An exploration of applied psychologists' experience of working with female refugees or asylum seekers that have experienced sexual violence

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ABSTRACT

There appear to be specific issues that psychologists need to consider when working with female refugees and asylum seekers that have experienced sexual violence. These include ethical, theoretical and practical concerns regarding psychological models and approaches, dilemmas regarding professional, personal and political stances, as well as challenges encountered when working with refugees and/or survivors of sexual violence in general. Research regarding applied psychologists' experience of working with this client group is limited, but it is important in order for them, and the services they work in, to meet the needs of this vulnerable group. Hence, eight applied psychologists were interviewed and transcripts analysed using Interpretive Phenomenological Analysis. The analysis resulted in the formation of four super-ordinate themes: 1) *Impact of the work, 2) Personal and professional identity,* 3) *Struggles with the tools of the trade* and 4) *Holding on to a 'both/and' view*. Implications of the findings concerned four areas: 1). politics and ideology of the profession, 2). psychological models and approaches, 3). support and supervision for professionals, and 4). increasing service user involvement in clinical practice, service development and research.

CONTENTS

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CHAPTER ONE: INTRODUCTION

BACKGROUND

Definitions

The definition of 'sexual violence' used in this study is that of the United Nations High Commissioner for Refugees (UNHCR, 1995, p. 4): "all forms of sexual threat, assault, interference and exploitation". The term 'gender-based violence' (GBV) can also be useful in the context of this study; the Inter-Agency Standing Committee's Guidelines (IASC) for Gender-based Violence Interventions have conceptualised sexual violence as a form of gender-based violence. They define gender-based violence as an "umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females" (IASC, 2005, p. 7).

The term 'refugee' in this document refers to people at all stages of the asylum process. This includes 'asylum seekers' (whose claim for refugee status has been submitted to the Home Office, and they are awaiting the decision) and 'refugees' (accepted as a refugee under the Geneva Convention[1] and being granted leave to remain in the UK for four years, after which it is possible to apply for settled status).

The term 'applied psychologists' or 'psychologists' refers to clinical and counselling psychologists.

Literature search

Literature was searched for using the EBSCO database for the years 1980 to 2012. Keywords included 'sexual violence', 'sexual torture', 'rape', 'sexual

[1] The Geneva Convention (1951) defines a refugee as any person who, "owing to well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to return it."

assault', 'trauma' and 'refugees'. These were searched for in combination with the terms 'professionals', 'psychologists', 'therapists', 'counsellors', 'clinicians', 'trauma' and 'refugees' in turn. Papers were selected for inclusion based on their relevance to the topic, i.e. whether they focused on professionals' experience of working with the client group of interest and whether they focused specifically on the gendered nature of sexual violence in non-western populations.

Sexual violence and refugee women: Global context

The UNHCR states that, between 2010 and 2011, there were 10 million refugees and 100,000 asylum seekers worldwide, a global problem of "enormous proportions" (UNHCR, 2011, p. 2). Sexual violence is considered by the UN as one of the "worst global protection challenges due to its scale, prevalence and profound impact" (Refugee Council, 2009, p.4). The Refugee Council (2009, p.4) state that "refugee women are more affected by violence against women than any other women's population in the world"; they are particularly at risk of rape or other forms of sexual violence. For example, it is thought that more than 90 per cent of women and girls were victims of sexual violence in Liberia, while three out of four women suffered sexual violence in eastern Congo (Refugee Council, 2009). A UN report states that "the nature of warfare is changing, in ways that increasingly endanger women and girls" (Ward & Marsh, 2006, p. 3).

Although it should not be assumed that all female refugees or asylum seekers have experienced sexual violence, or that males are not victims of sexual violence, the UNHCR report that "the majority of reported cases of sexual violence among refugees involve female victims and male perpetrators" (UNHCR, 1995, p. 3). Similarly, in a review of worldwide gender-based violence, The Reproductive Health for Refugees Consortium reports that "women and girls are the primary targets of GBV worldwide" (Ward, 2002, p. 4). According to the United Nations, "the impact of armed conflict and the specific vulnerabilities of women can be seen in all phases of displacement", such as flight and exile, as well as in the country of origin and "unaccompanied women and lone female heads of household are at the greatest risk of being subjected to sexual violence" (UNHCR, 1995, p. 4). Women and girls are also over-represented amongst those

suffering sexual violence outside of conflict, largely by being victims of forced marriage, enforced prostitution and trafficking (Hannan, 2004).

Sexual violence and refugee women: UK context

In 2011 there were 25,400 claims for asylum in the United Kingdom (UK), a 12 per cent increase from the previous year (UNHCR, 2011). The overall proportion of refugee women to men in the UK may be "approximately the same or possibly higher" if dependants or those arriving under family reunion rules are taken into consideration (Dumper, 2004, p.20).

It is difficult to obtain accurate data on the number of refugee women in the UK that have experienced sexual violence due to differences in research methods, differences in definitions of sexual violence, interviewer training and skills, and factors that affect women's willingness to disclose (Watts & Zimmerman, 2002). Due to the latter factor, it is thought that there is an under-reporting of sexual violence experiences; hence, it is thought that much of the data that does exist is an underestimate. The Refugee Council (2009, p. 4) state that "a substantial proportion of refugee women arriving in the UK can be assumed…to have survived rape, attempted rape, other sexual violence or sexual exploitation". The Medical Foundation for the Victims of Torture reported that "rape and sexual violence were prevalent forms of persecution" reported by women clients in 2007 (International Women's Day newsletter, 2008).

Psychologists are coming into increasing contact with female refugees or asylum seekers and, considering the statistics outlined above, it is likely that women from this population will have experienced some form of sexual violence.

THE GENDERED NATURE OF SEXUAL VIOLENCE AGAINST WOMEN

Kofi Annan, the former UN Secretary General, has stated that violence against women "is rooted in historically unequal power relations between men and women and the systemic discrimination against women that pervades both the public and private spheres" (as cited by Refugee Council, 2009, p. 13). Many authors have highlighted that sexual violence experienced by refugee women must be seen within the socio-cultural, economic and political contexts that exist in peacetime or in armed conflict (e.g. El Jack, 2003; Patel & Mahtani, 2004;

Patel, 2009; Pearce, 2003). For example, in some countries, traditional gender norms that reinforce male superiority and entitlement lead to rape being seen as a right and a reward in armies, as well as an initiation right, a social bonding process and a means of "humiliating male opponents who have failed to protect 'their' women" (Peel, 2004, p.12; see also Coomaraswamy, 2003; Farwell, 2004; Gratton, 2008; Kelly et al., 2012; Krug et al., 2002;).

Sexual violence is also seen as a way of controlling women and policing their sexuality by instilling fear and belief in their vulnerability; this has been acknowledged as a factor across societies and belief systems (e.g. Brownmiller, 1975; de Alwis, 2003; Kelleher & McGilloway, 2009). Agger (1992) proposes that, from a young age, girls learn to internalise shame, and to implicitly understand that women are responsible for ensuring that others do not transgress their boundaries. Consequently, it is thought that women are implicitly viewed by themselves and others as being partly to blame for any act of sexual violence committed against them (Anderson & Doherty, 2008). The result of this can be seen in the lack of appropriate redress in many countries (e.g. Amnesty International, 2006b; Stanko, 2008).

The ideology of 'honour' and 'worth' attached to women's bodies and their sexuality mean that rape can be used as a method to induce shame and dishonour, not just on individuals but also, by association, on their families and communities. This notion of honour (or dishonour) that can be brought to others by one's own behaviour is so prominent in some cultures there is specific language to refer to it: for example, the word 'izzat' in south Asian communities (Gilbert, Gilbert & Sanghera, 2004). In the Democratic Republic of Congo, Congolese people reported that sexual violence has become a "societal phenomenon, in which the community isolation and shame experienced as a result of the attack become as important as concerns about the attack itself" (Kelly et al., 2012, p.285). These beliefs are compounded by the view that women represent the reproductive power of a community, and hence symbolise their community's cultural worth, which mean that rape as torture is used as a method of destroying the opposing community by rendering women as "unclean, contaminated and unfit to bear children" (Patel, 2008, p.14; see also Freedman,

2007; Gratton, 2008; Palmary, 2005). This is the case in times of peace, but in conflict these beliefs, and the practice of rape to enforce pregnancy, mean that rape can be used as a weapon of cultural warfare and ethnic cleansing (e.g. in the conflicts in Bosnia-Herzegovina between 1992-1995 and in Rwanda in 1994).

Spiritual beliefs also appear to play a role in the meanings that women attach to sexual violence and their reactions to it. For example, in an exploration of the discourses regarding sexual torture in the Congolese refugee community, rape was understood as "bad luck…because their grandparents were bad people" and if a survivor were to speak publicly about the rape, this might be seen as questioning God's power (Gratton, 2008, p.19). Another powerful discourse was that of 'active forgetting' or 'sealing off'; for the community and the survivor to attempt to forget the incident, with the apparent function of the survivor being able to remarry and of the community maintaining positive stories. These discourses seem to play a part in beliefs regarding self-blame and responsibility, and the function of remaining silent about the rape or keeping it a secret, discussed in more detail below.

Considerations for psychological practice

For refugee women in the UK, some or all of the above factors are likely to be relevant, leading to the need for specific considerations when working with them in a psychological context. Authors have emphasised the importance of holding a political and gendered perspective when attempting to understand problems such as violence against women in the context of mental health and psychology (e.g. Kastrup, 2011; Webster & Dunn, 2005). Patel and Mahtani (2004, p.22) state that the factors outlined above "shape and define the way in which a person presents in a clinical context" and "the meanings that the survivor of rape attaches to their experiences and the way they make sense of their choices and the future". It is important that acts of sexual violence against this group of women are not seen as private acts, but seen within a broader political and socio-cultural context. Blackburn (2010) purports that, in work with female refugees, acknowledging and exploring dominant gender discourses is essential in therapeutic work, in order for people to create narratives where they can develop meaning from their experience, and re-connect with their preferred self identities.

Similarly, Holzman (1996) emphasises that it is crucial to understand the socio-cultural context of the experience of rape in order to provide effective therapy.

Many authors have reflected on how shame and beliefs about victim responsibility for being raped, and subsequently self-blame, are common psychological reactions to experiences of sexual violence across cultures. Self-blame has been theorised to have the function of defending against shame, and of managing the feelings of unpredictability and loss of control in oneself and others (e.g. Patel & Mahtani, 2004; Vidal & Petrak, 2007). Coomaraswamy (2003) describes how, in some cultures, the feeling of shame is so pervasive that death is seen as an alternative as it saves both the woman's and her community's honour; women are sometimes assaulted and killed as a result. Rejection, ostracism and stigmatisation by a woman's family and community, or even threat of further violence and assault, can continue in the UK, with the consequence of limited social support, isolation and feelings of threat or loss (e.g. Andric-Ruzicic, 2003; El Jack, 2003; Freedman, 2007; Patel & Mahtani, 2004). Due to the feelings of shame, fear of rejection, lack of confidence in redress, and internalisation of rape tolerant beliefs, it is thought that women will often hide their experience, or use silence as a way of managing shame and the possible consequences of this, for herself and her family; "silence can be a culturally specific and a culturally accepted form of communication" (Patel & Mahtani, 2004, p.27).

Considering aspects of gender, culture and politics is a complex process as these factors cannot be viewed as separate from each other. Tamasese (as cited in Blackburn, 2010, p. 20) writes:

> As women from subjugated cultures we have tried to point out that gender and culture cannot be separated. Our ways of living as women and as men are always influenced by the symbols, rituals, language and relationship structures of culture...It means that whenever we are talking about gender, cultural considerations are relevant, as are other considerations of class and sexuality etc.

Indeed, rather than making sense of experiences of sexual violence in terms of 'difference', some authors have highlighted the usefulness of the notion of intersectionality: "the relationships among multiple dimensions and modalities of social relationships and subject formations" such as gender, race and class (McCall, 2005, p.1771). Hence, in the current study, it is important to bear in mind the relevance of aspects of identity other than gender and that

> abstracting any single dimension of 'difference' as a focus of concern or intervention is inevitably – conceptually, politically and therapeutically – inadequate. However addressing 'intersectionality' – that is, the intersection between and within these various dimensions of difference – offers ways of working towards a more fruitful therapeutic and political practice (Burman, 2004, p.297).

For example, it is important to consider women's political as well as gender identity. Agger (1992) describes now, if a woman has taken a political stance and is then viewed as a political opponent, rape is a way of breaking down her political identity by breaking her personal identity. Hence, a woman's political identity is an important factor to consider when thinking about the meaning she attaches to, and her ways of coping with, the experience of sexual violence (Patel & Mahtani, 2004).

EXPERIENCE OF PSYCHOLOGISTS WORKING WITH THIS GROUP

Due to the dearth of literature specifically relating to psychologists' experience of working with female refugees that have experienced sexual violence, the following draws on literature exploring professionals' (such as counsellors, therapists and advocates, as well as psychologists) experience of working with refugees in general, and also working with those that have experienced sexual violence in general. Two further specific areas (*Psychological frameworks* and *Professional ideology and the political context*) are then reviewed in more detail because it appears from the literature that these areas entail specific challenges or dilemmas for psychologists when working with female refugee survivors of sexual violence, considering the gendered and political nature of sexual violence discussed above.

Professionals' experience of working with refugees

Working with refugees and asylum seekers has often been viewed as complex and challenging by psychologists (e.g. Burnett & Peel, 2001; Rees, Blackburn, Lab & Herlihy, 2007). There are a range of reasons for why this may be: for example, cultural differences, language differences and working with interpreters (e.g. Patel, 2009). Other factors include the vast range of difficulties that refugees can experience, such as loss, separation from family members, physical health difficulties, difficulties relating to asylum, poverty, housing, obstacles to integration, and the existential dilemma of exile and identity (e.g. Mahtani, 2003, Rees et al., 2007; Refugee Council, 2009). The wider context has also been said to present challenges such as limited resources and restrictive policies, hostile media coverage, public resentment and punitive political policies (Mahtani, 2003; Tribe & Patel, 2007).

Holmqvist and Andersen (2003) explored psychotherapists' reactions to undertaking therapy with survivors of political torture using interviews and 'feeling checklists' as data, and compared this to therapists who had worked with different client groups. Results indicated that therapists working with torture survivors experienced specific reactions to the work: they felt less enthusiastic and more affected by 'self consciousness and anxiety'. Therapists commented on feelings regarding the meaningfulness of the work and reflected on existential and ethical issues. The authors purported that the reasons for these reactions might include lack of treatment success, clients' unwillingness to talk about traumatic experiences, feelings of hopelessness about human nature, and the need to address clients' current difficulties. Considering the points outlined above regarding the possible reluctance women may have of talking about their experience of sexual violence, and the points to be outlined below considering the usefulness of psychological 'frameworks' for this work, the issues outlined in Holmqvist and Anderson's (2003) study also seem particularly pertinent in the context of the current research.

A study investigating family therapists' experience of working with refugees in Australia also indicated that many challenges were experienced by therapists (Codrington, Iqbal & Segal, 2011). These included difficulties with engagement

which seem to have arisen from misunderstandings between refugee families and therapists, such as differing expectations of therapy, mistrust in services, lack of problem definition, and there being no word for counselling in some cultures. Subsequently, therapists reported feeling de-skilled and inexperienced to the extent that they questioned whether it was appropriate to be doing the work. Differences in problem definition and solution, leading to difficulties with engagement, have also been reported by other authors (Sveaass & Reichelt, 2001). Another difficulty was that the necessity to ensure and support the basic needs of the family (e.g. housing) often meant that therapy was not appropriate.

Consistent with this, Misra, Connolly and Majeed (2006) reported that refugee community representatives stated that the factors affecting the mental health of refugees in a north London borough were not directly under the remit of National Health Service (NHS) professionals. They felt that practical issues such as education, employment, and social inclusion often need to be addressed, together with providing support such as psychotherapy. Historically, support with these wider systemic issues has not been seen as part of the psychological remit, nor has it been the main focus in training programmes (Rack & Shirley, 1988). Possibly as a consequence of this, psychologists have reported that separating "clinical issues from practical issues" was a concern for them when undertaking work with asylum seekers (Maslin & Shaw, 2006).

Professionals' experience of working with survivors of sexual violence

Studies have indicated that counsellors working with survivors of sexual violence have experienced a variety of challenges and dilemmas. These include: difficulties regarding the therapeutic relationship (boundaries, setting limits, trust, the length of the process); managing clients' emotions about the abuse (e.g. fear, anger, shame); funding, injustice in the legal system, public apathy about violence against women, and professionals managing their own emotional reactions to the work (e.g. Schauben & Frazier, 1995). Possibly as a result of these issues, the importance of supervision in supporting practitioners working with this client group has been highlighted (e.g. Sommer & Cox, 2005).

Much of the research and theorising in this area has been within the framework of 'vicarious trauma', the adverse psychological consequences of those encountering the experience of trauma through work such as psychological therapy (McCann & Pearlman, 1990). For example, research has indicated that counsellors who work with sexual assault survivors report intrusive thoughts or memories, increased arousal, avoidance or numbness, and disruptions in basic cognitive schemas regarding trust in oneself and others, escape or avoidance strategies and beliefs regarding safety (Johnson & Hunter, 1997; Schauben & Frazier, 1995; Wasco & Campbell, 2002). Counsellors' sense of safety and worldview has also been shown to be affected by the work (Benatar, 2000). The emotional affects on professionals working with this client group has included negative feelings (i.e. anger, sadness, horror) and 'rescue fantasies' in relation to their work (Knight, 1997). Research has highlighted the need for further investigation of supervision, training, teamwork and consultative support needs for professionals that work with this client group (e.g. Chouliara, Hutchison & Karatzias, 2009).

Conversely, there has also been literature highlighting the beneficial aspects of working with 'trauma', with concepts such as 'compassion satisfaction' (Figley, 2002), and more recently, 'vicarious resilience' (Hernández, Gangsei & Engstrom, 2007). This literature outlines positive changes in perception of the self, life philosophy and relationships, and emphasises features such as resilience in the client and professional. Wasco and Campbell (2002) undertook a qualitative analysis of rape victim advocates' emotional reactions. Although results showed that advocates experienced anger and fear as a consequence of both individual and environmental cues (e.g. community denial of a problem), some understood their emotional reactions to be a necessary part of their work with rape victims, bringing about motivation and indicators of personal growth. The authors state that "these findings suggest that intense emotional reactions, previously conceptualized within a vicarious trauma framework, may at times serve as resources for women working with rape survivors" (Wasco & Campbell, 2002, p.120). Similarly, other studies indicate that counsellors developed a critical political consciousness of sexual violence in the process of working with survivors, leading to feelings of anger and impacts on their relationship with

intimate partners (e.g. Garrity, 2011; Rath, 2008). Other positive aspects of the work include professionals' observing the creativity, strength and resilience of survivors; feeling honoured to take part in the healing process and increased spiritual or existential wellbeing (e.g. Schauben & Frazier, 1995).

Hence, it has been noted that vicarious trauma on its own does not completely capture the experience of working with survivors of sexual violence, and that the benefits experienced by professionals working in this area require further investigation (e.g. Benatar 2000; Chouliara, 2009; Steed & Downing, 1998). Additionally, it could be argued that the vicarious trauma discourse frames "normal" reactions to the hearing of extreme stories of human distress within a pathologising framework and is therefore stigmatising for professionals, as some argue it is for clients (see *Psychological frameworks* section below for further discussion regarding the latter point). Furthermore, the above research seems to be somewhat polarised, with a tendency to over-emphasise the pathologising impact of trauma work on professionals or over-emphasise positive aspects and resilience in professionals. Research and theorising regarding how both could co-exist for professionals, and how they may relate to each other, is limited.

Psychological frameworks

The construct of 'trauma' and the role of 'talking therapy'

The dominant psychological theoretical framework for understanding the consequences of experiences of sexual violence, and its treatment, involves the concept of trauma, in particular that of Post Traumatic Stress Disorder (PTSD) (American Psychological Association, 2000). Indeed, the National Institute of Clinical Excellence (NICE) guidelines for PTSD highlight the need to screen for PTSD symptoms in refugee and asylum seeking populations in particular (NICE, 2005). Although psychologists use various approaches in their work with clients that have experienced trauma or have been diagnosed with PTSD, the dominant approach remains cognitive behavioural therapy (CBT), which is recommended in the NICE guidelines as the treatment of choice (NICE, 2005). CBT for PTSD, among other techniques, involves a re-telling of the traumatic event with the aim of the memory of the event being re-processed (e.g. Brewin, Dalgleish & Joseph,

1996; Ehlers & Clark, 2000). However, guidelines for PTSD suggest a phase model, and acknowledge that CBT for refugees will only be appropriate in particular circumstances (NICE, 2005).

However, many have criticised the practical and theoretical usefulness of the construct of trauma, and the treatment of CBT in general, and with this client group in particular (e.g. Bracken, 1998; Kagee & Naidoo, 2004; Patel, 2003; Richman, 1998; Summerfield, 2001a, 2001b). Indeed, the way women refugees that have experienced sexual violence make use of silence, discussed above, has interesting implications for how they make use of treatments such as CBT, with its emphasis and value on 'talking' and self-disclosure as an essential part of treatment (Mahtani, 2003; Patel & Mahtani, 2004). It has been suggested that focusing on individual treatment can "unintentionally corroborate the themes of secrecy and of survivors' responsibility for recovery" (Gratton, 2008, p.21).

In a study exploring psychotherapists' and project workers' experiences of working with South Asian women that have experienced sexual violence, "the tension between individualised models of personhood in many psychological therapies and…South Asian communities who hold a more relational view of the person" was apparent for these professionals in their work (Reavey, Ahmed & Majumdar, 2006, p.171). In an attempt to manage these tensions, professionals appeared to translate the women's distress into symptoms of mental disorder; interestingly, it seemed that the discourses of diagnosis and mental disorder were used as by professionals a way of managing the cultural differences between clients' perspectives and western psychological therapies. However, this approach resulted in some concerning consequences for clients, such as pathologisation and stigma. Additionally, familial dynamics, gender roles and the significance of ideas about shame and 'honour' were all highlighted as important issues to consider when working with South Asian women.

Other authors have highlighted the differences between 'individualistic' cultures (defined as cultures that "tend to promote an independent self that is autonomous and self-contained", Kerman, 2001, p.1705) and collectivist cultures (defined as cultures that "foster an interdependent self that is part of a comprehensive social relationship and that is partially defined by others in that relationship", Kerman,

2001, p.1705) between non-western and western populations respectively, and purport that framing clients' experiences as 'symptoms' and ignoring the collective aspect of their experience and ways of helping is not appropriate (Bracken, 1998; Rechtman, 2000; Richman, 1998). In short, a CBT approach with this population has been criticised for not taking account of the differences in understanding and expressions of distress across cultures, and for the limited research demonstrating efficacy (e.g. Ager, 1997; Zur, 1996). Another difficulty with the concept of PTSD and its treatment is that most female refugees are not in a 'post-traumatic' situation, since they continue to experience a variety of stressors and factors that impact on their wellbeing, as discussed previously. Hence, some authors have stated that supporting refugees is complex and "not simply a question of treating their trauma" (Richman, 1998, p.179). More specifically, it needs to be considered what approaches or psychological models, if any, address and incorporate the multiple meanings that experiences of sexual violence can have for refugee women, considering the gendered, political and spiritual contexts within which they occur.

Alternative approaches

There is a growing literature describing alternative therapeutic approaches for those working with refugees, such as facilitating community groups and projects and working from a community psychology perspective (e.g. Webster & Robertson, 2007). Community psychology works from the premise that problems have social causes that interact, that problems should be analysed at the macro as well as micro level, and that preventative work should be emphasised (Orford, 1992). Community psychology allows for an acknowledgement and analysis of the political context, as it promotes social justice and aims to tackle social and service inequalities (Prilleltensky & Nelson, 2009). With regards to refugees, using a community psychology model is conducive to incorporating cultural understandings and meanings of mental health, developing protective factors such as social support and avoiding the stigma associated with mental health services (Webster & Robertson, 2007). Rappaport (1981) advocated that community psychology should be guided by empowerment and based on a rights model emphasising service user participation and control.

However, there are several potential limitations or difficulties with implementing a community psychology approach which may be encountered when working with women refugees. One is the problematic nature of the notion of 'community'; "the creation of the community with meaning for the people who are involved may have little to do with geographical contiguity of residence or even actual person-to-person contact" (Fernando, 2010). For example, the description of 'Asian' or 'black' community does not mean that communities of Asians or blacks exist in reality and that they can act together to address social injustice. Many people that may identify as a member of a black and minority ethnic group, for example, may also identify with others outside this group on different dimensions such as professions, or role as mother, for example (Yuval-Davis, 1994). This relates to the concept of intersectionality described earlier. It is important to consider the potential political and social meanings of simplifying the boundaries of "community groups". For example, dividing communities based on racial, cultural and ethnic boundaries in order for them to be governed has been described as a 'colonial strategy' (Baumann, 1996, p.29).

Another potential difficulty with implementing a community psychology approach is the assumption that refugee women want to be connected to their 'community' (whatever this maybe). Mistrust, political divisions and stigma around mental health may mean it is difficult to create meaningful community groups that refugee women can make use of (Kalathil, 2011). It appears essential to appreciate how gender and culture interact or intersect in order to provide adequate services. Burman (2004) points out the danger of focusing on gender alone, and ignoring aspects of culture: that a women may be concerned about the confidentiality of a therapeutic group due to the 'tightness' of community networks, especially if a culturally specialist organisation is providing the service and this organisation shares traditional cultural values; "presumptions on the part of providers around cultural matching may be actively unhelpful, and so function as a disabling approach to difference" (Burman, 2004, p.302). Furthermore, taking into account the patriarchy that still exists in various cultural 'communities', women may be excluded from participating in community structures and may not be adequately represented in existing groups (Webster & Robertson, 2007).

Using creative mediums such writing, art, drama, dance or crafts as ways of improving psychological wellbeing has also been advocated (Patel & Mahtani, 2007). Hearing the client's story as an empowering testimony and the therapist as bearing witness, whilst exploring issues of power and context, has also been suggested as an alternative 'talking therapy' (Agger & Jenson, 1990; Herman, 1992; Patel & Mahtani, 2004). Similarly, narrative therapy has been suggested as a means of naming and deconstructing, to allow clients to reposition themselves in relation to their experiences and allow an alternative narrative to be revealed (e.g. Rees et al., 2007).

Psychological frameworks: summary

The majority of UK applied psychologists are employed in the NHS, where there is an emphasis on treatments that are demonstrably effective and short in duration, hence the dominance of models that meet these requirements, such as CBT (Kuipers, 2001). Considering the possible difficulties and tensions in using western methods of therapy with this client group, it is likely that psychologists will encounter dilemmas regarding what theories and approaches to draw on to inform their work, possibly impacting on their feelings regarding competence and confidence. It has been noted that psychologists may find their offers of support to refugees "unacceptable due to their assumption that the intervention should involve therapy focusing on 'trauma'" (Richman 1998, p.179-80). Indeed, Maslin and Shaw (2006) asked a sample of clinical psychologists (both those that had worked with asylum seekers and those that had not) to complete a questionnaire regarding their thoughts on working with this group. The most commonly encountered issue was that of assessment and treatment, including concern regarding "inadequate therapeutic frameworks for working with this client group" (including the validity of the PTSD construct) and "culturally appropriate" interventions, and this was identified as a training need (Maslin & Shaw, 2006, p.11). It was found that those who used a cognitive behaviour/cognitive approach exclusively felt significantly less competent to work with clients seeking asylum than those who used other or more integrative/eclectic approaches, and this was stressed as an area for further exploration "because of the predominance of these approaches within clinical psychology" (Maslin & Shaw, 2006, p. 14)

The move towards alternative approaches could present challenges for psychologists as their training and repertoire of professional skills have been historically dominated by 'talking therapy'. Conversely, Smail (1999) argues that what a therapist can offer is primarily comfort, clarification and encouragement, and that s/he has no privileged expertise on distress or healing. Such an approach explicitly acknowledges the limits of clients' power within their environments, as well as the limits of psychologists' power to help clients.

Professional ideology and the political context

The professions of applied psychology, and clinical psychology in particular, in an effort to align themselves with disciplines such as psychiatry, and to distance itself from the image of the profession as a 'soft science', have established themselves on a scientist-practitioner model, using a positivist framework. This is so their knowledge can be seen as objective and value-free, and hence credible in the eyes of other disciplines and society in general (Pilgrim & Treacher, 1992; Prilleltensky, 1989). Inherent in this framework is the assumption of a stance of neutrality, for example, in the contexts of research (scientific neutrality) and therapy (Fox, Prilleltensky & Austin, 2009). This has led to the development of psychological theory and approaches that have historically neglected a consideration of political contexts (Fox & Prilleltensky, 1996; Patel, 2011). Related to this, Cox and Kelly (2000) argue that psychologists are socialised to think from an individualistic rather than a socio-political standpoint.

Consistent with this, the diagnosis of PTSD and the model of CBT have been criticised for de-politicising experiences such as sexual violence, as they locate the problem and its solution in the individual, rather than in wider political and socio-cultural systems, such as the gender inequalities described previously (e.g. Bracken 1998; Patel, 2003, 2011; Summerfield 1999). It has been argued that the psychological consequences of sexual violence should instead be seen as "normal human reactions to abnormal inhumane situations" (Refugee Council, 2009, p.29).

As outlined above, the political and gendered context appears to be essential to an understanding of women refugees' reactions to, understanding of, and coping with their experience of sexual violence. Indeed, it is likely to be clinically unhelpful to de-politicise clients' experience as this will lead to a limited psychological understanding. Patel and Mahtani (2004, p.25) describe working with a woman who was raped and beaten with the aim of terrorising "her and her family into ceasing their political activities" and how her aim for therapy was to develop the strength to continue "fighting" politically, rather than reduce symptoms of PTSD. These authors, amongst others, argue that incorporating these contexts into intervention and viewing rape as a political act is "essential in the therapeutic process" (Patel & Mahtani, 2004, p. 34; see also Agger & Jenson, 1990). Indeed, it is not just within the more explicit legal aspects of the work in which these dilemmas occur; Blackwell (1997, p.97) describes the practice of bearing witness as a "personal and political activity".

Some have commented on the potential moral and ethical consequences for individual psychologists, and for the discipline as a whole, of taking a scientific or therapeutically neutral stance. The discipline has been accused of "hindering the betterment of social conditions by guarding the interests of the status quo" (Prilleltensky, 1989, p.795). By focusing on the survivor rather than the perpetrator, the discipline of psychology has been criticised for ignoring, and even implicitly condoning, human rights abuses like sexual violence and systems of inequality (e.g. Patel, 2003). In the context of sexual violence, Patel (2009) advocates a human rights based approach to the prevention of torture; a moral and ethical stance that should inform psychologists' work, rather than particular models or techniques that dictate the nature of the work. However, Patel (2011) later discusses how the notion of "human rights" can also be viewed as a social construction that involves Eurocentric biases, and how the use of both a human rights framework and diagnostic constructs can be problematic if it is assumed these are essentialist constructs. Despite these problems, Patel goes on to acknowledge that psychology and a human rights framework (in the context of national or international law) can be a useful tool for psychologists to use; "for many torture survivors, medicalising and psychologising misery can be functional, a route to safety, security and life" (Patel, 2011, p. 254). Patel therefore purports

that what is necessary is for psychologists to be transparent and honest regarding their moral or political position “in psychologising or de-psychologising misery or distress” (Patel, 2011, p. 253). In the light of this, it is interesting to note that psychologists have reported concerns about becoming involved in the legal processes of their clients and their lack of knowledge about this, as well as ways that this may impact on the therapeutic relationship (Maslin & Shaw, 2006).

It may be anticipated, then, that for psychologists working with female refugees that have experienced sexual violence, tensions and dilemmas may be experienced between professional stances or frameworks, the reality of what is needed and what occurs in the work, and personal and professional ethics and values. This may be a reason that psychologists have reflected that the work is complex. Prilleltensky (1989, p.797) has asserted that “the persistent refusal of psychologists to elaborate on the role of values in their discipline has been one of the most influential factors interfering with an understanding of psychology in a social context”. Indeed, it has been stated that some psychologists may be reluctant to work in this area as it is seen as “too political” (Patel & Mahtani, 2007).

IMPLICATIONS FOR SERVICES

It seems that the specific issues with working with this client group have a broader impact on service provision. NHS guidelines on working with asylum seekers state that mainstream services have a “statutory responsibility to provide care” for this group (Burnett & Fassil, 2000, p.37). However, there is uncertainty about whether this is being carried out in practice (e.g. Kmietowitz, 2001). Senior (2002) discusses a report in a national newspaper with the headline “NHS psychologists refuse to treat ‘traumatised’ asylum seekers”. According to the article the trust in question had stated that they did not have the means to meet the needs of this group as they had no specific treatment programmes for PTSD, and this was exacerbated by the need to use interpreters and the long term nature of the work.

Lack of adequate guidelines may exacerbate these issues. NHS guidelines on *Meeting the Health Needs of Refugees* (Burnett & Fassil, 2000) point out the need to consider the context of torture and to not pathologise natural expressions of grief and distress, but at the same time lists symptoms of PTSD and outlines CBT treatments for this, which, as discussed above, could be considered as de-politicising distress and as ineffective with refugee populations. It seems that there is an acknowledgement of a need to use diagnosis such as PTSD and models such as CBT with caution but at the same there is not an agreed alternative framework for working with this group. A survey undertaken in 2006 showed that sixty nine percent of clinical psychologists were either not aware of any specific policy within their service relating to those working with asylum seekers or stated that there was none (Maslin & Shaw, 2006). Other factors also have an impact on whether an appropriate provision is and can be provided for this group, such as having access to adequate interpreting services (Refugee Council, 2009 p.9). These factors will inevitably have an impact on psychologists' experience of working with female refugee survivors of sexual violence, on an organisational as well as individual level.

SUMMARY

Justification for current research

It is clear that there are specific issues for psychologists to consider when working with women refugees that have experienced sexual violence. These include ethical, theoretical and practical concerns regarding psychological models and approaches, dilemmas regarding professional, personal and political stances, as well as the various other challenges encountered when working with refugees and/or survivors of sexual violence outlined above. In general, research into sexual violence is limited, partial and inadequate and "continues to remain low on the agenda of policy makers, service providers, and funders" (Dartnall, 2008). More specifically, research regarding applied psychologists' experience of working with this client group is limited, but it is important in order for them, and the services they work in, to meet the needs of this vulnerable group. Unfortunately, it seems that this is not currently the case; in a survey of refugees living in London, a majority of those offered some form of psychotherapy rated it

as poor or very poor (Summerfield, 2001b). Additionally, it is important services do not perpetuate instances abuse, resulting in 'secondary victimisation' (e.g. Campbell, 2008). Reavey et al. (2006, p.174) purported that "services and frameworks for understanding sexual abuse are often not 'culturally sensitive', that is they do not acknowledge the differences in experience and understandings of women from various diverse communities".

Research aims

This research will attempt to explore applied psychologists' experiences of working with female refugees that have experienced sexual violence. Much of the previous research investigating professionals' experience of working with this group has focused on the emotional impact of the work. This research aims to add to this literature by exploring the dilemmas that psychologists may encounter regarding the ethical, theoretical and practical concerns relating to psychological models and approaches, and their professional, personal and political stances. It is hoped that this will shed light on possible implications for psychological practice regarding theory and approaches, training and supervision, inform service organisation and guidelines, and subsequently improve services for women refugee survivors of sexual violence.

Hence, the aim of this research is to explore the experiences of applied psychologists when working with female refugees or asylum seekers that have experienced sexual violence.

More specifically, the research questions are:

- How do applied psychologists make sense of their experience and what theories, concepts or ideas do they draw on to do this?
- How do psychologists describe the challenges they experience in this work and how do they respond to these?
- How do psychologists experience dilemmas in this work regarding the relationship between their personal and professional values, beliefs, attitudes and roles, and how do they reconcile them?

CHAPTER TWO: METHOD

METHODOLOGY

Interpretative Phenomenological Analysis (IPA)

Considering the limited nature of existing research on the area of this study, an exploratory approach, and hence a qualitative methodology, was thought most appropriate. IPA was chosen as a method of analysis as it is a means to "explore in detail how participants are making sense of their personal and social world" (Smith & Osborn, 2008, p.53). This was in keeping with the aim of exploring psychologists' experience of their work with women refugees that have experienced sexual violence and how they make sense of this. Other methodologies were considered, such as Grounded Theory and Discourse Analysis. Grounded Theory was not chosen as a methodology because the aim of the research was not to propose a theory of how applied psychologists do this work. Discourse Analysis was not chosen because the primary aim was not to examine how language is used, or explore discourses between people, in this context.

IPA: Theoretical underpinnings

Three important influences on the development of IPA have been phenomenology, hermeneutics and ideography. Regarding phenomenology, the philosopher Hussurl (as cited in Smith, Flowers & Larkin, 2009) was concerned with how we can come to know the content of a person's experience by an attentive and systematic examination of consciousness. He argued that this can be achieved through suspending our assumptions ('bracketing off' culture, context, history, etc) in order to get at the essential and particular features of a phenomenon as a person experiences it. Later, Heidegger (1962, 1927) proposed that this can never be completely achieved as a person is always engaged in the world and in relationships with others, and hence can never be truly objective. A person's unique perspective and context are essential concepts to consider when they make sense of the world and experience. Consequently, Heidegger argues that what we can achieve is an interpretation of a person's experience. Hence, IPA is not just concerned with a person's experience, but

also with how a person makes sense of this experience regarding the meanings that they impress upon it.

The concept of hermeneutics is important here: the theory and practice of interpretation. Heidegger (1962, 1927) suggests that the listener or analyst inevitably bring their preconceptions and prior assumptions to the encounter, or to the text, and that they should ensure that they are aware of these preconceptions or assumptions. Hence, reflective practice on the part of the researcher is important during the process of data analysis in an IPA study. The process of IPA is not linear but circular in that "to understand any given part, you look at the whole; to understand the whole you look the parts" (Smith et al., 2009, p.28). The 'whole' in this case is the researcher and his or her history, values, assumptions, etc and 'the part' is the encounter with the participant. Hence, the analyst shifts between different ways of thinking about and viewing the data. However, IPA also entails a 'double hermeneutic' in that the researcher is making sense of the participant, who in turn is making sense of the phenomenon in question.

Ideography is a focus on the particular, rather than the general or universal. With regards to IPA, this is reflected in the detail and depth of analysis that is required, as well as the aim to understand how a particular phenomenon has been understood by a particular person, in a particular context.

Ontology and epistemology

Interpretative phenomenology represents an epistemological position in itself and my ontological and epistemological stance could be said to be one of 'interpretative phenomenology', outlined by Harper (2012). With IPA "we are assuming that our data…can tell us something about people's involvement in and orientation towards the world, and/or about how they make sense of this" (Smith et al., 2009, p.46). The phenomenological element of this epistemological approach means that the focus is on participants' subjective perceptions of the world rather than with any 'objective' reality.

Although it is assumed within this stance that there is some association between what a person says and their subjective experience, the interpretative element of this approach means that the data is not considered by the researcher as a direct reflection of events that the participant has experienced; the same event can be experienced in different ways by different people because of the meanings that people attribute to it. It is assumed that the meaning and sense making that participants carry out when telling of their experience is influenced by their social, cultural and theoretical context. Hence, it is necessary to consider the participant's context (such as social, political and historical factors) and that they are already "immersed in a linguistic, relational, cultural and physical world" (Larkin & Thompson, 2012, p.102). This is consistent with Heidegger's view, described above, and could also be said to be consistent with the epistemological position of 'contextual constructivism' outlined by Madill, Jordan and Shirley (2000); that knowledge is contextual and standpoint-dependent. Subsequently, the meaning and sense-making the researcher carries out of the data is influenced by their context: their preconceptions, values, beliefs and assumptions (the 'double hermeneutic' described above). As summarised by Larkin and Thompson (2012, p.103) "researchers do not access experience directly from these accounts, but through a process of intersubjective meaning making". Hence, this epistemological stance sits between the realist and relativist ends of the spectrum of epistemological positions.

Related to the issue of epistemology is that of different levels of interpretation in an IPA analysis. Larkin, Watts and Clifton (2006) suggest that, without sufficient interpretation, IPA accounts can be too descriptive, although they recognise that it can be difficult to balance the phenomenological requirement to 'give voice' to participants and the interpretative need to contextualise and 'make sense' of the data from a psychological perspective. Larkin et al. (2006) outline what these different levels of interpretation may involve. The initial level is one of description, which attempts to get as close to the participants' perspective as possible. The next level considers wider cultural, social and theoretical contexts and "aims to provide a critical and conceptual commentary upon the participants personal 'sense-making' activities" (Larkin et al., 2006, p.104). This level can be taken further to involve reflections of "what it means for the participants to have made

these claims and to have expressed these feelings and concerns *in this particular situation"* (Larkin et al., 2006, p.104). This means that, as long as the data and experiential account remains central and contextualised, then "IPA researchers can make cautious inferences about discursive, affective *and* cognitive phenomena" (Smith, as cited in Larkin et al., 2006, p.114). At this level of interpretation, the researcher may also be informed by existing theories (something which distinguishes IPA from grounded theory) and by the research question and aims themselves, although it is important for the researcher to be reflexive regarding these influences. These different levels of interpretation were applied during the analysis of the current study.

CRITERIA FOR EVALUATING THE RESEARCH

It is understood that qualitative researchers, like quantitative researchers, need to defend the scientific value of their work and its contribution to knowledge (Willig, 2008; Yardley, 2000). However, due to the subjective nature of the processes involved in qualitative research, it is recognised that the criteria traditionally used to evaluate quantitative research (such as objectivity, validity and reliability) cannot be meaningfully applied to the evaluation of qualitative research (e.g. Willig, 2008). Although a variety of evaluation criteria have been proposed for qualitative studies, there are no universally agreed guidelines. The guidelines used in the evaluation of this study are those of Elliot, Fischer and Rennie (1999) as these are located within a phenomenological-hermeneutic tradition and hence are consistent with the epistemological position of IPA (Willig, 2008). These criteria, and the attempts that have been made to meet them, are listed below:

- **Owning one's perspective: requires the researcher to disclose their own assumptions/values to allow the reader to interpret the analysis and consider their own alternative interpretations**.
  This is discussed below under *Relationship to the research* and in more detail in the *Discussion* chapter. The researcher kept a journal throughout the research process in order to record and to help process how her own assumptions and/or values may have changed and/or developed.

- **Situating the sample: requires the researcher to describe participants' and their life circumstances in enough detail to allow the reader to assess the relevance and applicability of the results.**
  Participants' gender, ethnicity and professional experience are described below under *Participants and recruitment*
- **Grounding in examples: requires the researcher to demonstrate, to the reader, the analytic procedures used and the understandings generated by providing clear examples from the data**.
  Quotes are used throughout the *Analysis* chapter to demonstrate themes. Examples of annotated transcriptions are presented in *Appendix I* in order to demonstrate different types of analytic comments made.
- **Providing credibility checks: this can be done through referring to others' (colleagues, participants) interpretations of the data.**
  The analytic process was supervised by a researcher who reviewed the themes that were generated at different stages, suggesting ways of developing the original analysis. However, the possible limitations of meeting this criterion are outlined in the *Discussion* chapter.
- **Coherence: requires the researcher to present a coherent and integrated analysis, whilst maintaining nuances in the data.**
  The themes are organised in the form of super-ordinate and relevant sub-themes, in a way that is hoped to reflect coherence. Additionally, many themes relate to each other and overlap in several ways, which is a reflection of how certain concepts interacted with each other in participants' accounts. It is stated in the narrative of the *Analysis* where this happens, and these connections are also reflected on in the *Discussion.*
- **Accomplishing general versus specific research tasks: being clear about the research tasks.**
  The research question states the specific phenomenon under investigation, and the aims specify what elements of experience are of particular interest. However, issues regarding how far the specific research was addressed are considered in the *Discussion* chapter, along with a consideration of the applicability of the findings to the experience of psychologists in general.

- **Resonating with readers: the researcher is required to present the material with the aim of stimulating resonance in the reader and to increase their understanding and appreciation of the subject**
  It is hoped that relevant literature and findings have been presented in such as way as to reflect the complexity of the topic, and to encourage and stimulate interest in the reader.

PROCEDURE

Participants and recruitment

Eight psychologists participated in the study, six women and two men. Smith et al. (2009) state that a sample size of between four and ten is adequate for a study such as this, it is thought more than this would make it difficult to maintain the ideographic stance of IPA and "keep in mind" each individual participant. Regarding ethnicity, five participants described themselves as white British, one as white European, one as black British, and one as South Asian. All participants had experience of working with several female refugees or asylum seekers that had experienced sexual violence. Seven were qualified clinical psychologists and one was a qualified counselling psychologist. The participants had worked in various clinical settings across London, including the National Health Service and charity organisations. These were specialist services with the remit of supporting and treating refugees or asylum seekers in the case of seven participants, and a service with the remit of supporting any adult who had survived sexual assault in the case of one participant. The participants were currently working at these services or had worked at these services in the past. The participants adopted a range of psychological approaches and models in their work, which are summarised in Table 1 below.

Table 1: Summary of the main therapeutic approaches adopted by participants

Participant	**Main therapeutic approach/s or model/s used**
Amita	Human rights approach/systemic
Amy	CBT
Anne	CBT/systemic
Faraa	Human rights approach/systemic
Jack	CBT/systemic
Marie	Community psychology/systemic
Paul	CBT
Sarah	CBT/systemic, used human rights approach in past

Contacts for potential participants were gathered from colleagues and from non-statutory groups or organisations on the internet (e.g. a support group for psychologists working with refugees). Potential participants were contacted via email and phone and invited to take part in the study. Those that expressed an interest were then sent the *Participant Information Sheet* (see *Appendix II*) via email and invited to contact the researcher with any queries. Dates and location of interviews were then arranged via email or phone. Interviews took place in the participant's home or at their workplace and lasted between 40 and 90 minutes.

Interviews

One-to-one interviews were conducted in order to gain a rich and detailed account of participants' experiences, consistent with the aims of IPA. Semi-structured interviews were conducted, allowing for the flexibility to follow up ideas or concepts that may not be addressed in the interview schedule but that were relevant to the research question, as they arose. This was to allow for the possibility of participants to developing and expressing their ideas flexibly, with the aim that this would result in more thorough and detailed data.

The interview schedule consisted of six open questions and was developed with a consideration of the research aims, and the existing literature on the areas (see *Appendix III*). The initial questions in the schedule required more descriptive responses, with progression to questions requiring more analytical or evaluative

responses later on in the interview, as suggested in Smith et al. (2009). This was to allow for a rapport to be developed between interviewer and interviewee, and hence for the interviewee to feel comfortable and to be able to share as much of their experience as possible.

Areas covered in the schedule included: career history and progression, the participant's view of their role and the aims of the work, factors that influenced psychologists in the work, challenges (e.g. conflicts or dilemmas) psychologists encountered in the work and how they managed these, and the impact of the work on their personal and professional life. The interview schedule was developed through discussion with the research supervisor and was slightly revised after consideration of the reflections from the first interview.

Before commencing the interview, I outlined the content of the participant information sheet and consent form with participants and allowed time and opportunity for any questions (see *Appendix IV* for a copy of the consent form). I explained issues regarding consent, and confidentiality that are outlined on the consent form.

Ethical issues

Full ethical approval was obtained from the *University of East London Ethics Committee* (see *Appendix V*). All participants gave written consent to take part and for interviews to be audio-recorded, transcribed and quoted anonymously. Anonymity was assured by assigning each participant a code. These codes, as well as the consent forms, were kept in a locked cabinet, separate to the digital records, transcribed materials and demographic details. All electronic files (e.g. files of transcripts and audio-recordings) were password protected.

Given the possible distressing nature of the work that was discussed in the interviews, it was considered that participants might feel emotionally distressed and in need of personal or professional support after the interview. Generally, applied psychologists are skilled at making use of appropriate support that is available to them. Nonetheless, it was planned that if participants did become distressed during the interview, they would be asked if they would like to pause or terminate the interview, or asked if they would like to discuss other options for

support. However, none of the participants did become emotionally distressed during the interview and so this was not necessary.

Transcription

All interviews were transcribed verbatim from the audio-recordings. The researcher transcribed all interviews using conventions described by Banister et al. (1994; see *Appendix VI).* All identifiable material contained in the transcripts were anonymised by deleting or editing it, including any client information that the participant referred to.

PROCESS OF ANALYSIS

Recommendations for the process of analysis described by Smith et al. (2009) were followed. This process involved moving from the particular to the shared; in other words, close analysis of each transcript in turn, followed by an analysis of shared themes across transcripts. Another important process involved moving from a descriptive to a more interpretative analysis of the transcripts. Throughout the analysis, a focus was kept on understanding the participant's perspective and meaning making, in their personal life context, as well as the context of the interview. This is consistent with the interpretative approach proposed by Heidegger, outlined above, as well as the epistemological position which assumes that, to some extent, understandings and meaning are constructed within a particular context, and influenced by factors such as history, culture, politics, etc.

The initial stages described here were initially undertaken for one transcript, and then the others in turn. Whilst transcribing the data, initial note-taking was made of any salient observations that I had, which may have involved my preconceptions or assumptions as it was appropriate to be aware of these and how they may have influenced the process.

Next, a close and active reading and re-reading of the transcripts was undertaken, involving detailed note taking and commenting on the transcripts in the margins of the transcripts. As suggested by Smith et al. (2009), three different types of comments were made: descriptive, linguistic and conceptual. Descriptive

comments focused on the content of the transcript, linguistic comments focused on reflections about the way the participant had used language, or non-verbal utterances, and conceptual comments focused on ideas reflecting a more abstract understanding of the participant's experience (the latter was considered to be part of a more interpretative process of analysis). I drew on theoretical knowledge at this point, alongside the developing understanding of participants' perspectives and experiences, although I always ensured that the comments were grounded in the data. At this stage, many alternative possible meanings and understandings were considered rather than there being an attempt to establish or 'pin down' set ideas. The above process was then repeated for subsequent transcripts.

The connections between, and patterns across, the notes on each transcript were then explored and organised into emergent themes. This process was then undertaken with the notes across the transcripts. This involved creating a word or statement that captured what was important in a range of comments within and across transcripts. However, I was also influenced by the whole texts, not just the individual sections; a manifestation of the hermeneutic circle. As described by Smith et al. (2009, p.92), the aim was for these themes to "contain enough particularity to be grounded and enough abstraction to be conceptual", combining an accurate reflection of participants' experiences with my interpretation. This resulted in a list of emerging themes, with references to where the theme occurred in the data.

The next stage involved outlining or mapping out how I understood the emerging themes as fitting together in order to create 'super-ordinate' themes. Themes were typed out and then 'moved around' in order to 'see' connections and relations between them. This resulted in a table of sub-ordinate themes and super-ordinate themes.

RELATIONSHIP TO THE RESEARCH

As suggested above, it is important for IPA researchers to "identify and reflect upon their own experiences and assumptions" (Larkin & Thompson, 2012, p.103). This seems particularly important considering that the epistemological

position I am taking emphasises the need to consider the *context* of the researcher, as well as that of participants. As a trainee clinical psychologist myself, I am interested in the experience of applied psychologists, particularly the challenges and dilemmas encountered when dominant or traditional approaches to intervention may not "fit" with presenting clients or their difficulties. I am also aware that the development of a majority of psychological theories and models has occurred within a western, white, patriarchal context and wonder about whether, and if so, how psychologists can use their knowledge and skills to support people who may have had experiences outside of this context. Being female, a particular personal concern for me is the occurrence of human rights atrocities such as sexual violence which I believe need to be understood within the context of unequal gender relations, as discussed in the *Introduction*. I also believe that psychologists have an ethical obligation to consider the role of the discipline of psychology, and their own individual practices, in relation to these wider issues. Hence, in the development of my interview schedule, whilst conducting the interview and during the analysis stage it is likely that I was influenced by my interest and awareness of these particular issues, and hence may have focused in on these issues or considered them in more detail. These reflections regarding my personal relationship to the research are considered further in the *Discussion* chapter under *Critical review and reflections.*

CHAPTER THREE: ANALYSIS

The results of the analysis of the interviews comprise four super-ordinate themes, each made up of two to three sub-ordinate themes, summarised in Table 1 below, along with sub-headings for these themes.

Super-ordinate theme one, *Impact of the work* includes discussion of the emotional reactions that the participants had in response to undertaking the work and how these were managed. Processes of identifying with or feeling different from clients appeared to be related to these emotional reactions. Super-ordinate theme two, *Personal and professional identity,* includes dilemmas regarding the relationship between participants' personal values and their professional role. A variety of factors seemed to culminate in the work being viewed as complex, 'different' and challenging. Super-ordinate theme three, *Struggles with the tools of the trade*, outlines how the various tools psychologists use, such as the construct of 'trauma' and psychological models, may contribute to these challenges. Super-ordinate theme four, *Holding on to a 'both/and' view*, details the recurring themes of holding in mind polarised positions, with regard to viewing the self (as the therapist) or the client as an expert and/or non-expert, and with regards to viewing clients as resilient and/or vulnerable.

Although the themes are conceptualised as separate from each other, there are occasional overlaps between particular concepts in each theme, a reflection of how these concepts interacted with each other in participants' accounts.

Table 2: Super-ordinate and sub-ordinate themes (sub-ordinate themes are shown in bold, with subheadings for these underneath).

SUPER-ORDINATE THEME ONE:
IMPACT OF THE WORK
Emotional reactions
Specific reactions
Anger
Making sense of their own reactions
Containment and coping
Where does it all go?
Supervision and support
What can and cannot be said
The work as worthwhile and rewarding
SUPR-ORDINATE THEME TWO:
PERSONAL AND PROFESSIONAL IDENTITY
Identifying and difference
Life experience and life circumstance
Immigration, 'refugeedom' and nationality
Gender
Political identity
Personal and professional values
Marginalisation of the client group and the work
Professional frameworks and 'being political'
Psychological models and 'being political'
Being able or choosing to 'be political'

SUPER-ORDINATE THEME THREE:
STRUGGLES WITH THE TOOLS OF THE TRADE
Struggles with the construct of 'trauma' and 'trauma focused' work
The use of the constructs of 'trauma' and PTSD
Role dilemmas: trauma focused work or addressing systemic difficulties?
Naming and describing the psychologist's role
Being 'able' to undertake a certain role
Finding a balance
Struggles with psychological models
Psychological models and psychological roles
The 'real' work of psychologists
Privileging and validating models
The importance of the therapeutic relationship
Struggles with the meaning of 'talking'
Talking or not talking?
Talking seen as 'good'

Talking and power

SUPER-ORDINATE THEME FOUR:
HOLDING ON TO A 'BOTH/AND' VIEW

Both/and expert and non-expert

'Schooled' to be experts
The 'rescuing' impulse
Whose meaning is privileged?
Collaboration and empowerment

Both/and resilient and vulnerable

Inspired and celebrating
Oppressed or empowered?
The best and the worst of 'human nature'

SUPER-ORDINATE THEME ONE:

IMPACT OF THE WORK

This super-ordinate theme includes the impact that the work appeared to have on participants, such as the emotional reactions described by participants in response to undertaking the work and how these were managed. This super-ordinate theme relates to super-ordinate theme two, *Personal and professional identity*, in various ways. For example, the emotional reactions participants experienced relate to aspects of their personal and professional identity; whether and why participants sometimes felt anger or guilt appeared to be related to their gender or cultural identity.

Emotional reactions

Specific reactions

Participants talked of having a range of emotional reactions to the work, including shock, numbness, horror and sadness. Some also described incomprehension and disbelief. For some, it seemed that hearing stories of sexual violence evoked specific reactions compared to hearing stories of other experiences clients may have had:

some of the stories are horrific…I think there is something about that where it's quite hard to be able to hear those things and not be horrified and not be shocked and not be completely overwhelmed (Amy, 260-266)

when there's a sexual element to any of the torture, or any of the violence, there's something particular that gets evoked in me that's really, really, um, hard to understand, to process, to, kind of, make sense of. I don't know where it comes from (Amita, 737-739)

Some participants spoke of the complexity of the work leading to the experience of feeling overwhelmed and incompetent:

I can't cope with this, it's too much, it's too overwhelming, I feel awful, I feel like I, not only, I feel it's a combination of feeling like the stuff that you're dealing with is overwhelming but also feeling like you don't really have enough skills or resources or capability or, you know, whatever it is, to be able to do anything. (Amy, 25:544-549)

Anger

Anger appeared to be a common emotion aroused in participants. Often, this anger was not just directed at the individual perpetrators of sexual violence but at the wider gender inequalities that surround sexual violence (this was true of both the male and female participants) and the current systems that were perpetuating clients' distress, such as the process of gaining asylum status via the UK Home Office. For both male and female participants, anger and a negative attitude towards males in general, as a group, was something that was spoken about. Some participants reflected that it was important to be aware of this attitude and "*keep on eye"* on it *(Amy, 346)* to ensure that their views remained balanced and not polarised:

this is outrageous, you know this should not be happening to all these women, they shouldn't end up feeling, having to carry all this shit (I: hmm) because, because they happen to be in a war and victims of this kind of abuse, you know (I: hmm), so I don't know what you do, but you feel very sad, and mournful, and very angry (Anne, 384-388)

very often that, um, fury and anger is focused on people's current situations…you can't deny the enormity of what people have been through, um, prior to coming here, but I think where it becomes the kind of focus of so much anger amongst us as workers is where you just see people being unnecessarily re-traumatised by the system that's supposedly (I: hmm), um, bringing safety to them (Marie, 24:769-770; 777-781).

it makes you think about your own gender it…your own group, um, and what utter bastards they can be…that makes me angry sometimes (Jack, 500-501; 505)

Interestingly, a way of coping with anger seemed to be to use it as a motivating force to continue the work and to participate in political or social action to instigate change on a wider level:

it's just infuriating, (I: yeah)…but then you just think, okay, well what can be done to highlight it…you can work with agencies, or you can talk, sometimes on the radio… it's working with legal organisations and charities, this is an example of how you can potentially promote change on a wider scale which keeps me sane when working with people on an individual basis (Paul, 252-260)

Making sense of their own reactions

Participants also talked about how they made sense of their emotions and their ways of coping. Unsurprisingly, given that they were psychologists, participants made use of psychological theories and constructs to do this. These theories and constructs included those of 'trauma' and 'vicarious traumatisation', symptoms of PTSD, CBT and 'defences'. However, most participants also spoke in a way that reflected their desire to normalise their reactions, and not pathologise them. This relates to the theme of containment and the need for others, such as supervisors, to not pathologise their reactions either (see below under *Coping and containment*).

I suppose in a way it's quite traumatic, it can be quite traumatic. Um, I don't necessarily think that that's a bad thing, I think that, you know, if I get to the point where I hear about, you know, somebody going through something horrific and don't have any kind of response to it then I've probably been in the job for too long (Amy, 266-271)

I don't know if it's pathological or not really (both laugh) I do know there's all the literature around secondary traumatisation and I do have some of those issues, I do…I cannot, um, watch movies that have violence in them at all but I think I saw Hurt Locker…and I watched it and I was running in and out of the room completely hyper-vigilant and avoidant (Sarah, 401-408)

Related to this, participants reflected on how they had learnt and grown regarding managing their emotional reactions over time, in particular feeling more familiar with the material and finding ways to make sense of it:

I do leave it at work. I think years ago I didn't have that and I would take it home a lot more and I was much more touched by it personally…I suppose I'm less shock-able (Sarah, 366-370)

when I was first starting as a psychologist…I was hearing all of those stories fresher and so your emotions are more raw…you don't have the defences (Paul, 218-221)

Containment and coping

Where does it all go?

Nearly all (i.e. seven) participants talked about the impact of the clients' stories that they had heard on them, regarding 'where' this information or knowledge 'goes' and if or how the thoughts and feelings this information evokes is processed. Three participants talked about how this material can stay with you in the form of images in particular:

Those stories are just horrific really, and you don't know where they go, and I think that's quite interesting (Anne, 354-355)

I have visual imagery of a particular story a client told me which I don't think I'll ever let go (Sarah, 413-414)

Some participants talked about how the stories they heard left them with a certain 'type' of knowledge, or a certain type of information, that then could not be 'unknown'. It seemed that this was due to the detail of their clients' experience that the participants were privy to as a result of their role of listening to a detailed account of their clients' experience:

you can read about if you seek it out, I think there's something very different to sitting in a room with somebody and listening to stories about how they've been gang raped or, you know, tortured (Amy, 136-140)

Supervision and support

Supervision and peer support were referred to as a possible resource for helping to hold, contain and process some of this material and manage the emotional impact of the work. However, there appeared to be mixed experiences regarding whether supervision had met this need or not. It seemed this was particularly pertinent as many commented that the work can be quite isolating. Hence, it seemed that supervision has a specific role in this type of work in particular.

if [emotions are] not properly, and appropriately, and effectively processed in their own clinical supervision, or talked about in the [service] in a containing and…helpful, supportive, nurturing way, then all these horrible, horrible, emotions spill out (Amita, 215-219)

you can have an hour of supervision a week…you can have peer support but it almost sometimes isn't enough for it all to (I: hmm), to go out there…it can pile up (Amy, 284-290)

What can and cannot be said

Relating to the issues of containment and supervision was the issue of what participants felt they could talk about regarding their work, and to whom. Participants spoke about how it was hard to talk about the specifics of the clients' stories that they had heard, and the impact the work had on them, within personal and professional, including supervisory, relationships. It seemed that this was due to the nature of the work, hearing and discussing cases of extreme violence, including sexual violence, which can be considered to be outside the realm of ordinary experience, and ordinary language, including that of supervision. Some participants also reflected on their hesitation to talk about the impact of the work due to the possibility that others may view their reactions through the lens of trauma and hence pathologise them. This latter point is related to the use of constructs such as vicarious traumatisation that are available to participants and their colleagues (McCann & Pearlman, 1990).

> *I think a lot of the clinical detail that you hear is really shocking stuff and there aren't that many people that can listen to it…so currently I have supervision but I cannot take that stuff there (Sarah, 318-321)*

> *supervision was incredibly important, and very challenging I have to say because...to talk to someone about really deep, dark feelings that, what rape arouses in you…again sometimes it's hard to find the words how can you talk about such a frightening thing about human nature…it's really hard to talk about, you know, really hard (Amita, 361-364; 369-371)*

> *I think working in a context that's supportive, that's (I: hmm), um, vocal and, um, doesn't pathologise the response to trauma, whether it's in the therapist or the client, then I think it's much easier than say working in a place that pathologises response to trauma (Faraa, 543-546)*

The work as worthwhile and rewarding

Converse to the challenging and difficult aspects of the role that have been outlined, participants also spoke about being inspired by clients' strengths and resilience, and how this was a positive and rewarding aspect of the work, and helped them to cope with the challenges. This relates to holding in mind a resilient view of clients, discussed below under the theme *Both/and resilient and vulnerable'*. Seeing positive changes in the clients and their circumstances appeared to make the work worthwhile, although this came with managing expectations about therapeutic change.

> *Thinking about when it's been successful with people (I: hmm), and that's, I think that's a really big way of coping with it…thinking about this, this one recent client that I worked with, um, you know, the fact that she is now getting better, significantly better is like, brilliant, that's fantastic (Jack, 528-532)*

SUPER-ORDINATE THEME TWO:

PERSONAL AND PROFESSIONAL IDENTITY

This super-ordinate theme relates to the processes of matching participants' personal values with their professional role and the dilemmas encountered in this.

Identifying and difference

Various aspects of identity were referred to by all clients. This was in relation to the experience of identifying with clients but also being aware of differences between themselves and clients. Identifying with certain aspects of women refugees' identity, such as gender or culture, was often referred to as being a motivating factor in the decision to work with this client group.

Life experience and life circumstance

One significant aspect of difference was between participants and their clients who had survived experiences of sexual violence. For some participants, this

difference presented tension with the stance they took regarding a 'them and us' perspective of clients and professionals:

> *it also made me think about, sort of, how easy it can be, how unwitting…to put people in a kind of us and them kind of situation…because of the traumas they've been through, because of their experiences placing them, you know, outside of their relating to <u>other</u> people who might not have been through the same experiences (Marie, 637-642)*

It appeared that differences in experience, culture and life circumstance also led to anxieties for participants concerning how this difference impacted on how they were viewed by clients; their ability to understand and empathise with clients, and hence how this might impact on the therapeutic relationship:

> *I can remember feeling quite frightened of them…thinking she's looking at me as if, I've not been raped, I'm a professional here, I've got money, I've got, um, I've got status in this country, I've got all these things that she hasn't got and she probably thinks, um, that I have no idea what she's been through, right, so that in some way, I felt <u>way</u> out of my depth (Amita, 722-726)*

> *what do I, as a white European…what do I have to offer to somebody who has, you know, survived a genocide or, you know, torture (Marie, 575-578)*

However, the complexity of the relationship between different aspects of identity, and of identifying or difference, was epitomised by Marie speaking of identifying with a service user (who was also a colleague) in terms of gender but not culture: *having grown up in a completely different culture, she's from [name of country], [we've] got all the same kind of experiences…the thing that bought us together…was our commitment to, sort of, feminist ideas (Marie, 289-293).* It seemed that, in this circumstance, identifying in terms of gender transcended the difference in terms of culture.

Having colleagues, such as supervisors, who identified with the client group and could provide a perspective that was close to that of the client groups appeared to be helpful for participants to feel that they were not making assumptions about their clients if they were from cultures other than their own; rather, they were gaining understanding of their clients:

> *My supervisor's also an African woman which, um, I'm very happy about because, again, I think she has a perspective that…she has a perspective that really helps, again, in this work (Marie, 16:519-523)*

Immigration, 'refugeedom' and nationality

Identifying with clients in terms of being an ethnic minority was something which those participants who belonged to an ethnic minority group reflected on, with regards to the experience of migration. Although, again, the possible differences between their experience and those of their clients were acknowledged. This was also talked about as something that initiated an interest in and motivation to work with refugees:

> *Because I come from a family, um, who came from [name of country]…so I remember coming to this country when I was very small and…my whole family found lots of things very difficult…[refugees have] not chosen to come here, they've actually been forced to flee and they've ended up here somehow, so that's different from my family who've made a decision to come here (I: hmm)…the effects of, you know, racism, hostility from the, um, neighbourhood (I: hmm), struck a chord with me…so, I was just drawn to that (Amita, 25-43)*

> *By virtue of who I am I feel a connection to the…experience of, um, refugeedom (Faraa, 36-37)*

Conversely, identifying with being a UK citizen led to feelings of discomfort and guilt, with regard to the negative experience clients have had in the UK. This relates to the feelings of anger towards systems and policies such as the UK Home Office, discussed above:

I think that one of the things that you become really consciously aware of is how abusive the system is here, um, towards people…and I think there can be, you know, a sort of degree of guilt about that, you know, we're sort of part of the system in some ways that, you know, um, I was working with a client…she was talking about the home office and she said it's like, um, they're beating me, they're abusing me like, er, like an angry father and you're like my mum, you're standing in front of me, protecting me. And at the time, I thought, oh, you know that's, that's quite a nice sort of image of my relationship to her as in, you know, and then I thought, ah-ha, but if I'm the mum in this scenario I'm also married to the Home Office (Marie, 793-805)

Gender

Some participants spoke of an awareness of identifying with the client in terms of gender. Female participants spoke about how this identification made them more aware of their own vulnerability and powerlessness or helplessness, although two participants also said that they had this awareness before commencing work in the area.

fearfulness, you know, terror, um, what if it was me, how would I have coped…how much does being raped…affect me, someone putting me in that position, it just creates intense fear and, feeling powerless, and, out of control, and, you know, just the thought of being pinned down…just the helplessness of it all (Amita, 698-708)

Similar to cultural identification, three participants spoke about how being a woman, and the gender inequalities that they had experienced in their own lives, were motivating factors to work with this client group:

I suppose also as a feminist, as a woman…I'm interested in supporting other women, other people generally, but, particularly drawn to, um, the issues that impact on women (Faraa, 53-55)

The usefulness of participants' own gender in the therapeutic process, either as a male or female, was spoken about. The two male participants, Paul and Jack, spoke about the awareness they had that female clients might identify male

therapists with perpetrators of sexual violence. However, Paul and Jack also reflected that being male may be therapeutically useful in that it provides clients with an alternative representation of a man or being male. Naming and initiating a discussion with the client about how they may feel towards a male therapist appeared to be a way that these psychologists had managed this possible difference:

> *being a man, that's challenging, that's a big challenge, and it's not so black and white to be honest…you're a man but sort of you're a different sort of man and that's been helpful (Paul, 452-55; 58-59)*

> *say listening to what you're saying makes me feel quite upset or angry at men in general, I wonder if you find it difficult saying what you think about men because I'm a man (Jack, 502-508)*

However, this is a complex issue. It could be considered that this alternative representation of a man is only provided within the context of a therapeutic, boundaried and, by its nature, 'safe' relationship; it could be questioned whether this will generalise to clients' view of and relationships with men outside of this context.

Personal, professional and political identity

Many issues within this sub-ordinate theme are related to the super-ordinate theme of *Struggles with the tools of the trade*.

<u>Personal and professional values</u>

Some participants talked about how their own personal values and interest regarding human rights were motivating factors in their reasons for deciding to work with refugees, and how previous experience in the human rights field inspired and drew them to the work. Whether this area of work in particular was seen as providing a good 'fit' between personal values and the role of psychology, or whether this was experienced as an area of tension and dilemma, differed between participants. The possible difficulties of matching personal principles and values to the work as a psychologist were apparent in what participants said. For some, the possibility of a 'fit' meant that this area of work

was particularly attractive to them, whilst others reflected that they felt they needed to align themselves to either the human rights field *or* the profession of psychology. If the latter was the case, then participants often spoke about having to make an active decision to undertake human rights and social justice work in addition to their day to day role as psychologists.

> *It's the human rights element that's really, that I really like (I: okay), and so it's tricky finding that in other areas of clinical work (Sarah, 24-6)*

> *how I could do that, how I could match who I was as a person, er, politically, socially, personally, spiritually, with what I actually did (Faraa, 158-159)*

> *I align myself with the human rights field in general (I: hmm), rather than aligning myself with psychology…and that I find quite helpful (Jack, 175-179)*

Marginalisation of the client group and the work

A more prominent issue relating to the decision to work in the field was the awareness that others (colleagues, etc) also viewed the work as challenging and 'different' compared to other areas of psychological work (these challenges are discussed in more detail under *Struggles with the tools of the trade*). A factor that was thought to be a reason for the view of the work as 'different' was that it represented for people, or involved dealing with, such extreme acts of atrocities: the "*darkest, most bleak kind of experience and behaviours" (Amy, 16:356-69)*. One participant remarked that this marginalisation of the work by colleagues did make her *"feel like the clients" (Sarah, 335).*

> *you constantly come up against prejudice and fear… you're constantly challenged by your peer group and your management system because it terrifies them, we can't manage, its so different, that work is so different, we don't know how to do it, so it reduces people's confidence (Sarah, 263; 276-280)*

Professional frameworks and 'being political'

It appeared that certain professional structures and ways of working seemed to create a barrier to being able to explicitly act from a political stance or not. These structures and ways of working included: the requirement to work from evidence based guidelines, the scientist practitioner model and the use of diagnostic constructs. These were experienced as encouraging a stance of neutrality with regard to taking a 'scientific', objective and value-free stance, and hence neglecting a consideration of the political and socio-cultural context. Additionally, two participants talked about how they felt that role definitions and the framework of diagnosis were 'silencing'. This possibly has wider implications regarding the moral and ethical position and role of psychology as a profession and what action it can or should take regarding human rights abuses.

> *if we stick in a, in a rigid way to this idea of being scientist practitioners…as if our knowledge was all kind of neutral…it seems slightly perverse to…take a neutral stance on that (Marie, 10:307-314)*

> *we could do it in so many different settings (I: yeah), we could do it when it comes to benefits, when it come to the DLA, but we choose not to, we say that we're psychologists and we take this very reserved position where we're essentially silent (Jack, 674-79)*

> *I think one of the professional things that stops us addressing these things is this sort of, is diagnosis really, a tendency towards manualised approaches. Um, it becomes a way of silencing the reasons why people are distressed (Marie, 834-838)*

A de-politicising stance was talked about as something that was inherent and historical in the profession, and which starts at the training stage. This appeared to have caused tensions for some participants between their professional identity and their personal and political identity throughout their career.

> *You're socialised not to be very political, so yeah, it was very difficult (Amita, 618-20)*

Psychological models and 'being political'

Assuming a political stance in the work appeared to involve being aware of and incorporating the socio-political context into their work with clients. For some, certain therapeutic models (e.g. the human rights approach and community psychology) were seen as more conducive to working from a political perspective and others, CBT in particular, appeared to be incongruent with this, or de-politicising in their nature. These latter models were talked about by some participants as if they restricted a comprehensive understanding of peoples' difficulties as well as not informing a sufficient intervention to meet people's needs. However, this was a complex issue and it seemed that the process of overcoming these dilemmas involved adapting models such as CBT and/or integrating different approaches in the work. These issues also relate to the super-ordinate theme of *Struggles with the tools of the trade*.

> *you can think systemically, and you can formulate in that way, and that helps, but then even that is limiting (I: hmm-mm) and you can think, alright CBT, you can formulate in some way, but that's heavily limiting because you're narrowing people's torture experiences to just their symptoms (Amita, 494-500)*

> *You're influenced by your political stance, the importance of community psychology, of empowering communities that are often disenfranchised or left, left by the wayside (Anne, 175-84)*

> *It's about understanding somebody within a kind of cultural context…and then something about how you apply the model to that (Amy, 309-311)*

Being able to or choosing to 'be political'

As well as the professional role and structures, some participants spoke about the specific context they worked in as either allowing them or giving them permission to take a more political stance in their work. These contexts included

staff culture, whether there was a dominant psychological approach in the service and what this was, or whether the service was a charity or NHS trust, and hence having certain remits or targets.

> *it's been much easier since I've been working in a voluntary organisation because, it's the sort of thing here that just accept…so they see people's psychological wellbeing as indivisible from their social circumstances, so, so here it's not a problem (Marie, 191-197)*

> *my supervisor, and my colleagues…we had shared understandings, so I was facilitated in that way… I was given, you know, the permission to understand clients' distress in a very different way to…to see that everything as political (Amita, 621-623)*

Rather than understanding this experience as involving the *ability* to take a political stance or not, depending on context, etc, some participants held the view that everything was political, but even more so working in this setting. Hence, taking some sort of political stance was inevitable and inherent in the work; whether to 'be' political or not was not a choice. Subsequently, by choosing to use certain approaches or models, a therapist was seen to be acting politically; actively neglecting or taking on board certain issues.

> *you can't help but question issues around, you know, racism and gender…they talk about them in a political way, you know, this happened to me because I was a woman, and this is the way that it is because I'm a woman, because I'm a woman from this part of the world (Faraa, 442-7, 448-9)*

> *There was nothing that wasn't political, in everything that I did or didn't do, in what I chose to do, what I ignored (Amita, 625-27)*

The therapeutic relationship and 'being political'

Related to this, some participants spoke about how and whether they shared and discussed with their clients their political opinions regarding the experiences of

sexual violence that clients had endured. For some, it seemed important that clients understood that they held a stance on this. Discussing alternative meanings of client's experience, by considering the unequal power relations between men and women, for example, seemed important in the therapeutic process and relationship. This is also related to the theme of *Both/and expert and non-expert.*

> *I think I probably have a lot of, um, maybe a lot of opinions about what should and shouldn't be the case politically but I think it's important that, you know, you do your job without that coming in …actually I think if a client understands that in a certain way then it's important to work with that (Amy, 312-321)*

> *I won't say anything very explicit but it will be clear to the client that I will not agree with that…you can be quite subtle about it. And the fact that you even see them again might say it all (Sarah, 441-456)*

SUPER-ORDINATE THEME THREE:

STRUGGLES WITH THE TOOLS OF THE TRADE

A variety of factors seemed to culminate in the work being viewed as complex and challenging. This section outlines how the various tools psychologists use may contribute to these challenges. These tools include the construct of 'trauma', which has led to the role of psychologists as being one of treating and intervening with trauma, the models psychologists use, and the predominance of 'talking therapy' as an intervention.

Struggles with the construct of 'trauma' and 'trauma-focused' work

<u>The use of the constructs of 'trauma' and PTSD</u>

The constructs of trauma, PTSD and its symptoms were used in the interviews when participants explained the type of work and the roles that they undertook. Participants appeared to be aware that they were using these constructs, and how they were using them, and some appeared to implicitly or explicitly acknowledge the potential problems with these constructs and that they were

contentious. Even though participants had implicitly or explicitly communicated their awareness of the problems of the use of the construct, they still used the word 'trauma' throughout the interview, possibly '*for want of a better word' (Marie, 8: 257-58):*

> *there is still a very powerful discourse that, um, refugee people are traumatised and it's important to recognise and talk about trauma (Faraa, 424-26)*

> *I do believe that PTSD sort of exists, in inverted commas, so I do think the clients that I see, they do have these very similar experiences where they're having flashbacks, where they're having nightmares… whether you want to all it PTSD, or a normal reaction to trauma it doesn't really matter (Jack, 132-137)*

<u>Role dilemmas: trauma-focused work or addressing systemic difficulties?</u>

It seemed that participants often came up against an assumption from others that clients from this groups' primary 'difficulty' was trauma, or symptoms of PTSD. However, in participants' experience, their clients' current socio-economic and political circumstances appeared to be the main cause of their distress and what they reported they needed help with. This appeared to lead to dilemmas regarding how to intervene, as well as difficulties conceptualising what clients' psychological difficulties were. Sometimes how participants' roles were defined or understood by others did not match the reality of what was needed in the role, or what participants felt that they could offer:

> *people say, oh, you know, you must be doing a lot of trauma work, or it must be about helping people come to terms with trauma, which it is, but actually exile is probably more of an identity crisis…they may have had traumatic experiences, but…what often isn't anticipated is how difficult it is to adjust to living <u>here</u> (Anne, 54-59)*

> *But if you ask people what is the thing that is most affecting their current wellbeing they almost will invariably identify the immigration*

process and the uncertainty as the first thing, social circumstance as well, poverty, um, poor housing, things like that…and then things that have happened in the past…so to divide off this psychological trauma as being something separate, er, doesn't make sense to them (Marie, 211-216; 235-236)

Indeed, one prominent issue that all participants talked about was what types of work they did or could do, or felt was necessary in their role, with regards to undertaking 'classical' psychological work, such as focused one-to-one therapeutic work with individuals, or wider systemic work involving intervening to address the socio-economic circumstances of clients. Various terms were used for the latter role, including 'holistic' work and 'advocacy'. This issue often appeared to create tensions and dilemmas for participants. Some referred to the efficacy of undertaking a direct psychotherapeutic intervention (such as CBT) when it was thought that this would not work, due to the client not being in a secure and stable situation (Maslow, 1943). For some, the 'holistic' work was viewed as a necessary but separate step to be undertaken before any direct therapeutic work could be started and was not necessarily seen as being part of the role of psychologists. For others, this was viewed as a therapeutic intervention in itself.

I just couldn't not see the whole picture, I couldn't see that it was going to work (I: mmm), the clinical work wouldn't work…I just thought it was peculiar… so the basic Maslow stuff wouldn't be there, and I just felt very strongly that it should be there (Sarah,115-117; 126-127)

it's focused but I mean…at this service where we have a support network, a support phase, and we have people to help us with social needs (I: hmm-mm), and, um, reintegration…my role is important but I wouldn't be able to <u>do</u> my role if the social needs…weren't met then we wouldn't be able to do the work, but yes, I focus specifically, specifically on PTSD (Paul, 45-53)

Naming and describing the psychologists' role

It is interesting to note how the different roles that psychologists took on were named, talked about and understood by themselves and others. It appeared that one-to-one individual therapy was viewed as 'classical' or 'traditional' psychological work, and that other types of work were seen as outside of this boundary. At other times, it seemed that these complexities led participants to have difficulty naming and describing their role. Interestingly, one participant referred to how providing wider intervention beyond talking therapy may be seen as a 'soft' approach*: we may be a little bit soft in comparison to other services, I don't think that's true, I think what we try and do is give a holistic approach (Jack, 81-5).*

> *in other areas of clinical work…you don't have the same sort of advocacy element to your work (I: yeah) which I probably enjoy as much as the clinical work, that's the sort of, you know, classical clinical work in terms of doing therapy with someone (Jack, 1:24-28)*

> *[outreach and community work] is the one bit of the work that we find so hard for people to recognise as psychological work, um (.) even amongst our management and, er, you know, colleagues here…basically I think sometimes this is seen as a place to send clients who can't or won't engage with psychological therapy but maybe they don't see what we're doing here as being psychological therapy (Marie, 162-165; 237-240)*

It may be that this apparent difficulty to name and label a particular approach was because participants did not want to fully 'own' this; it seemed important that they did not appear to be fully wedded to one approach. This may be an implicit way of communicating that the work is complex and it is not possible to label or simplify what one does. However, it may have been difficult to state this explicitly, as this seems incongruent with how psychologists are schooled to talk about their work and their role, for example, as 'experts' who are clear about theory-practice links:

I guess that is kind of a community approach (I: yeah), I just never thought of it that way (Paul, 184-5)

obviously the main role is doing therapy, and the main thing you try and do is help people, that obviously sounds really basic but it's difficult, I don't feel you can quantify it in the same way as you do other clinical work (Sarah, 31-4)

Being 'able' to undertake a certain role

Some participants spoke about the context they worked in as either allowing them or giving them permission to take on certain roles in their work. These contexts included the remit of the service as a whole, the remit of the psychologists within this (e.g. the length of therapy that was permitted with any one client) and the attitude of management. It appeared that there were divisions and gaps in services, with some services focusing on individual psychotherapeutic intervention for trauma and others on the holistic interventions, but with fewer services undertaking the latter. This created dilemmas for participants who sometimes felt that it was necessary for the holistic work to be done and that they should provide some service or intervention, but could not undertake this themselves due to various service restrictions:

there was a sense that one should just do this pure piece of clinical work and I really struggled with that and would sometimes do more than that and not tell anybody (Sarah, 101-102)

officially we're meant to, you know, we do only take people on if they've got PTSD symptoms (I: hmm), whether we, and we're only meant to formally take people on for trauma work, in reality as, as clinicians, and including managers, that's not what we do, we take on, um, we don't do trauma work with some people, we do other stuff (Jack, 380-87)

Finding a balance

Similar to the dilemmas regarding personal, political and professional stances described under the sub-theme *Political identity*, some participants talked of incorporating the wider systemic work into the more direct individual work, or

creating a balance between considering the wider socio-cultural and political issues, whilst also undertaking one-to-one direct work:

> *but I suppose always trying to sort of come back to the more psychotherapeutic, or psychological element of it as well (I: hmm-mm), so maybe, you know, even sort of, like, formulating the idea of doing some voluntary work as a good way of building up trust again (Jack, 101-105)*

> *so if somebody comes to you with housing, by all means write that letter, but at the same time, you need to leave room where you say, well what does home mean to you, and what does it mean to be a refugee, being forced to leave your home and now be in this situation, lets look at the symbolic meaning as well as do the practical work, and it's quite a, quite a careful balance (Anne, 76-90)*

Struggles with psychological models

Participants talked about the various models and approaches they used, which ranged from community psychology approaches, a human rights approach and more 'traditional' psychological approaches with regards to talking therapy, such as CBT.

Psychological models and psychological roles

In parallel with the type of struggles experienced regarding the trauma construct and the roles this led to, it appeared that using certain psychological models allowed for or led to either undertaking a more holistic role or a more individual psychotherapeutic one. Hence, some favoured an approach which allowed for an intervention on the wider socio-economic or political level, as they did not view an individual direct 'talking therapy' approach as being efficacious because it would not meet the needs of the client. Conversely, others spoke about how more individualistic approaches can and do allow for considerations of wider issues, and that trauma work still needs to be done in order to meet the needs of the

client. However, there seemed to be a general recognition by all participants that trauma work on its own would not be enough to meet clients' needs:

> *not many [models] can attend to the different layers (I: hmm) of people's existence and that's actually what you need to do when you work with this client group…things like power and social inequalities, … I think maybe that [the human rights approach] attends to those kinds of things more so than other approaches (Amita, 502-512)*

> *I don't think I've ever just used [CBT] by itself…particularly the refugee and asylum seeker group which is so, would be quite an odd thing to do (Sarah, 515-524)*

The 'real' work of psychologists

Some participants talked about exploring the cultural and gender meanings of experiences such as sexual violence with clients. Although this was considered an important part of the work, it was spoken about by some participants as if it was on the periphery of the rest of the work, for example 'talking around the trauma'; the trauma work being seen as the actual core or essence of psychological work and as separate from discussing and addressing contextual issues such as cultural and gender meanings. This could be because of the dominance of talking therapies such as CBT that do not incorporate cultural and political factors as a significant part of the model (as discussed in the *Introduction*); rather, these models have been viewed as focusing on the individual and the internal:

> *a good example is a client that I've been working…she got horrifically raped and, because she didn't have housing, didn't have anything, um, we couldn't do any, couldn't go anywhere near the trauma but we could talk around it, so we could talk around the shame, we could talk around the cultural issues to do with the trauma and how it was interpreted in the culture and things like this, which was really helpful, um, and now that everything's settled down we're now doing the trauma work (Jack, 296-301)*

Privileging and validating models

It seemed that when discussing why they used certain models, participants were aware of the discourses about these and potential criticisms. Indeed, when talking about all models, it appeared that various factors and language were drawn on to privilege and validate why a certain model was being used or to communicate why that participant held a belief in that model as being helpful or efficacious. These factors included evidence of good outcomes (including informal service user feedback as well as research) and indications that a model would have good cross-cultural applicability:

> *because the outcomes we've had here have been so good…also working alongside the women themselves who are saying what works for them it's made me feel…confident that what we're doing is actually helpful for people (Marie, 253-256)*

> *but I think things have changed in that field so much, there's so much research that's been done, so if I use CBT and behaviour models now it wouldn't be the same…we've got clearer, firmer, better, researched models that are really quite convincing (Sarah, 126-129; 182-188)*

It seemed that privileging and validating certain models was often done, not as a defence against potential criticism, but because participants genuinely believed that the models worked and were useful. In this vein, they talked about how, if they themselves did not believe in the model, then it would be difficult to do the work:

> *Knowing that it will work, it used to be very difficult to be able to do that but now it's much easier because I know that, some good, I think, will come of it (Paul, 12:360-62)*

However, nearly all participants appeared to communicate at one point or another that they were not rigidly wedded to one model, and that they could appreciate the benefits of alternative models. Indeed, boundaries between different models

and approaches did not seem clear or 'neat', and some spoke about using a mixture of models; an integrative approach, to different degrees:

> *I think some techniques and some things are very hopeful about [CBT], and of course I do use them from time to time (Marie, 246-248)*

> *It's a meld of different, um, approaches which I think I integrate more or less seamlessly but with an awareness of the bumps (Anne, 172-5)*

The importance of the therapeutic relationship

Some participants spoke of relying or 'falling back' on the therapeutic relationship and on just 'being human' whilst in the room with a client. Relating to this were reflections that participants made regarding therapist-client boundaries, and what is communicated to the client in terms of expressing empathy and compassion. It is possible that this reliance on the fundamentals of human relationships was a way of managing the difficulties that some participants had with solely drawing on psychological models or approaches, which often fell short of meeting the needs of the client and the aims of the therapeutic encounter. Some spoke of the therapeutic relationship as being the 'key' or the "*mission guiding the work" (Anne, 65-72)*.

> *a huge influence is, you know, knowing that the therapeutic relationship is the main essence of, you know, the work that you're going to do with this client group (I: hmm), it is the key… it's not that I'm going to use some fancy technique, or some fancy, um, tool, although they do help, it's not going to be the thing that makes someone (I: hmm) recover in the way that they want to (Amita, 692-702)*

> *Just really falling back on, er, my, well, my humanity really, sense of humanity, and compassion (Sarah, 15-17)*

Struggles with the meaning of 'talking'

Talking or not talking?

As noted in the *Introduction*, one of the main psychological methods or tools is that of talking therapy, although, as reflected in the sections above, this can take the form of several different frameworks or models. It is interesting to note how participants' comments sometimes alluded to their assumptions and meanings that they attached to talking, in particular, the client talking or *not* talking about their experience of sexual violence. Relating to what was discussed in the *Introduction*, some participants referred to shame as a way of understanding why clients remained silent about or had difficulty talking about their experience:

> *Shame is normally the main emotion, um, that victims of sexual violence experience people are less reluctant, or more reluctant rather to talk about the details of it (Paul, 11:315-18; 11:329-332, 11:335)*

However, Marie alluded to the complexities involved in this, and the possibility that certain ways and different types of talking were privileged amongst western psychologists. Hence, she emphasised the need for people to think about *how* clients may talk about these experience, not whether they *do* talk about them or not:

> *it's not that people don't want to talk about it, but they want to talk about it in a particular way …and to really listen to how women want to talk about those experiences…not just say it's because 'rape is a more shameful experience in this culture than that culture' (Marie, 475-476; 722-726)*

Talking is 'good'

How talking was spoken about suggested that there is an assumption that a client talking about her experience of sexual violence is 'good', and remaining quiet or silent about this experience 'bad'; some participants referred to the latter as 'avoidance' in the context of the symptoms of PTSD. As such, many spoke of naming or labelling the experience of sexual violence and talking about this as

being an important part of the therapeutic process. Subsequently, it seemed that participants viewed whether a client talked about their experience of sexual violence as a reflection of their competence as therapists:

> *but it took her ages to disclose it, but when she did, you know, it was a very emotional session, but afterwards, she was, well, I feel better now (I: hmm), because she'd named it, we'd addressed some of that shame (I: hmm), that then allowed her to start talking about it a bit more (Jack, 443-46)*

> *when they told me things I felt really, in one way quite, um (.) not good, but privileged or really like, oh my god, they're telling me all these horrible things, I must be doing really well (I: yeah) at this job (Amita, 254-260)*

Talking and power

However, this came alongside the feeling of discomfort participants had felt about asking clients about their experience of sexual violence, and the issue of power that is connected to this. Some participants talked about how they, the client and interpreter, would avoid the topic of sexual violence. Some referred to feeling abusive when they initiated discussion and asked questions about the experience of sexual violence as they had an awareness that this process may be experienced by clients as mirroring the initial abusive experience. Feeling abusive also appeared to be connected to what participants thought was evoked in clients, such as feelings of shame, when talking of experiences such as sexual violence. It seemed that participants often felt that a balance was needed between attempting to name and talk about the experience and not 'push' clients in an unhelpful way:

> *and I would sometimes even dread seeing the ones that had been raped because…I often felt like I had the power of whether it got talked about or not…it was always up to me whether that subject got talked about…so I was very powerful in that sense, and of course I didn't ever want to talk about it really…because…it would make me want to show her that I really care, and that I feel really upset for her…and I*

would find ways of filling the sessions with other things… but actually it was all different ways of avoiding talking about rape (Amita, 39-41; 969-1008)

because people are more ashamed, people are less, you know, less likely to tell you which means I have to ask <u>more</u> questions (I: mmm), which in itself can come, can feel potentially abusive to the person asking the questions, particularly if they, if the, um, sexual violence has happened under torture, and so it's a really difficult role to play, you <u>need</u> to ask the questions also it's embarrassing from my point of view to ask about these intimate details because it's not, you know, you feel the shame, being empathic, you feel the shame in yourself (Paul, 316-323; 3267-328)

you're trying to keep a balance between joining them in their avoidance and pushing them in an intrusive way (Anne, 469-471)

SUPER-ORDINATE THEME FOUR:

HOLDING ON TO A 'BOTH/AND' VIEW

Super-ordinate theme four, *Holding on to a 'both/and view'*, comprises the recurring themes of holding in mind polarised positions, with regard to viewing the self (as the therapist) or the client as an expert and/or non-expert, viewing clients as resilient and/or vulnerable, and the positive and negative views of 'human nature'. It seemed that the impact of the work could sway participants towards the extremes of these spectrums, but there was an ongoing awareness that attempts needed to be made to hold both these views in mind.

Both expert and non-expert

A recurring theme appeared to be holding in mind polarised positions, with regard to viewing the self (as the therapist), or the client, as an expert and/or non-expert. Some participants seemed to fluctuate between intentionally or unintentionally holding on to an expert position in some contexts and the need to recognise that the client was the expert in others. Marie, Amita and Faraa, in particular, seem to have reflected in detail on what it means to take an expert position, and appeared

to have consciously made efforts to ensure that they do not position themselves at extreme ends of the spectrum. It is interesting to note that these participants' predominant approaches were that of and principles based on a human rights framework and systemic models, and that they made less use of CBT in their work.

The dilemma regarding taking a non/expert position appeared to have various implications for the nature of the therapeutic relationship and for what was considered as the aims of therapy, with regards to empowerment, decision making and what role the participant took regarding the responsibility for therapeutic change.

> *I approach the work not feeling that I have to be an expert or have answers to give to someone, in fact, you know, who am I to, you know, give them answer (Marie,587-603)*

<u>'Schooled' to be experts</u>

Although many participants located their clients as experts, they spoke about the difficulty of letting go of an expert position themselves, partly because they felt they had been 'schooled' to be experts.

> *I think for people in professions [the expert position] is really, really difficult to implement sometimes because we're schooled to be experts somehow (Marie, 595-597)*

This seemed to be related to the expectations that participants had about themselves and what they anticipated the client's expectations were of them, such as 'fixing' them. This appeared to be connected to feelings of anxiety about skill and competence, and was compounded by the particular complexities and challenges encountered in this work.

> *if you're sitting in a room with someone who's been through so much and they've come to see you, they have probably expectations that you're going to say or do something to make them feel better, or to fix I*

felt pressured to, kind of, deliver something, um, maybe they wanted that, maybe they didn't (Amita, 17:402-06)

Accepting and acknowledging that it is not possible to 'know' everything, and hence taking a non-expert position, appeared to reduce anxieties about skill and competence. However, learning to just 'be in the room' with a client also appeared to be difficult and have its challenges as it seemed to appear counter-intuitive to what participants, as psychologists, had been 'schooled' to do. This is related to issues of relying on the therapeutic relationship rather than tools and techniques, discussed above.

my supervisor, you know helped me to just <u>be</u> in the room, which is also very uncomfortable…what I <u>hadn't</u> learnt throughout the three years was to just be, be in the room…the most challenging thing, which sounds simple (I: hmm), but was really hard (Amita, 323-329)

Interestingly, Amita and Marie questioned in whose interests was the need to feel competent and like an expert, and that focusing on being a 'good' therapist, and possible anxieties about this, meant that they were not focusing on the clients:

What's the priority here, it's not how I feel (laughs) about my work, you've got to sort of feel the fear and do it anyway (Marie, 603-608)

<u>The 'rescuing' impulse</u>

Alongside holding certain expectations of themselves as therapists came an impulse to 'rescue' or an expectation that clients were hoping to be rescued. Participants talked about this client group in particular evoking this in them, due to what was viewed as their vulnerability. Two participants particularly spoke about guarding against the rescue impulse as this would mean positioning clients as non-expert, vulnerable and disempowered. This latter point relates to the theme of *Both/and resilient and vulnerable*, discussed below.

when you see people be really, really disempowered, again, you know, it can bring about a desire to want to rescue them which can take

control away from people… it can be a sort of narcissistic sort of pleasure…but you have to guard against that (Marie, 805-813)

people may want to be rescued and that's, you know, part of what they want is for you to take, take away all the awfulness that they've had to live through (I: hmm) and you really can't, one, you can't do it, even if you wanted to, but two, you mustn't do it because really it's a process they've got to work through by themselves (Anne, 152-155).

Whose meaning is privileged?

The meaning attached to what was talked about in sessions, and to clients' experience was also influenced by the stance participants took regarding expertise. This was a complex issue, because some participants considered it an important part of the therapeutic process to present to the client alternative meanings regarding their experience of sexual violence. It appeared that this was another area of clinical work where a careful balance needed to be struck, in this case between whose meaning was privileged: the client's or the therapist's.

people are attached to the negative narratives they have about themselves to do with sexual violence (I: hmm), sometimes for reasons that need exploring before you can, before you can move on, but not offering another narrative isn't the solution, you know, offer that other narrative but say, that's another way that we see here, you know, what do you think of that (Anne, 384-95)

the most important thing about a, any piece of clinical work that, but definitely with this client group, is that what do these events mean to the client…what it means to the client is actually going to be the most important centre-stage thing at the time of therapy (Sarah, 485-492; 491-2)

The issue of whose meaning is privileged was particularly pertinent in this area of work due to the powerful meanings attached to the language that clients used regarding sexual violence. Particular language seemed to be connected to various meanings in terms of gender discourses and the impact of sexual violence on how women viewed themselves. For example, one participant spoke

of a client she had been working with labelling herself as ‘dirty’ as a result of being raped, and how it was difficult for her as a therapist not to challenge this, but at the same time being aware that this may be enforcing their view on clients. The participant spoke about managing this by holding both meaning systems in mind but not in an *“either-or kind of way” (Faraa, 331-35)*

> *saying that she, um, was dirty, and what that kind of bought up for me in terms of wanting to find a way of challenging that, um, as a woman, as a feminist…how this woman challenged me and challenged my thinking…so rather than going in there with an idea about how she should feel (I: right) she wanted me to understand how she <u>did</u> feel (I: yeah) and to understand what she wanted and what she needed to feel better (Faraa, 318-38; 407-13)*

<u>Collaboration and empowerment</u>

Holding an expert position influenced how participants talked about themselves in relation to clients, and how they spoke about the therapeutic relationship, particularly with regards to collaboration and power dynamics. Some participants talked about their stance in a way that emphasised their solidarity with clients, and about being led by their clients. Most participants, regardless of what model they predominantly used, talked about the role of ‘empowering’ clients and how this was a therapeutic intervention in itself.

> *For some of the clients it was about getting them back on their feet and out there fighting battles (Sarah, 72-73)*

> *Maybe part of the work would be about helping that person, taking more care and control over themselves and their identity and their lives (Amy, 271-279)*

Another aspect of empowerment appeared to be making decisions regarding what will be therapeutically helpful. One participant, Marie, described the process of making a decision about whether to ask a client if she would like to publicly speak about her experience of sexual violence at public event. Marie reflected that she had made the assumption that it may be too distressing for the client, but

then, after talking it through with a colleague, realised that she had been making the decision for the client.

> *So I was extremely tentative about it, thinking, you know, with all these different hats on thinking, oh, you know, whenever she talks about it in sessions, she's very distressed …[name of community worker], who survived the war in [country] (I: hmm-mm) convinced me that, you know, what was I doing there, I was making the decision for the client, I was putting myself in an expert position (Marie,654-659; 648-651)*

Additionally, participants spoke about clients as not knowing what they needed with regard to therapy, and this was related to an understanding that, for many refugee clients, talking therapy is unfamiliar. Two participants spoke about the difficulty of knowing what would be helpful, and not making assumptions about this considering the difference between clients and participants (this is related to issues discussed under the sub-theme *Identifying and difference*).

> *I guess a lot of the time people come and they don't really know what they need (Amy, 171-73)*

> *what's your idea of helping someone might not be what the actual person needs (I: yeah) and I think you, with this client group, there are many people that <u>think</u> they know what his client group needs, but actually it's really complicated (Amita, 241-250)*

Both resilient and vulnerable

Throughout the interview, all participants either referred to clients as being victims and vulnerable, but then, at other points in the interview, emphasised their resilience and strength. It seemed that the resilient view or story was less dominant than the vulnerable one as participants appeared more mindful when talking of clients as resilient, as if there was a need to emphasise this story to lessen the dominant story of vulnerability. However, nearly all clients recognised the importance of holding both stories of clients in mind, and to be aware of the

assumptions that can be made when holding polarised views and just focusing on one view or story.

> *Women which have experienced sexual violence may have all kinds of difficulties (I: hmm-mm), um, all kinds of strengths as well (Sarah, 32-34)*

> *what you're listening to is also the second story, as in the story of survival, the story of resilience, the story of resistance… to always be listening for the second story, so not just a story of victimisation, although that is extremely important too, because you have to acknowledge the enormity of it (Marie, 921-922; 938-941)*

Inspired and celebrating

The resilience and strength of clients was often seen as something to celebrate and be inspired by, and the view of clients as victims appeared to be in opposition with this. This is related to the process of therapists learning from clients and to the process of coping with the challenges of the job.

> *and there are times when I've sat in sessions with somebody and spent the whole session laughing …and yet some people would find that a bit, would be almost, would think that was, um, disrespectful or weird, so somehow refugee people stop being human (Faraa, 360-65)*

> *the victim discourse takes away from refugee people the idea that they actually have something important to say and something important to teach others (Faraa, 632-35)*

> *quite remarkable…heroism or, or, stamina,…these amazing incredible [clients]…who I work with, who have gone through stuff that we would never sort of imagine or believe…it's really remarkable (Jack, 610-620)*

Oppressed or empowered?

Interestingly, whether women were seen as either oppressed or empowered appeared to be influenced by cultural discourses about feminism. It appeared that the fact that some clients had come from non-western countries meant that some

participants viewed them as more disempowered than their western counterparts, and hence less aware of narratives and stories regarding feminism or female empowerment. Conversely, two participants pointed out that assumptions cannot and should not be made regarding the privileging of western versions of feminism, or gender power relations, compared to those of non-western countries.

> *there is a tendency I think to see, um, for example, African or Asian women as being, sort of, oppressed as women as if, you know, western women are not oppressed as women as well. And I think that can render women as being seen as passive, vulnerable, disempowered, and that the means to their empowerment is a western kind of model (I: hmm), and I think that what it ignores is the fact that so many, um, women who are refugees have, have had to take part and have chosen to take part in struggles, um, in their own countries, in their own communities, which, um, have required, enormous resilience, enormous courage…very strong political commitments (Marie, 702-716)*

> *women from the UK are bought up to be a lot more independent …probably shifting over towards more feminist culture…when you're working with people from different cultural backgrounds, um, they haven't really grown up with that… quite often I've worked with women who've said 'I was repeatedly raped and abused by my husband and I, I did get the courage to speak to somebody about it and they said well that's just what you put up with' (Amy, 259-266)*

It is interesting to note Amy's use of the term 'feminist culture' and to consider what is meant here: possibly that women from Western countries are more aware of inequalities between the sexes and feel more empowered and able to articulate these and raise them as issues to be addressed. The implication that this is not so apparent with women from other cultural backgrounds is in contrast to Marie's comment regarding refugee women that have taken part in 'struggles' which have required 'strong political commitments'.

The best and the worst of 'human nature'

As well as viewing clients from polarised views, with regard to resilient survivor or vulnerable victim, and the need to continually ensure a balance between these perspectives, participants also talked about how they feel they have been exposed to the extremes of 'human nature'; the best and the worst. These perspectives have been evoked by hearing the stories of the atrocities that have been committed against people but also hearing the stories of people's strength and ability to love and care for others despite these experiences:

> *It's an area of work that really throws you into contact with extremes of things, I think…very worst of human nature …However, it also puts you into touch with somehow the best of human experience, the things people can survive, you know. (Marie, 966-1000)*

Similar to being inspired by clients, participants spoke of being inspired by the positive aspects of human behaviour that they were exposed to whilst undertaking this work, and how it made the work rewarding and enjoyable:

> *I think that is what I go away with more actually…I could go away thinking, actually some people are really evil, and I don't somehow…I've also learnt, um, how amazing human beings are and human nature is…being able to love anybody…being able to laugh, being able to care about me (Faraa, 650-68)*

However, participants also talked about the need to hold on to the complexities of human behaviour or *"what it means to be human" (Amita, 611)*, and how people are neither all bad nor all good:

> *I suppose I think that's what the worlds like, but that's not horrible, it's also a beautiful place, and a lovely place but that's also a reality of it as well (Jack, 203-205)*

> *what it means to be human is full of so many different good and bad things…as time went on I was able to understand the complexities of being human, and the complexities of what it means to be good and*

what it means to be bad…what an ocean of, you know, different things we're all made up of (Amita, 569-71)

CHAPTER FOUR: DISCUSSION

This chapter presents a summary of the findings in the context of the research question and aims, and the literature. This is followed by a critical appraisal of the study, including personal reflections. A discussion of the clinical and research implications is then presented.

RESEARCH AIM AND QUESTIONS: THE FINDINGS IN THE CONTEXT OF THE LITERATURE

As in the *Introduction*, the following discussion draws on literature from the field of psychological work with refugees in general and from work with survivors of sexual violence in general, as well as specifically with women refugees who have experienced sexual violence. This is due to the dearth of literature investigating the latter. Salient issues that have emerged from the data are discussed in particular detail and other issues are mentioned in less detail due to the limited space to explore them further. (Note that not all themes map 'neatly' on to the aims. Hence, some themes may be mentioned more than once under different aims).

Research aim: to explore the experiences of applied psychologists when working with female refugees or asylum seekers who have experienced sexual violence.

Regarding the research question, the interviews resulted in rich data that could be used to inform an understanding of applied psychologists' experience of working with female refugees or asylum seekers that have experienced sexual violence. However, when speaking about their experience, it seemed that some participants did not always maintain the focus on women refugees, but may have shifted their focus to male refugees that have experienced sexual violence or refugees in general. This difficulty with the level of gender analysis in and of the data is discussed under *Critical review and reflections* below.

Question one: How do applied psychologists make sense of their experience and what theories, concepts or ideas do they draw on to do this?

Making sense of their experience: a summary

The theories, concepts and ideas that participants drew on to make sense of their experience of undertaking this work are apparent throughout the themes. For example, the sub-ordinate theme of *Emotional reactions* includes how psychologists used various psychological constructs and theories to make sense of their emotional and behavioural reactions. It is interesting to note how some participants also normalised their experiences and referred to their concern of being pathologised, using the notion of vicarious traumatisation. This issue is discussed in more detail below under *Aim two*, as it also relates to the challenges that are experienced by participants. Participants understood the processes they experienced regarding the therapeutic relationship by using ideas of identity and difference, in the context of life experience, nationality and gender.

Participants also used concepts from various fields of applied psychology such as 'containment' and 'non-expert', which have derived from psychodynamic and systemic theory respectively (Anderson & Goolishian, 1992; Bion, 1959, 1962b; Mason, 2005)[2]. It seemed that the concept of containment was important for participants as it was a way for them to articulate the processes of holding onto clients' stories and the feelings that hearing these stories evoked in them. It was

[2] On a more reflexive note, I am aware that I, as researcher, have used these terms in conceptualising and producing names for the themes. As Smith et al. (2009) state, often names for themes in an IPA analysis may come from a term participants have used themselves. Additionally, the researcher will and should bring pre-existing psychological knowledge to their examination of the data (Smith et al., 2009). Hence, it is a natural consequence that some themes and their titles will draw on psychological concepts or constructs.

also used by participants as a way of describing an important function of supervision.

Holding in mind a "both/and" view

The concept of balancing, or holding in mind two polarised viewpoints, was something that emerged throughout the interviews, in different contexts. For example, as well as the obvious contexts outlined under super-ordinate theme three (*Both/and expert and non-expert* and *Both/and resilient and vulnerable*), the concept of holding polarised views in mind was also in evidence when participants considered the positive and negative aspects of the work, and when considering issues of sameness with or difference from clients. It is interesting to consider what the function of identifying with clients was for participants. It seemed that identifying as different from clients led to feelings of anxiety regarding how they were viewed by clients and how this impacted on the therapeutic relationship. Hence, holding in mind similarities with clients (alongside the differences) may be a useful strategy in reducing this anxiety.

Resilient and/or vulnerable

Interestingly, one participant talked about how holding extreme views can be a consequence of the extreme stories that are heard: "*when you have extreme experiences and, and extreme, you know, presentation…it pulls us to be, um (.) almost extreme in our responses, so we have these sort of very, fragmented views about people" (Faraa, 354-357).* This comment is particularly significant when considering the theme of *Both/and resilient and vulnerable*. There is no definitive definition of the notion of 'resilience'. It has been described as the ability to: preserve a steady balance and maintain psychological and physical functioning when challenged with adversity (Bonnano, 2004) and to undergo stress whilst being able to retain one's strengths, abilities and values (Papadopoulos 2007). Some participants spoke about the need to emphasise the story of resilience because of the dominance of the story of vulnerability. Indeed, it has been stated that long term outcomes research appears to focus on the difficulties refugees continue to face and on their helplessness and victimhood, rather than focusing on what has enabled them to live with these difficulties (Papadopolous, 2007). In response to this, Papadopolous (2007) speaks of

“adversity-activated development” (AAD); the strengths that people develop as a result of adverse experiences. This notion emphasises the positive consequences of experiencing a traumatic event that “tend to be neglected by mainstream professional theories and practices” (Papadopolous, 2007, p.306).

It appears that there was a need amongst participants to not pathologise clients, or story them as weak and vulnerable but also a need to acknowledge and address their distress, suffering or symptoms. Regarding the latter, participants spoke of experiencing the impulse to ‘rescue’ clients. Blackwell (1997) states that therapists need to resist the urge to “help or make better” since this is primarily in the therapist’s interest; it relieves the therapist while reinforcing the idea that the client’s pain is unbearable. Indeed, two participants spoke of the anxieties they experienced attempting to meet their own expectations regarding competence. They reflected that this was, indeed, their *own* need, and concern about this should not overshadow or take priority over the clients’ needs. In relation to this dilemma, Blackwell (1997) advocates the approach of ‘holding’ and ‘bearing witness’ as an alternative to attempting to ‘make better’ when working with torture survivors.

However, it is important to note that some authors have highlighted potential problems with the resilience discourse. For example, that emphasising resilience may shift the focus of responsibility for change on to the individual or group of individuals, rather than society at large and governmental organisations that hold the ‘real’ power to make changes (Schoon & Bartley, 2008). This, in turn, may support a culture of victim blaming and dismiss or diminish the suffering that people have experienced, and hence the need for redress or prevention of further atrocities.

Within the context of black and minority ethnic groups, for example, the concept of resilience has been seen as disabling as well as enabling in that it perpetuates the expectation of ‘endurance’ and neglects or dismisses a space for, and an acceptance of, vulnerability (Kalathil, 2011). Indeed, it has been argued that the pressure for women to conform to the stereotype of a ‘strong black woman’ is opposed to emotional and mental development, allowing no space to feel

vulnerable without feeling guilty (e.g. Evans-Winters 2005; Hill Collins, 2000). In one study exploring Black women's meanings and experiences of recovery and resilience, some women felt that being unable to demonstrate resilience in their life increased their sense of self-doubt and failure (Kalathil, 2011).

Something that may help reduce the negative consequences of the resilience discourse is viewing resilience as a dynamic process that arises from interaction and social support, within cultures and societies, rather than individual personality traits (e.g. Fernando, 2010; Herman et al., 2011). Black feminist critiques of resilience have promoted the practice of focusing analysis on communities, families, spirituality, and shared resources rather than only on the individual (e.g. Evans-Winters 2005, Hill Collins 2000).

Empowered and/or oppressed

Another salient concept was that of empowerment. It is important to note that what professionals and clients consider 'empowering' may not be the same. Regarding empowerment, Gavey (2003, p.205) comments that psychologists do not necessarily know whether the frameworks they use "will be helpful or not for any particular women at any particular time. In our efforts for…empowerment…I think the least we can do is be acutely aware that our own professional work with women is always a process of subjectificaton". Hence, it seems important that psychologists, when viewing their role as one of empowerment, are clear about what they understand regarding what it means to be empowered or disempowered. The notion of 'empowering refugee women', for example, assumes "a non-problematic transition from individual to collective power, as well as pre-given, non-problematic definition of the boundaries of 'the people'" (Yuval-Davis, 1994, p.181). Yuval-Davis goes on to discuss the problems with the simplistic notion that people can become empowered without the possibility that this may have negative consequences on the lives of other powerless people or on the individual themselves. For example, if a woman becomes 'empowered' enough to leave her abusive husband but is then ostracised by some members of her family.

Furthermore, there is a danger of assuming that the interests of all refugee women are shared and reconciled (Yuval-Davis, 1994). As mentioned above, refugee women are clearly not a homogeneous group. Relating to the concept of intersectionality discussed in the *Introduction*, for any one group of women refugees, differences such as ethnicity, culture, class, and spiritual beliefs come into play when considering how members make sense of their experience, their purpose or goals and how they relate to other members of the group. Indeed, there are different levels and complexities of empowerment and disempowerment, which can interact or combine.

Yuval-Davis (1994, p.187) purports that a consequence of this is that, as women, to fight for liberation or empowerment is "senseless as long as their collectivity as a whole [e.g. ethnicity or having a status as asylum seeker/refugee] is subordinated and oppressed". Related to this, the feminist movement itself has been pointed out as an example of where racist, Eurocentric and middle class biases are in evidence, as it is based on the idea of all women experiencing a "common oppression…disguising and demystifying the true nature of women's varied and complex social reality" (bell hooks, 1990, p.29). Hence, simplistic notions of 'empowerment' are not helpful; what is important or meaningful for one refugee woman may differ from another woman depending on various factors of identity and personal experience (e.g. culture, class, as well as family history and personal experience of violence or oppression).

Some participants reflected a tendency to view some refugee women as less empowered than women that have grown up in the UK by virtue of the unequal power relations and the gender discourses that may be seen to exist in refugees' country of origin. However, western countries also have cultural constructions of women and sexuality, and discourses about what it means to be raped or sexually assaulted that can be seen as 'disempowering' (e.g. Lebowitz & Roth 1994). As stated in the introduction, the idea of shame and self-blame as a psychological consequence to sexual violence exists across cultures (e.g. Anderson & Doherty, 2008; Vidal & Petrak, 2007); Patel (2008) purports that sexual violence experienced by refugee women should be seen as one example on a continuum of violence against women internationally.

Indeed, Blackburn (2010, p.17), in the context of writing about therapeutic work with women refugees, stated that "it is important to acknowledge the differences in gender discourses between cultures, but not make assumptions about these, nor privilege a western discourses, by assuming that western women are more 'empowered', for example". She highlights that care needs to be taken when encouraging participants to adopt a particular gender role, which therapists may see as empowering, but which may be "culturally incongruent and [have] the potential for placing women in isolated or risky positions within their communities" (Blackburn, 2010, p.5). Blackburn (2010, p.19) reflects on the difficulty for her, as a therapist, of finding a balance between creating a space for clients to take a position on gender discourses within their cultures which have impacted negatively on their identity "without imposing [her] own understandings of life". However, if she notices that people are suffering from the effects of dominant discourses, she considers that she has a "certain responsibility to open up space for these to be considered" (p.18). This reflects the different thoughts that participants had regarding how much they shared their own political views with clients (see sub-ordinate theme: *The therapeutic relationship and 'being political'*).

Question two: How do psychologists describe the challenges they experience in this work and how do they respond to these?

Professional challenges: a summary

The challenges that participants spoke about are in evidence throughout the themes, and also relate to both aims one and three. The potential differences between themselves and clients were seen as a challenge for participants, in particular how these differences were seen to impact on therapeutic relationships. Dilemmas about what approach or role to take, and models to use also presented challenges and dilemmas, and are discussed below under *Aim three*. Positioning oneself as a non-expert and the client as expert was a way that some participants responded to the challenges regarding tools and techniques.

However, this appeared to be difficult for some due to the notion that psychologists are 'schooled' to be experts.

The meaning of 'talking'

One salient challenge encountered by participants related to the meaning of talking, and talking about the experience of sexual violence in particular. Participants reflected on how certain types of conversations with clients (e.g. talking about the experience of sexual violence) meant that they felt they were doing a 'good job'. The *Introduction* outlines various reasons why it may be difficult for women refugees to talk about sexual violence, some of which may be culturally specific (such as the concept of family honour); others may be in existence across cultures (such as concepts of shame and victim-blaming). One participant's approach, which may be an effective way of managing these dilemmas, was focusing on *how* women talked about their experiences, rather than whether they talked or not. Young and Maguire (2003, p.40) investigated women's thoughts and views about how their experience [of sexual violence] was named and explained and found that, although "some of the women had strong preferences for certain words over others, most participants avoided static labels altogether". These authors argue that "the recovery process may be impeded by restricting language choices or by forcing labels on individuals that they are unwilling or unprepared to embrace" (p.40).

Relating to what has been discussed above regarding how gender and cultural discourses are explored with clients, psychologists in this study seemed to fluctuate between making use of these discourses and meanings in discussion with clients, and making use of constructs that exist within medical and psychotherapeutic frameworks. Indeed, in a study investigating professionals' experience of working with south Asian women who had experienced sexual abuse, it was found that the difficulty in initiating and developing conversations about gender discourses led professionals to fall back on using the constructs of 'symptoms' and 'diagnosis' to explain clients' difficulties, and hence embed culture-related issues within a medical and psychotherapeutic framework (Reavey et al., 2006). Reavey et al. (2006, p.182) point out that a possible

consequence of this is the individualising and emphasising of the story of women being vulnerable to an illness, and in "need of expert guidance, and avoids having to address complexities of enmeshment in a cultural system that might not readily permit talk of sexual abuse, or an abuse of power by a male partner".

Vicarious traumatisation or 'vicarious enrichment'?

Managing the emotional consequences of hearing stories of sexual violence also appeared to be a challenge for psychologists. When participants spoke about their emotional reactions some made the point of normalising their experiences and reflected on their awareness that their reactions might be pathologised by others. This may be a result of the prevalent notion of vicarious traumatisation (VT), outlined in the introduction (McCann & Pearlman, 1990). Working with survivors of sexual violence and/or with survivors of torture is an area that is often highlighted in the literature where VT occurs (e.g. Johnson & Hunter, 1997; Lansen, 1993). As noted in the *Introduction*, it could be argued that the vicarious trauma discourse frames 'normal' reactions to hearing extreme stories of human distress within a pathologising framework and is therefore stigmatising for professionals. This may be partly why participants spoke of the notion of other professionals 'shying away' from the work and feelings of isolation associated with working in this area, as well as not being able to speak of some aspects of their experience of the work to others, including supervisors.

However, it seemed that there was a continual need to ensure that the positive aspects of the work were borne in mind alongside the challenges; for the work not to be viewed as either/or, but encompassing both rewards and difficulties. Despite the challenges of the work that participants referred to, they also referred to the positives of the work, particularly witnessing the strength and resilience of clients. The emphasise on the resilience and strength of clients is consistent with what is discussed in the *Introduction* regarding the concept of VT failing to capture the full experience of working with survivors of sexual violence (e.g. Chouliara, 2009) Indeed, Lobel (1996) reported that therapists who worked with rape survivors were more positively than negatively affected by their work, what the author terms 'vicarious enrichment'. Other findings have indicated that

counsellors working with sexual assault survivors have undergone a reflexive process and growth in spiritual beliefs as a result of the work (Brady et al., as cited in Garrity, 2011). Schauben and Frazier (1995) report that, overall, few counsellors who work with survivors of sexual violence reported 'symptoms' of vicarious traumatisation and it is thought that this is due to the positive aspects of the work that make the difficult aspects easier to bear.

Consistent with an appreciation of more positive aspects of working with survivors of sexual violence is the idea of anger being a motivating factor for some participants to attempt to effect change on a wider scale, rather than being a negative consequence of the work. For example, working with legal organisations and raising awareness of injustices. Similarly, literature reports anger being a motivating force in developing the political consciousness of professionals working in this area (e.g. Garrity, 2011; Rath, 2008; Wasco & Campbell, 2002).

Question three: How do psychologists experience dilemmas in this work regarding the relationship between their personal and professional values, beliefs, attitudes and roles, and, how do they reconcile them?

The sub-ordinate theme *Personal, professional and political identity* and the super-ordinate theme *Struggles with the tools of the trade* capture the types of dilemmas that psychologists experience in their work regarding personal and professional values, beliefs and roles.

<u>'Being' political</u>

It appeared that nearly all participants were motivated to engage in this area of work as they held a value system regarding human rights and social justice. It was interesting how, despite psychologists being drawn to this area because they felt that it would provide a 'fit' for them regarding their personal values and professional role, they nevertheless encountered dilemmas and tensions 'fitting' their personal value system with some aspects of their professional role. These dilemmas relate to the issues considered in the *Introduction*: the historical development within the discipline of a scientifically objective and value-free, and therapeutically neutral, stance and the subsequent neglect of the consideration of the political in the work of psychologists (Patel, 2003; Fox & Prilleltensky, 1996;

Pilgrim & Treacher, 1992; Smail, 1999). The notion highlighted by one participant that actions and inactions are in themselves political decisions, because "everything is political", can be applied to the political ideology of the discipline of psychology itself. Similarly, Fox and Prilleltensky (1996, p.22) purport that psychology cannot be separated from politics and that "acceptance of this premise should imply a standard of honesty in confronting this lack of separation, whereas refusal to admit this postulate can lead to political blinders".

The issue of acknowledging the political in the work appears to be particularly important when working with this client group for several reasons, one of them being the effect of current social and economic circumstances on their psychological well-being (e.g. Mahtani, 2003). Hence, participants often reported that they felt a need to intervene at wider social levels. The fact that this led to dilemmas for psychologists is not surprising given that the frameworks, or tools, that applied psychologists use advocate an individualistic approach to intervention (discussed in more detail below). Indeed, psychologists are socialised to think from an individualistic rather than socio-political standpoint when, in fact, it could be argued that "the notion of the individual self" is a cultural construction rather than an objective truth (Cox & Kelly, 2000, p. 3).

Psychological models and professional roles

In participants' accounts, broad issues of political identity and decision making were connected to more specific dilemmas and decisions regarding the use of psychological models and assuming specific professional roles. The need to find a balance between a "holistic" role and a one-to-one therapeutic role, a dilemma encountered by participants, is something that has been discussed in the literature regarding psychological work with refugees (e.g. Rees et al., 2007). Woodcock (2001) outlines the need to be holistic as one of the differences in work with refugees compared to work with other client groups. He advocates that therapists should at least 'hold in mind' the systemic difficulties that clients may be experiencing, if they are not able to actually engage in the practicalities of this. Indeed, participants spoke of incorporating the consideration of wider systemic and political factors into individual therapeutic work with clients. However, some

authors (e.g. Webster and Robertson, 2007, p.157) argue that, in the context of working with refugees, psychologists can and should “engage with the wider political and social context” and challenge structures that maintain or perpetuate psychological distress.

It was interesting to note *how* some participants talked about the work that they did and how they struggled to define it. This may be due to the fact that the way psychologists’ are schooled to talk about and present their work, with clear and ‘neat’ theory-practice links for example, is incongruent with the complexities of the work; the reality of clients’ needs fails to ‘map’ on to one psychological model or approach. Schon (1996, p.17) likened this position to a dilemma of ‘rigour or relevance’ and used the analogy of a high, hard ground overlooking a swamp:

> On the high ground, manageable problems lend themselves to solution through the use of research based theory and technique. In the swampy lowlands, problems are messy and confusing and incapable of technical solution. The irony of this situation is that the problems of the high ground tend to be relatively unimportant to individuals or society at large, however great their technical interest may be, while in the swamp lie the problems of greatest human concern (Schon, 1996, p.17).

Working with women refugees that have experienced sexual violence, with all its challenges and complexities, may well be considered to be the ‘swampy lowlands’. Schon (1996) goes on to write that the practitioner is faced with a choice of remaining on the high ground where he or she can ‘solve relatively unimportant problems according to his standards of rigor’ or ‘descend to the swamp of important problems where he cannot be rigorous in any way he knows how to describe’. Although Schon (1996) was referring to practitioners in general (such as teachers or social workers), it seems that this dilemma resonates with what was said during the interviews, and how participants sometimes struggled to define their work. Schon (1996, p.18) states that when practitioners who have chosen the swampy lowlands are asked to describe what they do “they speak of experience, trial and error, intuition, or muddling through”, which was somewhat true of the participants in this study.

Related to this, it seemed that one way some participants managed the dilemma of what tools or techniques (i.e. psychological models) to use was to rely on the fundamental aspects of the therapeutic relationship. Indeed, some literature supports the proposition that successful therapy is due to the nature of the therapeutic relationship rather than what model is used (e.g. Lambert & Barley, 2001).

CRITICAL REVIEW AND REFLECTIONS

Critical evaluation

The *Method* chapter outlined Elliot et al.'s (1999) criteria for evaluating qualitative research. Below is a critique of the study in the context of these criteria.

Owning one's perspective

I am aware that my own personal and professional interests and assumptions inevitably influenced what and how I asked questions and how I analysed the data, which I outlined briefly in the *Method* chapter. My own experiences as a trainee clinical psychologist, and the clinical and theoretical challenges I have encountered during training, and anticipate that I will encounter in my qualified life, meant that certain issues and challenges participants talked about resonated with me personally. For example the issues encountered when undertaking complex clinical work when clients' presenting difficulties do not map 'neatly' on to theory, as summarised by Schon's (1996) metaphor of the 'swampy lowland'. This may have influenced how much attention or consideration I gave to some aspects of the data compared to others, although I ensured that each of the themes were developed from patterns across all participants' transcripts.

Considering that an important element of my own interest, the research findings and their discussion, was the issue of how and if psychologists take an implicit or explicit political stance, it seems important that I reflect on what political purpose, if any, my own research may serve, or attempt to serve (Fox & Prilleltensky, 1996). I hope that the findings of my research will encourage psychologists to reflect on the roles that psychologists take on, and the frameworks that are in

place that influence decisions regarding this. This is a particularly pertinent point currently, considering the current changes in psychologists' roles and the contexts they work in (e.g. Taylor & Lavender, 2007), and is expanded on under *Clinical and research implications* below.

I was also aware that some participants felt passionately about opinions they were voicing and may have been using the interview as a forum to communicate these views. I partly felt obliged to give them a voice regarding this, particularly if I felt aligned with the principles inherent in the opinions being voiced. Hence, this may have influenced the development and consolidating of themes that were generated, although I feel I was consistently mindful that these were kept within the context of the research question and aims, and that the themes generated are a reflection of the data from all transcripts. Additionally, I feel that, when discussing the findings, I acknowledged when and if a participant appeared to attempt to communicate a particular view or opinion, and the language that was used in doing this.

Providing credibility checks

Although the process of analysis was reviewed by a supervisor at different stages, other methods could have been employed for checking the credibility of the account of the data and the themes, such as reviewing the themes with the participants themselves. However, due to time constraints this could not be done, although this is something that I will consider in future research.

A critique of phenomenological methods is that the level of analysis does not go far enough regarding interpretation, and that the resulting themes are therefore a description of what was said, often derived from the interview questions (Willig, 2007). Smith (2004) has purported that it is a common difficulty for new researchers to move towards the realm of more abstract analysis. Indeed, I felt tentative about over–interpreting participants' accounts and was concerned that, considering my own assumptions, preconceptions and research interests, that I accurately represented participants' experience. I was also aware that when making a decision regarding emerging themes, I was closing down the possibility of other themes, and hence other ways of conceptualising the data. This seemed

quite ‘final’, although a natural consequence of the analytical process and one that should still result in an accurate reflection of the data considering I followed a rigorous and methodical process of analysis. Indeed, Smith (2009) suggests that a balance is needed between analysing the data further whilst also accepting when it is ‘good enough’.

Accomplishing general versus specific research tasks: the research question

I am aware that women refugees are not a homogeneous group and hence, the findings gathered from reports of working with this group are likely to be different and variable. Additionally, as mentioned at the start of this chapter, participants did not always maintain the focus on female refugees who had experienced sexual violence during the interview. When participants stated that they were talking about a circumstance of working with male refugees specifically, these sections of the transcripts were not included in the analysis. However, it remains the case that participants appeared to talk about experiences that applied to working with refugees in general, and about issues refugees faced that were not necessarily specific to having experienced sexual violence. It is important to reflect on why this was the case.

One reason for this may be that it was a natural consequence of reflecting on and talking about their work, considering that most participants’ work involved working across genders and with clients that have encountered a variety of experiences. Although I emphasised the focus of the study to participants before commencing the interview, and prompted participants during the interview regarding the gendered focus, some of my interview questions did not emphasise this focus. I wonder if, as a new researcher and a trainee psychologist interviewing qualified psychologists, I did not feel confident enough to continue to prompt participants during the interviews. Possibly, this tentativeness was exacerbated by my awareness that, by frequently prompting rather than letting the interview develop naturally, I would have needlessly influenced the nature of what was talked about, and subsequently the data. These are issues that I will bear in mind for future research. The above issues regarding the interview schedule and prompting could also have been why there was a limitation of specific, detailed and rich descriptions of participants’ experiences. One way this could have been

done was to ask about precise instances of experience in detail, such as clinical cases. Again, this is something I will bear in mind for future research.

An alternative, or additional, reason for the lack of gender focus may be that participants were not used to conceptualising the issues and dilemmas they faced in their work from a gendered perspective, perhaps because discourses relating to the relevance of gender issues are not dominant in society in general. It seems that a focused perspective is more likely to be taken when psychologists consciously consider issues of gender or culture when using a formal framework such as formulation, rather than happening naturally when thinking and talking about their experience 'in general'. Similarly, the general silencing of female refugees' experience encountered across societies and communities may have been reflected in what participants consciously or unconsciously chose to speak about and not speak about (e.g. Ahrens, 2006). Indeed, it is as interesting to consider what was not said during the interviews as much as what was said.

However, I feel that, despite this, the data still includes some issues relating specifically to women refugees and, more generally, highlights some important issues currently faced by psychologists in their work. Indeed, it seems that many issues raised from the analysis and discussed above are applicable to psychologists working with clients other than female refugees who have experienced sexual violence. It could be conceptualised that many of the issues raised here are not necessarily a reflection of specific difficulties with working with this particular client group, but are difficulties encountered within the professions of counselling and clinical psychology. For example, the professional frameworks, tools, techniques and service context that may help or hinder how psychologists understand clients' difficulties and intervene. It may be that the challenges and dilemmas psychologists face in many settings are merely exacerbated or intensified with this group. Indeed, Blackwell (2005, p.307) states "therapy with survivors of torture and organized violence is not a special case of therapy in a political context, nor of the need for politicized therapy. It is rather an example where these issues are writ large and where the place of psychotherapy in a general struggle for collective civilization, personal liberation and human rights can be given a particularly sharp focus".

On an additional note, being a qualitative study, the sample only represents a small selection of psychologists, in particular, those who work in specialist services (mostly for refugees) in London. As such, the data may not reflect the experience of psychologists working in more generic services, including those working in other areas of the country with this client group, where there are less specialist refugee services. Further research may be necessary to consider the issues that are encountered by these psychologists, particularly as women refugees present in a variety of services.

Literature search

Using only one database for the literature search meant that some potentially relevant literature may have been omitted, particularly literature relating to disciplines other than psychology. However, due to the need to gather literature from various areas (e.g. professionals working with refugees or asylum seekers, professionals working with people that have experienced sexual violence, etc) the search terms were already rather broad and using only one database was one way of focusing an already extensive literature search.

Further reflections

Service user involvement

Issues of service user involvement appear to be an important clinical and research implication of these findings (discussed in detail below). I am aware that the voices of refugee women, and their views of their experience of psychological services, are neglected in this study. If undertaking a study that allowed for more time, it would have been useful to make links with refugee communities with the aim of involving them in the planning of this study, and to gain their feedback on what aspects of the study they would consider useful or not.

Reflexivity

I kept a research journal throughout the process of undertaking this study, and feel that it is important to note two points that appear salient from my journal. The first point is how inspired I was by the way the psychologists I interviewed had faced the challenges of the role, and their dedication to this work. This was

motivating and encouraging for me, given the stage of training I am at; anticipating the challenges of qualified life.

Secondly, some of the thoughts and reflections of some of the participants, and the themes that I have derived from them, made me reconsider some of my previous conceptions related to gender and culture. Although I have always been aware that unequal gender relations exist across cultures, albeit in different guises, the idea of not privileging certain cultural gendered discourses over others led me to reflect deeply on what we are doing when we make assumptions about the relationships between culture, gender discourses and sexual violence. In particular, the assumptions I might be making (or may have made at the commencement of this study) about how 'empowered' a person may be depending on my perspective of the gender discourses and gender relations that exist in their country of origin, and the subsequent inaccurate, and possibly negative generalisations I may have held (or continue to hold) about cultures other than my own. Indeed, Tamasese (as cited in Blackburn, 2010, p.21) discusses how, in every culture, there are "liberative as well as non-liberative stories" and that "what this has meant in terms of issues of gender and culture is that in order to address issues of gender justice we do not need to take an oppositional view of culture".

CLINICAL AND RESEARCH IMPLICATIONS

Considering the possible future shift in the roles and settings psychologists work in (e.g. Taylor & Lavender, 2007), the fact that this group may present in a variety of services, and the continuing demand for services for this group, it is important to consider the clinical and research implications of the findings of this study. The implications of these findings are also important since many areas of the UK do not have specialist services for refugees, although the UK government moves asylum seekers to these areas (Burnett & Peel, 2001). Additionally, as discussed above, many of the issues raised can be applied to the practice of psychology in general.

The politics and ideology of the profession

The findings of this study highlighted the need to consider the moral and ethical position and role psychology as a profession takes regarding human rights abuses. Prilleltensky (1989) argues that psychology has had a role in maintaining the societal status quo. As such, it appears important that psychologists consider the frameworks that they use, such as the scientist practitioner model, evidence based guidelines and constructs such as diagnosis, and how these may encourage a neutral position, clinically (e.g. therapeutically neutral) and theoretically (e.g. scientifically neutral) or the 'silencing' of psychologists. One way this can be achieved is by developments in training so that issues of social justice, human rights and socio-cultural and economic inequalities are integrated throughout the curriculum and trainees are encouraged to develop skills in reflecting on their role regarding this. For example, how psychologists can engage clients in discussions about gender or cultural discourses, as well as developing skills in incorporating these perspectives more readily into psychological formulations. Awareness of these issues could be increased, possibly by using publications and professional organisations such as the British Psychological Society (BPS) as a forum for these issues to be discussed.

Psychological models and approaches

A possible consequence of the over-emphasis on trauma-focused therapy as the predominant role for psychologists is that psychological services are not meeting the needs of women refugees. Richman (1993, p.179-80) states that "it is not uncommon for 'experts' to find that their offers of help are unacceptable because their approach is based on the premise that a high proportion need therapy, and that this needs to be focused on their past trauma…Instead of being able to decide the priorities for themselves [refugees] may be faced with a predetermined programme of therapy". Although individual therapeutic models of therapy, such as CBT, may be beneficial with this client group, it seems that there needs to be a shift within the culture of applied psychology regarding what is viewed as 'real' psychological work and an acceptance and value of alternative models and approaches. This may involve more research investigating the benefits of

alternative approaches of working with this client group, such as the human rights approach (discussed in the *Introduction*), or approaches that integrate western methods of healing with those from refugees' country of origin (e.g. Mercer, Ager & Ruwanpura, 2005). Other approaches that may benefit from more consideration include narrative therapy (Rees et al., 2007), using creative mediums such as art, movement and music (Patel & Mahtani, 2007) and the technique of 'bearing witness' (Agger & Jenson, 1990; Blackwell, 1997; Herman, 1992; Patel & Mahtani, 2004) discussed in more detail in the *Introduction* and above in the *Discussion*.

Relating to the points above, it is likely that in order for this to take place, there needs to be a change in how psychologists' general remits and roles are defined. However, this is complex as it also involves consideration of the remit of organisations such as the NHS; for example, the need for short term, cost-effective therapies. Subsequently, this may involve the reviewing of developing research and clinical practice in this area and discussion between organisations such as the BPS and the Department of Health.

These findings have also highlighted the need for an increase in services in general that support clients regarding their wider socio-economic needs. This may, however, seem idealistic given the current economic climate and the government's policy of austerity cuts. Furthermore, and related to the issue of psychologists' roles, there appears to be a need to narrow the gap between trauma-focused services and those that carry out a more holistic role. Considering this gap, and that these clients may present in a variety of psychology services, it may be that psychologists working in more generic services should be trained in working with this client group. A sharing of experiences and expertise between professionals may help reduce the prevalent view that working with this client group is complex and challenging, and increase awareness of and confidence in the notion that many core or generic, rather than specialist, professional skills can be used in this work (e.g. Rees et al., 2007; Woodcock, 2001).

Support and supervision

For psychologists working with clients who have experienced sexual violence, it appears that there is a need for adequate support systems to be in place, such as supervision, in order for psychologists to feel able to freely discuss certain aspects of the work in ways that are helpful for them. In order for this to happen, it seems that the dominant construct of vicarious traumatisation needs to be viewed critically, in order for there to be space made for the negative aspects of the work to be talked about alongside the positives, without psychologists being concerned that they will be pathologised. More research investigating the positive aspects of working with this client group may help with this. This may also encourage other psychologists to become involved in the area, and may mean professionals and services that work with this client group are not marginalised or isolated. However, for the latter to happen, it seems that there is also a need for the subject of sexual violence and the details of human rights abuses to be talked about more freely, which may involve wider social changes such as reducing discourses of shame associated with sexual violence.

Service user involvement

Although it needs to be recognised that not all refugee women, even those from the same community, are a homogeneous group, increased service user involvement within clinical practice will help ensure that psychologists are not making assumptions regarding what is therapeutically helpful for clients, what meanings they may draw from their experience and if and how they may want to talk about their experiences. This could take the form of service users working within services as ‘community workers’, for example, as well as service users having input as stakeholders in service development and in research. Service user involvement may also encourage empowerment with this group and hence highlight and strengthen the story of resilience. Regarding this, further research focusing on what factors enable these clients to recover from emotional distress, why some individuals attend therapy and others do not, and what they find helpful about this, will inform service development and psychological practice.

However, the reality is that in many mental health services much of the decision making is currently determined by staff and management (Palmer & Ward, 2007). Regarding refugee involvement in services, Palmer & Maffia (2008) comment that "there exists a fundamental distinction between tacit support of such user involvement and the establishment of clear, transparent and democratic processes to ensure success". As well as the existence of this power differential, other potential barriers to authentic and meaningful service user involvement include language, institutional racism and the understanding of trans-cultural issues. Furthermore, research has highlighted that commissioners and managers are unaware of some of the community services available that may be an effective way of linking refugee communities with health care services (Palmer & Ward, 2007).

Developing a culture of meaningful and effective service user involvement with refugee clients may be challenging and complex as it involves the consideration of issues of entitlement, membership of the community, and practices of social integration of refugees (Palmer & Maffia, 2008). Palmer & Maffia (2008) comment that:

> Although radical, it seems that user-led initiatives can be developed within psychiatric services, but this would require that the hierarchies that exist within the mental health system would need to be greatly reformed in order to allow for shared power and influence.

However, there are several positive examples of service user led initiatives which have led to effective service user engagement in research, service development and clinical practice. Palmer & Maffia (2008) describe several community groups which, among other practices, act as forums for exchanging information and sharing experience, leading to the identification of gaps in services and the lobbying of necessary provision.

CONCLUSION

The findings of the current study provide some rich information regarding applied psychologists experience of working with female refugees and asylum seekers

who have experienced sexual violence. One salient theme was that of psychologists' positioning, understanding and experience of clients regarding issues of empowerment and expertise. These issues relate to views that are held regarding what is 'empowering', the differing meanings that clients and psychologists hold regarding 'talking', and the meaning of experiences of sexual violence. Increasing service user involvement will be useful in managing these challenges.

More research on the positive aspects of this work and resilience in professionals will also be helpful in paving the way for a view that encompasses both the positives and negatives of the work, with the aim that this will allow psychologists to talk more freely about all aspects of the work without the fear of being pathologised. Hopefully, this will also mean that adequate support and supervision is provided. Other factors that appeared to hinder the freedom with which psychologists could talk about the work included those related to the subject matter: that of extreme acts of abuse, such as sexual violence. For the latter to happen, it seems that there is also a need for changes at wider social levels such as reducing discourses of shame associated with sexual violence.

Some caution needs to be taken when considering whether the findings apply to working exclusively with female refugees who have experienced sexual violence. Even if the findings do apply to working with other client groups with different experiences, the implications of the research remain relevant and important to the discipline of applied psychology in general. Possibly, the focus should be on the difficulties encountered within the professions of counselling and clinical psychology in general, which are merely highlighted or 'writ large' in the context of this client group (Blackwell, 2005). Further research on how psychologists experience and manage similar challenges in different contexts and with different client groups will be useful in clarifying these issues. It appears that there is a need for individual psychologists, and the profession at large, to consider the implications of the politics and ideology of the profession, and professional frameworks, models and approaches, on how psychologists experience their work.

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APPENDICES

APPENDIX I: ANNOTATED TRANSCRIPT EXTRACTS

Transcript 2

thing for her, and the people in the group, they were all sort of European's, they were all therapists, so they weren't people who had, um, experienced the same kind of, um, violence and abuse that she had. And yet it was such an impactful thing, she was really interested and really moved by the fact that her story had moved those people and made them think about their lives (I: hmm), um, and, to the point that she then took control of the process herself, she took their reflections to her church (I: hmm) and bought back reflections from people in her church. So, it, you know, it kind of made me think about some of the assumptions that I had (I: hmm-mm). Um, it also made me think about, sort of, how easy it can be, how unwitting, but how easy it can be to put people in a kind of us and them kind of situation (I: hmm-mm) because of the traumas they've been through, because of their experiences placing them, you know, outside of their relating to other people who might not have been through the same experiences. So, yeah, I think that again, and again I will come back to, you know, the really vital importance of working with [name of community worker] so when, you know when we did that international women's day event where, you know, one of the clients spoke about surviving the genocide in Rwanda, it was [name] idea to ask her to do that. And I thought, oh no, I'm not sure about that, I'm not sure of she's ready for that (I: hmm). And, um, [name of community worker], who survived the war in [country] (I: hmm-mm) convinced me that, you know, what was I doing there, I was making the decision for the client, I was putting myself in an expert position (I: hmm) and, and maybe seeing her as vulnerable rather than as resilient or capable of making that decision herself or whatever, so she said just ask her, you know (I: hmm-mm) and see what she says. So I was extremely tentative about it, thinking, you know, with all these different hats on thinking, oh, you know, whenever she talks about it in sessions, she's very distressed. But, you know, and if I hadn't had [name of community worker] voice I would probably not have asked her, but when I

models and different layers - holistic - power/ inequalities 502-12

human rights approach allows for formulating power/politics and other layers.

Models moral and ethical implications
By choosing a model, other moral choices are made *
choice re. politicising and taking wider perspective 514-16
by choosing a model 523-530

CBT approach ignores aspects of people's experience 516-522
* dehumanising 525

Honesty/bravery re what Ψ do and why
521-24
526-28

502 those models, but, so you can use aspects of them and bits and pieces of the techniques but
503 actually not many of them can attend to the different layers (I: hmm) of people's existence
504 and that's actually what you need to do when you work with this client group, you need to be
505 able to understand, make sense of, um, formulate and, you know, things like power and
506 social inequalities, you know, those kind of things are essential in understanding their
507 experience because they have very little power, um, and *they* experience inequality in the
508 worst ways possible, and they have done (I: hmm) by virtue of being tortured for their beliefs,
509 or who they are, um, so they've suffered at the hands of people that have oppressed them
510 and taken away any power that they've had, and controlled them completely, and so you
511 need to be able to understand that, and I think maybe that approach attends to those kinds of
512 things more so than other approaches.
513 I: hmm. And obviously, you feel it's important to attend to those things, yeah
514 P: hmm, absolutely, I don't think you can't, I think you, I think , um, it's not a *choice*, I think
515 this approach is, um, you know , I used to think that there's choices and things, in certain
516 aspects of the work, but in some things there's no choice, and I think if you do use CBT, or
517 you use a particular way of working, you know, um, you need to be clear *why* you're doing it
518 and be honest, actually, you're not a, you're ignoring a whole lot of other sort of aspects of
519 people's existence, and you're ignoring things about inequalities, and discrimination, and
520 difference, and you're ignoring a whole, um, you know, spectrum of emotions that torture
521 survivors feel, and you're just focusing on this, so, you know, put your hand up and say,
522 actually, I'm going to ignore that, but I am going to attend to this, so, and I think a lot of
523 psychologists don't, are not brave enough, or honest enough to say that, that actually, they
524 *choose* to ignore a lot of the other stuff, they *choose* to de-politicise what they're doing, um,
525 and de, you know, essentially they dehumanise the clients, I think, by virtue of picking a

positioning other services – 'good' 140
↳ ∆ allows for LT work and time for ~~other~~ holistic work

Positioning of other approaches:
stabilisation work – needed and takes time – viewed as 'good' and necessary (but not ψ work?)
↳ how is this type of work valued and viewed? 140–5.

Dilemma – service restrictions and aim of work 146–59.
how to intervene, if at all

Ser Positioning of services: – view of prof, self and services.
need to be specialised. 153–7.
lack of service provision → difficulty re. what do I offer?

needing to offer something 157–8.

expectation on self as clinician 163–4.

where a lot of the time they would have, you know, two years to see people, so they would say okay, we're going to spend, let's say the first few months, the first year doing stabilisation work: how can you manage, how can you feel as though things are okay? Doing some of the kind of work around some of the social areas and then saying, right, not we're going to focus on, um, some of the more psychological issues. I suppose, working in a service where you've got a limited number of sessions you can offer, it's a real dilemma because I suppose you're faced with a decision, what do you do? , do you decide that you're going to meet with somebody and do a very short term, or relatively short term intervention, just focused around what that person can manage at a particular time and then refer them somewhere else? Um, or do you not? Do you just assess them and think, actually, um, they'd be better seen somewhere else, so I think it's something about having a kind of dilemma where you've had to think about whether or not you really can offer somebody what they need at that time, um, and if not, what services are available because obviously, I'm aware that other services that do specialise in the treatment of, sort of traumatised asylum seekers and refugees, um, would have very long waiting lists and I think sometimes they're a year plus, um, so I think sometimes it's quite difficult, um, and I think sometimes you might think about, um, maybe working on a shorter term basis with a view to referring them on later on (I: hmm) for more work elsewhere, so…I don't know, does that cover it?

I: um, just, I've got some questions (P: sure) how, how does that, how do you feel about that? Is that something that kind of, those kind of dilemmas and kind of…yeah…is that difficult, or?

P: um…it's difficult in a sense that, I suppose it's about adjusting your kind of, um, expectations about what you can do, um…it's difficult if, um…if you can't find appropriate

not enough provision 164-5

overwhelming - so much - clients so many difficulties 167-8.
"complex" 169

"complex" 169 →
not knowing - overwhelming 169-171.
what to do? where to start?
what they need? ~ incompetence?
clients don't know what they need? -
↳ understanding of role and services
clients positioning of services
171-73. clients understanding of role/services
↳ impact on CPs feeling of competence

(hard to keep focused on this particular client group 178)

horrific 180 Holding the knowledge
stay with you 181.-2.

Emotional reactions
horrified, shocked, overwhelmed 184

Ordinary traumatisation idea 184-5
normalising
justifying reaction 183-4, 185-88.
↳ reassured by reaction - still 'human'

165 services for people. Um, and yeah, I guess it can be, I don't know, yes, I guess it can be
166 difficult, it can be very challenging part of the work, um, (I: hmm) yeah, and I guess, you
167 know, the thought of seeing somebody and working with them on a short term basis when
168 there's so much to kind of manage and work through can be quite overwhelming, um,
169 yeah, so we have a lot of, I suppose very complex clients that come through here
170 where…it's really difficult to know what to do, its really difficult to know where to start, it's
171 really difficult to know where to start, it's really difficult to know what, what they need and I
172 guess a lot of the time people come and they don't really know what they need, they just
173 need as much support as possible, so yeah, I think the works very challenging.
174 I: hmm. Um (pause) you said about, um, hearing people's stories can be very difficult as
175 well, um, what kind of, how, what kind of reactions does that stir up in you, again, like
176 personally and emotionally but also professionally? (P: hmm) and um, and what, how,
177 what do you do with those emotions?
178 P: um, I think that there are certain things that I've heard, um, I suppose in all of the work,
179 but yeah, I can pick out sort of particular cases where I've worked with, um, traumatised
180 asylum seekers and refugees and, and some of the, yeah, some of the stories are horrific,
181 some of the things stay with you, so there are certain stories from people that I saw four or
182 five years ago that I still bring to mind, they still come to me every so often and I think
183 there is something about that where it's quite hard to be able to hear those things and *not*
184 be horrified and *not* be shocked and *not* be completely overwhelmed and, I suppose in a
185 away it's quite traumatic, it can be quite traumatic. Um, I don't necessarily think that that's
186 a *bad* thing, I think that, you know, if I get to the point where I hear about, you know,
187 somebody going through something horrific and don't have any kind of response to it then
188 I've probably been in the job for too long but, um, at the same time sometimes it's quite

APPENDIX II: PARTICIPANT INFORMATION SHEET

Dear Psychologist

Research study: An exploration of applied psychologists' experience of working with female refugees or asylum seekers that have experienced sexual violence

I am a third year clinical psychology trainee at the University of East London, and I am carrying out research for my thesis on the experience of psychologists who work with female refugees or asylum seekers that have experienced sexual violence. I am interested in exploring the various ways psychologists experience this work on both a personal and professional level. The project is being supervised by Dr. Nimisha Patel.

I am gathering a range of views by conducting individual interviews with approximately eight psychologists who have worked with female clients that are refugees or asylum seekers and have experienced sexual violence (I am using the definition of sexual violence used by the United Nations High Commission for Refugees as 'all forms of sexual threat, assault, interference and exploitation'). Interviews will last approximately one hour and take place at an agreed location that is convenient for participants.

All information gathered will be kept entirely confidential. The interviews will be tape recorded and then transcribed, and the tapes will then be erased. In the transcriptions, all identifiable information will be removed and the transcripts coded to ensure anonymity. Individual transcripts will be available to check for accuracy if participants wish. Direct quotes will not be attributed. The transcripts will be kept securely at the University of East London for five years, and then destroyed.

The study will be written up as a doctorate thesis and publication may be sought subsequently.

I would be very grateful for your participation in this study, if you are able to help, although participation is entirely voluntary. If you decide to take part, you remain free to withdraw at any time.

Yours sincerely

Susannah Jenner
Trainee Clinical Psychologist, University of East London
Email: u0933882@UEL-Exchange.uel.ac.uk

Mobile

APPENDIX III: INTERVIEW SCHEDULE

An exploration of clinical psychologists' experience of working with female refugees or asylum seekers that have experienced sexual violence

Interview schedule

How did you come to work with female refugees/asylum seekers that have experienced sexual violence?

- Settings worked in
- Influences

How would you describe your professional role with this client group?

- Aims of work/definition of role
- Most important aspect of work

What influences the way you work with this group?

- e.g. your clinical psychology training, your beliefs or philosophies, professional values, personal experiences
- Helpfulness/importance of various ideas/concepts

Think about interaction of processes

How have various challenges you have experienced working with this client group influenced your work or thinking?

- Challenges - practical, emotional, theoretical, clinical
- Conflicts of different roles/approaches – political neutrality
- Implications/influence of these challenges
- One of the challenges that people mention is how difficult it can be to hear and respond to account of extreme sexual violence. What are your thoughts/views/experience on this?

In what ways has working with this client group impacted on you personally and professionally?

- Impact on view of the world, human nature, suffering
- Impact on non-professional life

Is there anything that we haven't talked about that you think is relevant to this subject?

APPENDIX IV: CONSENT FORM

Consent form for study: 'An exploration of clinical psychologists' experience of working with female refugees or asylum seekers that have experienced sexual violence'

This form requests your name but will not be kept together with the transcription or other details of the interview.

Please tick the following boxes:

- □ I have read the information sheet about this research and have had the opportunity to discuss the details and ask questions about this information.

- □ I understand that during this interview I will be asked about my clinical experience of working with survivors of sexual violence, and that some of the material may be distressing in nature. I undertake to use supervision, peer or personal support if appropriate

- □ I understand that the interview will be tape-recorded, and that the data will be anonymised to ensure confidentiality. I understand that I may see the transcript of the interview to verify it's accuracy if I wish. I understand that the transcripts will be anonymised and kept securely at the University of East London for five years, and then destroyed.

- □ I give my permission for anonymised quotes to be used and for the data to be submitted for publication

- □ Having given my consent, I understand that I may decline to answer any questions if I wish, and that I may withdraw from the study at any time without penalty and without having to give an explanation.

- □ I fully and freely consent to take part in this study

- □ I understand I am not taking part due to my status as an NHS employee or any other service in which I work

Your name…….

Your signature……

Date…….

APPENDIX V: UNIVERSITY OF EAST LONDON ETHICS LETTER OF APPROVAL

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology

UEL University of East London

Doctoral Degree in Clinical Psychology
Direct Fax: 0208 223 4967

June 2011

Name of Student	Susannah Jenner
Title of Research Project	An exploration of clinical psychologists' experience of working with female refugees or asylum seekers that are survivors of sexual violence

To Whom It May Concern:

This is to confirm that the above named student is conducting research as part of the requirements for the Professional Doctorate in Clinical Psychology. The Ethics Committee of the School of Psychology, University of East London has approved their proposal and they are, therefore, covered by the University's indemnity insurance policy. . This policy should normally cover for any untoward event provided that the experimental programme has been approved by the Ethics Committee prior to its commencement. The University does not offer "no fault" cover, so in the event of untoward event leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the above named is a student of UEL the University will act as the sponsor of their research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Kenneth Gannon PhD
Research Director

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POSITIVE ABOUT DISABLED PEOPLE
INVESTOR IN PEOPLE
CUSTOMER SERVICE EXCELLENCE UK The Government Standard

APPENDIX VI: TRANSCRIPTION CONVENTIONS

(Banister et al., 1994, p.64)

(.)	pause
(2)	two second pause (number indicates duration)
Xxx	not able to transcribe
Word underline	emphasis

Additional conventions added for presenting quotes from transcripts:

…	deletion of irrelevant material
()	signifies when another (i.e. interviewer) is speaking
[ ]	edition of content for clarity