



International Journal of Psychology and Counselling

Volume 6 Number 4 April 2014

ISSN 2141-2499



*Academic
Journals*

ABOUT IJPC

International Journal of Psychology and Counselling (IJPC) will be published monthly (one volume per year) by Academic Journals.

International Journal of Psychology and Counselling (IJPC) is an open access journal that provides rapid publication (monthly) of articles in all areas of the subject counter transference, Clinical psychology, Professional practice of behaviour analysis, Behavioural model etc.

The Journal welcomes the submission of manuscripts that meet the general criteria of significance and scientific excellence. Papers will be published shortly after acceptance. All articles published in IJPC are peer-reviewed.

Contact Us

Editorial Office: ijpc@academicjournals.org

Help Desk: helpdesk@academicjournals.org

Website: <http://www.academicjournals.org/journal/IJPC>

Submit manuscript online <http://ms.academicjournals.me/>.

Editors

Prof. Ahmed Awad Amin Mahmoud
*Faculty of Education and Higher Education
An-Najah National University,
Nablus.
Palestine.*

Dr. R. Joseph Ponniah
*Department of Humanities (English)
National Institute of Technology
Trichirappalli, Tamil Nadu
India.*

Dr. Kanwar Dinesh Singh
*# 3, Cecil Quarters,
Chaura Maidan, Shimla:171004 HP
India.*

Dr. S. D. Sindkhedkar
*Head, Department of English,
PSGVP Mandal's Arts, Science & Commerce College,
Shahada: 425409, (Dist. Nandurbar), (M.S.),
India.*

Dr. Marta Manrique Gómez
*Middlebury College
Department of Spanish and Portuguese
Warner Hall, H-15
Middlebury, VT 05753
USA.*

Dr. Yanjiang Teng
*801 Cherry Lane, APT201
East Lansing
Michigan State University
MI 48824
USA.*

Prof. Radhakrishnan Nair
*SCMS-COCHIN
Address Prathap Nagar, Muttom, Aluva-1
India.*

Prof. Lianrui Yang
*School of Foreign Languages, Ocean University of China
Address 23 Hongkong East Road, Qingdao,
Shandong Province, 266071 P
China.*

Editorial Board

Dr. Angeliki Koukoutsaki-Monnier

*University of Haute Alsace
IUT de Mulhouse
dep. SRC
61 rue Albert Camus
F-68093 Mulhouse
France.*

Dr. Martha Christopoulou

*Greek Ministry of National
Education & Religious Affairs
Xanthoudidou 2-4
Athens,
Greece.*

Dr. Zeynep Orhan

*Fatih University Hadımköy 34500 Istanbul
Fatih University Computer Engineering Department
Turkey.*

Dr. Tahar Labassi

*University of Tunis
94 Avenue 9 Avril, Tunis 1007
Tunisia.*

Dr. Ahmad M. Atawneh

*Hebron University
P.O.Box 40, Hebron
Palestine.*

Benson Oduor Ojwang

*Maseno University
P.O.BOX 333, MASENO 40105
Kenya.*

Lydia Criss Mays

*Georgia State University
30 Pryor Street, Suite 550
USA.*

Dr. Daniel Huber

*Université de Rennes 2
63, rue des Vinaigriers, 75010 Paris
France.*

Naomi Nkealah

*University of the Witwatersrand, Johannesburg
English Academy of Southern Africa, P O Box 124, Wits
2050
South Africa.*

Yah Awg Nik

*Centre for Language Studies and Generic Development,
Universiti Malaysia Kelantan,
Locked Bag 36, Taman Bendahara,
Pengkalan Chepa, 16100 Kota Bharu, Kelantan
Malaysia.*

ARTICLES

Research Articles

Four hidden matriarchs of psychoanalysis: The relationship of Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud to Sigmund Freud 32

Jerry Aldridge, Jennifer L. Kilgo* and Grace Jepkemboi

Perspectives of mental health professionals on treating refugees And asylum seekers in the United Kingdom 40

Annelisa P.

Full Length Research Paper

Four hidden matriarchs of psychoanalysis: The relationship of Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud to Sigmund Freud

Jerry Aldridge, Jennifer L. Kilgo* and Grace Jepkemboi

University of Alabama Birmingham, United Kingdom

Received 21 February, 2014, Accepted 24 March, 2014, Published April, 2014.

Sigmund Freud is considered the father and founder of psychoanalysis; however, numerous women contributed to its development and practice. Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud were instrumental in forming one of the leading psychological theories of the 20th century. Although the implications of each woman's work are different, they individually made a unique impact on the development and practice of psychoanalysis in specific ways. Lou von Salome contributed much to the development of psychoanalysis through the arts, as she was a prolific writer and novelist. Karen Horney eventually broke with Freud and developed her own version of psychoanalysis, incorporating feminine psychology and criticizing the phallogocentric and patriarchal nature of Freud's theories. Sabina Spielrein contributed the "death instinct" to psychoanalysis, although Freud did not credit her fully for this development. Anna Freud, the youngest child of Sigmund and Martha Freud, was the founder of psychoanalytic child psychology along with Melanie Klein. She focused on the ego in childhood and ways to encourage its healthy development. Although each matriarch of psychoanalysis extended the ideas and theories of Sigmund Freud, they have not been given the credit they deserved.

Key words: Psychoanalysis, women, history, mothers.

INTRODUCTION

The field of psychoanalysis began as a male dominated profession and from a decidedly masculine viewpoint (Paris, 1994). Freud's contempt for women was explicitly expressed in many of his publications. For example, Freud (1925) reported that women have the "hope of someday obtaining a penis in spite of everything" (p. 196). He continued, "I cannot escape the notion (though I hesitate to give it expression) that for woman the level of what is ethically normal is different from what it is in men...We must not allow ourselves to be deflected from such conclusions by the denials of the feminists, who are

anxious to force us to regard the two sexes as completely equal in position and worth" (p. 197).

Despite the male-dominated influences on the field of psychoanalysis, there are volumes of psychoanalytic theory and research by women. Jane Sayers (1991) described in detail four mothers of psychoanalysis, two of which appear in this article. Helene Deutsch and Melanie Klein have been described as founding mothers, but there were numerous others (Paris, 1994). Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud deserve their place as matriarchs of the movement as

Corresponding author*. E-mail: jkilgo@uab.edu

Author(s) agree that this article remain permanently open access under the terms of the Creative Commons Attribution License 4.0 International License

well. Each woman made salient, but different contributions to psychoanalysis. Lou von Salome brought psychoanalysis to the arts through her fictional and biographical writings. Karen Horney questioned the patriarchal nature of the field and brought a feminine perspective through her construction of womb envy to counteract Freud's emphasis on penis envy. Sabina Spielrein contributed child language development from a psychoanalytic perspective and the death instinct. Anna Freud was the heir of psychoanalysis after her father's death in 1939 and a developer of child psychoanalysis. She also extended psychoanalytic concepts, making significant contributions to the fields of developmental psychology and early education. Further, each woman influenced Sigmund Freud in her own unique way.

LOU VON SALOME (1861 TO 1937)

Lou von Salome was born in St. Petersburg, Russia on February 12, 1861, the youngest child and only daughter of Gustav von Salome and Louise Wilm. The family lived in the heart of the city near the Romanov Winter Palace and spent their summers in Peterhof (Vickers, 2008). Lou experienced an amazing childhood. While both of her parents were of German descent, the family spoke several languages, including German, French, Russian and English. In fact, it was rumored that Lou's family spoke a specific language on certain days of the week. For example, on one day of the week the family might converse in German, but on another day they would interact in English (Etkind, 1997).

Despite Lou's peaceful childhood, she became enthralled by a minister when she was 17 years of age. Pastor Gillot was a stranger to her except that upon reading his sermons, she became enchanted with them. After writing to him, Pastor Gillot agreed to meet Lou. Gillot was the first of a series of unusual encounters with men that Lou experienced, culminating with her interactions with Freud late in life. "Gillot loaded her down with lessons in philosophy, religion, history, Dutch and other subjects that he deemed important" (Etkind, 1997, p. 10). Lou was an eager student and learned quickly. Even though there was a 17-year age difference, Gillot decided to divorce his wife and marry von Salome; however, that never happened.

When Lou was 18 years old, her mother took her to Switzerland to attend the University of Zurich, one of the few places that admitted women at that time. When she was 21 years old, Lou and her mother traveled to Rome where Lou was introduced to Paul Ree and Friedrich Nietzsche. The three of them traveled throughout Europe, discussing possibilities of living together. Lou believed Nietzsche had fallen in love with her and some researchers believe Nietzsche asked Lou to marry him (Vickers, 2008). Lou entered a celibate marriage in 1887 with Friedrich Carl Andreas and remained with him until

his death in 1930. However, during much of her married life Lou engaged in affairs with other famous men, the most notable of which was the poet, Rainer Maria Rilke. Although she was 15 years older, Lou and Rainer became lovers for many years and kept in touch until his untimely death. She has been described as Rilke's mentor and muse, introducing him to numerous people in the art and literary communities (Etkind, 1997).

Eventually Lou became interested in psychoanalysis and "wrote Freud requesting permission to attend the Third Congress in the autumn months of 1912. Freud replied that he considered her presence at his lectures a 'favorable omen'" (Vickers, 2008, p. 161). Freud had met Lou earlier and became fascinated by her charisma and charm. Lou began attending Freud's weekly seminars and became the center of Freud's attention during his lectures. On one occasion when Lou failed to attend, Freud later remarked, "I missed you at the lecture yesterday...I stared at the space that had been left for you" (Livingstone, 1984, p. 153).

As with many of the women contributors to psychoanalytic thought, Lou became part of the tension that developed between Freud and other men. Specifically, Lou decided to attend Alfred Adler's lectures in addition to Freud's lectures. Freud informed von Salome that he thought of Adler as a traitor. Further, Freud's inner circle had nothing to do with the defectors who joined Adler. Still, Freud acquiesced to Lou's interest in Adler's psychology and did not talk extensively with her about her interest in Adler's work. She also became involved in the rivalry between Victor Tausk and Freud. In addition, Tausk attended Freud's Wednesday lectures; however, Freud saw Tausk as a threat to psychoanalysis. Tausk was young and attractive and soon von Salome began an affair with Tausk. Again, Freud was so enamored with von Salome that he continued to receive Tausk in the inner circle, explaining to Lou that he allowed Tausk to continue only because of Lou's relationship with Tausk. Eventually Tausk committed suicide. Vickers (2008) reported that Freud finally "turned away from Tausk professionally and personally" and that "some have suggested [that Freud] may have taken away Tausk's last hope" (p. 179).

Lou von Salome made numerous contributions to psychoanalysis. She was able to link the similarities between the healthy and the neurotic person rather than focusing on the differences as Freud had. She saw the role of the ego as important in the development of neurosis, pointing out that conflict between the libido and the ego was a contributor. Lou also took a more holistic approach to psychoanalysis and believed that culture and human nature could work together and were not always in great conflict as Freud had suggested. Her approach to psychoanalysis was more positive and hopeful than Freud's. Lou even considered narcissism to have positive aspects (Livingstone, 1984). While Freud sometimes disagreed with von Salome's version of psychoanalysis,

he was always respectful of her ideas. Perhaps this was due partly to Lou's charisma, but also due to Lou's former relationship with Nietzsche. Freud often quoted Nietzsche and was interested in Lou's interpretation of Nietzsche's life and his philosophy. Perhaps Lou von Salome's greatest contribution to psychoanalysis was her fictional and biographical writings. She was a prominent leader in bringing psychoanalytic thought to the arts, particularly the literary arts (von Salome, 2003).

In summary, Lou von Salome's contributions to psychoanalysis included:

- 1) Similarities between the neurotic and healthy personality (Etkind, 1997)
- 2) The importance of the ego in the development of neurosis (Vickers, 2008)
- 3) The positive aspects of human personality (Livingstone, 1984)
- 4) A more holistic approach to personality that included cultural influences (Etkind, 1997)
- 5) Positive aspects of narcissism (Livingstone, 1984)
- 6) The introduction of psychoanalysis to the arts, especially literature (von Salome, 2003)

KAREN HORNEY (1885 TO 1952)

Karen Horney was born in Blankenese, Germany on December 15, 1885. Like von Salome, Horney was the youngest child in the family, born to Wackels Danielson and Sonni Ronzelen. Karen had an older brother named Berndt and four half brothers and sisters from her father's first marriage (Quinn, 1987). Wackels was a sea captain and was gone much of the time. Karen became close to her mother and her older brother. During childhood and throughout life, she suffered from bouts of depression (Rubins, 1978).

Karen began her college career at the University of Freiburg because it was one of the only universities in Europe that allow women in medical college. In 1908, Karen transferred to the University of Gottingen and later matriculated to the University of Berlin before she graduated in 1913 (Westkott, 1986). Karen married Oskar Horney in 1909. They had three daughters, including the Brigitte, with whom Karen had the closest relationship. Karen raised her children based on Freudian theory but later changed her ideas about child-rearing practices (Paris, 1994).

In the 1920s, Karen worked at the Institute for Psychoanalysis in Berlin and then immigrated with her daughters to the United States in 1930. Horney became the Associate Director of the Chicago Institute for Psychoanalysis. As she developed her own theories about personality and neurosis, she eventually separated from traditional Freudian psychoanalysis. In 1941, she became the Dean of the American Institute of Psychoanalysis and developed her own psychoanalytic

school of thought. She also was the founder of the Association for the Advancement of Psychoanalysis (Paris, 1994).

Although Horney began her career as a classical Freudian psychoanalyst, she soon began to develop her own ideas, often contradicting Freudian theory. She is often described as the mother of feminine psychology; she presented papers and published articles that expounded innovative ideas regarding the development of personality in women. Early in her career she noted, "Psychoanalysis is the creation of a male genius and almost all those who have developed his ideas have been men. It is only right and reasonable that they should evolve more easily a masculine psychology and understand more of the development of men than of women" (Horney, 1967, p. 54).

Horney was especially critical of Freud's notion of penis envy in women. While Freud continually pointed out the inferiority of women, because they lack a penis, Horney turned this hypothesis on its head and suggested that men are the inferior ones. She reported, "the man's incapacity for motherhood is probably felt simply as an inferiority and can develop its full driving power without inhibition" (Horney, 1967, p. 62). Horney explained that it is just as likely that men have womb envy as women would have penis envy because it is women who are able to bring life into the world. To Horney, men compensate for their inability to produce life through the womb by their excessive efforts to be productive in the world of work (Paris, 1994).

As with Lou von Salome's beliefs about psychoanalysis, Karen Horney's views were more comprehensive and less fatalistic than Freud's ideas. Specifically, she believed that the role of culture was a predominant factor in the development of personality, not just biological drives as Freud expounded. Even with neurosis, she believed it had a positive goal—to make life more palatable (Quinn, 1987). Over time, she developed her own theory of neurosis. According to Horney, "there are four principal ways in which people try to protect themselves: affection, submissiveness, power, withdrawal" (Paris, 1994, p. 106). Consequently, individuals incorporate three possible coping strategies in approaching the world. These are compliance, aggression and withdrawal (Horney, 1937).

Compliance is a strategy in which an individual tries to please others. Horney called this a moving-toward strategy. A person who uses this strategy has a strong desire to be liked and tries to accomplish this through people pleasing behaviors. Aggression is the second strategy. This type of individual develops a moving-against strategy to cope with others. The need for power and control drive this type of person. The third strategy is withdrawal. An individual who uses withdrawal incorporates moving-away from others in an attempt to be self-reliant. Horney also explained that some individuals develop submissiveness, as well, to cope with

others. Horney explained that there are two drives that are the most important in the development of neuroses; they are the need for affection and the desire for control or power (Horney, 1937).

Karen Horney and Alfred Adler left the Freudian camp and developed what many refer to as the Neo-Freudian discipline. While von Salome had been interested in Adler's ideas, Horney, together with Adler, assembled a group of Neo-Freudians. This group included Eric Fromm, with whom Horney had a relationship. Horney, along with Adler and Fromm are described as "dissenters" in Paul Roazen's (1992) *Freud and His Followers*. Because of her emphasis on cultural and societal influences on personality, Horney was often called a social psychoanalyst.

Horney contributed many new ideas and theories to psychoanalysis. These included:

- 1) Founded feminine or feminist psychology (Horney, 1967)
- 2) Developed the theory of neurotic needs, describing methods people employ in coping with neurosis (Horney, 1937)
- 3) Founded the American Journal of Psychoanalysis (Roazen, 1992)
- 4) Founded the Neo-Freudian School along with Adler and others (Quinn, 1987)
- 5) Researched and described the nature of narcissism (Horney, 1950)
- 6) Described womb envy in men as a counter to Freud's penis envy (Horney, 1967)
- 7) Developed a more holistic, humanistic view than Freud of the human psyche (Horney, 1950)
- 8) Presented the first published papers on feminine psychiatry (Horney, 1967)
- 9) Developed one of the first self-help books entitled *Are You Considering Psychoanalysis?* (Horney, 1946)
- 10) Inspired the development of the Karen Horney Clinic in New York City (Quinn, 1987)
- 11) Revised and summarized her ideas about neurosis, expanding her ideas concerning neurotic solutions in *Neurosis and Human Growth: The Struggle toward Self-Realization* (Horney, 1950)

SABINA SPIELREIN (1885 TO 1942)

Sabina Spielrein was born in Rostov-on-the-Don, Russia in 1885 to a wealthy Jewish family. Unlike von Salome and Horney, Spielrein was the oldest child, having "three younger brothers: Isaac, Jan and Emile. All of the Spielrein children received formidable educations in Europe and became professors during the Soviet period" (Etkind, 1997, p. 132). Sabina also had a younger sister, Emilia, who died early in life of typhoid fever (Aldridge, 2009). Very little is known about Sabina's childhood until her admittance to the Burgholzli Hospital, near Zurich,

Switzerland on August 17, 1904, where she became Carl Jung's first patient (Kerr, 1993).

According to Covington (2003), "Sabina Spielrein is perhaps best known for her love affair with Carl Jung. While it is debatable whether their relationship was actually consummated, it bore fruit for them both in giving rise to psychological insights and discoveries that were to become the basis for fundamental theoretical concepts in psychoanalysis and analytical psychology" (p. 1). These include the death instinct, counter transference and the anima (Covington, 2003). Unfortunately, Spielrein's role in these contributions "to the early development of psychoanalysis have been overlooked and until recently was mainly forgotten" (Hall, 2005, p. 1).

In June of 1905, Spielrein was released from Burgholzli. She had already begun her study of medicine at the University of Zurich at that time (Aldridge and Christensen, 2013). After her involvement with Jung, Sabina turned to Sigmund Freud for advice and counsel (Kerr, 1993). As with many of the women associated with Freud, there was a triangular conflict involving another man. In this case, the other man was Carl Jung. In fact, Jung and Freud split supposedly over ideological issues; however, some researchers believe Spielrein's relationship with both men was a catalyst to the inevitable Freud and Jung split (Kerr, 1993). Spielrein requested to see Freud in 1909, but Freud rejected her request because Jung and Freud had been corresponding about Jung's relationship with Spielrein. She eventually traveled to Vienna and met Freud personally in 1911. According to Hall (2005), "He was greatly impressed with her" (p. 2).

In 1911, Sabina Spielrein received her doctoral degree in medicine (Spielrein, 1911). According to Hall (2005), her dissertation, entitled "Concerning the Psychological Content of a Case of Schizophrenia," was the "first dissertation written by a woman that was psychoanalytically oriented" (p. 2). Sabina soon became the second woman doctor who was active in the Vienna Psychoanalytic Society, presenting papers and attending the weekly meetings of the group (Hall, 2005; Kerr, 1993).

In 1912, Sabina married Pavel Scheftel, a Russian doctor and in 1913 they had a daughter named Renata. This was about the time that Jung and Freud departed ways. Still, Spielrein continued to correspond with Jung until 1919 and with Freud until 1923 (Hall, 2005). From 1920 to 1923, Spielrein worked at the Jean-Jacques Rousseau Institute in Geneva, Switzerland, where she became Jean Piaget's psychoanalyst. She also contributed to his ideas on child language and thought (Aldridge and Christensen 2013). Spielrein and Piaget were both researching child language and thought and considered collaborating (Covington and Wharton, 2003). In 1923, Spielrein returned to Russia and Piaget's research appeared to have changed quite suddenly from language to cognitive and moral development. Although Piaget lived until 1980 and continued a rigorous research

agenda, he abandoned his study of childhood language after his colleague, Sabina Spielrein, left Switzerland (Aldridge and Christensen, 2013).

Upon returning to Russia, Spielrein joined the Russian Psychoanalytic Society, "which had recently been created by Luria and of which Vygotsky was also a member" (Santiagi-Delefos and Delefos, 2002, p. 723). What is remarkable is that of the major psychologists of the 20th century, Spielrein worked closely with five of them (Kerr, 1993). While Spielrein was Jung's patient and Freud served for a short time as her mentor, she was a colleague and psychoanalyst of Piaget. Her role with Vygotsky and Luria when she returned to Russia was more or less that of a mentor for these two men (Kerr, 1993). In fact, Santiago-Delefos and Delefos (2002) concluded, "...although Spielrein's work is rarely quoted, it has inspired several important lines of thought in psychology and language sciences (not only Piaget and Vygotsky, but Freud, Jakobson, and Leontiev as well)" (p. 724). There is limited information about Sabina Spielrein's life after she returned to Russia as compared to her years in Switzerland and Germany. She worked for the State Psychoanalytic Institute and assisted in overseeing the work of the Russian Psychoanalytic Society (Carotenuto, 1982). At one time, she actually had "three jobs from September 23 on: as a researcher at the State Psychoanalytic Institute, as a doctor and pedologist in a village called Third International, and as chair of the child psychology division at the First Moscow University" (Etkind, 1997, p. 171). A year after Sabina returned to Russia she moved back to Rostov-on-the-Don where she was reunited with Pavel Scheftel, her husband. They had a second daughter named Eva. During the 1930s, the family lived in a three-room dwelling. "In 1937, Pavel Scheftel died of a heart attack" (Etkind, 1997, p. 176). And, in August of 1942, Sabina Spielrein and her daughters, Renata and Eva, were executed along with many other Jews at a synagogue in Rostov (Kerr, 1993). Like Lou von Salome and Karen Horney, Sabina Spielrein contributed much to psychoanalysis. Some of her contributions included:

- 1) An explanation of the death instinct (Spielrein, 1912)
- 2) The definition and beliefs about transference and countertransference (Kerr, 1993)
- 3) Explorations into the nature of eros (Carotenuto, 1982)
- 4) The discovery of the anima (Covington and Wharton, 2003)
- 5) The development of language in children (Spielrein, 2003)
- 6) The development of language in individuals with schizophrenia (Etkind, 1997)

ANNA FREUD (1895 TO 1982)

Anna Freud was born in Vienna, Austria on December 3,

1895, the youngest of Martha Bernays' and Sigmund Freud's six children. The Freud children were divided into two groups. The older children were Mathilde, Martin and Oliver. The younger children were Enst, Sophie and Anna (M. Freud, 1964). "For Anna Freud, Sophie was the most difficult sibling, the focus of her jealousy" (Young-Bruehl, 2008, p. 45). Sophie was quite beautiful, while Anna was considered smart. The sisters developed separate roles; Sophie was the beauty of the family while Anna had the brains (Coles, 1992).

Josefine Cihlarz was hired as a caregiver when Anna was born. She provided care for Anna and the three youngest children. Even though Martha Freud's sister, Minna, had come to live with the Freuds shortly after Anna's birth, neither Martha nor Minna had the role that Josefine acquired as the "psychological mother." "Josefine cared for the little children at home and for all on their daily walks in the public parks around Ringstrasse" (Young-Bruehl, 2008, p. 32). Anna Freud and her father were quite close. He included one of Anna's dreams, from when she was only 18 months old, in the book, *The Interpretation of Dreams* (S. Freud, 1899). Throughout Anna's life, she and her father remained exceptionally close. During the early 1900s, it was not uncommon for the youngest daughter to live at home and take care of the aging parents. This eventually became Anna's role (Peters, 1985).

Anna Freud was taught in elementary school by traditional methods in which rote memorization was used. She learned Hebrew the same way. She was taught the words but not what they meant. Later, in her own work with children, Anna used her experience to describe how not to work with children. Despite the inappropriate methods that were used to teach her, Anna developed a love for reading and writing, as well as weaving and knitting. Anna's preferences in reading were for non-fiction or realistic fiction and not stories that involved unrealistic fantasy (Young-Bruehl, 2008).

As a young woman, Anna became a teacher from 1917 to 1920, after her training period which began in 1915. She left teaching because of illness. By this time, Anna had already begun psychoanalysis with her father. Sigmund Freud served as her psychoanalyst from 1918 to 1922 and by this time, she was already involved in the Vienna Psychoanalytic Society. She began presenting papers to the Society. The first paper she presented was entitled, "Beating Fantasies and Daydreams" (Coles, 1992). She started her own practice of psychoanalysis with children in 1923. She later began teaching at the Vienna Psychoanalytic Training Institute on methods of child analysis. By 1935 she was director of the Institute (Young-Bruehl, 2008). One of her major contributions to psychoanalysis during this time as her work on defense mechanisms, published in *The Ego and the Mechanisms of Defense* (A. Freud, 1936).

In 1938, the Freud family moved to London because of the war. Anna was in charge of all of the logistics of the

family move because Sigmund Freud's health had deteriorated due to his lengthy fight with cancer. Anna was the family caregiver in London and nursed her father through his death in 1939 (Peters, 1985). In London, Anna Freud opened the Hampstead War Nursery for young children who were victims of the war. Anna's program of treatment included a focus on attachment and continuity of the children's experiences through foster care. She continued this work after World War II at the Bulldogs Bank Home, an orphanage run by Anna's friends. During this time Anna also developed a long-term relationship with Dorothy Burlingham-Tiffany. Together they published many studies on children in crisis and emphasized how young children develop attachments among caregivers and peers when parents are not available (Freud and Burlingham, 1944).

Anna Freud visited, lectured and taught short courses in the United States from the 1950s until her death in 1982. She also published many research studies and books during this time. Her writings have been collected into eight volumes entitled, *The Writings of Anna Freud*. Anna Freud made arrangements before her death in 1982 to turn her London house into a museum dedicated to the works of her father, despite the fact that he lived there for only a year while she had been a resident for decades (Peters, 1985).

Anna Freud made extensive contributions to psychoanalysis, many of which have been attributed to her father (Aldridge and Christensen, 2013). She and Melanie Klein are considered the mothers of child psychoanalysis (Young-Bruehl, 2008). The following is a summary of many of the additions that Anna Freud made to the field of psychoanalysis:

- 1) Pioneered the area of child psychoanalysis, along with Melanie Klein (Freud, 1965)
- 2) Pioneered the area of ego psychology, expounding the defense mechanisms, even though her father is attributed with the development of defense mechanisms (Freud, 1936)
- 3) Developed a comprehensive developmental theory that includes basic drives and object relations (Freud, 1965)
- 4) Organized prominent researchers and child psychoanalysts to study personality development and deviations that included Margaret Mahler and Erik Erikson (Young-Bruehl, 2008)
- 5) Catalogued the normal and exceptional development of later childhood and adolescence (Edgumbe, 2000)
- 6) Helped develop a continuum and scale from self-reliance to emotional dependency in children and adults (Edgumbe, 2000)
- 7) Explained the importance of parents and caregivers in the psychological development of children (Freud and Burlingham, 1944)
- 8) Extended the knowledge base of childhood

development for numerous professions including psychology, education, social work, sociology and human ecology (Freud, 1930)

- 9) Developed a comprehensive view of psychoanalysis that included environmental and cultural factors as well as biological drives (Freud, 1965)

DISCUSSION

Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud each had important connections with Sigmund Freud. From the story of each matriarch, we learn much about the relationship patterns Freud had with both women and men of psychoanalysis. Lou von Salome was perhaps the most revered woman in Freud's life. Everything on or near Sigmund Freud's desk in his London home in the Hampstead is exactly as he left it. There is a statue of the Sphinx, another of the Goddess Athena and finally a framed picture of Lou von Salome. "He kept it on his desk, he told her, for inspiration" (Vickers, 2008, p. 158). From the beginning of their relationship, Freud was allured, like all the men who met Lou, by her independence, unconventional ways and charm. Freud often quoted Nietzsche and was interested in Lou's understanding of him.

Many of Lou von Salome's ideas about psychoanalysis ran contrary to Freud's classical approach. Still, Freud was always respectful of Lou's contributions and accepted her into his inner circle, unlike others who contradicted him. For some reason, he did not think of Lou as a traitor, as he did others who were interested in Adler's ideas. And, he allowed Victor Tausk to remain in his group because of von Salome's relationship to Victor. Although the relationship between Lou and Sigmund was one of great respect, it is quite clear that their relationship was strictly platonic (Vickers, 2008). Finally, Lou and Sigmund remained friends until Lou died in 1937. The evidence of this intense friendship was catalogued in the letters between Lou and Sigmund. Pfeiffer (1966) published the letters between von Salome and Freud from September 27, 1912 through May 6, 1936.

The relationship between Karen Horney and Sigmund Freud was not a personal one as was the case with the other three matriarchs described here. We do know that she began her career as a disciple of Freud. According to Roazen (1992), Karen was the analysand of Hans Sachs. She was also analyzed by Karl Abraham (Paris, 1994). Both Sachs and Abraham were part of Freud's secret society. "Sachs was named, along with Otto Rank, Sandor Ferenczi, Karl Abraham, and Ernest Jones, to a secret committee founded by Freud before World War I (after the loss of Adler, Jung and Stekel) to forward the cause" (Roazen, 1992, p. 323). Despite this close connection between Karen Horney and two of Freud's secret committee members, Horney "had no personal relationship with Freud" (Roazen, 1992, p. 510).

Sabina Spielrein's relationship with Sigmund Freud and Carl Jung has been the subject of several publications including *A Secret Symmetry: Sabina Spielrein Between Jung and Freud—the Untold Story of the Woman who Changed the Early History of Psychoanalysis* (Caratenuto, 1982) and *A Most Dangerous Method: The Story of Jung, Freud and Sabina Spielrein* (Kerr, 1993) and the 2011 movie, *A Dangerous Method*, based on Kerr's book. Of the four matriarchs reported here, Spielrein appears to have received the shortest shrift of all of them. Her influence in the early days of psychoanalysis was profound, but until recently few people had ever heard of her. According to Hall (2005), Spielrein "was a major figure in the development of the psychoanalytic movement—and a rare woman in that field. Her thought and work had significant impact on the theories Jung and Freud developed" (p. 4). Although Spielrein's experience with Freud was vastly different from von Salome's, Spielrein's relationship with Freud showed his pattern of how women acted as a catalyst for his conflicts with other men.

Volumes could be written about Anna Freud's relationship with her father. We began this article with Freud's contempt for women, as expressed in his paper, "Some Psychical Consequences of the Anatomical Distinction between the sexes" (Freud, 1925). What is most interesting to note is the fact that Anna Freud delivered this paper for her father at the International Psycho-Analytical Congress in Hamburg, Germany on September 3, 1925 (Young-Bruehl, 2008).

Anna Freud should be recognized for her explanation of defense mechanisms that she expounded in *The Ego and Mechanisms of Defense* (Freud, 1936). However, almost all of the introductory texts in general psychology, developmental psychology and human development credit her father with these, never mentioning her name. In fact, Anna is rarely, if ever, mentioned in courses that use these texts. If she is mentioned, she is reported as a neo-Freudian, along with Alfred Adler, Karen Horney, Eric From and Erik Erikson. Further, Anna is the one who studied and worked with children for decades, first as a school teacher and then as the co-developer of child psychoanalysis. Still, Sigmund Freud's work is explained in child psychology and child development texts, while Anna's contributions are rarely, if ever, mentioned.

Despite all of this, Anna was completely devoted to her father and his legacy. As previously noted, she is responsible for her London home becoming a Sigmund Freud museum. In spite of all her knowledge of psychoanalysis and children, Anna Freud lived out the archetype of the youngest daughter during the early 1900s. She never married, becoming the caregiver for her father until the day he died (Roazen, 1992). So why has Anna Freud not been noted for her contributions to child psychology, when her father is constantly at the forefront? Aldridge and Christensen (2013) have suggested that "there is evidence that Anna Freud's

devotion to her father may have resulted in hegemony on the part of Ms. Freud. Anna was devoted to preserving her father's work and legacy" (p. 103). They go on to explain, "In all of her research, she always referred to her father's theories when, in fact, many of them were her own inventions" (p. 103). Roazen (1992) remarked that Anna's "relationship with her father deprived her of what is conventionally thought of as a full life" (p. 452).

Another question is what relationship did these four matriarchs have with one another? There is little doubt that Lou von Salome, Karen Horney, Sabina Spielrein and Anna Freud were acquainted with each other through Sigmund Freud and through their own work in psychoanalysis. The most notable relationship was between Lou and Anna. Their connection was quite remarkable. Sigmund introduced Anna to Lou when Anna was an adolescent. They developed a bond that lasted many years. During Anna's early life, her favorite volume of poetry was written by Rainer Rilke, one of von Salome's lovers (Young-Bruehl, 2008).

As a child, Anna went mushroom picking with her dad. Many years later, "Anna Freud reminisced about their mushroom-picking expeditions to her friend and confidante Lou Andreas-Salome, who committed the description to her journal" (Young-Bruehl, 2008, p. 36). There are also rumors about the role Lou played in Anna's life. For example, "one of the well-established legends among Freud's pupils was that Lou Andreas-Salome was Anna Freud's analyst" (Roazen, 1992, p. 438). Roazen goes on to say, "Lou and Anna became great friends in later years and Lou dedicated one of her books to her" (p. 438). Lou von Salome, Karen Horney, Sabina Spielrein, and Anna Freud contributed much to the field of psychoanalysis during a time when views on women were even more oppressive than they are today. According to Roazen (1992), Freud "could not conceive of a woman as a competitor. He had great success in keeping women in a dependent relationship to him and he admired his female pupils" (p. 469). Each matriarch of psychoanalysis described here extended the ideas and theories of Sigmund Freud, but they were not given the credit they deserved, perhaps because of the times in which they lived. We are now well into the 21st century. It is time the matriarchal contributors of psychoanalysis are given their proper dues and their works should be given considerable attention, along with those of Sigmund Freud, Carl Jung and Alfred Adler.

Conflict of Interests

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

REFERENCES

- Aldridge J (2009). Another woman gets robbed? What Jung, Freud, Piaget, and Vygotsky took from Sabina Spielrein. *Childhood Educ.*

- 85(5): 318-319.
- Aldridge J, Christensen L (2013). *Stealing from the mother: The marginalization of women in psychology and education from 1900-2010*. Lanham, MD: Rowman and Littlefield Education.
- Carotenuto A (1982). *A secret symmetry: Sabina Spielrein between Jung and Freud—The untold story of the woman who changed the early history of psychoanalysis*. New York, NY: Pantheon Books.
- Coles R (1992). *Anna Freud: The dream of psychoanalysis*. Reading, MA: Addison-Wesley.
- Covington C (2003). Introduction. In C. Covington and B. Wharton (eds.), *Sabina Spielrein: Forgotten pioneer of psychoanalysis (1-14)*. New York: Routledge.
- Covington C, Wharton B (2003). *Sabina Spielrein: Forgotten pioneer of psychoanalysis*. New York, NY: Routledge.
- Edgumbe R (2000). *Anna Freud: A view of development, disturbance and therapeutic techniques*. London: Routledge.
- Etkind A (1997). *Eros of the impossible: The history of psychoanalysis in Russia*. Boulder, CO: Westview Press.
- Freud A (1930). Four lectures on psychoanalysis for teachers and parents. *The Writings of Anna Freud*, 1:73-136.
- Freud A (1936). *The ego and mechanisms of defense*. London: Hogarth Press.
- Freud A (1965). *Normality and pathology in childhood: Assessments of development*. London: Karnac.
- Freud A, Burlingham D (1944). *Infants without families: The case for and against residential nurseries*. In A. Freud and D. Burlingham (eds.), *Infants without families and reports on the Hampstead Nurseries 1939-1945* (pp. 543-664). London: Hogarth.
- Freud S (1899). *The interpretation of dreams*. New York: Basic Books.
- Freud S (1925). Some psychical consequences of the anatomical distinction between the sexes. In J. Strachey (Ed.), *Collected papers vol 5* (pp. 186-197). New York, NY: Basic Books.
- Hall K (2005). *Sabina Spielrein*. *Jewish women's archive: A comprehensive historical encyclopedia*. Online available: <http://jwa.org/encyclopedia/article/spielrein-sabina>.
- Horney K (1937). *The neurotic personality of our time*. New York, NY: W. W. Norton.
- Horney K (1946). *Are you considering psychoanalysis?* New York, NY: W. W. Norton.
- Horney K (1950). *Neurosis and human growth: The struggle toward self-realization*. New York, NY: W. W. Norton.
- Horney K (1967). *Feminine psychology*. New York, NY: W. W. Norton.
- Kerr J (1993). *A most dangerous method: The story of Jung, Freud, and Sabina Spielrein*. New York, NY: Alfred A. Knopf.
- Livingstone A (1984). *Salome: Her life and work*. Mount Krisko, NY: Moyer Bell.
- Paris B (1994). *Karen Horney: Psychoanalyst's search for self-understanding*. New Haven, CT: Yale University Press.
- Peters U (1985). *Anna Freud: A life dedicated to children*. New York, NY: Schocken.
- Pfeiffer E (1966). *Sigmund Freud and Lou Andreas-Salome letters*. New York, NY: Harcourt Brace Jovanovich, Inc.
- Quinn S (1987). *Mind of her own: The life of Karen Horney*. New York, NY: Summit.
- Roazen P (1992). *Freud and his followers*. New York, NY: Da Capo Press.
- Rubins J (1978). *Karen Horney: Gentle rebel of psychoanalysis*. New York, NY: Summit.
- Santiago-Delefos M, Delefos J (2002). *Spielrein, Piaget, and Vygotsky: Three positions on child thought and language*. *Theory Psychol.* 12(6):723-247.
- Sayers J (1991). *Mothers of psychoanalysis: Helene Deutsch, Karen Horney, Anna Freud, Melanie Klein*. New York, NY: W. W. Norton.
- Spielrein S (1911). *Concerning the psychological content of a case of schizophrenia*. Unpublished doctoral dissertation. (Translated by K. J. McCormich, 1992)
- Spielrein S (1912). *Destruction as the cause of coming into being*. *J. Anal. Psychol.* 39(2):155-186.
- Spielrein S (2003). *The origin of the child's words papa and mama. Some observations on the different stages in language development*. In C. Covington and B. Wharton (eds.), *Sabina Spielrein: Forgotten pioneer of psychoanalysis (289-305)*. New York: Routledge.
- Vickers J (2008). *Lou von Salome: A biography of the women who inspired Freud, Nietzsche, and Rilke*. Jefferson, NC: McFarland and Company.
- von Salome L (2003). *You alone are real to me*. Rochester, NY: BOA Press.
- Westkott M (1986). *The feminist legacy of Karen Horney*. New Haven, CT: Yale University Press.
- Young-Bruehl E (2008). *Anna Freud: A biography (2nd ed.)*. New Haven, CT: Yale University Press.

Full Length Research Paper

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

Annelisa P.

Graduate Center, City University of New York, New York City, United States

Received 24th February 2014; Accepted 1st April 2014, Published April 2014

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

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

INTRODUCTION

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

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

Irrespective of legal status, resettling refugees and

E-mail: apedersen@gc.cuny.edu Tel: (617) 710-0007 Fax: (212) 650-7025

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

Author(s) agree that this article remain permanently open access under the terms of the Creative Commons Attribution License 4.0 International License

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

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

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

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

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

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

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

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

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

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

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

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

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

MATERIALS AND METHODS

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

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

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

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

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

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

RESULTS

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

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

Theme 1: Two Perceived Prerequisites for Beneficial Treatment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Along similar lines, Julia describes one of her experiences:

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

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

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

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

Theme 2: The Disputed Significance of Culture

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Julia elaborates on the specifics of the communication challenges:

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

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

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

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

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

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

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

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

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

Theme 3: Differing Idioms of Distress

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

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

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

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

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

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

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

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

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

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

Theme 4: Adjustment and Acculturation Facilitating Ease with Counseling

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

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

And Pauline:

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

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

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

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

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

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

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

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

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

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

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

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

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

And Ella:

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

Clearly, time appears to be a significant factor in the participants' perceptions of their refugee and asylum-seeking clients' interest in pursuing counseling. After time has passed and a client has established residency and basic stability in life, the participants recognize how he may suddenly discover a newfound interest in connecting with mental health services³.

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

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

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

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

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

DISCUSSION

Reflecting on the initial questions motivating this study, it is interesting to consider how the data clearly respond to some questions and others hardly at all. The questions pertaining to the general effectiveness of psychotherapy for the displaced population, and, for the most part, those pertaining to the influence of a client's cultural background yielded rich responses. Yet, those questions of a more theoretical nature—relating to how the participants perceive the utility of the diagnostic system, and their thought about the ethics of using treatments developed in the West with clients of non-Western backgrounds—returned hazier perspectives, and thus are addressed just briefly in this discussion⁴. Perhaps such responses suggest that theoretical concerns pertain tangentially to the work these practitioners conduct with their clientele. The insights of the theme about adjustment and accul-

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

On the whole, this investigation has articulated the critical

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

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

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

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

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

Conflict of Interests

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

ACKNOWLEDGEMENTS

Special thanks are due to Brendan Burchell, Laura Nellums, Georgia Black, Derek Summerfield, Jane Gilbert, Denise Hien and the San Francisco Chapter of the English Speaking Union.

REFERENCES

- Alarcon RD, Westermeyer J, Foulks EF, Ruiz P (1999). Clinical Relevance of Contemporary Cultural Psychiatry. *J. Nerv. Ment. Dis.*, 187:465-471.
- Berry JW, Poortinga YH, Segall MH, Dasen PR (1992). *Cross-cultural psychology: Research and applications*. New York: Cambridge University Press.
- Berry JW (1997). Immigration, Acculturation, and Adaptation. *Appl. Psychol.*, 46:5-34.
- Bhui K, Stansfeld S, Head J, Haines M, Hillier S, Taylor S, Viner R, Booy R (2005). Cultural identity, acculturation, and mental health among adolescents in east London's multiethnic community. *J. Epidemiol. Commun. H.* 59:296-302.
- Blackwell RD (1989). *The disruption and reconstruction of family, network and community systems following torture, organised violence and exile*. London: Medical Foundation.
- Blair IV, Havranek EP, Price DW, Hanratty R, Fairclough DL, Farley, T, Hirsch HK, Steiner JF (2013). Assessment of Biases Against Latinos and African Americans Among Primary Care Providers and Community Members. *Am. J. Public Health* 103(1):92-98.
- Blinder S (2013). Migration to the UK: Asylum. Migration Observatory briefing, COMPAS, University of Oxford, UK.
- Bracken P, Giller JE, Summerfield D (1997). Rethinking mental health work with survivors of wartime violence and refugees. *J. Refug. Stud.* 10(4):431-442.
- d'Ardenne P, Mahtani A (1989). *Transcultural Counselling in Action*. London: SAGE.
- Frank JD, Frank JB (1993). *Persuasion and Healing: A Comparative Study of Psychotherapy*. Baltimore: Johns Hopkins University Press. (Originally published 1961)
- Gilbert J (2008). *Mental Health: Culture, Language and Power*. [online] *Global Health Watch 2*: Zed Books. Available at: <<http://www.janegilbert.co.uk/publications.htm>> [Accessed 18 March 2014].
- Hinton DE, Rivera EI, Hofmann SG, Barlow DH, Otto MW (2012). Adapting CBT for traumatized refugees and ethnic minority patients: examples from culturally adapted CBT (CA-CBT). *Transcult. Psychiatry* 49(2):340-365.
- The Program on Humanitarian Policy and Conflict Research (2004). *UNRWA Conference on Humanitarian Assistance to Palestinian Refugees: International Assistance to Palestinian Refugees in a Human Security Perspective*. Geneva, Switzerland. June 2004. Cambridge: Harvard School of Public Health.
- Jayasuriya L, Sang D, Fielding A (1992). Ethnicity, immigration and mental illness: A critical review of Australian research. South Carlton, Australia: Bureau of Immigration Research.
- Johnson AW, Nadirshaw Z (1993). Good Practice in Transcultural Counselling: An Asian Perspective. *Br. J. Guid. Couns.*, 21: 20-29.
- Karachiwalla FI (2011). Mental health considerations in refugee populations. *Univ. BC Med. J.* 2(2):20-22.
- Koehn PH (2005). Medical Encounters in Finnish Reception Centres: Asylum-Seeker and Clinician Perspectives. *J. Refug. Stud.* 18:47-75.
- Koneru VK, Weisman de Mamani AG, Flynn PM, Betancourt H (2007). Acculturation and mental health: Current findings and recommendations for future research. *Appl. Prev. Psychol.* 12:76-96.

- Lopez SR, Guarnaccia PJ (2000). Cultural Psychopathology: Uncovering the Social World of Mental Illness. *Ann. R. Psychol.* 51:571-598.
- Maslow AH (1987). *Motivation and Personality*, 3rd ed. New York: Harper and Row, Publishers, Inc.
- McFadden J (1999). *Transcultural Counseling*, 2nd ed. Alexandria, VA: American Counseling Association.
- Meredith WH, Abbott DA, Cramer SL (1986). Family Stress and Cultural Adaptation: Home Economics Needs of Lao Hmong Refugees. *Home. Econ. Res. J.* 15:90-96.
- Miller KE (1999). Rethinking a familiar model: psychotherapy and the mental health of refugees. *J. Cont. Psychother.* 29(4):283-306.
- Miller KE, Rasmussen A (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Soc. Sci. Med.* 70:7-16.
- Moodley R, West W (2005). *Integrating Traditional Healing Practices Into Counselling and Psychotherapy*. Thousand Oaks, CA: SAGE.
- Neuner F, Schauer M, Roth WT, Elbert T (2002). A Narrative Exposure Treatment as Intervention in a Refugee Camp: A Case Report. *Behav. Cog. Psychother.* 30:205-209.
- NHS (2013) About asylum support. [online] Available at: <http://www.nhs.uk/carersdirect/guide/asylum-support/pages/asylum-support.aspx> [Accessed 18 March 2014]
- O'Mahony JM, Donnelly TT (2007). Health Care Providers' Perspective of the Gender Influences on Immigrant Women's Mental Health Care Experiences. *Iss. Ment. Health. Nutr.* 28:1171-1188.
- Patel N, Mahtani A (2007). The politics of working with refugee survivors of torture. *Psychologist* 20:164-166.
- Pedersen P (1985). *Handbook of Cross-Cultural Counseling and Therapy*. Westport, CT: Greenwood Press.
- Refugee Council (2014). Therapeutic casework. [online] <http://www.refugeecouncil.org.uk> [Accessed online 18 March 2014]
- Rogler LH, Cortes DE, Malgady RG (1991). Acculturation and mental health status among Hispanics: convergence and new directions for research. *Am. Psychol.* 46:585-597.
- Silverman SJ, Hajela R (2012). Immigration detention in the UK. Migration Observatory briefing, COMPAS, University of Oxford, UK.
- Smith JA (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qual. Res. Psychol.* 1:39-54.
- Smith JA, Flowers P, Larkin M (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: SAGE.
- Smith JA, Osborn M (2008). *Interpretative Phenomenological Analysis*. In JA Smith (Ed.), *Qualitative Psychology: A Practical Guide to Research Methods* (pp. 53-80). Thousand Oaks, CA: SAGE.
- Stuber JP, Rocha A, Christian A, Link BG (2014). Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public. *Psychiatr. Serv.*, doi: 10.1176/appi.ps.201300136
- Sue DW, Sue D (2012). *Counseling the culturally diverse: theory and practice*. Hoboken, NJ: John Wiley & Sons.
- Summerfield D (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Soc. Sci. Med.* 48(10):1449-1462.
- Summerfield D (2000). Childhood, War, Refugeedom and 'Trauma': Three Core Questions for Mental Health Professionals. *Transcult. Psychiatry*, 33:417-433.
- UK Border Agency (2014). Current support amounts. [online] Available at: <http://www.ukba.homeoffice.gov.uk/asylum/support/cashsupport/currenrentsupportamounts/> [Accessed 18 March 2014].
- UNHCR (2013a). *Displacement: The New 21st Century Challenge*. [online] Geneva: UNHCR. Available at: http://unhcr.org/globaltrends/june2013/UNHCR%20GLOBAL%20TRENDS%202012_V05.pdf [Accessed 18 March 2014].
- Van Beek A (1996). *Cross-cultural Counseling*. Minneapolis, MN: Augsburg Fortress.

UPCOMING CONFERENCES

26th Chinese Control and Decision Conference, Changsha, China. May 31-June 2, 2014 Changsha, China.



The banner features a scenic view of a city by the water on the left and a mountain landscape on the right. The text is centered and includes the year '2014', the conference name, dates, location, and website.

2014
The 26th Chinese Control and Decision Conference
May 31-June 2, 2014, Changsha, China
www.ccdc.neu.edu.cn
English | 中文

**IEEE Symposium Series on Computational Intelligence, Orlando, USA
14 in Orlando, Florida, December 9 to 12, 2014**



The banner features a cityscape with a 'WELCOME TO DOWNTOWN ORLANDO' sign in the foreground. It includes the IEEE logo, the IEEE Computational Intelligence Society logo, and a collage of images including a globe, a rocket launch, a castle, and Disney characters.

IEEE SSCI 2014
December 9 to 12, 2014 Orlando, Florida, U.S.A.

Important Dates

Special Session Proposal	April 15, 2014
Paper Submission	June 15, 2014
Notification to authors	September 5, 2014
Final Submission	October 5, 2014
Early Registration	October 5, 2014

2014 IEEE Symposium Series on Computational Intelligence

Conferences and Advert

April 2014

Canadian Anthropology Society (CASCA) Annual Conference, Toronto, Canada

2014 International Conference on Innovation, Service and Management- ICISM 2014

27th Conference on Software Engineering Education and Training, (CSEE&T 2014), Klagenfurt, Austria

18th International Research Society for Public Management Annual Conference, Ottawa, Canada

International Conference on Corporate Social Responsibility, Governance and Sustainable Development (ICCSR-GSD), Accra, Ghana

May 2013

5th World Conference on Psychology, Counseling and Guidance, (WCPCG-2014), Dubrovnik, Croatia


Peace Studies International Conference, Bradford, UK

7th Conference on Language, Discourse, and Cognition (CLDC 2014), Taiwan, Taiwan

13th International Public Communication of Science and Technology Conference, Salvador, Brazil

International Conference on Language, Literature and Culture in Education, Nitra, Slovakia

9th International Conference for Literary Journalism Studies (IALJS-9), Paris, France



International Journal of Psychology and Counselling

Related Journals Published by Academic Journals

- Journal of Media and Communication Studies
- International Journal of English and Literature
- Philosophical Papers and Reviews
- Educational Research and Reviews
- Journal of African Studies and Development
- Philosophical Papers and Reviews

academicJournals