

**“If I speak English, what am I? I am full man, me.” Learning
English: emotional impact and barriers for refugees and asylum
seekers**

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Abstract

Lack of proficiency in the language of the host country predicts distress in refugees, but many refugees and asylum seekers in the United Kingdom have less than functional English.

We wished to understand how learning English affected refugees' and asylum seekers' lives, particularly their emotional wellbeing, and to explore what factors, particularly psychological ones, facilitated or impeded their learning English.

Sixteen refugees and asylum seekers were recruited from an inner-city National Health Service trauma service and from a charity providing one-to-one English classes. All were interviewed in English. Interview data were analysed using thematic analysis from a critical realist perspective. Interviewees provided consistent accounts of their efforts to learn English, integrated into often unsettled and difficult lives.

The analysis generated six themes in two domains. The impact of learning English was mainly positive, associated with autonomy, sense of achievement, and aspirations. Barriers to learning English consisted of other problems affecting refugees' capacity to learn, limited opportunities to speak English, and a sense of shame associated with perceived lack of English language competence. Findings highlight the need to provide adequate psychological support for refugees and asylum seekers learning English, recognising its importance in promoting both their integration in the UK and their individual psychological well-being.

Introduction

Many refugees and asylum seekers arrive in the host country having incurred extensive material and social losses (United Nations High Commissioner for Refugees (UNHCR), 2007). Asylum seekers are those whose claims for refugee status are to be determined, a stressful process with measurable adverse effects on mental health (Fazel, Wheeler, & Danesh, 2005; Johnson & Thompson, 2008; Silove, 1999). Refugees' psychological problems are better understood in the context of the challenges of adaptation to many difficult circumstances (Burnett & Peel, 2001b; Miller & Rasmussen, 2016; Summerfield, 1999, 2000; Watters & Ingleby, 2005) than in psychiatric terms, and the aim of any intervention is to promote autonomy despite psychological problems (Strang & Ager, 2003). Many refugees and asylum seekers in the UK have little English (Adams, 2007), a situation portrayed negatively by politicians and the media (Cooke, 2006) without considering possible barriers to language proficiency.

Distress in refugees is consistently predicted by post-migration factors such as lack of social support, poor living conditions, uncertain legal status, detention, unemployment and poverty (Brewin, Andrews, & Valentine, 2000; Carswell, Blackburn, & Barker, 2011; Chung & Kagawa-Singer, 1993; Gorst-Unsworth & Goldenberg, 1998; Li et al., 2016; Miller & Rasmussen, 2010; Momartin et al., 2006; Silove, 2002; Steel, Frommer, & Silove, 2004). In addition, poor language proficiency is a significant predictor of post-migration distress in adults (Alemi et al., 2014; Bogic et al., 2015; Chung & Kagawa-Singer, 1993; Hinton, Tiet, Tran, & Chesney, 1997; Westermeyer, Neider, & Callies, 1989) and in children (Fazel et al., 2012). Proficiency in the host country language enables easier access to health and welfare services, legal support, participation in children's schooling (Hek, 2005), and employment and other opportunities in the community (Ager & Strang, 2008; McColl & Johnson, 2006). The association between poor language proficiency and psychological problems may also

be mediated by unemployment (Hinton et al., 1997; Westermeyer et al., 1989), in itself a risk to mental health (Dooley, 2003). Host language competence can influence decisions on status (Aspinall & Hashem, 2011; Morrice, 2007): in the UK, English proficiency is required for citizenship (Home Office, 2002).

Refugees have clearly elevated rates of mental health problems but poorer access to appropriate primary care or specialist health services (Aspinall & Watters, 2010), and lack of host language proficiency significantly worsens the effects of stress on immigrants' health (Ding & Hargraves, 2009). Recent systematic reviews raise concerns that language difficulties mediate persistence of psychological problems (Alemi et al. 2014); five years or more post-resettlement (Bogic et al., 2015), and have a serious negative impact on clinical outcomes in psychiatric assessment (Bauer & Alegría, 2010).

Despite rights to interpretation in health and other public services in the UK, provision is often poor, particularly in community services from which specialist referrals are made (Watters, 2001). While the use of professional interpreters can mitigate the effects of poor host language skills on communication of health care needs (Bauer & Alegría, 2010; Karliner et al. 2007), healthcare staff tend to overestimate immigrant patients' language proficiency and so neglect to use available interpreting resources (Balakrishnan et al. 2016). Further, interpretation is a short-term solution (Adams, 2007; Cooke, 2006) that is not always satisfactory (Burnett & Peel, 2001a; Tribe, 1999).

Factors affecting language learning in refugees and asylum seekers

Posttraumatic stress symptoms, anxiety and depression are common in refugees (Fazel et al., 2005; Johnson & Thompson, 2008; Silove, 1999) and associated with attention difficulties and memory disruption, making learning harder (Castaneda, Tuulio-Henriksson,

Marttunen, Suvisaari, & Lönnqvist, 2008; Christopher & MacDonald, 2005; Horner & Hamner, 2002; UNHCR, 2001). The long-term consequences of torture, experienced by up to half of all refugees and asylum seekers (Steel et al., 2004), may include neuropsychological difficulties where individuals have received blows to the head (Burnett & Peel, 2001b).

Various factors may offer opportunities for language acquisition, or may encourage or inhibit it. Having children who speak the host country language at school and socially may foster or discourage their parents' language acquisition (Chiswick & Miller, 1995; McGregor, 2008; Mitchell, Kaplan, & Crowe, 2007), but many refugees, especially torture survivors, have lost or are separated from family members including children (Watters & Ingleby, 2005). Exposure, or no exposure, to host country language in the individual's ethnic community or support network affects language acquisition (Ager & Strang, 2008), as do social connections with the host community that may provide or restrict informal practice in the language (Ager & Strang, 2008; Morrice, 2007; Roberts et al., 2004).

Interaction between cultural groups has been described in terms of 'integration', where there is a balance of the person's own and the host country's culture; through 'assimilation' and 'separation', a rejection of the person's own culture in the former and of the host country's culture in the latter, to 'marginalisation' when the person is excluded from or rejects both the host country and his or her own culture (Berry 2001). These processes interact with varied host country strategies for integration, strategies often described in terms of 'multiculturalism', 'melting pot', 'segregation' and 'exclusion'.

In the UK, resettlement policy has recently shifted towards emphasising integration and "Britishness" (Aspinall & Hashem, 2011, p. 146; Strang & Ager, 2010), including a policy of

formal language learning based on a “narrow and prescriptive curriculum which assumes refugees come to the UK with few or no skills” rather than using less formal methods that develop refugee social connectedness with the native-speaking community (Morrice, 2007, p. 158). Other policies adversely affecting acquisition of the language of the host country include dispersal of refugees away from London and SE England (Home Office, 1999), detention, and rapid deportation, all of which undermine social networks and exacerbate isolation (Morrice, 2007). All these factors constitute less than ideal conditions for refugees to learn English, even when the mental health is good, and their lives stable. They are likely to be more problematic for refugees with psychological and social difficulties.

Rationale and aims of the study

Given the association between lack of proficiency in the host language and psychological distress (Aspinall & Watters, 2010; Atfield et al., 2007; Chung & Kagawa-Singer, 1993; Hinton et al., 1997; Westermeyer et al., 1989), further studies of language learning as a possible protective factor for psychological wellbeing have been recommended (Fazel et al., 2012). We found no study of refugees’ viewpoints on how learning English affected their psychological health, and vice versa, despite a call for such studies (Miller & Rasco, 2004; Watters, 2001). We therefore sought to explore refugees’ emotional experience of learning and trying to speak English.

Methods

Setting

Ethical approval was obtained (NHS Ethics reference: 11/LO/1302) for two services for refugees and asylum seekers: an inner-city NHS trauma clinic, and a charity providing one-to-one English classes where physical or mental health difficulties prevented clients' access to mainstream services. Given that the referral criteria for both services was similar, and some participants used both services, it was considered that there were unlikely to be significant differences between samples from the two services.

Participants

Between November 2011 and February 2012, we recruited 1) refugees and asylum seekers over 18 currently residing in England, 2) with little or no knowledge of English before arriving in the UK, 3) currently able to communicate in English without an interpreter, 4) providing informed consent to participate, and 5) willing to be audiotaped for qualitative research. Staff excluded potential participants for whom they judged the interview potentially detrimental.

In the NHS site, all staff identified potential participants from their caseloads, gave them the standard information and requested consent for contact by the researcher. Participants who agreed to participate following telephone discussion then met the researcher on site.

In the charity, contact details of potential participants were provided to the researcher, who sent letters with information sheets and followed up by telephone two weeks later. All these participants opted to be interviewed in their homes.

Sixteen participants were interviewed, nine from the charity and seven from the NHS. The nine men and seven women ranged from 20 to 65 years (mean 37 years) and had lived in

the UK for five months to 14 years (mean 7 years) (see Table 1: for confidentiality, age and area of origin are provided in general terms). All participants had attended, were currently attending or were waiting for treatment by mental health services. All participants were able to read and write in at least one language. Three further potential participants dropped out, one who refused audiotaping, and two because of changes in circumstances.

Using recommendations by Guest, Bunce and Johnson (2006) for selecting across different groups of interest and adapted for homogenous groups, a sample of 16 was considered sufficient for data saturation and diversity (Barbour, 2001). Purposive sampling aimed for broad recruitment, including 'negative cases' (Mays & Pope, 2000), in characteristics including gender, age, time in the UK and status

Interviews

Prior to interview, the information leaflet was re-read, questions answered by the researcher, and consent forms signed. Participants provided information about themselves, with the researcher's help if preferred (see table 1). The interview lasted from 45 minutes to two hours, in one case split over two sessions, in English, and audiorecorded. Participants were offered £5 vouchers and travel expenses. They were also asked if they could be contacted for respondent validation, and offered a summary of results.

An open-ended semi-structured interview was developed using guidance from Charmaz (2006) and Patton (2002), and refined throughout data collection following participants' suggestions (see supplementary file for interview schedule,). Main areas covered were the participant's experience of learning English and his/her experience of speaking English, including any changes over time; impact on wellbeing; concerns about learning the language; and family and community members' views and knowledge of English. All

interviews were transcribed verbatim by the researcher and identifiable information removed. A completed interview transcript was reviewed (AW) to check quality and to guard against overrepresentation of existing perspectives in interviews (Charmaz, 2006).

Researcher's perspective

The first author is a white British/Chilean female in her early thirties whose father was a refugee to Europe. She grew up bilingual in French and English and fluent in Spanish. The study was completed while working in the NHS trauma service where she recruited half her sample but none was her client. She attempted to remain open about participants' perspectives. The second author is a white British female academic and clinical psychologist in her early sixties with experience of therapeutic work with survivors of torture.

Analysis

Thematic analysis from a critical realist epistemology following Braun and Clarke's (2006) approach was used to explore themes and their inter-relationships. Inductive coding was used to identify semantic themes and applied line-by-line to the entire data set, with key words and actions noted in the margin (Charmaz, 2006); then initial codes were combined into tentative sub-themes then themes. An iterative refinement of themes and sub-themes was carried out by checking against initial codes and accompanying extracts (Patton, 2002, p. 466). Key themes were those that were present across a majority of participants and addressed the research aims. Analysis was carried out on the sample as a whole.

Credibility checks (Barker & Pistrang, 2005; Mays & Pope, 2000; Spencer & Ritchie, 2011; Willig, 2008) on themes, sub-themes, initial codes and accompanying quotes were made by the second author and discussed to reach consensus. Respondent validation was sought

from two participants who reviewed themes, sub-themes and supporting quotes from their own interviews; labels were clarified in response to feedback.

Table 1 *Description of participants ordered by length of time in UK*

<i>ID</i>	<i>Gender</i>	<i>Age</i>	<i>Area of origin</i>	<i>Marital status</i>	<i>Children (in UK)</i>	<i>Occupational status</i>	<i>Legal status</i>	<i>Years in UK</i>	<i>Other languages spoken</i>
P8	M	20s	East Africa	Single	0	Student	Refugee	5 months	4
P1	M	30s	East Africa	Married	1 (0)	Unemployed	Refugee	4	1
P2	M	40s	Middle East	Married	2 (2)	Unemployed	Refugee	4	2
P10	M	20s	Greater Middle East	Single	0	Student	Refugee	4	2
P14	F	30s	Middle East	Single	0	Unemployed	Asylum seeker	4	3
P15	M	20s	Middle East	Single	0	Student	Asylum seeker	4+	1
P4	F	40s	Middle East	Divorced	1 (0)	Student	Refugee	7	1
P11	F	20s	East Africa	Single	1 (0)	Unemployed	Refugee	7	1
P12	F	30s	Greater Middle East	Married	0	Unemployed	Refugee	7	4
P13	F	60s	Greater Middle East	Single	3 (2)	Unemployed	Refugee	7	1
P7	F	50s	Middle East	Single	0	Unemployed	Refugee	10	1
P9	F	50s	Middle East	Married	4 (4)	Student	Refugee	10	1
P5	M	20s	Eastern Europe	Single	0	Unemployed	Refugee	11/12	1
P6	M	30s	Middle East	Single	0	Unemployed	Refugee	12	1
P16	M	40s	Middle East	Single	0	Student	Asylum seeker	12	3
P3	M	40s	Middle East	Single	0	Unemployed	Refugee	14	2

Results

Thematic analysis generated seven themes organised in two domains (see Table 2). The first domain relates to the impact and expected impact of learning English on participants and their daily lives, the second to barriers to learning, including emotional barriers to speaking English. A brief context precedes elaboration of the themes with illustrative quotations labelled with participant ID, gender and age.

Table 2 *Overview of domains and themes*

Domain	Theme
1. Impact of learning English	1.1 Dependence and autonomy <i>"I can do everything for myself. Same I think I can swim in the English."</i>
	1.2 Sense of achievement <i>"I'm happy I was when I was study English, and I feel I win something. I feel for example I am human, I am active."</i>
	1.3 Hopes of further changes <i>"if I speak English, what am I? I am full man, me."</i>
2. Barriers to learning	2.1 Experiencing difficulties in the UK <i>"my mind is not in peace to learn"</i>
	2.2 Not having a chance to speak English <i>"no one speak to you, no one come close to you"</i>
	2.3 Sense of shame <i>"he gonna be thinking "oh this person and living for three years and they can't speak English"</i>

All participants spontaneously talked about English classes as part of their experience of learning English; all had attended "school" or "college" (their terminology) at some point since arriving in the UK and 10 were still attending classes or receiving home tuition.

Whereas home tuition was valued by all who received it, participants' view of the usefulness of college varied: most found English for Speakers of Other Languages (ESOL) classes "unhelpful" or insufficiently tailored to their needs, particularly to their physical and psychological difficulties associated with current and recent adverse experiences, especially those not disclosed to teachers.

Some participants differentiated oral from reading/writing fluency, considering college to be useful mainly for the latter and speaking English outside college useful for the former. Participants using "school" as a term to describe English classes tended to see themselves as "too old" to be attending classes. Participants also considered talking to others and "real-life" practice, as well as independent learning such as using subtitles and language books or dictionaries, to be a desirable part of their learning experience.

Domain 1: Impact of learning English

Theme 1.1: Dependence and autonomy: *"I can do everything for myself. Same I think I can swim in the English."*

All participants found their freedom in the UK was restricted through dependence on others: friends, relatives, or children; they were unable to go out alone, and needed to ask others for help in all aspects of their lives, particularly when attending appointments.

"I like to do things my own but it's not happening." (P5, male, 20s)

"In the beginning it was very difficult, because when I come as a refugee and I have to go to the Home Office or I have to go to solicitor, everywhere they have to bring interpreter." (P6, male, 30s)

Participants' emotional reactions to this dependence were mainly negative, especially in relation to interpreters.

"Int: And how does it feel when you have an interpreter?"

P16: I'm not happy, very difficult for me, same [as having] something over my shoulder." (male, 40s)

Learning English was associated with developing autonomy, demonstrated by willingness to speak English and refusing the offer of interpretation. Refugees being able to speak for themselves felt they had regained lost freedom in many areas of life, and some began to interpret for others who could not speak English.

"[...] they say to me "OK, because if you need interpreter, we bring interpreter" but I say to him I want to try to learn something and I want to try. But if you not understand about some my words, then you can tell me and I'm gonna explain to you again." (P10, male, 20s)

"P16: I can do everything for myself. Same I think I can swim in the English.

Int: You can swim in the English?"

P16: Swim in the language because I understand what I say, I can explain opposite me, I understand if go to airport, [...]." (male, 40s)

Limitations in language ability were recognised, both vocabulary and sentence construction being "broken" or "not that perfect"; but for some, this did not appear to undermine autonomy.

"So I stay talking with the people and ask them always to slowly, to speak with me slowly, because I'm not, I don't speak real English. I say always, I speak my English, not politician English or UK English." (P2, male, 40s)

Theme 1.2: Sense of achievement: *"I'm happy I was when I was study English, and I feel I win something. I feel for example I am human, I am active."*

When they first arrived in the UK, participants' inability to express themselves felt restricting: they lacked control over their communication, feared being misunderstood or mistranslated and unable to explain themselves. Participants also expressed concern about possible consequences for others: inadvertent offence or misunderstanding, and being unable to show respect to others by not knowing words of common courtesy.

"P7: I can't talking, I don't know. Maybe like a wall.

Int: Like a wall? Can you tell me more about the wall?

P7: Because I'm thinking maybe I'm speak and is sentence is wrong and not understand and sometimes I can't explain so it's very far with me." (female, 50s)

"P2: I feel, even if I talk good English but I feel I didn't talk or say what I want to say, as my language.

Int: And how does that make you feel, when you can't say?

P2: Very bad, I feel so in small place I couldn't breathe" (male, 40s)

The lack of control over expression through language and the impact on social identity generated varied feelings, often including sadness and anger.

"Same I'm feel I'm broke. I can't speak English, I'm boring, something like that. You go to somewhere, you can't speak to people." (P16, male, 40s)

"Sometimes, yeah, I feel angry because I lost my right because I don't have language." (P2, male, 40s)

Participants then described the emotional impact of learning English, in particular the sense of achievement associated with regaining a sense of social identity and agency by

understanding and being understood, compared to the experience of arriving in the UK not speaking English.

"Sometimes yeah, you feel, I feel happy when I speak with someone understand me, and me understand him, was nice time we have chatting." (P3, male, 40s)

"I'm happy I was when I was study English, and I feel I win something. I feel for example I am human, I am active." (P16, male, 40s)

Theme 1.3: Hopes of further changes *"if I speak English, what am I? I am full man, me."*

Participants' judgements of their own English skills ranged from "not good at all" to more qualified statements such as "not speaking right". Participants' perceived attained level of English varied according to their own definitions of 'proper' and 'perfect' English.

"[S]ome people thinks if they learn just first step of speaking or listening or writing or reading in English they are perfect, but it's completely wrong because for final, you cannot speak and you cannot, you know, know English as a native, never, ever."
(P14, female, 30s)

"P8: For example, if I speak English, what am I? I am full man, me.

Int: You're a full man?

P8: Yes.

Int: In what way?

P8: Because I get everything as I want, as you like, I get job, I will communicate with people what am I want." (male, 20s)

Participants also described direct practical benefits of being able to speak English sufficiently fluently, particularly in relation to employment and further education.

"Yeah, if I could learn and I will be good at English, it will help me I think. I can get my job and I can change my situation and yeah, I can communicate with people more." (P1, male, 30s)

Domain 2: Barriers to learning

Theme 2.1: Experiencing difficulties in the UK: "my mind is not in peace to learn"

Difficulties in the UK intruded on capacity to learn. Three participants were waiting for a decision regarding their refugee status; most had experienced homelessness or unstable living conditions since arriving in the UK:

"Int: OK. Has anything made it difficult to learn English?"

P15: Yes, it is a lot of things but most, for immigration, my immigration is not very good at the moment. That's all. I can't work to any job, I can't be to the community more, less than before, I know less than people." (male, 20s)

P14: Because of all my problems, I'm waiting for Home Office, my life in [own country], previous life is ruined, completely ruined, my mother and here I have no, you know, good condition for living, so, you know my mind is not in peace to learn or to make myself busy with learning English. Even if I wanted, they don't allow me, so." (female, 30s)

In addition, the impact of psychological and physical problems, depression, flashbacks, and sleep disruption in particular, was associated with difficulties concentrating and remembering the content of classes, and with missing college. For most, their broader hopes for the future were dependent on their psychological and physical problems.

"Before, I think so, it's for maybe three or four months I go college but it's not regular because I had a physical problem and mentally, and college told me not come in because two times is called hospital with ambulance." (P7, female, 50s)

Int: Do you think it [being able to speak English] will have any impact on your future, on your life here, on...?

P3: (sigh) It's very good question, it's very interesting. It's depends what's going happen in my psychology problems.

Int: OK

P3: Depends, I don't know. But I got, I'm still half hope to do something [...] Go to work, find job, treatment, medical treatment." (male, 40s)

Theme 2.2: Not having opportunities to speak English: "no one speak to you, no one come close to you"

The lack of informal opportunities to speak and practice English were identified by most participants as a significant barrier to learning. Few had any contact with neighbours, and one contrasted this to "being given a chance to learn" in his own country.

"The difference in here why you don't learn English, one problem I think, I remembered now (laugh), like for example in my back home country, people communicate with you when you come from different area, everyone want to talk to you and if, especially if you don't speak their language, everyone try to teach you and, um, I think because there's not that much different people in there... Here, always coming different people so no one care about them (laugh). (P1, male, 30s)

Lack of English-speaking friends, especially native English speakers, was emphasised, resulting in not speaking English outside college and therefore learning slowly. Some

participants found themselves surrounded by other non-English speakers at work or at their accommodation; others described difficulties becoming acquainted with neighbours because of their psychological difficulties. Several participants described actively avoiding their own communities in order to focus on improving their English fluency.

"But um, it's difficult, really English is difficult. Maybe because I don't have friend, English people maybe? Maybe if you live with English people or neighbours or, then you learn. If you have children with you, then maybe, you catch some words, you learn. But if you live like people from different language, [names of countries], everybody have broke English, we don't say it in good way, we don't learn anything." (P4, female, 40s)

"Because I don't want to go to them [community]. Because many [own country] people they came, they didn't speak English, and I don't want to go, I want to learn English, my aim is how can improve my language." (P8, male, 20s)

Theme 2.3: Sense of shame: "He gonna be thinking "oh this person and living for three years and they can't speak English"

A further barrier to speaking English was a sense of shame, leading to a fear of making mistakes, of eliciting negative responses from others including being laughed at, which for some had particular negative meanings from earlier experiences. Participants managed this anxiety in several ways, often avoiding specific words, topics or situations or not talking, although they recognised that this could be counter-productive.

"I'm afraid to use the word because sometimes I hear one word, he mean many thing, he give many meaning and I don't want to make mistake." (P4, female, 40s)

Shame associated with anticipating judgment by members of their own community, not least interpreters, was a further barrier. It was also associated with self-criticism about the

fluency level compared with other refugees, or by reference to years spent in the UK, or to refugees' own earlier educational achievements.

"When interpreter with me, I feel like very bad, because I feel like shy or, because he think, he gonna be thinking "oh this person and living for three years and they can't speak English, they need interpreter". Very bad, very bad." (P10, male, 20s)

"Guilty because I'm thinking 10 years I'm stay here, why I'm not talking? And inside is very bad about myself. And very, it's same ashamed." (P7, female, 50s)

Discussion

While our questions concerned learning English, our participants' responses contained much emotional content and many references to psychological state: both positive emotions – hopes, optimism, pride, self-respect, and connectedness – and many negative emotions were evoked by the experience itself and by the multiple barriers to achieving competence. Although a cross-sectional study, our findings add a dimension to important longitudinal studies of acculturation processes or identity change associated with learning the host language (Berry, 2001; Mestheneos & Ioannidi, 2002) that contain relatively little consideration of mental health problems.

Domain 1: Impact of learning English

The impact of English on participants' lives consisted of moving from dependence to autonomy, a sense of achievement, and associated with hopes for further changes including in employment and education. This complements qualitative and quantitative accounts of low levels of host language competence predicting distress and depression in resettled refugees (Chung & Kagawa-Singer, 1993; Hinton et al., 1997; Westermeyer et al., 1989), and appears to be true in general of refugees' experience of learning the host language, and not specific to those with psychological problems (Phillimore & Goodson, 2008). In the current study, perceived autonomy was associated both with lack of proficiency in English and distress or depression, such that participants associated learning English with increased autonomy and the development of a renewed social identity. A qualitative study by Miller (1999) similarly highlighted the role of "empowerment, being heard and the ongoing process of self-realisation" in the relationship between language acquisition and social identity of 'new speakers' (e.g. refugees and asylum seekers) of English (Miller, 1999, p.163).

Additionally, unemployment, a consistent contributor to distress (Hinton et al., 1997; Westermeyer et al., 1989) and resulting in loss of status and of identity in refugees (Orford, 2008; Summerfield, 1999), was a primary incentive for learning English for our participants. This is consistent with other research on self-reported priorities of refugees and asylum seekers (Alemi et al., 2014; Colic-Peisker & Walker, 2003; Mestheneos & Ioannidi, 2002; Phillimore & Goodson, 2008). Half the respondents in a study by Phillimore & Goodson (2008), investigating the usefulness of the indicators of integration in the UK developed by Ager and Strang (2008), identified employment second only to housing in importance for making them “feel at home” (p. 314). The sense of autonomy may well relate to purpose and status conferred by employment, as well as to its loss through forced migration, detention and waiting for decisions on immigration status (Momartin et al., 2006; Silove, 2002; Steel et al., 2004). When describing hopes for the future, participants often specified work as a central goal that would be more attainable with better English (Beiser & Hou, 2001).

Domain 2: Barriers to learning

Participants described several significant barriers to learning: the disruptive effect of psychological problems related to the experience which made them refugees; self-censorship for fear of causing offence through errors; anticipated criticism from others of their inadequate English; and lack of opportunities to practice everyday English. All but the first are also reported in some studies of refugees not identified as having psychological problems (Ager & Strang 2008; Atfield et al., 2007), but not in others (Phillimore & Goodson, 2008); our participants emphasised it and described their shame very acutely.

The detrimental effects on mental health of the situation of refugees have been consistently demonstrated: importantly detention, dispersal and uncertain asylum

applications (Silove, Austin, & Steel, 2007; Silove, Steel, & Watters, 2000; Steel et al., 2006), and homelessness (Orford, 2008). Further, PTSD, depression, and anxiety disorders negatively affect neurocognitive functioning, in particular attention and memory (Castaneda et al., 2008; Christopher & MacDonald, 2005; Horner & Hamner, 2002). While participants in our study made the connection unprompted (as do refugee respondents in the study by Atfield et al., 2007) between these various problems and difficulty learning English, distress and psychological disturbance may be under-recognised by providers as barriers to learning English, and inadequately addressed in training and briefing of teaching staff (Chung & Kagawa-Singer, 1993).

In the light of their psychological state, a cognitive behavioural formulation might suggest that participants were more fearful of causing offence by errors or of being unable to join in social situations than was warranted (Clark & Wells, 1995). However, language instruction based primarily in classrooms, and lack of a social network, have been associated with higher anxiety about speaking a foreign language (Dewaele, Petrides, & Furnham, 2008). These findings suggest an interaction between fears about speaking and the lack of opportunity to speak English, identified as an external barrier. Participants' experiences of limited opportunities to speak English associated with a lack of English-speaking friends, unstable housing and lack of social connections through employment, supports previous findings (Beiser & Hou, 2000; Hou & Beiser, 2006; Morrice, 2007). Exposure to the host language is a predictor of language acquisition, and fear of causing offence or of social embarrassment may reduce opportunities further.

By contrast, shame was described predominantly in relation to perceived or intuited judgments by members of their own community about participants' lack of language competence. We found no reference to this in the existing literature but participants

preoccupied with this tended not to identify external barriers to gaining language competence, such as unstable housing or unemployment. Their experiences might therefore be explained in part by Hagan and Smail's (1997a, 1997b) "internalisation of deprivation" or "moralizing of power and powerlessness", whereby people are "encouraged to feel a sense of personal responsibility for their social position and a sense of shame for their failure to cope" (Orford, 2008, p. 38). Further, according to their target for acculturation (Berry, 2001) and with reference to the length of their residence in the UK (as found by Horwitz, 1988, with foreign university students learning the host language), participants compared their level of English either to that the host population of native speakers or to people from their ethnic group. In contrast to previous literature (Mitchell et al., 2007), participants with children reported no inter-generational tensions or family conflicts as barrier or incentive to learn English, although it is possible that participants were not comfortable discussing these with the researcher. All participants with children, living in the UK or not, identified their children as a resource for learning English.

The particular difficulties of accessing and using mental health services for a refugee with poor English have been addressed at a practical level, in terms of difficulties in expression (Brisset et al., 2014), errors in assessment and diagnosis (Bauer & Alegría, 2010), and the provision of interpretation leading to longer term savings in healthcare (Aspinall & Watters, 2010; Bischoff & Denhaerynck, 2010). At a broader level, a recent systematic review (Alemi et al., 2014) found language problems to mediate persistence of psychological problems and to predict a low rate of use of psychological services, while Terui (2016) identified multiple pathways connecting language difficulties with health disparities for refugees, including health literacy, access, discrimination, communicating with clinicians, and satisfaction-based adherence to treatment recommendations.

Methodological limitations

Our selection criteria excluded people who did not speak English. We could (with funding) have used non-English speakers and interpreters, and in line with good practice in qualitative studies, involved interpreters in analysing data (Vara & Patel, 2012); that is a worthwhile study for which ours might provide hypotheses. We do not claim that our study findings are generalizable to non-English speaking refugees and asylum seekers in the UK. Nor did we have access to assessment of participants' fluency in English, which (if not overly biased by speakers' concerns about the quality of their English) would have enriched data. We therefore also have no data on whether fluency in English was related to participants' years in the UK or to literacy in their mother tongue.

Since translation, in particular of emotions, may be inaccurate (Pilgrim & Bentall, 1999; Tribe, 1999), and given participants' repeated descriptions of difficulties expressing themselves in English, meaning may have been lost in their descriptions of emotions and psychological experience and distress. Using interviews in English was demanding for people who struggled to express themselves in English, risking misunderstandings (Patton, 2002) and stressing participants. Care was taken to enable participants to express themselves, whilst clarifying meaning, to minimise the chance of the researcher imposing her meanings on participants' words. All this limits the extent to which we can relate our findings to the wider literature.

Our participants were also primarily recruited in clinical settings, with those who were recruited via a charity also mostly attending or having attended mental health services; they may therefore have been more distressed than many refugees and asylum seekers, and raised issues related to that distress.

Validity checks on coding were used in place of independent coding (Barker & Pistrang, 2005; Elliott et al., 1999; Mays & Pope, 2000; Spencer & Ritchie, 2011; Willig, 2008), and only two participants contributed to respondent validation. Disclosure of researcher perspective and extensive use of quotes in the results we hope enables readers to judge for themselves the fit of the data to the interpretation.

Clinical and policy implications

Findings from this study highlight the relevance of language acquisition and skill in the mental health of refugees and asylum seekers. Interventions, such as learning a language, that are not formally considered as psychotherapeutic may nevertheless play an important part in improving psychological wellbeing of refugees alongside other forms of psychological and psychiatric support (Miller & Rasmussen, 2016). Supporting the process of language acquisition could be incorporated in a range of interventions, including political and legal advocacy, fostering new social support networks and supporting refugees and asylum seekers in gaining employment (Miller & Rasmussen, 2016).

Aspinall and Watters (2010), in their review, state that “English language acquisition is vital in the process of integration” (Aspinall & Watters, 2010, vii). All participants would have liked opportunities to practice speaking English informally with native speakers (such as ‘English Conversation clubs’: Sorgen, 2015); this is also recommended in educational policy (Morrice, 2007). Formal language learning may promote the ‘internalisation of deprivation’ such that learners blame themselves for their ‘failure’ to learn English, while observers criticise the speed or extent of their ‘adjustment’, a fact of which they showed themselves to be acutely aware. While refugees’ social situations, such as being unemployed and in unstable accommodation, restricted their opportunities to converse with native English speakers, it is not clear how open the host society was to cultural diversity, or whether

policies of multiculturalism discouraged language acquisition. Effective adaptation requires mutual accommodation (Berry, 2005).

Findings from this study also highlight the importance of involving refugees and asylum seekers in planning policy and services in order to address issues that concern them, such as those outlined here. There are no grounds to suppose that these implications do not apply in other developed countries. Service-user involvement is a principle in the UK National Health Service (Department of Health (DoH), 1999) but is not necessarily common practice in educational or social welfare services. Participants in this study raised issues that have not previously been discussed in relation to language learning and mental health. Adequate and appropriate support could enable refugees and asylum seekers to make far more effective use of English language learning, with benefits for their mental health and their integration in the UK. Participants' quotations illustrate shortcomings in their English that are likely to affect their prospects in work and social settings.

Cross-sector communication between education, social services, health and mental health services could enable teaching professionals to address with more confidence any relevant issues of post-traumatic distress symptoms, depression and social difficulties affecting language learning. Flexibility in responding to the needs of asylum seekers and refugees is emphasised by the UNHCR (2001); for example, providing language programmes as home tuition for people who have experienced trauma. Bekar (2000) suggests adaptations to classes, such as greater flexibility about attendance and punctuality, length of classes, pace of the curriculum, and using varied activities to help with attention problems. In addition, Bekar (2000) argues that smaller class sizes, smaller groups for practice and more student-centred content can build self-esteem and reduce the risk of pathologising those with difficulties, perpetuating feelings of shame already experienced by refugees and asylum

seekers and undermining continued learning. At the same time, UK government moves to impose formal sanctions on those who cannot speak English, while cutting funding to language classes, must be resisted (Monaghan, 2015).

Research implications

This is an under-researched area, where research findings could inform service provision. At an individual level, qualitative research exploring the views of refugees and asylum seekers not attending English classes and unable to speak English would usefully complement this study. Understanding the association between language acquisition or non-acquisition and psychological distress requires longitudinal studies.

Community capacity-building could link all levels of the system: Mitchell et al. (2007) used a community recovery model with refugees resettled in Australia in which refugees' concerns were addressed by integrating findings from collaborative research with the promotion of leadership and participation within the community. Even where the community is not as cohesive as in the Mitchell et al. study, the process of research and of identifying refugees' concerns might foster community ties, and enable refugees and asylum seekers to gain control in another area of their lives.

Conclusions

Participants in our study identified learning English as a move towards autonomy and integration, but encountered internal problems, including psychological distress affecting their learning, and social anxiety about their inadequate English, and external problems, particularly restricted opportunities to practice everyday English. Providing psychological support could facilitate the process of acquiring English and thereby promote their integration alongside their psychological well-being.

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Table 1 Description of participants ordered by length of time in UK

Table 2 Overview of domains and themes

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