot participants were informed of the intention to test each item using the three attitude components (Eagly and Chaiken, 1993). They all offered feedback on the questionnaire. Six of the nine participants (excluding the advocate, counselling psychologist and one clinical psychologist) felt that it was unclear as to whether the behavioural items were really asking about their experiences and behavioural intentions with asylum seekers. They perceived eight questions as asking about thoughts or feelings instead. Further, all of the participants considered three items as vague and open to multiple interpretations. All of these items were re-written in collaboration with the researcher’s supervisor to improve clarity. The questionnaire was then piloted again with the same sample and no further corrections were considered to be necessary.

Procedure and ethical considerations

The study was designed as a questionnaire survey carried out over three months. Each of the six hundred and sixty participants received a pack, sent to their professional address, containing a personalised covering letter explaining the purpose of the study and specific instructions for participating (see Appendix A), the questionnaire on attitudes (see Appendix B), a demographic questionnaire (see Appendix C), and a pre-paid addressed envelope.
The data ascertained through the completed questionnaires were entered on to the Statistical Package for Social Sciences (SPSS) version 10.1 (2001) for windows. The responses to the questionnaire on attitudes were entered using the seven point Likert scales.

Sanders and Liptrot's (1993) ethical guidelines for research were followed. These guidelines are based on the 'four C's' of ethical research: competence, consent, confidentiality and conduct (Sanders and Liptrot, 1993: 89). Both the ethics committee and the researcher's supervisor passed the proposal (refer to Appendix E). Within this study all the professionals approached were adults capable of giving informed consent. Further, a letter (refer to Appendix A) accompanied the questionnaire fully explaining the research aims and objectives, in order to enable participants to offer completely informed consent. In order to protect confidentiality, the participants were not asked to disclose their name on the questionnaire and were invited to return them to the researcher by mail. Confidentiality is especially important when asking professionals to comment on controversial or particularly topical issues. In regard to conduct, the researcher conducted in accordance with the University of Surrey's code of practice for research degrees (2000). Further, in order to comply with ethical and professional issues regular supervision sessions were attended.

Data analysis

A factor analysis was run to assess if the expected domains of respondents' attitudes (i.e. human rights, psychological problems, professional intervention, control and neediness) were reflected in the questionnaire. Then as the necessary conditions were met the data were analysed using analysis of variance (ANOVA), t-tests and multiple regression. The independent variables considered were: gender, age, professional identity, overall experience, number of asylum seekers worked with, any contact with asylum seekers, formal training, motivation, and finally desire to receive

14 Continuity of the measures, homogeneity of variance and normality of mean distributions.
training in this area. The dependent variables were human rights, psychological problems, professional intervention, asylum seekers' sense of control, and neediness.

Results

Scale validation

As mentioned before, the items used in the questionnaire were derived from previous qualitative work. In order to test whether the intended scales (i.e. human rights, professional intervention, psychological problems, control, and neediness) were reliable enough to allow for the derivation of composite scores, Principle Component Analyses (PCA) with oblique rotation and Reliability Analyses (RA) were run for each scale. These are discussed below for each scale individually.

1) Human rights scale

**PCA:** This scale included items: 5, 8, 18, 20, 23, 24, 28, and 29. Results yielded a single factor solution, which explained 45% of the variance. Item communalities, indicating the item variance accounted for by the factor, were all above the conventionally accepted minimum of 0.3 (Tabachnick and Fiddell, 1996). Table 2.1 shows the item communalities and factor structural coefficients (i.e. factor loadings).

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Label</th>
<th>Communality</th>
<th>Structural Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Right to employment</td>
<td>0.42</td>
<td>0.65</td>
</tr>
<tr>
<td>8</td>
<td>Right to indefinite stay</td>
<td>0.33</td>
<td>-0.58</td>
</tr>
<tr>
<td>18</td>
<td>Right to financial independence</td>
<td>0.46</td>
<td>0.68</td>
</tr>
<tr>
<td>20</td>
<td>Economic asylum seekers</td>
<td>0.39</td>
<td>-0.63</td>
</tr>
<tr>
<td>23</td>
<td>Validity within society</td>
<td>0.54</td>
<td>0.73</td>
</tr>
<tr>
<td>24</td>
<td>Detaining asylum seekers</td>
<td>0.68</td>
<td>0.82</td>
</tr>
<tr>
<td>28</td>
<td>Wanting a chance</td>
<td>0.16</td>
<td>0.39</td>
</tr>
<tr>
<td>29</td>
<td>Right to citizenship</td>
<td>0.64</td>
<td>0.79</td>
</tr>
</tbody>
</table>
This factor was titled 'human rights' and was seen as measuring the participants' attitudes towards asylum seekers' human rights from both a political and moral perspective.

2) Psychological problems scale

**PCA:** This scale included items: 1, 4, 13, 16 and 17. This time results yielded a two factor solution based on the criterion of retaining factors with eigenvalues greater than 1. However, the interpretation of the solution was not sufficiently obvious and therefore a single factor solution was examined. This actually accounted for 46% of the variance and was therefore deemed valid. Further, item communalities were all above the conventionally accepted minimum of 0.3 (Tabachnick and Fiddell, 1996). Table 2.2 shows the item communalities and factor structural coefficients.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Label</th>
<th>Communality</th>
<th>Structural Coefficients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Problems with autonomy</td>
<td>0.56</td>
<td>0.62</td>
</tr>
<tr>
<td>4</td>
<td>Emotional stability</td>
<td>0.71</td>
<td>0.69</td>
</tr>
<tr>
<td>13</td>
<td>Emotional instability</td>
<td>0.58</td>
<td>0.74</td>
</tr>
<tr>
<td>16</td>
<td>Relocation problems</td>
<td>0.71</td>
<td>0.65</td>
</tr>
<tr>
<td>17</td>
<td>Depression</td>
<td>0.75</td>
<td>0.68</td>
</tr>
</tbody>
</table>

This factor was titled 'psychological problems' and was seen as measuring the participants' attitudes towards asylum seekers' psychological problems, compared to the rest of the British population.

3) Professional intervention scale

**PCA:** This scale included items: 6, 7, 9, 10, 12, 19, 25, and 27. Results produced a single factor solution, which explained 29% of the variance. Item communalities were once again all above the conventionally accepted minimum of 0.3 (Tabachnick and Fiddell, 1996). Table 2.3 illustrates these item communalities and factor structural coefficients.
Table 2.3: Item Communalities and Factor Structural Coefficients for Professional Intervention

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Label</th>
<th>Communality</th>
<th>Structural Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Readiness to offer professional time</td>
<td>0.32</td>
<td>0.56</td>
</tr>
<tr>
<td>7</td>
<td>Asylum seekers’ willingness to engage</td>
<td>0.30</td>
<td>0.55</td>
</tr>
<tr>
<td>9</td>
<td>Neediness beyond professionals’ capacity</td>
<td>0.42</td>
<td>0.65</td>
</tr>
<tr>
<td>10</td>
<td>Necessity of contained settings</td>
<td>0.18</td>
<td>0.43</td>
</tr>
<tr>
<td>12</td>
<td>Asylum seekers difficult to engage</td>
<td>0.38</td>
<td>0.62</td>
</tr>
<tr>
<td>19</td>
<td>Resistance towards professional support</td>
<td>0.29</td>
<td>0.54</td>
</tr>
<tr>
<td>25</td>
<td>Ability to benefit from intervention</td>
<td>0.39</td>
<td>0.62</td>
</tr>
<tr>
<td>27</td>
<td>Right to treatment</td>
<td>0.28</td>
<td>0.53</td>
</tr>
</tbody>
</table>

This factor was labelled ‘Professional intervention’ and is perceived as measuring the participants’ attitudes towards asylum seekers’ relationship with professional intervention.

4) Control scale

**PCA:** This scale included items: 2, 11, 14, 15, and 21. Results yielded a single factor solution. However, looking at the scale reliability when each item is deleted, it was found that deleting item 21 (label, free thinking) improved the scale reliability considerably. Deleting the item was also seen as making theoretical sense because when compared with the other items it was less about having an internal locus of control and more about cognitive independence. Therefore, this item was excluded from further analyses. Once this item had been deleted this single factor solution explained 38% of the variance. Item communalities were all above the conventionally accepted minimum of 0.3 (Tabachnick and Fiddell, 1996). Table 2.4 shows the item communalities and factor structural coefficients after deleting item 21.

Table 2.4: Item Communalities and Factor Structural Coefficients for Control

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Label</th>
<th>Communality</th>
<th>Structural Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Taking control</td>
<td>0.42</td>
<td>0.65</td>
</tr>
<tr>
<td>11</td>
<td>Difficulty taking control</td>
<td>0.48</td>
<td>0.69</td>
</tr>
<tr>
<td>14</td>
<td>Loss of control</td>
<td>0.50</td>
<td>0.71</td>
</tr>
<tr>
<td>15</td>
<td>Vulnerable as no control</td>
<td>0.49</td>
<td>0.70</td>
</tr>
</tbody>
</table>
This factor was titled ‘control’ and is seen as a measurement of participants’ attitudes towards asylum seekers’ control capabilities.

5) Neediness scale

**PCA:** This scale included items: 3, 22, and 26. These results once more yielded a single factor solution, which explained 48% of the variance. Item communalities were all above the conventionally accepted minimum of 0.3 (Tabachnick and Fiddell, 1996). Table 2.5 illustrates these item communalities and factor structural coefficients.

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Label</th>
<th>Communality</th>
<th>Structural Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Neediness</td>
<td>0.51</td>
<td>0.71</td>
</tr>
<tr>
<td>22</td>
<td>Needing help to manage</td>
<td>0.45</td>
<td>0.67</td>
</tr>
<tr>
<td>26</td>
<td>Needing help to be resourceful</td>
<td>0.48</td>
<td>0.69</td>
</tr>
</tbody>
</table>

This factor was entitled ‘neediness’ as is perceived as measuring participants’ attitudes towards asylum seekers’ neediness.

Since all the five scales seemed to be valid it seemed appropriate to proceed with reliability analysis. These highlighted that all of the five scales were at least moderately reliable when all issues were considered. The reliability analysis results are illustrated in Table 3.

<table>
<thead>
<tr>
<th>Attitudinal Scale</th>
<th>Human Rights</th>
<th>Psychological Problems</th>
<th>Professional Intervention</th>
<th>Control</th>
<th>Neediness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cronbach’s Alpha</td>
<td>0.82</td>
<td>0.68</td>
<td>0.63</td>
<td>0.63</td>
<td>0.46</td>
</tr>
</tbody>
</table>
However, the neediness coefficient fell below conventionally accepted levels (i.e. 0.6) with alpha= 0.4673 and indicated the possibility that the scale might not provide reliable scores. Nevertheless, it must be noted that there were only three items in the scale. According to Fife-Schaw (1997) reliability can be significantly reduced by small numbers of items in a given scale. This possibility was seen as the most likely reason for the low alpha, and for this the scale was retained but results involving it were interpreted with caution.

**Descriptive analyses**

The five main attitude variables that emerged after the completion of exploratory factor analysis were: human rights, psychological problems, professional intervention, control, and neediness. Table 4 illustrates the descriptive statistics for these variables and Figure 2 graphically illustrates the means.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Minimum Score</th>
<th>Maximum Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Rights</td>
<td>4.12</td>
<td>1.02</td>
<td>1.00</td>
<td>6.71</td>
</tr>
<tr>
<td>Psychological Problems</td>
<td>2.38</td>
<td>0.66</td>
<td>1.00</td>
<td>4.14</td>
</tr>
<tr>
<td>Professional Intervention</td>
<td>5.61</td>
<td>0.87</td>
<td>2.86</td>
<td>6.57</td>
</tr>
<tr>
<td>Control</td>
<td>1.62</td>
<td>0.49</td>
<td>1.57</td>
<td>3.29</td>
</tr>
<tr>
<td>Neediness</td>
<td>1.30</td>
<td>0.38</td>
<td>1.43</td>
<td>2.57</td>
</tr>
</tbody>
</table>

Note: 1 = strongly agree 7 = strongly disagree
The control and neediness scores are particularly noteworthy. They indicate that participants tended to see asylum seekers as having little control and being very needy with the mean score representing the 'strongly agree' end of the scale. Indeed no respondent believed that asylum seekers had as much personal control as the rest of the British population. Further, all respondents felt that asylum seekers are more needy and have more psychological problems than the rest of the British population.

The greatest range and standard deviation relate to the Human Rights responses, which ranged from ‘strongly agree’ to ‘strongly disagree’. Only 4 (1.6%) participants ‘strongly agreed’ or ‘agreed’ that they had positive attitudes towards asylum seekers’ human rights. Twelve mental health professionals (4%) held negative attitudes towards asylum seekers’ human rights. Further, 37 (14.9%) participants somewhat disagreed with asylum seekers’ human rights, and 106 (42.6%) participants somewhat agreed. The remaining 90 (36.9%) participants were ambivalent towards asylum seekers’ human rights. These descriptive frequencies are felt to be particularly noteworthy and are therefore visually presented in figure 3 and will be discussed later in the report.
Pearson’s correlations were run in order to test for a significant relationship between the five attitude scales. The most significant results were between control and psychological problems ($r=0.39$, $n=249$, $p<0.001$). This suggests that when participants held the attitude that asylum seekers have more psychological problems than the norm, they also believe them to be less in control and vice versa. Another significant result was control and neediness ($r=0.36$, $n=249$, $p<0.001$). When participants held the attitude that asylum seekers are less in control, they also held the attitude that they are more needy. Further, when participants strongly agreed with asylum seekers’ human rights they were also ready to support them professionally ($r=-0.36^{15}$, $n=249$, $p<0.001$).

---

15 This score is minus because all human rights scores were inverted to correspond with other scales.
Table 5: Pearson’s Correlations among Attitude variables (N in parentheses)

<table>
<thead>
<tr>
<th></th>
<th>Human Rights</th>
<th>Therapeutic Intervention</th>
<th>Psychological Problems</th>
<th>Control</th>
<th>Neediness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Rights</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significance (2 tailed)</td>
<td></td>
<td>-0.357 **</td>
<td>-0.040</td>
<td>0.048</td>
<td>0.071</td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>(249)</td>
<td>(249)</td>
<td>(249)</td>
<td>(249)</td>
</tr>
<tr>
<td>Therapeutic Intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significance (2 tailed)</td>
<td></td>
<td>0.282 **</td>
<td>0.131*</td>
<td>0.083</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>(249)</td>
<td>(249)</td>
<td>(249)</td>
<td></td>
</tr>
<tr>
<td>Psychological Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significance (2 tailed)</td>
<td></td>
<td>0.395**</td>
<td>0.304**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td>(249)</td>
<td>(249)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significance (2 tailed)</td>
<td></td>
<td></td>
<td></td>
<td>0.357**</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td>(249)</td>
<td></td>
</tr>
<tr>
<td>Neediness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significance (2 tailed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: * p < 0.05

** P < 0.01

Hypothesis testing

Hypothesis 1: It is expected that professionals who have had prior contact with asylum seekers will hold more positive attitudes towards asylum seekers.

Prior professional contact

Five one-way analyses of variance (ANOVAs) were carried out in order to test for effects of professional contact with asylum seekers on the five attitude scales. The grouping (independent) variable was the number of asylum seekers participants had worked with and consisted of four levels: none (coded as 1), 1-10 (coded as 2), 11-50 (coded as 3), and more than 50 (coded as 4). Each of the five attitude variables was treated as a dependent variable. Results showed that there were significant differences among the four groups only when attitudes towards human rights and professional intervention were considered. Specifically, human rights differed significantly among the 4 groups with $F(247,3) = 3.17$, p<.05. Post hoc tests (Scheffe) revealed that those having had 1-10 asylum seeker clients as well as those having no asylum seeker clients had more negative attitudes towards asylum seekers'
human rights than those with 11-50 or more than 50 asylum seeker clients. Professional intervention differed among the groups with \( F(247, 3) = 5.75, p < .001 \). Participants who had worked with no asylum seeker clients were more reluctant to engage professionally with asylum seekers than the other three groups. Table 6 shows results from the ANOVA reported here.

Table 6: Effects of Professional Contact with Asylum Seekers on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>F</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>3.17</td>
<td>3, 247</td>
<td>0.02*</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>1.06</td>
<td>3, 247</td>
<td>0.36</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>5.75</td>
<td>3, 247</td>
<td>0.00**</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.13</td>
<td>3, 247</td>
<td>0.93</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>0.89</td>
<td>3, 247</td>
<td>0.44</td>
</tr>
</tbody>
</table>

Note: * p<.05  
** p<.01

Prior professional and personal contact

In order to test for effects of any type of contact, professional or personal, on the five attitude scales, a T-test was carried out. The grouping (independent) variable was whether or not the participants had had any contact with asylum seekers. As with the ANOVA described above, each of the five attitude scales was treated as a separate dependent variable. Results showed that participants with no/limited professional or social contact held more negative attitudes towards asylum seekers' human rights and were more reluctant to engage in professional intervention with them.

Specifically, human rights differed between the two groups with \( t = -1.96, df = 242, p< .05 \). Professional intervention differed between the two groups with \( t = 3.65, df = 242, p< .05 \). Table 7 shows the results from the T-test presented here.
Table 7: Effects of Professional and Personal Contact with Asylum Seekers on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>T</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>-1.96</td>
<td>3, 247</td>
<td>0.04*</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.26</td>
<td>3, 247</td>
<td>0.79</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>3.65</td>
<td>3, 247</td>
<td>0.00**</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.25</td>
<td>3, 247</td>
<td>0.80</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>1.00</td>
<td>3, 247</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Note: * p<.05
** p<.01

Hypothesis 2: It is expected that there will be a difference in attitudes between the participants on the grounds of professional speciality

In order to test for effects of professional speciality on the five attitude scales, 5 one-way ANOVAs were carried out. The grouping (independent) variable was the participants’ professional speciality. Again, each of the five attitude scales was treated as an independent variable. The results showed that no differences existed between the participants’ attitudes towards asylum seekers on the basis of their professional orientation. Table 8 presents these results.

Table 8: Effects of Professional Speciality on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>F</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>0.64</td>
<td>2, 246</td>
<td>0.52</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>2.47</td>
<td>2, 246</td>
<td>0.08</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>2.37</td>
<td>2, 246</td>
<td>0.09</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.74</td>
<td>2, 246</td>
<td>0.47</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>0.92</td>
<td>2, 246</td>
<td>0.39</td>
</tr>
</tbody>
</table>

However, it was felt appropriate to test for differences between professional specialisms among participants who had had no contact with asylum seekers because the strength of the ‘prior contact’ effect might mask other significant differences. In fact, differences between professional orientations were found to be significant among professionals with no prior contact with asylum seekers, (F (101, 2) 4.05, p <.05).
Specifically, among professionals with no prior contact with asylum seekers, counselling psychologists (trainees and chartered), psychotherapists, and counsellors were significantly more ready to work with asylum seekers than the other participants. Table 8.1 illustrates these results.

### Table 8.1 Effects of Professional Speciality Between Those Participants Without Contact with Asylum Seekers on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>F</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>1.75</td>
<td>101,2</td>
<td>0.17</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.16</td>
<td>101,2</td>
<td>0.86</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>4.06</td>
<td>101,2</td>
<td>0.02*</td>
</tr>
<tr>
<td>4 Control</td>
<td>1.48</td>
<td>101,2</td>
<td>0.23</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>1.56</td>
<td>101,2</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Note: * p<.05

Hypothesis 3: *It is expected that participants who are personally motivated to work with asylum seekers will hold more positive attitudes towards this population*

In order to test for effects of motivation to work with asylum seekers on the five attitude scales, a T-test was run. The grouping (independent) variable was the type of motivation and this consisted of two levels. The first was personal (coded as 1) and the second organisational (coded as 2). Once again each of the five attitude scales was treated as a dependent variable. Results showed that there was a significant difference on attitudes towards asylum seekers between those personally motivated and those organisationally motivated. Specifically, those personally motivated to work with asylum seekers are more ready to engage in professional intervention with asylum seekers with t = 2.40, df= 101, p<.05. Table 9 tabulates these results.
Table 9: Effects of Motivation on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>T</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>1.96</td>
<td>101</td>
<td>0.05</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.34</td>
<td>101</td>
<td>0.73</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>2.40</td>
<td>101</td>
<td>0.02*</td>
</tr>
<tr>
<td>4 Control</td>
<td>1.51</td>
<td>101</td>
<td>0.13</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>0.56</td>
<td>101</td>
<td>0.58</td>
</tr>
</tbody>
</table>

Note: * p<.05

Hypothesis 4: *It is expected that attitudes towards formal training in this area will impact upon professionals’ attitudes towards asylum seekers.*

Effect of Actual Experience of Formal Training

In order to test for effects of formal training for working with asylum seekers on the five attitude scales, a T-test was carried out. The grouping (independent) variable was whether or not participants had received formal training. Each of the five attitude scales was treated as a dependent variable. Results showed that there were significant differences among the two groups only when attitudes towards human rights and professional intervention were considered. Specifically, participants who had received formal training agreed more with asylum seekers’ human rights with \( t = -2.48, df = 246, p < .05 \). Furthermore, they were more ready to professionally engage with them with \( t = 3.56, df = 246, p < .001 \). These results are presented in table 10.

Table 10: Effects of Formal Training on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>T</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>-2.34</td>
<td>246</td>
<td>0.02*</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>-0.01</td>
<td>246</td>
<td>0.98</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>3.56</td>
<td>246</td>
<td>0.00**</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.53</td>
<td>246</td>
<td>0.59</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>-0.66</td>
<td>246</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Note: * p<.05

** p<.01
Effect of desire for (more) formal training

In order to test for effects of desire for (more) training with asylum seekers on the five attitude scales, five one-way ANOVAs were carried out. The grouping (independent) variable was the participants’ desire for (more) training and consisted of four levels: ‘yes definitely’, ‘possibly’, ‘not sure’, and ‘definitely not’. Each of the five attitude scales was treated as a dependent variable. Results showed that there were significant differences among the four groups, but once again, only when attitudes towards human rights and professional intervention were considered. Specifically, human rights differed among the four groups with F (246,3), = 14.71, P<.001. Post hoc tests (Scheffe) revealed that those who replied ‘yes definitely’ to more training held more positive attitudes towards asylum seekers’ human rights than everyone else. Further, people who replied ‘possibly’ differed from those participants who replied ‘definitely not’ in their perception of asylum seekers’ human rights. Further, professional intervention differed among the four groups with F (246,3)= 7.63, p< .001. Post hoc tests (Scheffe) indicated that participants who replied ‘yes definitely’ to the desire for more training were more ready to engage professionally with asylum seekers. Table 11 illustrates these results.

Table 11: Effects of desire for more training on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>F</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>14.71</td>
<td>246, 3</td>
<td>0.00**</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.45</td>
<td>246, 3</td>
<td>0.71</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>7.63</td>
<td>246, 3</td>
<td>0.00**</td>
</tr>
<tr>
<td>4 Control</td>
<td>2.33</td>
<td>246, 3</td>
<td>0.07</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>1.07</td>
<td>246, 3</td>
<td>0.36</td>
</tr>
</tbody>
</table>

Note: * p<.05

** p<.01

Hypothesis 5: It is expected that a gender difference will be found with females being more positive about asylum seekers.

In order to test for the effects of gender on the five attitude scales, a T-test was carried out. The grouping (independent) variable was gender male/female. Each of the five
attitude variables was each treated as a dependent variable. Results showed that there was a significant difference only when attitudes towards human rights were considered. Specifically, females agreed with asylum seekers’ human rights more than males with t=-2.78, df=247, P<.01. These results are presented in table 12.

### Table 12: Effects of Gender on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>T</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>2.783</td>
<td>247</td>
<td>0.00**</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.755</td>
<td>247</td>
<td>0.45</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>0.424</td>
<td>247</td>
<td>0.67</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.888</td>
<td>247</td>
<td>0.37</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>1.216</td>
<td>247</td>
<td>0.22</td>
</tr>
</tbody>
</table>

Note: ** p<.01

### Effects of age

In order to test for a significant relationship between age and each of the five attitude scales, Pearson’s correlations were run. Results showed a low but significant correlation between ‘Age and Neediness’ (r= 0.17, N= 246, p< 0.01). This suggests a tendency for neediness scores to decrease (i.e. perceive asylum seekers as more needy) as participants’ age increases.

### Effects of overall professional experience

In order to test for the effect of overall experience on the five attitude scales, 5 one way ANOVAs were carried out. The grouping (independent) variable was number of clients and consisted of four levels: 1-100, 101-500, 501-1000, and more than 1000. Each of the five attitude variables was each treated as a dependent variable. Results showed that there was no difference between the participants’ attitudes towards asylum seekers on the basis of their overall professional experience. This is illustrated in Table 13.
Table 13: Effects of Overall Experience on Attitudes

<table>
<thead>
<tr>
<th>Attitude</th>
<th>F</th>
<th>Degrees of Freedom (DF)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Human Rights</td>
<td>2.06</td>
<td>243, 3</td>
<td>0.10</td>
</tr>
<tr>
<td>2 Psychological Problems</td>
<td>0.31</td>
<td>243, 3</td>
<td>0.81</td>
</tr>
<tr>
<td>3 Professional Intervention</td>
<td>0.86</td>
<td>243, 3</td>
<td>0.45</td>
</tr>
<tr>
<td>4 Control</td>
<td>0.61</td>
<td>243, 3</td>
<td>0.60</td>
</tr>
<tr>
<td>5 Neediness</td>
<td>1.39</td>
<td>243, 3</td>
<td>0.24</td>
</tr>
</tbody>
</table>

Regression

Attitudes regarding human rights and professional intervention were regressed from some of the personal characteristics variable in order to identify the most important predictors. Specifically, participants’ gender, formal training, number of asylum seeker clients seen, contact with asylum seekers, and need for more training were entered as independent variables in linear regression analyses.

Regarding human rights the resulting regression model was significant (F (240, 5) = 11.1, p< .001) and explained 17% of the variables variance. The best predictor of human rights in this model was participants’ attitudes about need for more training (Beta= 0.33, p< .001) followed by gender (Beta= 0.14, p, .05). The predictor of number of asylum seeker clients seen was approaching significance (Beta = 0.13, p= .06). Contact with asylum seekers and formal training were not significant predictors (Beta = -0.02, p= ns; Beta = 0.04, p= ns respectively). A graphic representation of the model is shown in Figure 4.1.
Regarding professional intervention, the resulting regression model was significant ($F(100, 5) = 2.782, p < .05$) and explained $8\%$ of the variables variance. The best predictor of professional intervention in this model was participants’ formal training ($\beta = -0.223, p < .05$). Number of asylum seeker clients seen, contact with asylum seekers, participants’ motivation and their attitudes about their need for more training were not significant predictors ($\beta = 0.024, p= \text{ns}; \beta = -0.093, p = \text{ns}; \beta = -0.155, p= \text{ns}; \beta = -0.082, p= \text{ns}$ respectively). A graphic representation of the model is shown in Figure 4.2.

Figure 4.1: Human Rights Regression Model

Note: ns = non significant paths, indicated by the light text.
The purpose of this study was to explore mental health professionals' attitudes towards asylum seekers on five attitudinal domains: human rights, psychological problems, professional intervention, control and neediness. The impacts of demographic and professional characteristics such as motivation to work with asylum seekers, desire for formal training, and prior contact on these attitudinal domains were also explored. Several important findings emerged.
Most of the hypotheses were confirmed; prior contact and the experience of formal training did impact upon professionals’ attitudes towards asylum seekers. Prior contact and experience of formal training could be described as indicative of past behaviour towards asylum seekers, thereby corresponding with the three component model (Eagly and Chaiken, 1993), which suggests past behaviour and experience with the attitude object are vital components of attitude formation. Furthermore, personal motivation to work with and/or be trained to work with asylum seekers impacted upon participants’ attitudes towards asylum seekers. Personal motivation and desire for training could be described as indicative of beliefs about asylum seekers and the value participants place on working with them. This also corresponds with the three component model (Eagly and Chaiken, 1993), which suggests beliefs about the attitude object are a vital component of attitude formation.

However, these results did not pertain to all five attitudinal factors: human rights, psychological problems, professional intervention, control and neediness. Indeed, contact, desire for or experience of formal training, and motivation only significantly impacted upon attitudes about professional intervention with asylum seekers and their human rights. Specifically, the more prior contact and formal training they had with asylum seekers, the more they supported their human rights and were ready to engage professionally with this client population. The present findings suggest that, in this instance familiarity eliminates contempt. Further, those participants who were personally motivated and those who were enthusiastic about formal training in this area were more ready to engage professionally with asylum seekers and more supportive of their human rights. These results should be interpreted with caution because it may also be true that those who seek to work therapeutically with asylum seekers have more positive attitudes about the value of this work and asylum seekers’ human rights from the outset.

Within this study, females were more positive about asylum seekers’ human rights. This resonates with Bylund’s (1992) and Gilligan’s (1982) findings about females’ moral attitudes. Gilligan (1982) discovered that females tended to perceive dilemmas
in terms of how they affected the people themselves and those involved with them. Therefore, they were far less likely to be influenced by apparently objective cultural codes. However, the effect of gender should be interpreted with caution because more females (177, 71.1%) than males (72, 28.9%) participated in this study and it may, therefore, be biased in favour of females.

The results revealed that professional orientation did not impact upon participants’ attitudes towards asylum seekers. However, among professionals with no prior contact, it is noteworthy that chartered and trainee counselling psychologists, counsellors, and psychotherapists were more positive about working with asylum seekers than chartered and trainee clinical psychologists, advocates and social workers. Between professionals with experience of working with asylum seekers this effect was not present.

However, certain factors must be remembered when generalising from these results. The response rate was 37%. Although this constitutes an average response rate, a question arises about those professionals who decided not to take part. It is likely that those who held more negative attitudes did not return the questionnaire, whereas those who held more positive attitudes were more inclined to participate. Bearing this in mind, it is noteworthy that only 31 counselling psychologists out of a possible 200 chose to participate. Therefore, the finding that counselling psychologists without contact were more positive towards asylum seekers human rights and professional intervention with them should be interpreted with caution, as 138 clinical psychologists chose to participate.

The demographic questionnaire did not ascertain participants’ ethnicity. This could by some be considered a limitation. However, this was done for reason. The purpose of this research was not to attribute attitudes towards asylum seekers to different cultures but to different professions. One of the research aims was to discover whether ‘the culture of disbelief’ existed within the professional contexts, not cultural contexts. This research may hopefully be used to deconstruct cultural stereotypes not
create them. The possibly utopian view is that asylum seekers should perhaps be treated as citizens of the world, regardless of their cultural background, by citizens of the world. Cultural origin would then be irrelevant. Finally, another limitation may be that the themes were principally derived from a qualitative analysis of interviews with asylum seekers, not professionals. Factors important to the asylum seekers may not have been important to professionals. Further research could perhaps be based on interviews with professionals regarding their attitudes about asylum seekers.

It would be particularly useful for future research to explore professionals' attitudes towards asylum seekers' psychological problems, sense of control and neediness because this research did not sufficiently explore variables that may impact upon these attitudinal factors. In order to achieve this, it may prove useful to question mental health professionals about their diagnostic trends and formulations by incorporating vignettes into the questionnaires. Future research could also consider the impact of professionals' religious beliefs, political ideas, moral reasoning about all human rights, ratio of different cultures in their current caseload, and their personal ethical code for professional practice on their attitudes towards asylum seekers. However, I feel that this study did achieve its aim of beginning exploration into professionals' attitudinal relationships with asylum seekers.

This is especially the case, if one considers the alarming side of the results. Within the culture of the mental health service, one may expect to find supportive and nurturing attitudes. However, in this study, participants' responses showed some degree of polarisation between attitudes towards asylum seekers, categorising them as non-deserving versus deserving. Indeed, one participant added their own definition, 'Illegal economic migrants abusing the term "asylum seeker"'. The attitude that some asylum seekers are non-deserving because they are attempting to cheat the system may explain why only four mental health professionals (1.6%) strongly supported asylum seekers' human rights and 12 (4%) mental health professionals even held negative attitudes towards asylum seekers' human rights. The majority of the rest of the participants were somewhat ambivalent on this issue. This corresponds with
British society’s culture of disbelief and ‘firm but fair’ policy. However, if the participants were really answering the questionnaire while considering the ‘system cheats’, they would have perhaps held the attitude that asylum seekers were more in control. Surely, one needs personal control to manipulate a system. This result also correlates with a finding within the aforementioned qualitative study where asylum seekers reported feeling that they were stigmatised by professionals until they actually met with them, the implication being that actual contact broke down the stereotypes. Nevertheless, it is not ethical to wait for experience of working with asylum seekers to create positive attitudes towards their human rights or the value of professional engagement, as initial clients would be used for the therapist’s personal growth and not the clients’. Therefore, therapists need to reflect upon their attitudes towards asylum seekers’ human rights and the value of professional engagement and how these may impact upon the therapeutic relationship. Therapist reflection promotes the therapist thinking about their differences from the client and any stereotypical attitudes they may have formed about these differences. The hope is that, through conscious reflection, therapists will be able to limit their stereotypical attitudes. Of course this preventative strategy has limitations, in that it requires therapists’ conscious insight into attitudes which may be so deeply ingrained as to be unconscious.
Behind the numbers: Use of self as researcher

["The field of statistics is concerned with methods of organising, summarising and interpreting data.' Data' means information: Any collection of information is a collection of data.... Statistics really amounts to a collection of techniques for dealing with sets of numbers: organising them, summarising them, figuring out what they mean". (Kranzler and Moursund, 1999: 4).

The above quotation reflects the objectivity of quantitative research because it does not mention the use of the researcher's reaction to the information to aid interpretation. However, this could be perceived by some as a limitation of this paradigm because humans are not neither neutral nor objective and to eliminate the subjective is impossible (Burr, 1995). In my study, the information I was gathering was professionals' attitudes towards asylum seekers. This is, for me, an emotive topic and I certainly had affective reactions to the data. I was most shocked by the range of attitudes to the human rights attitude scale. Within the human rights paradigm, the answers ranged from strongly agreeing with asylum seekers' human rights to strongly disagreeing. I find this of great concern as it illustrates not only a 'culture of disbelief' (Harris, 2002) but a 'culture of disregard' towards asylum seekers within the caring professions. Although the responses that 'strongly disagreed' were statistically insignificant, the fact that some participants strongly disagreed that they would treat asylum seekers as valid members of British society (Item 30, appendix B) worries me greatly. Moreover, one participant strongly disagreed that they were 'somewhat distressed by news features that Britain detains asylum seekers in institutions' (Item 32, Appendix B). This raises questions for me about their clinical practice. Are the caring professions perpetuating the anti-asylum seeker trends as portrayed in both popular and political literature? Like politicians, are mental health professionals justifying prejudice against this client population by endorsing the need to be 'tough' on system cheats (Blunkett, 2001: 4)? Can mental health professionals, who are supposed to try and engage with individuality and the relativity of human nature, really be encouraging the idea that it is possible to generalise and categorise
people fairly and objectively? I wanted to explore these questions but in my study the statistical interpretation of the data could not justify their inclusion. I found this very frustrating because the data suggest that attitudes tantamount to racism exist in my professional culture, yet I could not express this without being criticised for being quantitatively inaccurate or overly dramatic.

Further, the result that contact impacted upon participants' attitudes towards human rights and readiness to engage professionally with this client group was also incredibly significant to me. The fact that those professionals who have worked with asylum seekers are more likely to support them in the future suggests that the professional attitude is based on stereotypes, which is challenged through actual professional or social contact. This endorses the need for therapist reflection and a much-increased self-awareness. Some of the responses in this study are shocking but they are diluted by the requirement for statistical significance. Prejudice becomes a number and the potential for racism becomes a level of probability. However, perhaps it is in the asylum seekers' best interests that I should compromise and use the quantitative objective strategy (with its perceived credibility and legitimacy) in order to communicate the research message.]
References
Harris, K. (2002). The importance of developing a ‘culture of belief’ amongst counselling psychologists working with asylum seekers. Counselling Psychology Review, 17, 1, 4-16.


Appendices

A. Letter to professionals

B. Attitudinal questionnaire

C. Demographic questionnaire

D. Notes to contributors to Counselling Psychology Review

E. Ethical approval notification
Dear

Re: A Study of Professionals’ Attitudes Towards Asylum Seekers

I am a final year PsychD in Psychotherapeutic and Counselling Psychology trainee. As part of my doctorate I am researching professionals’ attitudes towards asylum seekers. I am equally interested in the attitudes of professionals who have not had any contact with asylum seekers. My research represents an ongoing interest in professional interventions with asylum seekers and the value I place on such work.

I feel it is important to study attitudes towards asylum seekers as they are an increasing population within our communities. Furthermore, due to recent political events, this has become a more topical subject within the popular press. Consequently, I am interested in all professionals’ attitudes towards asylum seekers as this voice is often ignored by current media reports.

In order to protect confidentiality I will not be asking you to sign a consent form. I will take completion of the questionnaire as an indication of consent. If you have any questions please contact me or my supervisor Dr. R. Draghi Lorenz. You can contact us via my course secretaries (Mrs. K. Hambleton and Mrs. M. Steed) on 01483 876 931. I have enclosed a self-addressed pre-paid envelope for you to return the
questionnaire to me. In accordance with the Data Protection Act (1998) I will not attempt to identify responses and they will remain anonymous throughout the study so that no data is stored under your name or other identifying information.

If you are interested in my findings, then please communicate this to me separately by e-mail, letter or telephone call, so as not to compromise your confidentiality. I would be happy to offer you a copy of my research in return for your kind interest and efforts on behalf of the study.

Therefore, I would be very grateful if you could take the time to fill in my enclosed questionnaire. It should take no longer than fifteen minutes.

Thank you in anticipation.

Yours sincerely

Lucy Atcheson
Counselling Psychologist in Training
Appendix B

Questionnaire

Below is a set of statements. Please indicate the degree to which you agree with these statements by ticking the appropriate box.

‘Asylum seekers’ refers to individuals seeking citizenship in the UK because they no longer feel able to stay in their home country.

<table>
<thead>
<tr>
<th>Please tick one box for each statement</th>
<th>Strongly agree</th>
<th>Agree somewhat</th>
<th>Neither agree nor disagree</th>
<th>Disagree somewhat</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel asylum seekers are as autonomous as the rest of the population.</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2. Once in England, I believe asylum seekers have difficulties in taking control of their own lives.</td>
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</tr>
<tr>
<td>3. I (would) treat asylum seekers as needy.</td>
<td></td>
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<tr>
<td>4. I feel that asylum seekers tend to be as emotionally stable as the British population.</td>
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<tr>
<td>5. I (would) offer asylum seekers a job.</td>
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<tr>
<td>6. I (would) feel comfortable offering asylum seekers my clinical time.</td>
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<td></td>
</tr>
<tr>
<td>Please tick one box for each statement</td>
<td>Strongly agree</td>
<td>Agree</td>
<td>Agree somewhat</td>
<td>Neither agree nor disagree</td>
<td>Disagree somewhat</td>
<td>Disagree</td>
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<tr>
<td>7. I feel that asylum seekers are generally willing to engage in professional interventions.</td>
<td></td>
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</tr>
<tr>
<td>8. Not all asylum seekers have a right to indefinite stay in the UK.</td>
<td></td>
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<tr>
<td>9. I am (would be) reluctant to work with asylum seekers as their neediness is beyond my capacity.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>10. I (would) only work with asylum seekers in highly contained settings.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11. I believe asylum seekers find it quite hard to be entirely independent.</td>
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</tr>
<tr>
<td>12. I think that asylum seekers are a difficult population to professionally engage with.</td>
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<tr>
<td>13. I find that asylum seekers tend to be more emotionally unstable than the rest of the population.</td>
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<tr>
<td>14. I feel asylum seekers have lost their ability to feel in control of their environment.</td>
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<tr>
<td>15. I believe asylum seekers can show signs of vulnerability.</td>
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<tr>
<td>16. I believe that asylum seekers are likely to have psychological problems caused by their relocation.</td>
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</tr>
<tr>
<td>17. I feel that asylum seekers are more prone to depression than the rest of the population.</td>
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</tr>
<tr>
<td>18. I believe all asylum seekers should be given money rather than vouchers so they can be more financially independent</td>
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<td></td>
</tr>
<tr>
<td>19. I find (hear) that asylum seekers are usually resistant towards professional support.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Please tick one box for each statement</td>
<td>Strongly agree</td>
<td>Agree somewhat</td>
<td>Neither agree nor disagree</td>
<td>Disagree somewhat</td>
<td>Disagree</td>
<td>Strongly disagree</td>
</tr>
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<td>---------------------------------------</td>
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</tr>
<tr>
<td>20. I believe that Asylum seekers can come over here for purely economic reasons and therefore do not deserve to be able to stay.</td>
<td></td>
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<tr>
<td>21. I feel asylum seekers are free thinkers as portrayed by their decision to flee their own country.</td>
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</tr>
<tr>
<td>22. I (would) treat asylum seekers as needing help to manage their daily lives.</td>
<td></td>
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</tr>
<tr>
<td>23. I (would) treat all asylum seekers as valid members of British society.</td>
<td></td>
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<tr>
<td>24. I become somewhat distressed by news features that Britain detains asylum seekers in institutions.</td>
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<tr>
<td>25. I believe asylum seekers could/ do benefit from my professional intervention as much as my other clients.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>26. I (would) treat some asylum seekers as needing support to be independent and resourceful.</td>
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<td></td>
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</tr>
<tr>
<td>27. I sometimes feel ethically torn about working with asylum seekers who may need to leave the country when there are so many people with citizenship or permanent visas on the waiting lists.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28. I find that asylum seekers just want the chance to make a better life for them and their children.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>29. I feel that even economic asylum seekers should be granted British citizenship.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

215
Background Information
Finally, I’d like some basic information about you. The reason for this request is so that I can demonstrate that I obtained views from a cross section of professionals for this research. This information will not be used to attempt to identify you as this research is entirely confidential. If you do not wish to answer any of these questions you are under no obligation.

1. Are you female or male?
   Female __________
   Male __________

2. Please state your age?
   Age __________
3. Are you?
(Please tick or write in the appropriate answer)
Chartered Counselling Psychologist
Chartered Clinical Psychologist
Assistant Psychologist
Trainee Counselling Psychologist
Trainee Clinical Psychologist
Advocate
Counsellor
Psychotherapist
Social Worker
Other

4. How many clients in total would you estimate you have worked with during your professional career?
(Please tick the appropriate answer)
1 - 100
101 - 500
501 - 1000
More than 1000

5. As far as you can remember, how many asylum seeker clients have you knowingly worked with during your professional career?
(Please tick the appropriate answer)
None
1 - 10
11 - 50
Over 50
6. Have you had any contact with asylum seekers? (Please specify)
Yes ___________
No ___________

7. Have you received formal training to work with asylum seekers?
Yes ___________
No ___________

8. Was it a personal or organisational decision for you to work with asylum seekers?

9. Would you like to receive (more) training on working with asylum seekers?
Yes definitely ___________
Possibly ___________
Not sure ___________
Definitely not ___________

Thank you for your co-operation
MATERIAL REDACTED AT REQUEST OF UNIVERSITY
08 April 2002

Ms Lucy Atcheson
PsychD Trainee
Department of Psychology
University of Surrey

Dear Ms Atcheson

A study of attitudes towards asylum seekers in professionals
(ACE/2002/04/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2002/04/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 08 April 2002
Date of expiry of approval by the Advisory Committee on Ethics: 07 April 2007

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr R Draghi-Lorenz, Supervisor, Dept of Psychology