An Evaluation of the Sociodemography, Presenting Symptoms and Treatment Outcome of Patients Treated with Intercultural Therapy

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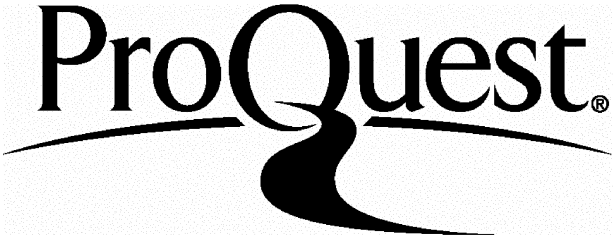

Abstract

Ethnic minorities are traditionally excluded from psychotherapy This study aimed to see whether a "culturally sensitive" psychodynamic psychotherapeutic treatment model could be an effective treatment option.

A questionnaire based outcome study was carried out at the Nafsiyat Intercultural Therapy Centre. The questionnaires were completed at various stages of therapy, dovetailing with the normal running of the Centre. For each patient, detailed sociodemographic details, presenting issues and therapeutic information was collected. Their psychiatric/psychological symptoms were measured using standardised measures

Demographic information was collected on 157 patients assessed (*Referred* group) during the years 1986-1992. Of these, 52 patients, agreed to take part in the research (*Treatment* group). They completed a pre- and post- treatment Present State Examination [P.S.E.] and General Health Questionnaire [GHQ 60].

Patients were generally seen for individual therapy, with a significant number seen for 12 sessions or less. Many fulfilled the YAVIS criteria, although they had very complex life experiences and severe presenting symptoms. The majority had not been offered psychotherapy before.

The results show little difference between the *referred* group and the *treatment* group in terms of their demographic profile. The ethnic balance was similar, although there were a higher number of South Asian patients and the mean age

of men was slightly higher in the *treatment* group. There were difficulties in defining ethnic and cultural origin.

There were differences between the Referrer's (symptom-based) and Clinical Director's (causal-based) assessment of the presenting problem. The Clinical Director's and Patient's assessments showed consistency, and were comparable with initial GHQ and P.S.E. scores. Therapists assessments were more conservative.

The majority of patients described a good outcome to their therapy. Comparable reductions were found on P.S.E., GHQ and in-house checklist scores.

This study shows patients "improve" on several measures after intercultural psychotherapy. These results are discussed in comparison with previous research.

Acknowledgments

There are particular difficulties in researching psychotherapy. Therapists have to allow close scrutiny of their work, and patients have to commit extra time to the research as well as allowing close observation of their therapy. I would like to thank all the patients, therapists and administration staff at Nafsiyat (past and present) for helping me to understand the important issues in intercultural work. To those patients who were part of the study, their help and co-operation is gratefully acknowledged.

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INTRODUCTION

1.1 The context

Britain is a multicultural society, and although psychotherapy is more unevenly distributed than other health care (Holmes 1985), the proportion of patients from ethnic minorities in therapy does not reflect the cultural diversity of Britain at the end of the millennium. In inner London over a quarter (641,140) of the population come from "non-white" ethnic backgrounds (whether this underestimates the total numbers of ethnic minority people is unknown - CRE 1985) and in Islington (the Borough where Nafsiyat is based, and hence of particular relevance to this research) just under a fifth of the population (31,126) are members of an ethnic minority group (OPCS 1991 Census).

There has been increasing research effort into ethnic minority mental health problems in the USA. Most of this research has identified problems in current service provision but these findings have not translated into clinical applications (see Comas-Diaz 1988 and special section of the Journal of Clinical and Consulting Psychology 1996 Vol 64, number 5) .

In the UK it has been argued that there is a lack of informed discussion and research into service provision, even though there has been a changeover from hospital to community based resources (Peet 1986). Such changes have been queried, particularly

the level of service provision for ethnic minorities in the community (Rack 1982, Cox 1986, Fernando 1988).

However, at a theoretical level, there seems to be increasing interest in (and understanding of) transcultural issues in psychiatry (e.g. Littlewood and Lipsedge 1997). While, at the same time, psychotherapy still seems to be unsure about its ability to help patients from other cultures and is seemingly unwilling to address the issues of inter-cultural work.

This difficulty is compounded as doctors do not consider psychotherapy as a "first option" for ethnic minorities; for example Littlewood and Cross (1980) found that black patients were more likely to be given medication than psychotherapy and counselling, a finding independent of diagnosis (see also Dolan et al 1991).

Research discussed in this chapter will show that ethnic minorities are rarely referred, or refer themselves, to traditional[1] psychotherapists and then they tend to either not be taken on for, or drop out of, conventional therapy. This dropout is taken by therapists (surprisingly unquestioningly), to mean that patients from minority ethnic backgrounds are not suitable for psychotherapy and this perpetuates the "myth" of the unsuitability of ethnic minority patients. This notion (that ethnic minorities do not benefit from psychotherapy) belies the fact that while some white non-European patients have problems finding therapy in Britain, there are thriving psychoanalytical societies in their

[1] I am using "traditional" to mean the majority of psychotherapists who do not work under a specifically "intercultural" ethos (see section 1.3).

home countries (e.g. in South America there are many Lacanian and Kleinian analysts - see Temperley 1984)[2]

Historically, unsuitability for therapy was always predicated on the patient "variables", never the therapy or the therapist; perhaps this related to the psychotherapeutic emphasis on case history reporting rather than quantitative research. It is only relatively recently (with the increasing interest in therapy research in the last twenty years, as well as the increased interest of psychotherapists in the notion of counter-transference) that the emphasis has shifted and the characteristics of the therapist and the therapy have been acknowledged and investigated. But, it can be argued that, in the arena of ethnic minorities and mental health, minority status is often taken as a *de facto* contraindication to therapy.

However, it would be unprofessional and unethical to offer therapy to someone who was unable to benefit from it (or if it potentially could do them harm). Papers addressing how mainstream theoretical constructs can be shaped appropriately for patients from different cultural backgrounds are rare (Thomas 1992, 2000), and there are a few papers in the literature reporting the practice of intercultural therapy in Britain (e.g. Kareem and Littlewood 1992, 2000). These suggest that it is the "myth" that is wrong and query the psychotherapeutic folklore, suggesting that therapy (sometimes with suggested modifications to technique, Sue et al 1998) is an effective, albeit underused, treatment option.

[2] I think part of the confusion is that many traditional therapists are white. Hence there is a confusion between whether white therapists can work across cultures, with the secondary problem that the therapy itself is culturally encapsulated because of its focus on the inner world. Moreover, theory is predicated on practice: usual therapy patients are white, middle class "neurotic" patients who may not present with symptoms in the same way as ethnic minority patients nor share the same life experiences.

The aim of this study was to review who has "the problem" in an intercultural context (the patients, the therapists, the therapy or the referrers[3]). The research focused on therapy at a centre where there was a positive approach to cultural differences, and evaluated whether therapists and patients could detect changes in symptoms etc. after such therapy (a decrease in symptoms, for example, would potentially identify *a positive therapeutic effect*).

In the latter part of this chapter I will look at three different areas that inform research in an intercultural context which are relevant to this research. Firstly the origin and development of psychotherapy together with Freud's early thoughts on culture and how these have been developed. Secondly, I will be referencing Howard et al's (1995) tripartite model of psychological characteristics that affect utilisation of psychotherapy (life stresses, psychopathology, psychological proneness), emphasising the role of culture and the specific experiences of ethnic minorities. Thirdly I shall review some of the relevant therapy and counselling research literature.

But before addressing these issues, certain definitions need to be clarified. The different definitions of culture, race and ethnicity need to be identified, together with the author's understanding of the different ways of describing work with ethnic minorities (those termed transcultural, crosscultural, intercultural and multicultural).

[3] The referrers are included here to emphasise their role in referring for psychotherapy.

1.2 Definitions of Origin

1.2.1 Culture

For therapists the focus of work is predicated on feelings, emotions and attitudes. Therefore the psychological interpretation (at a cultural level) of the emotional language, values, norms and belief systems should be a fundamental objective in the *process*[4] of therapy (Jalali 1988).

Opler (1956) notes that

all actions should be interpreted through our cultural milieu, as culture pervades our lives and shapes our personality and perceptions of reality.

For psychoanalysis there are historical, linguistic problems with this understanding. For Freud (1927) *culture* is used in a specific sense *I scorn to distinguish between culture and civilisation*[5] (1927a). For Freud *culture* meant "cultured, refined" (the so called "civilised" world), and he almost invariably contrasts the difficulties of "civilisation" with the lives of "primitives" and "savages".

Here (and his other works), despite his interest in anthropology, he is using the term in a "social hierarchy" context[6], and in a different way to other authors who see an anthropological context where culture is seen as a set of traditions, values and attitudes:

[4] I am using *process* here to indicate the interactions that happen within a therapeutic dyad. I am emphasising that in any therapeutic interpretation the "cultural" metaphors and meanings have to be taken into account and incorporated into that interpretation, not merely ignored or added as an afterthought.

[5] In the Editors introduction to "'Civilised' Sexual Morality" (1908), Strachey notes the problem of translating the German word *Kultur* - it can be translated as either Culture or Civilisation.

[6] Although we must remember that, at the time Freud was writing many anthropologists were thinking along the same lines.

an integrated pattern of human behaviour that includes thoughts, communications [both verbal and non-verbal - my addition], *actions, customs, beliefs, values, and institutions of a racial, ethnic, religious or social group* (Cross, Bazron, Dennis and Isaacs 1989 quoted in Sue et al 1998)[7].

Culture is generally thought to be passed on through generations by the process of *enculturation.* This is the socialisation process where developing individuals acquire, either by generalised learning in a particular cultural milieu or by specific training, the variety of qualities that are necessary to function as a member of the group. Such cultural transmission is effected by three different methods: *vertical* (influences from parents), *horizontal* (influences from peers) and *oblique* (influences from other adults and institutions within a given society) (Berry 1993). Obviously this definition allows consideration of the influences of children growing up in bicultural families as well as the influence of British culture on the first and subsequent generations born in Britain of families who migrated.

For those who migrate, and subsequent generations, there is a further process, that of *acculturation.* This is generally considered to be the process of cultural learning that occurs as the product of contact between members of two or more culturally distinct groups. These attitudinal and behavioural changes can occur willingly or unwillingly by individuals who live in multicultural societies, or those who come into contact with a new culture due to colonisation or invasion.

Hence culture is generally considered to be a *learned* experience, it refers at one and the same time to the sociological dimension where the members of a particular society transmit the specific learning between members and through generations, but also to

[7] This of course could also be used to describe psychotherapy, which has its own actions, customs and

how aspects of culture are experienced or internalised (the psychological aspect). This explains the differences in cultural views between people in the same culture (Takamoto 1989).

This *internal* (psychological) *culture* becomes more complex where people have experience of more than one culture; then the *internal culture* may be a combination or rationalisation of the different cultures. While this can occur between people in the same culture (Takamoto 1989), it is more pronounced in migrant people and the subsequent generations.

As Kakar (1995) elegantly states

Contrary to the stance popular amongst many anthropologists of Indian society, the traditional Hindu villager is not the only Indian there is, with the rest being some kind of impostors or cultural deviants.

In psychodynamic terms:

The sad truth is that no one can simply construct for themselves "an identity". Culture is both inherited and has to be recreated through experience so that it might reside within the individual in memory and feeling. It is the product of experience and history represented in individuals through our internalised parents and by the values and traditions they have passed on to us. Ethnic minority children are born into a society which often differs markedly in its social and family organisation (Andreou 1992).

The net result is an individual culture that contains aspects of the culture and some recognised deviations from this. For example, the young Muslim woman who wishes to go out with her friends in the evening contrary to her parents' expectations, or the young people who do not wish to have arranged marriages or the western young people

beliefs.

who "drop out" and abandon the western work ethic. Such adoptions of aspects of very different cultures may cause extreme distress to the individual and their families especially during the transition stage (here we must remember that individuals within a family may adapt to, and adopt, divergent aspects of the different cultures).

Shapiro (1996) writes movingly of this:

Although I believed that I remembered little about my first 8 years in Cuba, psychoanalysis helped me discover how textured and physically detailed was my sense of homeland there, and how intense my forbidden longings.

She continues:

I began to reclaim my most precious possessions, the memories and desires that we immigrants are often forced to jettison by the emotional imperatives of coping with the overwhelming tasks of transplantation. Many of these still cherished memories and ideals still resided within my own directly lived experience, stored in the twilight world between worlds - what Bollas called the unthought known (emphasis in original).....

Travelling to both Cuba and Israel, I reestablished family relationships that, unlike those with my materialistic and anti-intellectual Miami relatives, were based on shared ancestral values cherished by both my cultural legacies as a Cuban and a Jew....I could return to Miami...as a woman whose choices reflected values I learned at home, even if my interpretation introduced a measure of difference (my emphasis). *We had come far enough as a family to challenge earlier, more constricted adaptations mobilised to cope with the stress of immigration.*

In this thesis "culture" will refer to a learned *system of meaning shared by people in a particular context where the meaning are transmitted from generation to generation*

(Betancourt and Lopez 1993 cited in Carter 1995). It will relate to peoples' language, religion, behaviour, social interactions, communication styles and ways of seeing the world (including thinking patterns and organisation of that information). It should be recognised that culture is not static and it changes over time even without the influence of other cultures. For those who migrate, or who grow up with bicultural influences, the experience of cultural identity seems to be intensified as cultural values, attitudes and beliefs are open to critical reappraisal during the process of enculturation/acculturation and may be an ongoing, lifetime process of change and adaptation.

In the context of this thesis, intercultural work will refer to culture as experienced by different cultural groups in Britain in the late 1980's and 1990's, and will reflect the diverse cultural experiences of ethnic minority people living in Britain today.

But the "culture" of psychotherapy also needs to be reappraised (see Fuller Torrey 1986). This contentious issue would (arguably) be denied by psychoanalysts as they believe that Freud put together a universal theory, one that is appropriate to all situations. But we know that psychotherapy has gone through several reinventions, even within the English Institute of Psychoanalysis there are the Freudian and Kleinian schools (as well as the compromise "Middle" school). There are the Jungian analysts. There are the ego psychoanalysts in America. In France the situation is much more complex with a number of splits and reinventions (see Turkel 1992).[8]

[8] The original Paris psychoanalytical society (SPP) split in 1953 and a new group was formed (SFP - *Societe Francaise de psychoanalyse) after the President of the SPP and Director of the Institute, Jacques Lacan was forced to resign from the SPP. Many Lacanians joined Lacan in the SFP. Lacan later split from the SFP (which in turn became the French Psychanalytical Association) and formed the Ecole freudienne de Paris, which was dissolved in 1980 and replaced by the Ecole de la Cause Freudienne 1981. In 1969 some Lacanian analysts left the SFP to form the Quatrieme Groupe, Organisation psychoanalytique de langue francaise (OPLF)* also see Turkle 1992).

It might be expected that that such changes reflect the varying worldviews of the different societies within which analysts are born and work, and the multiethnic composition of the early Freudian analyst group demonstrates how differing cultural values may have negative effects (for example, the "excommunication" of the talented analyst Ferenczi). Perhaps a critical reappraisal of such experiences with a "cultural gaze" might yield ways of looking at psychotherapy creatively.

1.2.2 Ethnicity

Historically the term "ethnicity" is mired in difficulties with different (and often contradictory definitions): it is often used as a "backdoor" way of getting "racial" information.

Sue et al (1998) define ethnicity almost identically to their definition of "culture" (described above) and supplement it with *common ancestral origin.* Similarly Littlewood and Lipsedge (1997: note 1 pg. 25) "define" it broadly as *a nation, a people, a language group, a sociologically defined so called race or group bound together in a coherent cultural entity by religion.*

The Oxford English Dictionary (OED) defines "ethnic" in two ways.

1) Having a common national or cultural heritage (in my terms *ethnic identity* see later)

2) Denoting origin by birth or descent rather than nationality (in my terms *ethnic origin* see later).

In this thesis, I propose to explore a slightly different notion of ethnicity, based on clinical practice with migrant and first (and subsequent) generations in Britain. It seems to have more relevance to their life experiences. This hypothesis is that that people have potentially two ethnicities, an external identity based on their race and culture, their *ethnic origin;* and an internal psychological identity that is unique and is a combination of different cultural and life experiences (including discrimination), which

produces an *ethnic identity.* This identity is unique and may bear little relationship to one country or cultural background[9].

Ethnic identity can be, for some people, an identification with a culture. In Freud's terms identification is *an assimilation on the basis of similar aetiological pretension; it expresses a resemblance.* Laplanche and Pontalis (1988) describe it as *a psychological process whereby the subject assimilates an aspect, property or attribute of the other and is transformed, wholly or partially, after the model the other provides. It is by means of a series of identifications that the personality is constituted and specified.* As we are talking about ethnic minority patients in Britain in the late 1980's and the 1990's, this ethnic identity reflects their experiences in Britain and can be their identification with a culture, other than their immediate cultural or racial heritage (for Caribbean people, it may be a "black" culture or it may be more specific, for instance, an Ethiopian culture).

By this definition the content of ethnic identity is influenced by not only the normal enculturation (developmental processes) but also the acculturation processes and the intergroup/intragroup processes that occur as the result of being a minority within a majority culture. It reflects a person's search for an identity, a realistic "self", and is as such an individual response, so other variations within an ethnic group, such as demographic or social variables, will also introduce a measure of difference between individuals.

However, it will be clear for dual heritage children the enculturation process will be more complex: enculturation at home into the values and beliefs based on the ethnic

[9] Hence there are differences in ethnicity between Greek and Greek Cypriot people, and between both of these and British Greek and British Greek Cypriot people. There are also differences between individuals within any cultural group.

origins and identity of the family; whilst at school and from peers from different backgrounds there will be both enculturation and acculturation into the majority culture. This will be made even more complicated if the family is still in the early stages of adaptation to a new country and is in the early stages of acculturation. All the different influences will need to be incorporated and mediated within the child, leading to an understanding about ethnic self-identification, ethnic constancy, ethnic role behaviours, ethnic knowledge and ethnic feelings and preferences (Casas and Pytluk 1995).

For those minorities born and brought up within a majority culture, defining ones own ethnic and racial identity is a complex psychological process. The reaction of the external environment influences on self identity will follow a process of psychological growth. So, for example, Helms (1995) suggests a hierarchical "stage" theory, the Racial Identity Ego-Statuses. These statuses also seem appropriate when considering ethnic or cultural identity. She proposes several levels of identity development for minorities in a white majority culture:

- Conformity – An external self definition that implies devaluing of own group and allegiance to white standards of merit.
- Dissonance – An ambivalence and confusion concerning own socio-racial group commitment and ambivalent "socioracial" self definition.
- Immersion/Emersion Status – An idealisation of one's socioracial ("sociocultural" could also be added here) group and denigration of that which is perceived to be White. Use of own –group standards to self-define, and own-group commitment and loyalty is valued.

- Internalisation Status – A positive commitment to one's own socioracial group, internally defined racial attributes; capacity to assess and respond objectively to members of the dominant group.
- Integrative Awareness Status – A capacity to value one's own collective identities as well as to empathise and collaborate with members of other oppressed groups.

Helms (1995) claims that these racial identities or identification statuses occur in response to a society where resources are differentially allocated on the basis of racial group membership. She also notes that these statuses develop sequentially and that they eventually will be accessible to the ego, so that they are available to help cope with racial material.

The problem with this model is that it uses race as its defining variable, seemingly ignoring sociodemographic, sexual, gender etc. issues that also influence the formation of identity. One assumes that such a process would occur as part of the enculturation and acculturation processes described above.

Where it is useful is that it describes a process of maturation. By thinking of race as one of the predicators of the ethnic identity model described above, it helps us to think in terms of people being at different stages of development of self identity. In the context of therapy we can begin to think about the patients' capacity to talk about their own relationship to their race, culture and ethnicity, and what strategies they use in the presence of racial conflict (e.g. denial[10]). The same factors will also be relevant for therapist.

[10] Of course these strategies will also be era-specific. For instance when racism was legal a "sensible" strategy was denial, now racism is illegal a "sensible" strategy is to challenge racism.

Another way of looking at ethnic identity conflicts was suggested by Ruiz (quoted Casas and Pytluk 1995). Ruiz suggests stages of development, transformation and resolution of ethnic identity conflicts. The advantage of this model is that it works for both migrants and the first and subsequent generations (born in a culture other than the family's culture), and is based on the enculturation and acculturation experiences of such people.

The five stage model is:

- Causal stage – variables either affirm, ignore, negate or denigrate the family's ethnicity. Additional factors may cause conflict e.g. the failure to identify with one's ethnic group.
- Cognitive stage – variables include the association of ethnic group with poverty and prejudice, the belief that the only way out of poverty and prejudice is through assimilation, and the belief that life success is through assimilation.
- Consequence stage – the fragmentation of ethnic identity; the individual experiences intensifying ethnic identity conflicts and may even flee from his or her ethnic self-image. The use of defence strategies to manage the conflicts intensifies.
- Working Through stage – a person recognises that the distress they are experiencing is caused by their inability to cope with ethnic conflict and a realisation that an "alien" ethnic identity is no longer acceptable. It is characterised by a dis-assimilation, an increase in ethnic consciousness, a reclaiming and reintegration of disowned ethnic minority fragments and a reconnection with ethnic consciousness. People are more willing to enter therapy at this stage in order to make sense of the changes.

- Successful Resolution stage – The person has a greater acceptance of self, ethnicity and culture and greater self esteem. They recognise that ethnic identity represents a positive and success promoting resource.

Another useful model to consider in this context is the *Orthogonal Cultural Identification Model* (Oetting and Beauvais 1990-1991 quoted in Casas and Pytluk 1995). This model basically suggests that identification with any one culture in no way diminishes the ability of an individual to identify with another culture. So unlike the previous two examples where the individual is seen as on a continuum between two cultures, here the person is seen to be able to hold different cultural values. Obviously this helps avoid the overly stereotyped "ethnic gloss" approach to certain ethnic groups by emphasising the individual's dynamic interaction with important cultural dimensions and variables. Thus such dimensions and variables are seen as part of the individual rather than the culture or race. It is also very helpful in thinking about dual heritage individuals and how they integrate the differing ethnicities within their self identity.

The advantage of the notion of *ethnic identity* is that it recognises that it is not a discrete entity but is a psychological process which involves both cultural (external and internal) and life experiences (e.g. the social and psychological effects of migrations, separations together with the experience of racism and, usually, common ancestral roots), and is uniquely individual. Hence, in my view, there is a difficulty in providing a consistent or global definition of it.

This definition also implies that *ethnic identity* is the product of psychological adaptation to a new culture(s) – acculturation - recognising that it is almost impossible to live in another country without adapting to it and adopting some changes from the original culture (see Shapiro 1996 earlier).

This notion of *ethnic identity* will be particularly important for those patients whose cultural origins are non-English and where the original cultural and racial origins are interwoven with a life in the UK. The original culture may continue to have an (perhaps more distant) effect on the migrant and subsequent generations, and, for those who have had a series of migrations this sense of culture may be complex and (for some) contain contradictions. To try to understand the different weightings of the different cultures and life experiences - i.e. what *ethnic identity* means to patients and how this relates to their sense of self - may be the whole focus of therapy.

Another consideration is whether the term "ethnicity" should just be kept for those people who are living away from their home country, accepting the inherent difficulties of defining *home country, culture* and *race* in the context of a history of migrations and inter-cultural marriages. Clearly there is a need for a way of communicating the multicultural experiences of these people.

Therefore two notions of ethnicity will be used here, one where *ethnic identity* is reserved for the special situation of being a migrant and subsequent (British born) generations (OED definition 2). The other definition of *ethnic origin* is where we identify a person's culture and "descent" (OED definition 1).

There are difficulties. For example, in China we would make distinctions between different cultural, linguistic, religious groups. In Britain, Chinese migrants from different cultures are seen as a homogeneous group - "Chinese", and whilst ethnically *(ethnic origin)* there will be similarities in the British Chinese group (experience of being Chinese in Britain, a greater commonality within the group in terms of beliefs and attitudes that outside the group); culturally they will all have their individual "roots" depending on from where they themselves, or their family, originate *(ethnic identity)*.

1.2.3 Race

Despite the appalling history of the understanding of "race" in psychology and psychiatry (usually created to justify injustices by citing inferiorities of psychological development of one sort or another - see Hilliard 1996 for a full discussion of this), "race" merely refers to a set of physical characteristics that broadly define a group of people who live in a geographical area, the combination of which, to some extent, *distinguishes one subgroup from other subgroups of mankind.* This seems a contradiction as only three groups have conventionally been identified (Caucasoid, Mongoloid and Negroid)[11]. The terms seem to ignore the various migrations that have occurred and the fact that there are many more biological differences within races than between them (see Sue et al 1998, Carter 1995 for further discussion of this).

Definitions of race have social implications, usually linking racial groups with certain psychological[12] or physiological characteristics without any formal scientific evaluations (e.g. black children are poor at academic work). Often the outcome of this is that they become self fulfilling prophecies (i.e. black children are then not expected to do well in school and all their behaviour is interpreted through this construct).

A second perspective is that *race* has a sociological perspective. People may identify themselves with certain racial characteristics and form relationships with others perceived as from the same background. This, of course, implies a (perhaps) different relationship with *others* who are seen as unlike themselves.

[11] Because of their historical associations, these terms seem not only derogatory, but also have powerful (negative) connotations, and because of this they need redeveloping and redefining.

[12] See Chapter 4 for some of the difficulties with using psychological tests cross-culturally. I.Q. tests are the most researched and have identified problems in administration, scoring and providing comparative statistics - see Butcher 1975)

1.2.4 Minority

In this thesis "minority" will refer to a group who are dominated (politically, educationally, socially), by another group usually a numerical majority[13].

[13] I do not wish to imply anything derogatory in this statement of "minority". I am emphasising this group's lack of access to the power structures of the majority groups.

1.3 The "Culture" of Therapy

1.3.1 Intercultural, Transcultural, Cross-Cultural

It is not only patients who arrive in therapy with their differing "cultures", the therapy itself may provide a different and alien experience. Therapists often fail to recognise that their ways of working are predicated on their worldview. What therapy is offered, how the sessions are structured, where the sessions are, who (by profession, gender[14]) treats the patient and the length (of time) of the sessions. All these constraints introduce different and complicated cultural contexts. Our difficulties (or different ways of working) are evident in our use of terms to describe our work.

Historically *transcultural* is associated with clinical psychiatry together with its concomitant power relationships (Mercer 1986), which of course leads to much discussion as to the appropriateness of transcultural diagnosis. It is viewed with concern, with some suggesting that it may be acting as a social controller by moderating conformity (see Ineichen et al 1984, D'Ardenne 1986). It is perceived as the majority culture defining what is healthy (although in the 1990s, about 57% of junior psychiatrists were themselves not born in the UK, whilst significantly, only one in eight of consultants were born outside the UK- Littlewood and Lipsedge 1997). In the past, medical schools operated an allocation of places that discriminated against potential students from ethnic minorities (see Lowry and McPherson 1988, McKeigue et al 1990).

Transcultural psychiatry in the last century was associated with colonialism, and earlier

[14] I shall use the term gender when I am considering both the psychological and physical aspects of a person, and the term "sex" when I am referring to physical characteristics.

with slavery. Currently it not only refers to work with the diverse ethnic minority population described above, but also can refer to specific diagnostic schemata considered across cultures, delineating cultural understanding of mental illness e.g. cannabis psychosis (Lipsedge and Littlewood 1979 Littlewood and Lipsedge 1989), as well as "culture-bound syndromes" such as *koro* and *amok.*

It also refers to the ability of a clinician from one culture to make a diagnosis for a patient from another culture (Westermeyer 1985, Littlewood 1990).

Some counsellors use the term *transcultural* (D'Ardenne and Mehtani 1989 and Eleftheriadou 1994) to delineate a cultural approach to counselling. However *cross-cultural* is more usually associated with counselling. It may focus on specific cultural attributes of groups (cf. Speight et al 1996) or it may refer to the attitude of the counsellor, but usually with reference to traditional counselling practices. The literature tends to report research into specific cultural groups and their specific needs with the emphasis ostensibly on intra-cultural counselling. As Thomas reminds us, such intra-cultural counselling raises its own problems. For example, he notes that the black therapist will need to have to have worked through (in their own training therapy) their issues about being black in British society, in order to understand and help their patients (Thomas 1992, 2000).

The problem with the notion of *cross-cultural* is that it, in my opinion, tends to de-emphasise the role of the ethnic minority practitioners working with patients culturally different to themselves (traditionally therapists tend to choose patients that are similar to themselves). This seemingly ignores the number of ethnic minority practitioners and the specific experiences, skills and knowledge accrued during their own lives (as professionals training in predominantly white organizations – which might be expected

to have a differing worldview, and their personal experiences as migrants, refugees or British born ethnic minorities).

The problem with some *cross-cultural* or *transcultural* (exceptions include Littlewood and Lipsedge 1997, and Eleftheriadou 1994) work, is that they both try to impose a western theoretical framework and practice on patients whose life experiences can be construed to be very different from a white British population. They do not seem to challenge the theoretical basis of their skills nor recognise the inherent power relationships (for white therapists) in the therapy situation. They seemingly ignore the essential "working with loss" inherent in all intercultural work. Their work can variously imply work with migrants, with the British-born children of these migrants or with those whose parents are of different cultures from each other, economic migrants or refugees - groups who might be expected to present with rather different problems, experiences and assets. They seem to regard cultural groups (e.g. Afro-caribbean) as homogeneous (cf. Sayal 1990, Patel 1997) without assessment of the level of assimilation/ integration/ cultural pluralism (Verma 1985, Pederson et al 1981, 1987) of individuals (consolidated during the acculturation process), their ethnicity, culture, language and current economic situation (such conflicts are well demonstrated in Guzder and Krishna 1991). Such experiences form the basis of the term *intercultural* as previously used in the United States (Verma 1985, Pederson et al 1981, Pederson 1987).

One of the fundamental differences between *transcultural* and *cross-cultural* on the one hand and *intercultural* on the other is that intercultural therapy in this context has not only tried to understand the inherently individual (internal, psychological) experience of

patients. Kareem notes that therapy should be *"taking into account the whole being of the patient - not only the individual concepts and constructs as presented to the therapist, but also the patients' communal life experience in the world - both past and present. The very fact of being from another culture employs both conscious and unconscious assumptions - both in the patient and in the therapist"* (Kareem 1987, see also Hawkes 1997, Gaston, 1984). It also reflects upon the psychological "choices" made by bi-cultural patients[15]. Intercultural therapists have tried to look at both the theory and practice of therapy with ethnic minority patients. Moreover, they have accepted the notion of a critical mass of ethnic minority practitioners as fundamental to practice (Bender and Richardson 1990, but cf. McKeigue et al 1990 and Lowry et al 1988), but not necessarily matching patients and therapists and accepting that all practitioners need to be proficient in working with patients from backgrounds different to their own (Carstairs 1961, Pederson et al 1981). They have also lead the move towards the importance of intercultural supervision as being vital to the process of successful therapy.

Intercultural therapy is therefore different from transcultural and crosscultural therapy. Although it uses the tools of psychotherapy, those of transference, countertransference, boundaries etc, the intercultural therapist will interpret in terms of the patient's cultural background, religion etc, making the connection that a person's *ethnic origin and ethnic identity* have implications for therapy. Intercultural therapists will interpret (where appropriate) enculturative and acculturative aspects of the person and the effects of these on the therapy encounter.

[15] *Bicultural* in this sense not only includes those people whose family backgrounds are from two different cultures, but might also be usefully used for people who have spent time living away from their home cultures and have experienced the culture of a different society (e.g. Japanese workers in Britain).

They work with, the often complex, geographical relocations experienced by minority patients, and help the patient to understand, and emotionally work through, the separations and losses that these entail.

Intercultural therapists are aware that psychotherapy itself has a cultural underpinning that may be different to the cultural experience of the patient, they recognize that their own culture will impact on the session and that there is a potential for a power relationship to develop between patient and therapist, again this is dealt with within the therapeutic context.

They work with the external issues of poverty, racism etc within the interpersonal relationship that is psychotherapy. Moreover, they make no assumptions about the homogeneity between persons from similar geographical, cultural, religious etc backgrounds, understanding that everyone is an individual with individual life experiences that shape our identities.

The differences between the different schools are summarized in Table 1a

Table 1a

SOME DIFFERENCES BETWEEN TRANSCULTURAL, CROSSCULTURAL AND INTERCULTURAL THERAPY

Transcultural

Usually psychiatrists

Mostly white therapists

May use cultural stereotypes

Ignores the potential impact of the culture of therapy

May define symptoms in a culture context

No necessity to reflect on the impact of therapist's culture (including historical issues between the culture of therapist and culture of patient).

Cross cultural therapy

Mostly white therapists

May see other cultural groups as homogeneous

Sees therapy as a universal tool and uses traditional techniques

Symptoms may be defined in a cultural context

Some reflection on impact of therapist's culture

Sees culture in a social context.

Intercultural Therapy

Mostly minority therapists

Sees patients as both part of a culture and as an individual within that culture

Sees therapy as a universal tool that can be modified where necessary

Symptoms understood in a cultural as well as individual context.

Uses the knowledge that the therapist and the patient bring a cultural context to the therapy, which itself is culturally determined

Sees culture as a psychological as well as social experience

Understands that enculturation and acculturation may be potent determinants of psychological conflict

1.3.2 Multicultural Counselling.

Some authors in America have moved towards a viewpoint, which they have called "multiculturalism". In this model, every part of the therapeutic alliance is open for change: thus they see the role of counselling by the counsellor as only one of the possible roles to adopt (others include advisor, advocate, consultant, change agent, facilitator of indigenous support (or healing) systems) and the consulting room based, one-to-one, talking therapy as only one of the possible treatment options (Sue et al 1998).

Although this thesis will reflect on the needs of ethnic minorities in therapy, it will concentrate on the role of the counsellor to carry out (verbal) counselling. The proviso is that therapists need to be aware of the special requirements of ethnic minority patients and have access to advisors with relevant experience (e.g. advice on asylum/migration issues, advisors to help with housing, benefits etc).

This research reflects on whether acknowledging the cultural dynamic and working with the difficulties within the therapeutic relationship (including the power relationship) inherent in all psychological therapy, make a "talking" intercultural therapy a viable (and an effective) treatment option. These changes, together with changes in technique[16], potentially enhance the treatment value of intercultural therapy.

[16] Patients do not necessarily use couches nor pay for sessions; sessions are not necessarily in the same room nor necessarily weekly etc.

1.4 Cultural Counselling Philosophies.

All cultural counselling is predicated on a particular philosophical understanding of the experience of minorities. Currently there are approximately five recognised "schools". The *universal* school defines people as basically the same and affirms similarities. It suggests counselling should transcend race, seeing each person as a unique individual not solely as culturally determined. The second school - the *ubiquitous* - is where all loci of identity or shared culture are considered constitutive of culture; therefore people can belong to multiple cultures, which are situationally determined. A positive aspect of this is that both the counsellor's and patient's cultural and social identity are identified. One of the problems with both of these "schools" is that they tend to de-emphasise the sociopolitical arena within which certain minority groups grow up.

The *race* based school sees race as the superordinate locus, belonging to a racial group transcends all other experiences. A positive aspect of this is that it recognises the importance of sociopolitical and historical events but may be less efficient at understanding the experiences of some migrants and their children, remembering that there are difficulties in assigning "race". The *traditional* (anthropological) position, looks at culture and defines it in terms of country of birth, upbringing and environment. An individual's circumstances are superseded by general culture. On the positive side this school emphasises that societies' institutions and traditions reinforce the meaning of behaviour, thoughts and feelings, but it de-emphasises similar processes that occur

[17] Patients do not necessarily use couches nor pay for sessions; sessions are not necessarily in the same room nor necessarily weekly etc.

within a country as a result of oppression and racism as well as the effects of acculturation.

The fifth view is the *pan- cultural.* Here culture is seen as a function of a dynamic other than the geosocial; and racial group membership determines one's place in the distribution of power. On the positive side this notion gives a broad and global understanding of race and oppression and makes the connexion that some experiences have a commonality (e.g. colour); on its negative side it focuses primarily on racial oppression and perhaps neglects other important reference groups (e.g. class and religion).

Intercultural therapy can be considered a new sixth "school", and in some ways is, a synthesis of other five. Its philosophy is to regard personal experience of culture as fundamental to the individual and thus to therapy. Such personal experience includes the home culture and any other cultures the patient has lived in, together with the psychological aspects of being a minority within a white majority culture; the common experiences of some groups, for example the experience of being black in a white society; as well as the sociopolitical experience of minorities. It recognises that some psychological compromises have to be made by individuals in order to interweave different cultural experiences. Where it differs from all the other schools is that it recognises such experiences have an influence on both participants, in any encounter but in our current context between patient and therapist, which gives a particular context to the therapy. Thus all participants (therapists, patients, supervisors) have to work through the transference/countertransference dynamics that are engendered by such encounters between cultures; or for intra-cultural work, the different cultural experiences of the same culture between participants.

However, intercultural therapy is theoretically no different to other forms of psychotherapy, and its aims are to improve mental health, deal with complex life problems and life experiences (Muench 1968). However, unlike traditional psychotherapy it also aims to provide therapy based on the patients' own beliefs and attitudes as defined by their culture and their life experiences – in my terms, consistent with a person's *ethnic identity*. It uses psychodynamic tools of working in the transference (and with countertransference[18]) with repressed material, while recognising that family/cultural history is important.

This area of work is still contentious as the applicability of a therapy devised within a Western therapeutic model and its relevance to non-European peoples, has been (and still is) vigorously debated over the last twenty years (see Pederson et al 1981, Sue et al 1974, Sue et al 1991, Kareem, 1978, 1987, 1988,1992, 2000, Berke 1987 and Evans Holmes 1992). Before considering the current psychotherapy situation it is important to understand its origins, in order to recognise the cultural aspects of it.

[18] see Laplanche and Pontalis (1988)

1.5 Psychoanalysis and Psychotherapy

Historically, psychotherapy developed from psychoanalysis. Freud developed psychoanalysis, a therapy based on a psychosexual model of development, from which he advanced a theory of human behaviour and personality structure (Bettelheim 1984, 1987). He first referred to this as *psychoanalysis* in 1896; over the next 40 years he pioneered the systematic use of psychological techniques to alleviate psychological distress, and defined the "unconscious" in man and its role in mental life. His creation, psychoanalysis, *was the first distinctively recognised form of psychotherapy....it has also been the most influential, and it clearly dominated psychotherapeutic thought* (Garfield and Bergin 1986, pg. 3).

In his early trials (in collaboration with Breuer) he used an hypnotic technique learnt from Charcot in Paris. However he was largely unsuccessful with this and with the help of Anna O (Bertha Pappenheim) he developed the "talking cure". What is particularly pertinent for ethnic minority patients (who are often reported to present their psychological problems somatically) is that most of Freud's early work was with patients who had somatic presentation (e.g. Elizabeth von R who had "great pain walking" for two years - Breuer and Freud *Studies on Hysteria* 1895). This is an important point and one that is rarely recognised when ethnic minority patients are refused treatment or treated by non - psychological means when they present somatically. It is also interesting to reflect on whether there are some commonalities between women in the nineteenth century and ethnic minorities in the twentieth century. Perhaps the fact that women (of that era) had very restricted options and a sense of powerlessness, is one of the possible considerations?

1.5.1 Aims

Freud hypothesised that his patients, providing their early life was uncomplicated by trauma (i.e. they were mentally well before they became ill and had not had a traumatic life history), quickly responded to treatment (e.g. Katerina needs one session, and Lucy, seven - see Gustafson, 1986, Freud 1955). Even where there was a more complicated life history, Freud rarely gave the months of treatment that are now seen as necessary.

His early writings show that, in his view, the aim of therapy was work towards the *disappearance of the patient's symptoms and the undoing or correction of the pathological processes which had lead to the illness* (Sandler and Dreher 1996 pg. 1). It can be argued that Freud's successful psycho-analytical practice was developed on the basis of short, successful therapy of patients who had, what were considered then, long-term intractable problems which medicine had failed to cure. This has implications as this suggests that short-term therapy is appropriate for somatic presentation, where somatic presentation is associated with trauma, (provided that it is not a long term problem).

Later *Freud began to think of the aim of analysis as being one of scientific research and added different formulations of aim (for example that the aim was to make the patient's unconscious conscious)* ...[and subsequently whether] *analysis* [is] *a therapy or is it a scientific procedure which has as its aim simply to analyse, but which may be incidentally therapeutic (Sandler and Dreher 1996: 1).*

This seems to reflect the change in Freud's patient profile. His early detailed case histories are replaced with more theoretical material, and he writes less about his cases as time progresses. Simultaneously his case load increasingly becomes training analyses (we know that he has difficulty taking on the six American trainees - he has to

reduce their training analysis to one hour, five days a week; unlike the other training analysands who see Freud six times a week)[19]. It seems that he becomes increasingly concerned in developing his second topography (that of the structural: id-ego-superego). His earlier (first) topography (that of the unconscious - preconscious -conscious) was developed while he was still concentrating on "real trauma". Although he still uses both topographies in his later works (see "The Outline of Psychoanalysis" 1964), the second one is the one that is given most emphasis in his later writings, and subsequently by analysts[20]. This perhaps reflects a change from his earlier patients with hysteria (and who had potentially suffered "real trauma", usually women) to a patient group which was a predominantly a neurotic one (his training analysands, a predominantly male group).

Such differences in aims, plague not only analysis but also psychotherapy. Fundamentally how the aims of therapy are defined mediates how efficacy is assessed. Most funding bodies (in the UK as well as in America)[21], tend to want to justify their investment in the therapy in terms of their improving symptomatology, the emphasis tends to be on outcome studies to answer the question - how many patients improve (Maling and Howard 1994)? To summarise, funding bodies tend to fund clinical and research work that has measurable efficacy and where improvement is measured by decrease in symptomatology (but this is obviously predicated on how the symptoms are

[19] Freud by seeing trainees, is actually "skewing his population" and his theories reflect this. Obviously if the purpose of analysis is to prepare relatively mentally healthy individuals for work as analysts; then making their unconscious conscious is important for their future work. Symptom relief is inappropriate for such asymptomatic individuals. If, however, you are working with patients with debilitating symptoms, then symptom relief is a priority, which will be achieved by making the unconscious conscious. Therapy for such patients cannot be *incidentally therapeutic* it must be its primary goal. Therefore I feel both his first and second topographies are appropriate, but each is only appropriate for its specific group.

[20] One can argue here that they used their own analyses to develop their view of therapy, i.e. most analysts have not had any profound mental illness so their analyses were compatible with Freud's later view of making the unconscious conscious. I wonder if the early analysts had suffered trauma whether their theories would have reflected this (notable exceptions include Margaret Little).

understood which, in turn, is affected by culture). Here the goals of therapy are defined according to the early Freudian notion, but not how current analysts and therapists (or the "later" Freud) understand them.

1.5.2 Symptom Definition

Defining symptoms presented by patients in therapy is problematic. "Diagnosis" in psychoanalysis and psychotherapy is based on different criteria, and uses different nomenclature[22]. Often in research (and indeed in clinical referral) the "diagnosis" is a psychiatric one, with obvious problems for the psychotherapist (see later). However, most patients in psychotherapy research (and in private clinical practice) tend to be those suffering from the "neuroses". In reviewing research it is often difficult to assess what is exactly meant by this term because an exact patient "diagnosis" (psychotherapeutic or psychiatric) is rarely given. This means that comparison between "outcomes" of patients is difficult, certain "diagnoses" might be expected to more amenable to psychotherapeutic treatment, and certainly we know that certain aetiologies have better outcomes (for example, a depression following a loss or bereavement).

Moreover, patients do not come to therapy in isolation from their environment. Real patients present with psychological problems which affect other areas of their life, which in turn may affect or delay their "recovery". A patient may lose their job, have serious emotional problems within the family or other relationship problems, for ethnic minority patients there may be added factors e.g. difficulties with asylum etc.

[21] Particularly because of the rigorous evaluations needed to justify therapy to American medical insurance companies.

[22] Although there are two different psychiatric classificatory systems; The International Classification of Diseases (WHO 1978) and The Diagnostic and Statistical Manual IV (A.P.A. 1994), it seems the latter, because of its flexibility and recognition of different aspects of mental illness, is becoming the classification system of choice for psychiatrists.

This of course mitigates against the research techniques advocated by many psychological researchers: those of control groups (matched groups on sociodemographic data), waiting list controls or randomised controlled trials (but see Chambless and Hollon 1998, Roth and Fonagy 1996). Psychologists have tried to define a "gold standard", usually a measurable loss of symptoms (defined by one of the many objective measures) and increased ability to function within the family. For therapists of the psychodynamic school the criteria that reflect "improvement" or "cure" (if indeed that is what they are aiming for) are more nebulous.

However, what is not in dispute is that improvement is theoretically predicated on the therapeutic relationship (later in this chapter I shall review the research literature on the notion of the therapeutic relationship); the personality of the therapist seems very important (here we are looking, in some respects, to Rogerian notions of warmth, empathy and unconditional positive regard). In analytical terms the relationship is theoretically and clinically defined in terms of the ability to "hold" a patient in therapy (i.e. being able to nurture them through the difficulties associated with therapy), to interpret sensitively and accurately and to provide a "safe" unchanging environment to explore their inner world.

1.6 Psychotherapy and Culture

Both psychoanalysis and psychotherapy have had a problematic relationship with culture and clinical practice with black patients is still less than adequate. Arguably, Freud's anthropological works show the influence of, and are consistent with, the then current anthropological view (quoted at some length in *Totem and Taboo* (Freud 1913).

However, Freud believed that his theories provided an understanding of man, a universal theory of man's psychology predicated on some questionable assertions about a certain hierarchy of races. These notions have now largely disappeared from the literature (but see Rushton 1990). This was, in essence, racist (Dalal 1988). Tribal peoples were viewed as primitive (or *savages* - Freud 1913). There are different "levels" of man. He clearly delineates a continuum between the *primitives and savages* and the so-called *civilised* [23] (for *civilised* read *white, middle-class western European*) man, the former being represented in both children and neurotics in the *civilised* societies. Male adult Europeans unsurprisingly were at the top end of "civilisation"[24], although admittedly struggling with "civilised" sexual morality (1908).

It was not only in anthropology, and the developing arena of psychoanalysis, that such "layering" of societies was apparent. Sue et al (1998) refer to this as "scientific racism" where others are seen as inferior because of their biology[25].

Most of the clinical disciplines were, in some way, trying to justify "empire building" if not slavery. Psychiatry was providing diagnoses for slaves (e.g. Cartwright's

[23] In several papers (most notably *Civilised Sexual Morality 1908)* Freud notes that civilisation involves a relinquishing or constraining of instinctual needs. In this he is consistent, with the then, current notion of the *"savage"* living with nature being content and free of illness (of course the corollary of this is that "civilisation" leads to illness).

[24] But see Freud's definition of culture pg. 21

[25] They also cite the alternative explanation – " the cultural deficit model" - which suggests that ethnic minorities come from impoverished environments compared to whites (see Kardiner and Ovesey later).

drapetomania "the irresistible urge to run away from plantations" (Thomas and Sillen 1991), elsewhere described as the "flight from home madness" (Carter 1995), i.e. pathologising what can be understood as normal behaviour in an abnormal situation.

However, importantly (notwithstanding the racism), Freud was putting "social effects" (Abel and Metraux 1978) and "cultural effects" (cf. Turkle 1992), on the psychoanalytical agenda. How and where you were raised affected your worldview and your psyche. Freud wrote at length about the role of perception and its influence on our unconscious and our thinking. Freud's influence can be still be seen in modern psychology which has accepted the role of culture (in part by developing the field of cross-cultural psychology), looking at the dynamic interplay between the internal world of the mind and its perception of the social world.

It is clear from many scientific disciplines that the way a child is brought up by their family, in a given society (remembering that the body, the psyche and the community do not possess fixed, immutable meanings across cultures - Kakar 1982, quoted 1995), have profound effects on the individual and their view of the world. People will also assimilate and choose to follow some (if not all) aspects of their culture, and in some ways these are selected through individual life experiences (see Kakar 1995).

If one re-evaluates Freud's thoughts (discarding his inherent layering of societies) he is recognising the need for understanding cultural norms and values. Paradoxically in none of his case studies, nor in his theoretical works, does he show whether psychotherapy would work in other cultures where child rearing practices and family constellations are different. Nor does he convincingly show how his theory could be applied to patients from other cultures.

Early psychoanalytical writings, by other analysts, approached "culture" with the bias of looking at whether Freud's assertions about man's more primitive drives (*Trieb*)[26] could be shown in *primitive* cultures - his "anthropological approach". However, in anthropology the ideas have moved on, as Krause (1998) notes

other cultures could now be seen as living concerns rather than as museum pieces or exotic, malfunctioning survivals of the past....more importantly customs, ideas and ways of living which had before seemed irrational and exceptional now came to be understood as well functioning and sensible alternatives, at least by the anthropologists who had studied them (pg. 9).

Conversely for psychoanalysis we find that for European and (North and South) American peoples the emphasis has been on clinical studies, while the emphasis of psychoanalysts working with Non-European or Non - Euro-American peoples has been anthropological. Is this yet another reflection of the "inherent" layering of societies – a form of scientific racism?

Psychoanalytical/psychotherapeutic researchers have concentrated their cultural research on therapy with either preliterate, isolated societies trying to fit western psychoanalytical conceptualisations to such groups (e.g. Roheim (1932) working in Somaliland, Western Australia and New Guinea, or with indigenous peoples in Western society (e.g. the Native American Indian - Devereux 1951, Erikson 1995). Others have looked at indigenous psychotherapy, e.g. "Religious Psychotherapy of the Iroquois" (Wallace 1959), and "Ute Dream Analysis (Opler 1959a,b). Such research tends to concentrate on internal processes to the exclusion of the external world. This

[26] Strachey in the Standard Edition of Freud's works translates "Trieb" as "instinct" however, most modern authorities would translate the word as "drive" - see LaPlanche and Pontalis (1988) for a fuller discussion of this.

has lead, on the one hand, to a misunderstanding of the cultural processes, and on the other, to viewing other groups as "exotic". This has had the effect of forcing an homogeneity onto "other groups", an approach similar to that of early anthropology.

Even excluding such ethnocentrism, such anthropological/psychoanalytical work should have delivered some coherent ideas on whether psychoanalysis really is pancultural, and therefore whether Freud's "universal" theory needs amendment.

However these approaches have emphasised the essentially *primitive and different* nature of the tribal peoples. There are, of course, theoretical (as well as ethical) difficulties with this. Looking beyond the racism, if as Freud postulates, the savage is seen in the neurotics and children of the *civilised* societies[27] then the argument that black people will not understand therapy, put forward by therapists, is untenable. Therapists work with both neurotics and children and therefore should be able to treat all patients with equal success. Therefore they must feel that culture has a role, in which case the tautology is that "external" reality has a place in therapy.

In psychotherapy the view of the ethnic minority patient is that they are incomprehensibly different (and therefore unanalysable) rather than explaining symptoms as comprehensible in terms of a different understanding of the world, or for others (especially those born in the UK) a similar understanding of the world expressed in a different way due to different life experiences and upbringing.

In a similar way to other disciplines, such work is then generalised to ethnic minorities in American and European countries. The net effect of this has been to encapsulate the individual "black experience" into a "primitive society experience" relieving the

[27] This is not an argument to which I would subscribe. In a similar way to my view that black patients do not present with "exotic" problems, I include it to emphasise that the arguments put forward to exclude black patients from therapy do not hold up to close scrutiny.

burden of having to understand the complex transitions that have happened within the different cultural communities in Britain today (with similar effects in other European and American Countries), the strengths of different cultural groups, and has lead to a generalisation of the group experience to an individual one. This, may show the discomfort of psychoanalysis in working with difference, and therapists' inability to react to and reflect upon difference, especially cultural difference. They seem unable to adapt their technique to accomodate such differences.

Psychotherapy has been unable to think about different family frameworks and different religious practices, but also itseems unwilling to contemplate working with single people living outside the expected social organisation, and situations where such family organisation is not protective.

The role of "culture" has not been discussed in the therapeutic literature to a great extent so it has not been translated into a coherent psychoanalytical/ psychotherapeutic theory to produce a truly "universal" theory. Nor has it been reflected in therapeutic practice. However, in the modern world, where patients may not be culturally similar to their therapist this neglect seems inappropriate. The reason for this "neglect" seems to be predicated on the psychoanalytic focus on the internal world and psychic reality. Psychoanalysis is, according to (Oliner 1996),

insensitive[28] *to conditions in external reality such as abuse, poverty, oppression, or the analyst's contribution to the transference.*

I would add to this the difficulty of understanding patients who present different life experiences and who are from different cultures[29]. Therefore, contrary to current

[28] I believe "unaware" is a better term, although the patient will experience this as "insensitive".

psychoanalytical thinking, culture and the experiences of minorities in Britain should be an implicit part of the understanding of the person and their presenting problems and thus of the therapy. Culture is fundamental to the person (for majority as well as minority cultures). Individual development from the infant to the grown adult is in a specific familial context[30], and such contexts may be different from, in this case, those of the white British culture or as Kakar (1995) says:

In a fundamental sense, psychoanalysis does not have a cross-cultural context but takes place in the same culture across different societies; it works in the established (and expanding) enclaves of psychological modernity around the world....the clientele for psychoanalysis....are involved in modern professions....in the sociological profile, at least, this client does not significantly differ from one who seeks psychoanalytic therapy in Europe and America.

Hence one can argue that changes in traditional family structure and cultural support structures (e.g. religion), allow psychotherapy to take on a more important role.

The idea that the psychotherapeutic worldview was culture free, encouraged a predominantly white European/American profession to believe that their values, attitudes and beliefs and the predominantly verbal, non-physical therapy was in some way inherently "correct", not merely an artifact of their upbringing, the class into which they were born and the societies into which they were born and were raised. But in this they are also conforming to the original anthropological view that the European/American worldview is in some way inherently superior (*more civilised*) to

[29] We can return to the idea that when Freud worked with real trauma, his theories reflected this. Therefore as most therapists are white and middleclass, and see patients from a similar demography, then their theories are compatible with this group. By this argument, if they worked inter-culturally their theories and practice would develop accordingly, and perhaps provide insights into their work with their white patients too.

those of other races, and hence cultures who did not subscribe to these "ideals" were in some way "lacking" (*more primitive).*[31]

This notion of *primitive* has lead to a rather paternalistic view of different cultures by therapists and analysts alike. It should be remembered that psychoanalytical views on other cultures seems to be limited to those "black cultures", where society is not generally structured in a hierarchical way. Hence we find Freud in 1935 (in his Postscript to "An Autobiographical Study") talking about thriving psychoanalytical societies in non- European/American situations:

In addition to the older local groups (in Vienna, Berlin, Budapest, London, Holland, Switzerland and Russia), societies have since been formed in Paris and Calcutta, two in Japan, several in the United States, and quite recently one each in Jerusalem and South Africa and two in Scandinavia. (pg. 258).

This is an important distinction, for psychoanalysts (including Freud) the emphasis is on how closely your society is structured. Most societies that have a hierarchical structure based on class or caste systems have embraced psychoanalysis (including, more recently, South American countries including Brazil)[32]. This can be viewed in a cultural perspective. For many therapists, psychoanalysis is viewed as a universal understanding of man. In fact, psychoanalysis can be seen not only as predicated on Freud's Jewish upbringing (see Roith 1987) but also on his middle -class life and the structured society he lived and grew up in (initially Moravia in Czechoslovakia, which was at that time was part of Austro-Hungarian Empire, and after he was three years old, in Vienna), as well as the era in which he lived and worked (see Kakar 1995).

[30] Thus all therapy is (in a sense) intercultural, as no two individuals will experience their cultures identically (following from the notion of a psychological culture I proposed earlier).

Freud was not only part of an oppressed minority (by virtue of his Jewish origins), but also a migrant. This man who wrote extensively about the human psyche, who might have been expected to write extensively on the experience of being culturally "different" does not show this in his writings.

However, many of Freud's early writings, particularly the early ones and specifically his understanding of "real trauma" and his notion of *nachtraglichkeit*[33] which he developed in the time prior to his renunciation of the seduction theory, can be seen to be reflections of his own family history and the effect on him. There were limitations put on his career development because of his Jewish origins and he identifies some of the conflicts with his identity and his biculturalism in *The Interpretation of Dreams* (1900), perhaps most notably in his description of the hat incident (pg. 286).

For Freud's patients (at the end of the 18th and early part of the 19th centuries), the theory and practice are *emic* (they reflect a similar worldview); for patients at the start of the new millennium there is a vast array of therapies open to them, and often the therapies reflect a particular worldview (e.g. the Lacanians in France and South America, the ego psychologists in America). Therapies have developed to keep in touch with the culture within which they are applied, so that the theory and therapy remain *emic.* For ethnic minority groups in Europe and America the theory and therapies may seem to be *etic* to them (they do not reflect their worldview, depending on the level of assimilation/integration/ cultural pluralism of the individual).

[31] Perhaps paradoxically, Freud believed one of the problems of civilisation was that it lead to neuroses (1908).
[32] It is largely the middle classes who have adopted psychoanalysis.
[33] This is the notion of "deferred action". This is where an incident happens which is then repressed. If a similar set of circumstances reoccurs then the person reacts to it as if it was the original trauma. Hence in the "Project for Scientific Psychology" (1950) we find the example of Emma.

The question remains as to whether a therapy that was developed within a particular cultural framework has any relevance to patients whose cultural backgrounds are different to those of the majority culture.

1.7 Patients from Ethnic Minorities and Psychotherapy

There are seemingly no norms and little research interest in (non-pathological) black families. Many of the studies on black families in psychological difficulties are confounded by poverty. There is the strong sense that whilst black families are viewed as homogeneous (stereotypes?); the same rules are not applied to white families (Sayal 1990, Patel 1997). This leads to assumptions (stereotypes) which are then applied to individuals of the culture who may or may not live within this experience.

Differences are deprecated if they do not fit an (imposed) Western framework, for example Kardiner and Ovesey (1951):

The Negro lower-class family is often unstable and disorganised.....The absence of a stable male spouse and father leads to other consequences .....in the sense that the family does not provide the protective environment it should to prevent characterological distortions.

(but see Watson 1977, Thomas 1984, Mullard 1973, who redress this balance).

There are problems with this idea, not only does it seem that this seems to be stereotyping, but that one is left with the question that other families who are not African Americans (from a similar class) may experience the same problems (due to social factors e.g. poverty).

In Britain there is a similar approach where the academic split has left a legacy where black people are not invited for psychotherapy even though they may be British born (although there is the obvious problem of payment for some minorities, some of whom are psychotherapeutically "doubly disadvantaged" as they are from lower socioeconomic groups: see also Little 1986), as they are seen as culturally different and thus psychotherapy is not seen as a *culturally appropriate* treatment. Sometimes these critics come from within the same culture.

However, most therapists believe that for the therapy to succeed, patients must subscribe to the psychotherapeutic assumptions, expectations and beliefs[34] (Smail 1987). So what are the problems from the therapeutic viewpoint? Therapists question such patients' ability to understand the psychological nature of their illness - (e.g. Kakar (1982) discusses the problem of the universality of the concepts), to communicate their distress verbally (using the "middle-class" code and in English) and to engage in therapy (paradoxically at a time when there are an increasing number of therapists who are from ethnic minorities, who were obviously appropriate for training therapy). A few authors discuss the importance of reducing bias in training and supervision by taking account of these differences where they exist (Cooley and Murray 1983, Batten 1990). These, when added to the difficulties of conventional therapy in working with different cultural dynamics (e.g. the well reported extended family framework for some cultures, different familial relationships, views on mental health etc.), leads to ethnic minority patients being denied psychotherapy, even though many are asking for the same therapeutic options as white patients (and it is here, where the theory and practice collide).

[34] This is, of course, true of any treatment from non- medical beliefs to "high- tech" beliefs.

It is inconsistent that the concept of race and culture is largely ignored by psychoanalytic literature, and that patients from certain minorities are considered not suitable for psychotherapy, as early psychoanalytical work was *inter-cultural* in the sense that most of the early analysts travelled from other European countries and America to train with Freud (e.g. Lowenstein practiced in Austria, France and the USA). One can also argue that most of the early American psychoanalytical work was by migrants for migrants.

Another inconsistency is that many of the psychoanalytical ideas were based on Judaism, and yet this has not prevented non-Jewish people benefiting from therapy (Roith 1987).

But there are difficulties. Therapists in other countries have noted the difficulties of importing analysis into other countries (e.g. Figueira 1991), the difficulties seem to be enhanced around the psychoanalytical emphasis on the "inner" world (an important point that has not been investigated is whether people from different cultures have differences in their "inner world"). However, in modern multicultural societies understanding of the "outer" world of one's patients (e.g. meaning of child rearing practices or "racism" - see Frosh 1989, Westwood et al 1989) is also fundamental to psychotherapeutic interpretation, especially where therapist and patient are from different cultures and there is a potential for distortion.

Hence the need for revision of the theoretical component of psychoanalysis: to take more care of the *spirit* of Freud's arguments and learn to be aware of cultural differences and work with them. As currently practiced, outside its frame of reference (white middle class patients) psychotherapy can distort meaning (cf. Bettleheim 1987), as therapists' understanding of what the patient is saying is overlaid with cultural

assumptions and interpretations. The questions raised here are what is its "appropriate frame of reference", and how much does the "doctrine" or "organisation" (Gellner 1988) allow such concerns to be investigated.

1.8 Intercultural Therapy: The Practice.

Almost all reviews of cross cultural therapy are American (e.g. Comas- Diaz et al 1988, Sue and Sue 1990, Ponterotto et al 1995). This strong emphasis on cross cultural work in America has occurred because of a more active political perspective on mental health for minorities. This combined with the financial constraints imposed by insurance companies, who wish to be assured of success of therapy cross culturally, have ensured the investigation of the effectiveness of therapy.

Certainly the major studies into psychotherapy, including the Menniger Clinic study (Kernberg et al 1972) and the Penn psychotherapy project (Luborsky et al 1988) have been carried out in the U.S.A. The U.K.does not have equivalent studies of groups of patients undergoing therapy nor does it have the diversity of smaller scale therapy research found in the American literature.

Such diversity of research varies between reviews of aspects of technique (Abel and Metraux 1974, Sue and Sue 1990, Grinberg and Grinberg 1992) to reviews of the therapeutic interventions on the basis of migration experience (Dellarossa 1978). Reviews of the pertinent literature are Hartmann et al 1964, Marsella 1978, Pederson et al 1987, Abramowitz and Murray 1983, McGoldrick et al 1982.

There are some British reports of individual case studies (e.g. Evans Holmes 1992, Andreou 1991, 1992, 2000, Kareem 1992, 2000, Thomas 1992, 2000, Roberts 1994) and some from non-North American sources (e.g. Figueira 1991). There has been a recent review of intercultural therapy in Britain (Kareem and Littlewood 1992, 2000, see also Marrett 1981),

The uniqueness of inter-cultural work is of course one that specifies "difference", and hence there must be more consideration of what you change and why (Fairbairn and Fairbairn 1987). Lago (1981) suggests that there are several possible types of cultural difference in therapy. There is the way in which emotional problems are presented to the therapist (see also Rack 1982); the style of experiencing and communicating distress and also linguistic difficulties - not only those situations where the therapist speaks another language (Antinucci-Mark 1990, Greenson 1950) and communication is through an interpreter, but also those situations where literal translation of the patients' meanings may result in confusion for the therapist (see also Lago and Thompson 1996). There may also be occasions where a particular language may be overlaid with meaning, perhaps it is a language related to oppression, or of childhood. Such therapeutic issues need to be identified and explored with the patient.

While some studies show that there are universal patterns of non-verbal communication (Ekman and Friesen 1971 Sorenson 1975), others (Clark and Lago 1980) suggest that this is not so. Other factors identified include; the possible lack of awareness by the patient of what the offered therapy or counselling is (see above 1.7); failure by the counsellor to be aware of the patients' cultural and family constellation (e.g. Roy 1975); and prejudicial attitudes (both conscious or unconscious) of both parties to each other.

Moreover, the more culturally unique the patient the more mental health problems they are likely to have (Moritsugu and Sue 1983)

In opposition to the emphasis on "cultural difference as problem", Patterson (1978) argues that cultural differences in counselling are of no greater import than class differences, and thus he suggests it would be equally valid to have specialised training for psychotherapists of the poor. In both cases therapists may need to be more sensitive and aware of the particular social situations of their patients.

In what Garfield and Bergin (1986) consider to be the most "thorough review of the literature", Abramowitz & Murray (1983) found that white reviewers tended to minimise the effects of ethnicity, whilst black reviewers tended to emphasise findings in which differences are found.

Some authors suggest group therapy is more appropriate for ethnic minorities (Bavington, 1992) others suggest otherwise (Kanishige 1973). Nishizono (1969) discussed the take up of psychoanalysis and compared it to Morita therapy. The results were the same for both therapies (80% of patients lost neurotic symptoms), although he noted with Japanese patients the cultural aspect of dependency, which came out in psychoanalysis, needed to be processed

1.9 Sociological Characteristics That Affect Utilisation of Psychotherapy.

1.9.1 Race

Race[35] as can be seen has been used as a contraindication to therapy by therapists. It has been seen as a barrier to the setting up of a therapeutic relationship, with research tending to concentrate on therapist/patient misalliances, therapists' over-reliance on ego supportive approaches to black patients, therapists' ignorance, prejudices and countertransference; white therapists' guilt and black therapists' overidentification with "down trodden children" (Curry 1964, Evans Holmes 1992, Abel and Metraux 1974). In opposition, Evans Holmes (1992) argues convincingly that race can be a useful facilitator of transference, and is not only something just to be worked through. However, the power in the relationship between therapist (white) and patient (black), or vice versa, must be explored because this experience of the patient will be important in the transference and hence outcome (see Thomas 1992, 2000).

Certain theoretical issues have yet to be resolved. Do all cultures have the same view of "unresolved issues"? It is frequently reported that Black people feel infantilised by British society, if so, how do they react to the infantilising process of therapy during the analysis of resistance?

Unfortunately in the two British studies of community based psychotherapy services,

[35] I'm using the word *race* as it is commonly used in the literature (American). It identifies the situation of the black patient and white therapist and reflects the social and power relationships brought into the therapy from the outside world as well as those inherent in the therapy. It reflects the transferences/countertransferences implicit in such encounters.

both Hutton (1985) and Caccia and Watson (1987) again give only partial information, in one "93% had British nationality" which is not helpful in terms of detailed analysis. Campling (1989) notes that none of her N.H.S. psychotherapy centre patients were from ethnic minorities and very few minorities were referred. Although she makes the valid point that all therapy resources are stretched and it is difficult for therapists to go out and search for patients when therapists' waiting lists are long anyway.

Arguably the two most renowned studies of long term therapy, the Menninger Clinic study (Kernberg et al 1972) and the Penn Study (Luborsky et al 1988) have failed to note the specific ethnicity of the patients studied; in the former there were no ethnic minority patients (Wallerstein 1989) in the latter study 6 out of the 73 were ethnic minority patients (Luborsky et al 1988).

However, it is important to remember that it is not only the white North American and European middle-classes who are aware of psychotherapy, some South American patients are more familiar with therapy than Hampstead patients (Temperley 1984). However, certain cultural expectations may influence the process, for example the psychosexual developmental theories of Freud may infringe societal taboos (Temperley 1984).

1.9.2 Sex Ratio

Figures for the efficacy of community based psychotherapy services are rare. Although Luborsky (1971) found that men and women have equal chances of being helped by therapy, Caccia and Watson (1987) (see also Hutton 1985) working at a London

Counselling Centre offering psychotherapy (not specifically aimed at ethnic and cultural minorities) found that the commonly quoted figure of 3:1 or 4:1 (women:men) was not applicable to their community based study, where the ratio of 1.5:1 women:men was found (cf. Meng Hoi Lim 1983, Moodley 1987). This is the same as those found in both the Salford and Camberwell Registers. This may be explained by Pollitt's (1977) finding that if depressive illness is considered solely, then the ratio is 2:1 (women: men). Pollitt (1977) notes this ratio could be closer if alcoholism is considered as "masked depression". It may also be that men are more likely to approach a non-medical organisation or that women are less likely to approach such a Centre.

1.9.3 YAVIS Criteria

The first reference to to the YAVIS criteria is in 1964 (Schofield 1964). In his book Professor Schofield notes the preference of some therapists to select patients who fulfill the YAVIS criteria over other potential patients. According to the YAVIS criteria, psychotherapy patients tend to be young, verbal, attractive (although this can create problems: Hatfield and Perlmutter 1983) intelligent and successful, additionally they are reported as middle class. Hence one can reflect that the YAVIS criteria are the cornerstones of a model of systematic selection of patients which reflect therapists' practice, and by definition then such patients become "good" therapy patients.

The difficulty with the YAVIS criteria is that it is a common selection practice of therapists as opposed to a theoretical framework, i.e. the YAVIS criteria are all cornerstones of a model that was derived from therapists practice and is not a theory *per se. H*ence a theoretical framework around the YAVIS criteria is notable by its absence.

This leads to difficulties in research. If the research is based on normal therapeutic practice (in the UK) most patients will be found to be

- Predominantly white North American or Western European.[36]
- Mostly middle class
- Usually YAVIS
- Usually paying for their therapy
- Those with few external problems, that might be seen to influence "success" e.g. poverty.

Continued justification of the YAVIS criteria are difficult to sustain in the light of a more diverse population seeking therapy, and the therapists' need to maintain the same population may reflect some of the unconscious processes of therapists, we know from anecdotal evidence that therapists tend to choose patients who similar to themselves in some aspects. It might also explain the contradictory results and the lack of interest in researching other groups (e.g older patients, less verbally adept patients etc).

Therefore only those studies which specifically set out to look at patients who do not fulfill one or more of these criteria, give us information about the relevance of the YAVIS criteria.

The well-known large-scale studies which have explored several facets of therapy have tended not to research ethnic minority patients. The Menninger study patients were all white, middle class or upper middle class with high I.Q.'s with a mean age of 33:30 (men:women) (Wallerstein 1989), and the Penn study had only six "black or oriental"

[36] Here we are talking about research carried out in Britain, obviously the south American therapeutic community also produces research relevant to its own population.

patients, with only one of the total sample being less educated than a high school graduate and a mean age of 26 years (Luborsky et al 1988) (see Table 9a).

The Sheffield Psychotherapy Projects (the first and second projects, Shapiro and Firth 1987) had very stringent symptom and occupational criteria, however they do not report any ethnic minority patients in their first study, while in the second study they note that the patients were "predominantly white Anglo-Saxon". The mean age of their sample was older than the other studies at 40 years.

Such lack of clarity creates difficulties when comparing and contrasting population profiles, presenting issues and outcomes.

Hence the few major studies of psychotherapy tend to review patients who fulfil the YAVIS criteria because they are part of the "normal" population seen by therapists and hence are the ones available for research.

Common therapy research may identify certain individual components of the YAVIS criteria for investigation, e.g. do older patients have equivalent success rates, or whether intelligence is a predictor of success. However, by varying one factor e.g. age, other factors are influenced certain age groups have certain external concerns that vary through the life cycle. Older patients may be coming to terms with "retirement", middle aged patients may be deciding on a final career move, younger patients may be worrying about examinations. There may even be age related medical problems.

Young

Therefore the difficulty with measuring age is that it is a continuous variable and although there will be similarities between, say, two twenty year olds, their levels of maturity (psychological, emotional) as well as their life situation may vary.

Luborsky et al (1988) reviewed eleven studies that related age and outcome and found that older patients tended to have a slightly worse prognosis than younger patients, although the evidence is weak. While Garfield and Bergin (1986) found that age does not seem to be an important variable in relation to continuation of therapy. It can also be noted that Smith et al (1980) found an overall correlation of .00 between age and outcome.

Attractive

There is support for good outcome being related to patient attractiveness/ likeability in the literature (Stoler 1963). Stoler notes that successful clients were rated more highly on likability than less successful ones. Garfield and Bergin (1986) review the literature and note that there seems to be a relationship between likability and outcome, but the evidence seems to be "far from clear" (pg 244), and the risk of providing contaminated research is high when the ratings of both likability and outcome are completed by the therapist involved.

Verbal

Obviously a verbal therapy requires both participants to be able to communicate meaningfully with each other. There is often reference made to the difficulties in therapy between a middle class therapist and working class patient (see 1.9.4 below). There are also similar difficulties where the two participants speak different languages, and particularly where the patient is speaking in their second language. This may mitigate against a patient being taken on by the therapist

One of the measures of verbal abililty is the amount of post -school qualifications achieved by the research subjects. Many of the studies cited reflect the bias of therapists (e.g. the Menninger study researched patients who were mostly middle class with a mean I.Q. of 124 (Wallerstein 1989), while in the Penn study only one research patient was educated to less than a high school graduate (Luborsky et al 1988)).

Intelligence

Reviewing the literature it is clear that the major research studies have chosen patients who are clearly highly educated (of course, people can be not educated and still intelligent) only the Menninger collated information on I.Q., and as stated above, their figures show a highly intelligent and educated group. Luborsky et al (1988) note that in 5 out of 7 other studies educational achievements have been shown to relate to improvement with psychotherapy, whilst 6 out of 9 studies they reviewed showed that higher intellectual functioning was associated with better improvement in psychotherapy, a finding that replicated in the review by Garfield and Bergin (1986).

Successful

"Successful" is a very nebulous concept and can arguably be defined in terms of social class as defined by occupation: professional people tend to be seen as more successful. Such professional people also have the ability to pay for therapy. Luborsky et al (1988) note that in 5 out of 7 studies occupational achievements have been shown to relate to improvement with psychotherapy while Sheffield Psychotherapy Project specifically targeted managerial staff (Shapiro and Firth, 1987).

This brief review of the literature relating to the YAVIS criteria, show the relative paucity of research into non-YAVIS populations. This difficulty becomes more apparent when researchers try to evaluate a culturally diverse population. There is little research, but obviously applying the same YAVIS criteria cross-culturally will have implications in relation to age (expectations of people at different ages is different in different cultures, e.g. the notion of adolescence is a western notion). The notion of attractiveness and similarity to the therapist may have implications in finding a therapist and starting therapy. Verbal ability in a second, or for some, a third language, may make the process of therapy more difficult and less responsive to the patient. While, for migrants (and more particularly for asylum seekers and refugees) they might find their intelligence and success assessed on distorted facts (for example a person may a doctor in their home country, and unemployed refugee in Britain).

While reporting the current research facts, the cross cultural aspect needs to be investigated in its own right. To assess a patient on the same factors as a white English population might lead to distortion and thus provide erroneous results.

However, there are patients from a variety of cultural backgrounds who understand and/or want to use psychotherapy as a treatment option. Such patients may be thought

to have been acculturated into the particular cultural context of psychotherapy. Questions now to be asked are whether these criteria are universally applicable (i.e. are those who fulfill theYAVIS criteria the only successful patients), are there are any young, middle-class and intelligent ethnic minority people (which, of course, there are), are they acculturated into the culture of psychotherapy (or can they be so?) and is psychotherapy an effective treatment for them?

1.9.4 Social Class

The Hollingshead and Redlich (1958) study associated low socioeconomic class with higher incidence of psychiatric problems, with (in Britain) referrals from G.P.s showing a marked underrepresentation of working class patients (Holmes 1985). Of relevance to this study, Hollingshead and Redlich (1958) found that people of the two lowest social classes were seldom offered psychotherapy (see also Littlewood and Cross 1980). Of those offered psychotherapy, many (19 out of 20 in one study) social class V patients broke off their attendance before the intake procedure was completed (Hollingshead and Redlich 1958)[37]. The reason for the dropout from therapy was explained in terms of mutual incomprehension - leading to mutual hostility - between middle class psychiatrist and working class patient.

There are resonances in treatment availability for ethnic minority patients and working class patients. The question is why ethnicity or class affects the treatment offered? Certainly both white working class and ethnic minority patients (whether or not from working class background), experience external, practical, problems which

traditional psychotherapists would define as outside their remit of uncovering unconscious "inner world" problems, and would regard as a contraindication to therapy.

1.9.5 Payment

Psychotherapy has not always been seen as a private transaction between therapist and patient. Freud is (in his later writings) very enthusiastic about free therapy:

The foundation of a first psychoanalytic out-patient clinic (by Max Eitingon in Berlin 1920) has therefore become a step of high practical importance. This institute aims on the one hand to make analytic treatment to wide circles of the population (1924a PFL 15 pg. 175).

The quality of the therapy is also important. In a "postscript" to his Autobiographical Study (1935) he comments on the training institutes which provide

out-patient clinics in which experienced analysts as well as students give free treatment to patients of limited means (PFL 15 pg. 258)

It is interesting how modern therapists seem less enthusiastic about free therapy; some therapists regarding it as the last taboo (Weissberg 1989), other therapists being unable to think about free therapy, suggesting that payment motivates patients to come to sessions. Certainly payment creates a dynamic - how much a therapist charges a patient, whether they charge if the patient fails to come to their appointment due to illness or if the patient takes time away from therapy at different times to the therapists'

[37] Some caution has to be addressed in taking American results and translating to a British population as some authors have argued that American researchers exaggerate class differences (see Geller 1988). Moreover using CMHC (Community Mental Health Clinics) results are comparing them with a British N.H.S. group may also cause difficulties, but they are a close approximation as such clinics take on ethnic minority and low socio-economic class patients for therapy, and hence provide one of the few comparisons available.

designated holidays. What happens if the patient loses their job? Can the patient continue with reduced (or free) fees? Or as Little (1986) points out what happens if the patient becomes much more disturbed and loses their job during the course of therapy?

Although there is some evidence that payment of a fee was also indicative of good outcome (Goodman 1960, Rosenbaum, Friedlander and Kaplan 1956), these studies do not reflect upon the particular social conditions of those who are being offered "free" therapy, which may seriously affect outcome.

Therapists charge because most of their work is private and not funded by the National Health Service in the UK (or other funding bodies elsewhere in the world). However, this obvious necessity has become an ideology, and is discussed in terms of being the only option and from this baseline the benefits that can accrue are discussed. There seems to be little discussion of the Tavistock Clinic where most of the work is not paid for by the person in therapy (Health Authorities or Social Services pay for the service) and its success. Likewise, Nafsiyat offers free therapy to patients in the locality, and seemingly has none of the difficulties envisaged by the private therapists, either in motivation or in attendance.

1.10 Psychological Characteristics That Affect Utilisation of Psychotherapy : Life Stresses

1. Migration

Migration has only been studied cursorily by psychoanalysts, "despite - or perhaps because of - the fact that many pioneers were themselves emigrants" (Grinberg and Grinberg 1992), and not only trained but worked in other countries (in the terms of this thesis their work was "intercultural").

Psychologists and psychiatrists acknowledge that factors in the country of origin, the migration and the country of resettlement will affect the experience. However migration is not a unitary experience and it consists of different phases.

The premigratory phase seems pivotal:

Is the migration forced? Are they refugees? Have they experienced persecution or torture? Are they migrating to improve some aspect of their life - through studying, work, marriage etc.? What expectations do they have of the new country?

The migratory phase builds on the events before and provides its own stresses:

Who moves? How is it managed? When does this happen? How stressful is it?. For example, Elliston (1985) found better adjustment in West Indian immigrants in Canada when families moved together.

The adjustment phase adds new experiences and potential difficulties.

Are there social support structures? Are family, friends or people from similar cultural backgrounds geographically close by? What are the individual's expectations - a person who anticipates returning "home" will have different expectations and

aspirations to a person who wishes to make a new home in this country (Grinberg and Grinberg 1992, Rack 1982). It is at this stage that the migrant may begin to experience "culture shock" (Furnham and Bochner 1986).

Finally, there is the post-migratory phase, which is particularly relevant for the British born children of migrants as it is in this phase that unresolved problems in the other three phases may surface: sadness and loss, difficulties in reconciling cultural differences, anger, frustration etc. causing family difficulties (Martin 1985). This is when (somewhat paradoxically) adjustment disorders may tend to surface.

Three factors seem important

- Age: young West Indian immigrants in Canada had more mental health problems if they came in their early to mid teens(Elliston 1985), similarly people who came to Australia at a later age had better mental health (Krupinski 1967, 1973).
- Urban/Rural Changes: those moving from a rural home had worse adjustment than those from urban Centres (Elliston 1985). Although for internal migrants the reverse may be true as urban, black migrants fared psychologically worse when moving to Philadelphia than rural blacks (Parker et al 1966). The authors suggest urban blacks were unable to achieve what they had expected to achieve. Krupinski et al (1967, 1973) also found that availability ofequivalent employment important (as was a pre-existing disorder). This has resonances for British migrants as often equivalent employment is not available.
- Acculturation: Fabrega and Wallace (1968) found that (for Mexican Americans) those who were more marginally acculturated (perhaps we can think of these people as "falling between two cultures") had a higher number of hospitalisations (compared to those who were either traditional or highly acculturated (see

Kennedy 1961, Miranda and Castro 1977). Here we must remember that some cultures will be more culturally similar than others (i.e migrants between the islands of the Caribbean will find more similarities in culture than those between the Caribbean and Europe).

Here we see the value of understanding the complexity of integration/assimilation/cultural pluralism factors. It is beyond the scope of this research to go into detail of the relationship between these three factors and identity, although it should be recognised that this is an important aspect to inter-cultural therapy. Where you identify your psychological identity is predicated how far you wish to retain your "home"[38] culture, how much this is at odds with life in the UK (in this particular case) and this affects how you settle in, and adjust to life in the new country. This obviously affects how the subsequent generations relate to their own lives and life in the UK

Bettelheim (1987) provides another way of understanding the issues relating to this dilemma, although in another context, the essence of the work is how people adapt to changes in life experience. Either the person holds on rigidly to his/her traditional values, many of which are no longer relevant, or completely adjusts to the new environment and disposes of all previous ways of living, or thirdly there is a synthesis between the two cultures. He believes that therapy should be aiming to achieve the third state. In this I believe he is saying that it is neither assimilation nor cultural

[38] This relates to the culture of origin of migrants, which may or may not be the culture of the last country in which they lived. This is an increasingly nebulous concept, as in the 1990's people often have had a series of migrations in their lives. So hence "home" culture refers to their psychological culture - where they feel their origins are and the culture within which they live their lives.

pluralism, but a specific form of integration where the emphasis is on synthesis not *dis-integration.*[39]

The British born minorities may find themselves culturally alienated from Britain (where they were born) and from their heritage (their culture), which may manifest itself in many different ways including underachievement (Martin 1985). Even though they may share many of the same assumptions, life-style and experiences as their parents (for example the experience of racism), the fact is that they will be increasingly generations away from immigrant status (Acosta 1977). However, the subtle differences of experience and resources between these two groups have yet to be studied (Acharyya et al 1989, but see Grinberg and Grinberg 1992).

2. Prejudice

Experience of the outer (social) world may be different for different cultures (e.g. experience of racism and prejudice); the individual may be "psychically free" to achieve but society may prevent this occurring (Abel and Metraux 1974).[40] For example Kardiner and Ovesey's influential "The Mark of Oppression" (1951) contends that the American Black suffers a sense of inferiority based on discrimination. In Brazil, the difficulties of (both black and white) patients in dealing with both the imported European culture and the conscious and unconscious stereotypical expectations of black people, has been shown together with its therapeutic influence (it has an effect on symbolisation in therapy - Da Conceicao Dias et al 1987).

[39] Most of the research around "integration" seems to regard *dis-integration* from "home" culture as an important part of the integration process

[40] This failure to grasp the nature of the experience of ethnic minorities (e.g. prejudice) is reminiscent of the controversy over Freud's "so-called" Renunciation of the Seduction Theory (Masson 1985), perhaps because it raises a similar uncomfortable reality for the analysts (Grinberg and Grinberg 1992).

Freud himself was well aware of racism, in his Autobiographical Study (1925), he writes:

When, in 1873, I first joined the University, I experienced some appreciable disappointments. Above all, I found that I was expected to feel myself inferior and an alien because I was a Jew. I refused absolutely to do the first of these things. I have never been able to see why I should feel ashamed of my descent or, as people were beginning to say my 'race'. I put up, without much regret, with my non-acceptance into the community.... These first impressions at the University, however, had one consequence that afterwards was to prove important; for at an early age I was made familiar with the fate of being in the Opposition and of being put under the ban of the "compact majority". The foundations were thus laid for a certain degree of independence of judgement. (pg. 9)

Although, for Freud, racism allowed freedom of choice[41], subsequent experience has shown this not always to be the case. It was unfortunate he restricted his knowledge of this to his Autobiographical Study and his "Comment on Anti-Semitism" (1934). Psychoanalytic explanations have never addressed racism proper, largely because of their focus on the inner world. Those times when psychotherapists have tried to address "outer" world experiences they have interpreted with an "inner" world focus, predominantly looking at Oedipal reactions. Hence riots have been seen as violent outbreaks of father hatred, and lynchings as castration by rebellious sons.

[41] Although it is interesting to note that all his early significant papers, including those on sexuality, were delivered to the B'nai B'rith - a Jewish academic group - before presentation to his medical peers.

3. **Separations**

Fundamental to work with migrants are separation and loss (Bowlby 1977); separation and loss of family, culture, language, religion and familiarity of the known environment. A significant number of migrant ethnic minority people have experienced many separations during their lives (Watson 1977, Robertson 1977, Spitzer 1989, Arnold 1996). For example, in the 1950's the pattern of migration for West Indian children was for the parents to come to Britain, leaving the children behind with a relative. (first separation). Later the children would be brought to the UK by the parents, often leaving behind the person who represented mother (second separation) (see Sewell-Coker et al, 1985; Robertson 1977, Cheetham et al 1986). Thus children who migrate often suffer many losses during their lives, some of which may not be recognised (see Bowlby 1977).

1.11 Recognition of Psychopathology

It is impossible, in this introduction, to carry out a systematic review of all the literature on cross-cultural psychopathology, however, it is important to recognise the difficulties of transcultural work on mental illness by looking at some trends in the literature.

All societies have behaviour that deviates from the norm, and whether this is seen as "mad, sad or just plain bad" (Fransella 1975) is culturally determined. Cultures have not only developed explanations for abnormal behaviour, but also culture specific ways of dealing with human problems and distress. So conceptualisation of causation of symptoms is culturally and socially sanctioned and determined (Mechanic 1986 but

see also McPherson and Gray 1976). However, most societies have behaviour (which perhaps comes under the rubric "mental illness"), where the individual is not held personally responsible for his/her actions and some course of "treatment" is prescribed (see Kleinman 1980, Randall 1984, Mechanic 1986).

As there are different conceptualisations of mental illness, which questions need to be reviewed? Do symptoms mean the same? Can western notions of "normality" pathologise other cultures as Littlewood and Lipsedge (1989, 1997), Reeler (1991), Craissati (1990), and Bal (1984) have suggested. Are there universals in occurrence, aetiology, symptom pattern, presentation, recognition, course of illness and outcome (Senay and Redlich 1969, Lipsedge and Littlewood 1979, Littlewood and Lipsedge 1989), are others culture bound? (see Carstairs and Kapur 1976, Littlewood 1986a, 1992, 2000). Is there the implicit notion of a hierarchy of symptoms seen in the Western psychiatric diagnostic symptoms (see Goldberg 1978)?

How culture-specific is psychotherapy?

This is an important question which has ramifications for therapists from all cultures. The problem for therapists (and doctors and psychiatrists) working cross culturally is whether the initial assumption that a "diagnosis" (based on psychological symptoms) that has been standardised and evaluated on one culture can then be used without modifications in another culture. How far is it ethnocentric to use such criteria across cultures? It is not known whether the psychoanalytic concepts of neurosis and psychosis are relevant to those from other cultures. If indeed they are relevant (see later) then the question remains as to which symptoms universally define the two classes of distress and which may be culture bound. Are guilt and shame the same

emotion expressed through the different lenses of individual and collective cultures, or are they fundamentally different? If they are fundamentally different then this begs the question as to whether they need different "treatments" or if they need treatment at all. When do the symptoms of psychosis require treatment and when do symptoms have a cultural weighting? All these questions and many more, which are beyond the scope of this thesis, need to be addressed in the research forum.

However, what is universal is that people experience distress and that talking about problems is a universally acknowledged way of dealing with problems. Where differences arise is who is consulted and what is the treatment offered.

Western therapists regard some interventions (e.g. the use of shamans) as having little applicability to Western populations, which implies a cultural dimension to interpretation of symptoms and the therapy available to those with mental distress. The corollary of this is that psychotherapy itself may have little applicability outside its own white, North American and Western European roots.

1.11.1 Cultural Aspects of Psychopathology and Treatment

What is interesting is that although Freud believed that he had found a universal theory of man, therapists (by their action of not taking on certain cultural groups) emphasise that, in fact, the practice of psychodynamic psychotherapy (at least) is not a "universal" therapy.

The insistence of some therapists in keeping the therapeutic orthodoxy, by keeping certain parts of the setting consistent and interpreting with a western understanding, leads to the notion that psychodynamic therapy has only one frame of reference. Intercultural therapy addresses the practicalities of the therapy (several sessions per week, payment of fees etc) and queries the application of the theory .

Cultural specificity of the treatment incorporates at least four aspects of the encounter.

Firstly there is the setting. How emic or etic is the setting. Does the patient understand the context? In the case of individual therapy is the patient able to speak about self, perhaps family, emotions and experiences with a stranger. Is he or she "allowed" a conversation with a single therapist without a chaperone? Is the room layout comfortable and appropriate e.g. are the positioning of the chairs too close or too distant. Is the room culturally comfortable, in terms of pictures or ornaments.

Working interculturally, the therapist, as well as listening to the information being brought to the session and their understanding of the mental distress, will also be considering whether there are anxieties about the setting for the patient. This may be by verbal or non-verbal means. The therapist then needs to consider whether action needs to be taken to remedy these problems. Perhaps alterations in the therapy may be needed. For example, for those from rural, traditional cultures, a group may be more appropriate for exchange of thoughts, feelings and emotions, particularly single gender, single language groups. For others there might be thoughts about leaving a door to the therapy room ajar (of course arranging this at a time where others cannot overhear the conversation), arranging for patients to be seen by another therapist of the same gender or culture as the patient and discussing the issues with the patient.

Secondly, the patient has a culture and this is brought to the encounter. Some of their cultural experiences may be consonant with psychotherapy as many cultures have "talking therapies". However, such talking therapies are rarely with people who are unknown to the person, and adding the extra dimensions of the therapist potentially being of a different gender, culture and younger (age is associated with wiseness in many cultures), this may add complications to the encounter. Other cultural experiences may be dissonant with psychotherapy such as expectations of medicine or herbal remedies, or perhaps of advice rather than counselling. There may also be differences in the patients understanding of mental distress, its causes and its cure.

Thirdly, the therapist is brought up in a culture and thus brings their own culture to the encounter. Their own interpretations of psychotherapy theory and practice affect the

encounter, as does their understanding of racism or of being a minority in Britain. They may also have a western view of mental illness which may be at odds with that of their patient. Therapists should be aware that their understanding of other cultures has an impact on the encounter. This may be productive or counterproductive.

Hence, through an intercultural gaze, it is clear that a silent therapist may be interpreted differently by a white European patient (who may be expecting this) compared to a refugee fleeing their own country, where the relationship between themselves and a silent "other" might have been one of differential power relationships. For those whose experiences include torture, such an experience may exacerbate serious psychological problems. It is therefore of great importance that the psychological interpretation of such situations is recognized as different, as the intercultural aspect is explored and understood.

Finally it is the theory of psychodynamic therapy that may impinge on the process. Can psychotherapy offer the same insights into the workings of a family when confronted with the many and various different extended family frameworks? How does the theory adapt to the situation where individuals are considered not individually but as part of a community? The aims of therapy may not be to increase the individuality but work with the person to find their own solution to their difficulties within the community.

The question on the cultural specificity of psychotherapy remains an interesting one. Some of the skills and therapeutic practice have arguably universal significance, for example those of boundaries, confidentiality and interpretation. However, from the

work carried out at Nafsiyat, it seems the most important factor is whether a rapport, an understanding, can be built up between the therapist and the patient. Therapists can use therapy tools within the cultural world of the patient. This is achieved by discussion and understanding of the potential for culturally dissonant therapy practice. Modifications may be helpful on the basis of this "conversation". However, the goal of therapy is to make the therapy culturally relevant, so that the cultural significance of the material brought by the patient can be understood and the therapy can be helpful.

Table 1b

CULTURAL FACTORS IN THERAPY

Setting

Room, how arranged (ornaments, painting, cultural artefacts)

Physical distance of chairs, use of couch

Where consulting room situated – geographical location

Therapist

Culture of therapist
Language of therapy/therapist
Whether the therapist is male or female
Age (older people may be more respected)
Values, attitudes and beliefs

Patient

Culture of patient
Language of patient
Whether the patient is male or female
Age (younger people may have different cultural values or belief compared to older people)
Values, attitudes and beliefs

Therapy

Expectations of directive or non directive therapy by patient
Interpreter (possibly)
Usually one to one
Interpretation
Boundaries
Confidentiality
Emphasis on inner/outer world
Understanding of reality/fantasy
Understanding of dreams

Distress

The perception of mental illness the therapist and patient and the community.

1.12 Psychoanalysis and Mental Illness

Freud was sceptical about the use of psychoanalysis with anything other than neurotic illness. He initially said that schizophrenia was not amenable to psychoanalysis, In 1933 he writes about *The radical inaccessibility of the psychoses to analytic treatment pg. 154*). Latterly he saw it as helpful in some cases - see Freud 1927b, Freud 1950, Benvenuto and Kennedy 1986).

Most of Freud's case histories and papers record work with neurotic patients and neurotic mechanisms, with the notable exception of the case of Schreber (Freud 1911) where he addresses psychotic processes in a case history. One can argue that his papers on paranoia touched on various aspects of psychotic mechanisms and his two papers comparing neuroses and psychoses (1924b, 1924c) develop hypotheses on psychotic mechanisms, not only to illustrate his points about neurotic mechanisms, but also as an increasing part of his developing ideas on mental functioning.

Laplanche and Pontalis (1988) note that

The task of trying to define neurosis, as revealed by clinical experience, in terms of the concept of neurosis [emphasis in original], *tends to become indistinguishable from the psycho-analytic theory itself, in that this theory was basically constituted as a theory of neurotic conflict and its modes. (pg. 269).*

1.12.1 Psychotherapeutic Classification

Laplanche and Pontalis (1988) note the changing patterns in the differentiation of clinical entities. In 1915, Freud talks of *Actual Neuroses* and the *Psychoneuroses* (The latter subdivided into *transference* and *narcissistic* subdivisions); by 1924 this had developed into a four part division of *Actual Neuroses, Neuroses, Narcissistic Neuroses, Psychoses.* The present day classification is again four part but is defined slightly differently, *Psychosomatic Conditions, Neuroses,* and the *Manic-Depressive Psychoses* and *Paranoid Schizophrenia* (see Laplanche and Pontalis 1988). In this definition there seems to be much agreement with current psychological nosologies especially Foulds' Hierarchy (Foulds 1976, Foulds and Bedford 1975).

The question is whether the notion of a hierarchy is applicable in psychotherapeutic terms, i.e. are the symptoms arranged in order of increasing severity and are the symptoms of the lower categories (i.e. the psychosomatic and neurotic groups) still in evidence in the more severe illness (Foulds' "King Lear" Principle, "when the greater malady is fix'd, the lesser is scarce felt" - Foulds and Bedford 1975).

It is clear from psychotherapeutic literature that there are two schools of thought as to the whether there is any relationship between neuroses and psychoses. Freud tended to keep them distinct. In his two papers on neuroses and psychoses (1924b, 1924c), he claimed different mechanisms ("aetiologies"):

He says

one of the features which differentiate a neurosis from a psychosis.....in a neurosis the ego, in its dependence on reality, suppresses a piece of the id .... whereas in a

psychosis, this same ego, in the service of the id, withdraws a piece of reality (PFL 10, pg. 221).

Most modern day therapists and psychologists in Britain would perhaps see a continuum from the neuroses to the psychoses. However, Lacanians see the two illnesses in the original Freudian way, as separate and distinct categories. There is certainly evidence that Lacanians would not take on severely psychotic patients, while the Kleinian school of psychoanalysts (notably Bion) were interested in working with psychotic patients and are probably responsible for the development of psychotherapy from psychoanalysis. This is, in part because, because when working with psychotic patients some of the central tenets of psychoanalytic technique - five, hourly sessions per week, using verbal exchanges with the analyst sitting behind the patient - needed modification with this patient group.

1.12.2 Psychotherapeutic Issues in Presentation

Borrowing Freud's notions of *Manifest* and *Latent* (which he developed in relation to dreams, see Freud 1900), we can see that symptoms have two dimensions: the *manifest* content - hearing voices, feeling depressed, and the *latent* meaning, the meaning of these symptoms in the particular culture. Symptoms also have another function they also allow the person to be seen in a different way, as "ill" or "possessed by spirits" usually with some culturally sanctioned reduction of expectations of the "patient".

In diagnosis both the *manifest* and the *latent* aspects need to be considered. It should be that psychotherapists have privileged access to both aspects because of their way of assessment (an hour long consultation over one or more weeks). However, until they

recognise the role of the outer world, they will be unable to work effectively with ethnic minority patients and the cultural dimension of their distress.

1.13 Psychiatric Classifications

Any psychological/psychiatric/psychotherapeutic classification must have transcultural validity and conceptual equivalence (Sears 1961). Psychiatrists use two different classification systems [the DSM IV (American Psychiatric Association 1994) and ICD9 (WHO 1978)] which both show the difficulty of providing consistent diagnosic categories when symptoms vary amongst different cultures (WHO 1978). The DSM IV emphasises symptoms not aetiology, but this is a drawback as certain aetiologies appear to have better outcomes. On the positive side the D.S.M. IV has gone some way towards a pancultural ideal by identifying *Specific Culture, Age and Gender Features* for each "diagnosis". This notion of a differential diagnosis is no longer as radical as when it was first proposed by Littlewood and Lipsedge in the first edition of *Aliens and Alienists* back in 1982 and subsequently discussed by Philip Rack (1982), Suman Fernando (1988) and Cecil Helman (1984).

That there may be differences in presentation and outcome, in different ethnic groups compared to the white indigenous population, is now accepted. It is known that current classifications produce false positives when applied to the black community. There is over-representation of ethnic minorities in certain diagnostic categories, particularly in psychoses (Rwegellera 1977a). Part of the problem encountered by transcultural psychiatrists is the amount of work carried out in other cultures which is then generalised to a British migrant and second (and subsequent) generations.

This suggests that professionals will need to radically rethink how they approach the process of diagnosing mental illness to make sure it takes into account cultural/ethnic/racial factors so that appropriate and adequate treatment is available for all patients (Littlewood and Lipsedge 1997).

The D.S.M. IV (A.P.A. 1994) incorporates an important additional classification for *adjustment disorder* which seems to be a relevant "diagnosis" for migrants and particularly those who have moved to a country with very different cultural norms. It might be expected that migrants moving within Western Europe would have to make fewer "adjustments" than those who were moving from a small rural African village to a Western European city. Migration is not specifically cited, but this seems appropriate category for the particular stresses of migration. The major problem with this diagnosis is the stringent criteria. It is assumed that the reaction will begin within three months of the stressor and will abate with the cessation of the stressor or a new level of adaptation will be achieved - A.P.A. 1994). The question is whether these criteria are applicable to migrants and whether they are too stringent, as for example, a migrant whose breakdown occurs three months after migration.

The International Classification of Diseases, ninth edition (WHO 1978) had a separate category specifically for migrants, this is the relevant (although controversial) category of *culture shock* - a phenomenon that most professionals broadly acknowledge, although there is limited support for it in the literature (Parker et al 1966, Rwegellera 1980).

1.13.1 Psychiatric Presentation

There are psychiatric research reports that indicate that there are differences between the prevalence of mental illness in the original culture compared to the emigrants from that culture. However there are also similarities between the prevalences in culturally similar groups compared to different groups (Ndetei and Vadher 1984). This might suggest a tentative interpretation that there are some cultural elements in the expression of illness, and perhaps during the acculturation process a measure of difference is introduced. Differences in socioeconomic, regional background and religion have also been found to influence presentation (Crassati 1990).

1.14 Psychological Characteristics That Affect Utilisation of Psychotherapy.

1.14.1 Psychosis in Country of Origin

In order to have treatment, the illness must be recognised and there must be no "cross over" of symptoms, for example hearing voices is seen by psychiatric diagnostic systems as a symptom of schizophrenia; in other cultures it can be seen as "symptomatic" of a healer or a wise man.

The major psychoses make up a small proportion of the psychiatric illnesses yet they are the most researched, while comparatively little is known about the outcome of depression and anxiety (Sims 1983).

Debate continues over whether psychoses are universal, some finding psychosis absent in tribal peoples, others finding similar incidence/prevalence to Western findings. Others have cited specific organic reasons (e.g. trypanosomiosis) for the differences (see Kiev 1972 and Littlewood and Lipsedge 1989 for a fuller review), yet others have

argued for a genetic predisposition for certain psychiatric symptoms moderated by environmental factors (Kendler et al 1987).

As in the West, schizophrenia (or illness that approximates to the western notion of schizophrenia) is stigmatised in most non-European societies. Unlike in the West it has a better prognosis in developing countries, with shorter episodes and in many cases only a single episode (WHO 1973, Craissati 1990, Wig et al 1987a, 1987b; Westermeyer 1985, Cooper et al 1972, Lin 1953). Some (e.g. Leff 1973, 1977, 1981) have offered explanations for this (see also Leff et al 1987). Several authors report differences in outcome for *acute psychotic episodes* (Littlewood and Lipsedge 1988), which have acute onset due to a severe stressor, but with better premorbid adjustment and a better outcome (Lipsedge and Littlewood 1979, see also Westermeyer 1985); there is also a "diagnosis" of cannabis psychosis which has become a readily used diagnosis for ethnic minorities (Littlewood 1988a).

1.14.2 Differential Presentation

Somatic and non-psychological presentation of psychological illnesses, is reported with reference to ethnic minority patients (Littlewood and Lipsedge 1989, Rack 1982, Cochrane 1977, Leff 1974, Krupinski 1967, see also Hall et al 1978); for example in a British study, English patients referred to "nerves" whilst West Indian patients record "aching all over" (Kiev 1965). The difficulty with the notion of somatisation is that its use has become more generalised. I am not sure the use of "somatisation" is appropriate in the above example. The West Indian use of the term "aching all over" is describing how they feel. The English term "nerves" is also non-psychological, it is just that we understand the cultural metaphor.

In some studies somatisation is inversely related to the level of acculturation (here we could argue that migrants haven't learned the psychological language and the cultural metaphors, and similarly the therapists are not culturally astute enough to recognise this). It is positively related to age (Escobar et al 1987, Bal 1984). For some authors somatisation is the core symptom of depression in all cultures (Escobar et al 1987), for others depression and somatisation may be substitute ways of expressing the same thing (Beiser and Fleming 1986). However, recognition of the potentially important role of somatisation in psychiatric illness is not disputed, with some psychotic patients being identified through multiple somatic presentation (Reeler 1991). Here we seem to be returning to the notion of a hierarchy (see Foulds 1976 and section 1.9.2). It should be remembered that it is not just ethnic minority patients who may present with unusual beliefs, there is a high frequency of non-medical beliefs in patients who are neither obviously psychotic nor from a none western cultural background.

More hallucinations have been found in African, West Indian and Asian cultural groups than in other groups, and Ndetei and Vadher (1984) challengingly suggest that perhaps the diagnosis of schizophrenia is misplaced in some of these patients and that perhaps "hysteria" is a more appropriate label (see also Rwegellera 1977b). This taken together with the finding of somatic presentation lends support the suggestion that it may be possible to think in psychoanalytical terms of a conversion hysteria, *where there is a transposition of psychical conflict into, and its attempted resolution through, somatic symptoms which may be either of a motor nature...or of a sensory one* (Laplanche and Pontalis 1988).

Conversely, in Southern India there has been found to be a widespread belief that psychotic symptoms are the result of spirits, and hence faith healers are commonly

consulted for treatment. Culturally appropriate presentation included a high level of catatonia and culturally relevant delusional material (for example infidelity). Serious illness seemed to occur when there was a breakdown in traditional social norms (Craissati 1990). This again has implications for those migrate.

1.14.3 Depression in Country of Origin

These "less serious" illnesses are not necessarily less debilitating, over a quarter of patients in one study reported themselves as never free of the symptoms (depression having a significantly poorer outcome than anxiety), and the majority of these patients were on (or had been given) psychiatric medication (Sims 1983).

The universality of depression is controversial (Kleinman 1980,1987). In developing countries it is seldom described locally, perhaps due to a lack of facilities (Burke 1974, Rwegellera 1977b, Littlewood 1985) or the use of traditional healers (Kiev 1972, Littlewood 1985, Vogelman 1986a,1986b). Burke (1974) notes that in Trinidad and Tobago there is little difference in the admission rates for African and East Indian population of similar social class. However, some differences are found in the differential diagnosis, for minor depression East Indian patients were diagnosed as having a reactive depression more often than the African population (the reverse was true for major depression).

1.15 Psychological Characteristics That Affect Utilisation of Psychotherapy.

1.15.1 Access to Care in the UK

Only a small minority of those who are mentally ill reach the psychiatric services (Goldberg and Huxley 1980, Shapiro et al 1984) with prevalence rates for the general population varying between 10% and 20% (Bebbington et al 1981) up to almost 27% (Eastman and McPherson 1982). The main arbiter of access is the general practitioner, but migrant West Indian and African people are less likely to be referred to the psychiatric services through their G.P. (Rwegellera 1980). Historically, the reason may be that many ethnic minorities were (and perhaps still are) not registered with a G.P. (Rwegellera 1980). Kiev (1965) in the UK found the West Indian population registered with a G.P. was skewed to the 26-35 age group (perhaps reflecting migration patterns) and these were generally unskilled workers in social classes IV and V. They attended the G.P. more regularly and had significantly more "conspicuous psychiatric morbidity" (this has to be balanced against the finding that somatisation is more prevalent in this group - 1.14.2) than the English group (a six month prevalence rate of 17.4% compared to 12.6%) although this was not controlled for age.

1.15.2 Admission to Hospital

Of those who do get to psychiatric assessment a disproportionate number of black patients (born in Britain, the Caribbean and West Africa) are involuntary patients in psychiatric hospitals under the Mental Health Act. It has been found that black patients are more likely to see a black doctor (over 60% of junior psychiatrists are born

overseas), are more likely to see a junior doctor (Littlewood and Cross 1980), and yet paradoxically are likely to present with more severe pathology. Although black patients are more likely to be diagnosed schizophrenic some authorities claim that affective disorders in black patients may be misdiagnosed as schizophrenia (Lipsedge and Littlewood 1979, Littlewood and Lipsedge 1989, Fernando 1988), with such patients twice as likely to have their diagnosis changed during treatment (Lipsedge 1985). This latter point may also reflect on the relative diagnostic inexperience of the junior doctor. It seems that black patients are less ready to approach hospital services, and they will only be admitted if they are they are diagnosed as schizophrenic (Littlewood 1988b).

Some surveys suggest that West Indian immigrants experience higher number of admissions (Rwegellera 1970, 1977a, 1980. Littlewood and Lipsedge 1989); others suggest the proof is not at all conclusive (Leff 1981, Ineichen et al 1984). There seems to be consistency in the finding that Asians seem to be underrepresented (Rack 1982), although this may be changing (see Beliappa 1990).

The degree of over-representation of ethnic minority patients varies, but most studies suggest that it is between two and three times the white UK born rate (Littlewood 1986b, see also Pinto 1970). McGovern and Cope (1987) suggests the figure may be as high as three to five times the white rate while Harrison et al (1988) have suggested that the admission rates for ethnic minorities vary from 3 to 6 times the majority population even when sociodemographic details are controlled (see also Cochrane 1977). Race/culture/ethnicity seems to be implicated as results show that it is not only the immigrant generation who have increased admissions for schizophrenia, but also the second generation (Harrison et al 1988). Another explanation is that the

effects of immigration have longer term effects than previously thought, perhaps spanning generations. One factor may be the increased risk of depression in the migrants: the literature relates depression in parents to an increased likelihood of children developing depression (Anthony 1983). Another factor would be that outer world problems (e.g. racism) face all ethnic minority people whether they are migrants or not.

1.15.3 First Admission

Dean et al (1981) found a higher incidence of first admission for schizophrenia for people from the Caribbean (five times the expected) and Africa (four times the expected number) and India (three times the expected number) whilst single (not currently or previously married) immigrants are more at risk than other groups. New Commonwealth women are more at risk from depressive psychoses, while immigrants from Poland and Germany with a diagnosis of schizophrenia are also represented significantly more than expected. However, immigrants from the New Commonwealth were significantly underrepresented in alcohol related diseases.

Three contrasting hypotheses have been put forward to account for the higher levels of mental illness in migrants: the selection theory (migrants either came to the new country with the illness or were particularly vulnerable (see also Odegaard 1932)); the social causation model (changes in life style, economics and family life, and language and values might cause mental distress - See Cochrane 1983 for a fuller review); the third hypothesis, proposes a higher or lower level of morbidity in the country of origin (Rack 1982). These hypotheses are not sufficiently sophisticated to

represent the complexity of migration (Murphy 1977), as for many migrants all may be operating, with different weightings at different times.

However such differences are difficult to assess. A census of all mental hospitals in 1903 in the USA found that there were more than three times the expected percentage of immigrants in these institutions. When the data was reevaluated (Malzberg 1936, 1940), it was found that if influencing variables were taken into account (gender, age, class, and marital status) then the proportion of immigrants in mental institutions was about the same as in the community (quoted Furnham & Bochner 1986). This is supported by a recent British study, Bouras et al (1983, see also Bouras 1982) at the Lewisham Walk-In Centre found the overall percentage of patients from the minorities was similar to their proportion in the community

So perhaps we should be asking the more sophisticated question as to whether they have higher rates and, if they do, under what conditions this happens (see also Littlewood 1988b).

1.15.4 Differential Admissions

The other consistently reported finding is that young Afro-Caribbean men in Britain present as disturbed, the degree of disturbance (especially violence) determining admission to hospital. Rwegellera (1980) claims that migrants unconsciously learnt to behave in this way to gain help; while Harrison et al (1984) suggests that such presentation is related to living in the inner city. A third explanation is that they do not seek help early and hence come to hospital when they are very disturbed (see 1.15.1). What is not in dispute is the fact that degree of disturbance is related to diagnosis of psychosis and compulsory admission.

Psychiatrists have tried to explain these differential admissions by saying that psychiatric illness is different in black patients more acute, florid and aggressive[42]; it is more "toxic" therefore less likely to resolve in the social context, there are different patterns of illness, sometimes it has been thought that the illness has migrated with the culture (see 1.14), that the culture is pathogenic, that black patients are uncooperative. The more liberal psychiatrists suggest that aggression came as a response to racism (see Sayal 1990).

Others suggest that ethnic minority communities stigmatise illness more, therefore patients are less likely to come forward, the model of illness is more antisocial, ethnic minority patients coming to hospital later (twice as many West Indians came to the attention of mental health professionals in a "walk-in" clinic in Lewisham through the crisis intervention team than through the "walk-in" service, whilst for other ethnic minorities the ratio was slightly reversed - Bouras et al 1983). The corollary of this is, of course, that they are more ill and less likely to accept treatment (but see Craissati, 1990, Wig et al 1987a).

1.15.5 British Born Minorities

Several authors predicted that the rates of mental illness of the second generation (British-born) would conform to the white British-born population (e.g. Cochrane 1983). Recently, Harrison et al (1988) reported that the rates for schizophrenia are higher in all Afro-Caribbean patients and especially amongst the second generation identified using the Present State Examination (Wing et al 1973). McGovern and Cope

[42] One could argue from a psychotherapeutic viewpoint that, people living with racism (a form of aggression) may project out the aggression that has been introjected during their experiences of racism, and hence it is unsurprising that aggression is one of the prime features of presentation. Moreover, the experiences of racism may also make them feel very vulnerable when in contact with institutions seen as part of a racist society, and exacerbate the aggressive feelings.

(1987), report incidence rates of psychoses amongst the same group of 13.8 per 100,000 population for male patients and 9.8 per 100,000 population for female patients (second generation), compared to 2.05 and 0.7 respectively per 100,000 white population (in the same age range of 16-29 years). Hence the rates for ethnic minority men are 6 times that of the white population; while for women the rate is thirteen times that of their white counterparts.

1.15.6 Outcome

Prudo and Munroe Blum (1987) looked at five year prognosis and outcome in 100 patients and found that West Indian patients were over- represented in the sample, and underrepresented in the follow up[43], due to the repatriation of these patients to their country of origin. Race was a factor, in interaction with others (e.g. housing status), in poor clinical and social outcome. A longitudinal study found that class seems to be important, as immigrant groups were no more likely to become hospital inpatients than others from urban central areas from low social classes, but were more likely to be compulsory admissions (Ineichen et al 1984).

1.15.7 Depression in Ethnic Minorities in the UK

Misdiagnosis (and the underrepresentation) of depression in West Indian patients has been found in one study (Cochrane and Bal (1987), see also Fernando 1988), while outside hospital one study of minor psychiatric disorder found higher rates of depression and psychosomatic illness in Afro-Caribbean people (Burke 1984).

[43] There are problems with follow ups, Rosser et al (1986) note that at follow-up interviews, five years after discharge from inpatient psychotherapy, some patients were "upset" by being recontacted.

1.15.8 Better Adjustment in Immigrants

However, just being a migrant does not automatically increase the chances of becoming mentally ill, some internal migrants have more mental health problems than migrants from the New Commonwealth (Murphy 1977).

Some studies have shown better adjustment in a immigrant population as measured by hospital admissions (Cochrane and Stopes-Roe 1977, Murphy 1965, for a full review see Murphy 1977). One study found no significant difference in the slightly different concept of "conspicuous psychiatric morbidity" between English and West Indian women (Kiev 1965). Other find the reverse e.g. Pinsent (1963). However, age was a factor in this study, concentrated in the younger age groups in West Indian population (perhaps due to migration patterns) and the older English population, and we know that psychosis is more common in a younger population. Murphy (1977) notes the better mental health in some immigrant communities, in most cases in relation to non-schizophrenic psychosis (in Israel, Singapore - Murphy 1961, in Canada - Murphy 1965, in America - Parker et al 1966). What is particularly interesting is that all these studies showing less severe mental illness appear to be older studies. The later studies show differences, why this should be is unknown but perhaps some of the social as well as psychological problems of migration can be implicated here, as may the finding that white researchers tend to minimise the effects of ethnicity (Abramowitz & Murray 1983). Clearly there appears to be a problem about migration in the long term which has yet to be investigated.

What these studies reflect is the lack of detailed work on why certain ethnic minorities have higher rates of admission (if they do), what triggers this, what the effect of their specific life experiences are, and which therapies are the most effective. There is also

the difficulty of generalising studies carried out in different countries and generalising to the migrant population in the UK to be considered here.

1.16 Sociological Proneness

The sociological explanations for the increased rates of mental illness in ethnic minorities range from the differential patterns of migration (see 1.10 [1]) to sociological explanations of limited opportunity and psychiatric explanations of culturally determined response to stress and service utilization (Littlewood 1988b, Sayal 1990). Other factors that have been identified which can be related to the development of depression are poverty, early bereavement and maternal deprivation (a feature of some migrations, particularly those from the Caribbean) (Grad de Alarcon 1976 see also Bowlby 1977). There is an inverse relationship between increased rates of mental illness and social class. (Murphy 1983, Grad de Alarcon 1976). Sayal (1990) suggests that expressions of frustration and anger at racism can be labelled mental illness.

1.17 Therapy Research

1.17.1 Research and Psychotherapy

Freud held that empirical research on psychoanalysis was redundant as the tenets were conclusively established. While this view has been vigorously debated (e.g. Eysenck 1952, 1985, Gellner 1988), most traditional analysts do not recognise the need for an empirical research (e.g. Greenberg 1994).

Bloch (1982) describes this as a "rickety bridge" between researchers and practitioners but I believe he is underestimating the chasm between researchers and clinicians. Recently Talley et al (1994) tried to "bridge the gap" with a book where clinicians and researchers discussed therapy research. The editors' concluding chapter, which tried to find common factors, showed the lack of a consensus between the two camps and how far apart they were (clinicians wanting case studies and researchers demanding empirical outcome studies). Points of agreement were few (Talley et al 1994). This is the crux of the matter. Differences in aims between researchers and clinicians (and subtle differences in technique) make finding meaningful dialogue and a common language an aspiration for the future.

There is a consensus is that research should be carried out. There are now over 400 distinct types of therapy (Karasu 1985) and there is a need to evaluate which therapies are effective, and whether some approaches are better with some patients with certain identified symptoms. The questions at the heart of the debate are how should it be carried out? The difficulties are well summed up by Candy et al (1972): What should be

measured? How should it be measured? What technique should be used? Who should be involved in the evaluation?

1.17.2 Evaluation of Psychotherapy

Four ways are commonly used to evaluate psychotherapy: process research, single case studies, variable research and outcome studies. Variable research tries to identify key factors in the therapeutic relationship. Outcome studies evaluate whether psychotherapy causes any perceptible change in functioning of the individual, usually using an "objective" measure of change, for example, Luborsky (1971, 1988) recommends the use of Sanford's (1962) model: pre-treatment measures plus post-treatment measures (at termination, then at one year following termination).

Practicing psychotherapists tend to use, preferentially, case reports and sometimes process reports. They want to change the emphasis from outcome to process research (e.g. Sanford 1953, Holmes 1985, Greenberg 1994) which they feel has greater resonances with the therapeutic process and hence will produce more accurate results[44]. On the other hand, other researchers (usually non-clinical) feel that there should be more outcome studies (Paul 1967, Luborsky 1975).

Goldstein et al (1966) amongst others have argued that the best way of assessment is having the results accumulated over thousands of studies (cf. Smith et al 1980). However, such meta-analyses, such as that carried out by Smith et al (1980), have been criticised because they rely on selection of research, assume it is of similar quality, and ignores the fact that researchers often do not report insignificant results that do not tie in with their hypothesis, etc. (Strube and Hartman 1982).

[44] This of course reflects their interest as practitioners. Their emphasis is primarily not whether therapy works, but what techniques or theory worked or didn't work with a patient.

Rachman and Wilson (1980) point out that there are three basic assumptions in all conventional outcome research. The first is that there is an implicit accommodation of psychological difficulties within a medical model: hence the use of "neurotic" (cf. the French schools of psychoanalysis who have moved away from "psychiatric" diagnosis which they see as merely a clinical picture and towards providing a concept that understands the illness and hence provides a treatment strategy). Secondly, there is an assumption that a key symptom, anxiety, is a unitary concept and a universal experience; they note that Lang (1969) defines "anxiety" as a set of at least three loosely coupled components - verbal reports, behavioural avoidance, and psychophysical changes. The third assumption is that while setting up their own measures of therapeutic change (such as therapists' impressions, patients' expression of satisfaction, changed scores on personality tests etc.), they have adopted rather soft (non-quantifiable) signs of change. To this list I would add the assumptions that whoever carries out the therapy (whether trained or not) is actually facilitating change through psychotherapy, that therapists are of comparable skill as therapists and that all psychotherapy is addressing the same kind of problems (e.g. "neurotic" problems).

Shapiro et al (1987) quoting Luborsky (1971) notes that although there are over 400 distinct types of therapy (Karasu 1985) most return to the Dodo's verdict "all have won and all must have prizes". Authors have found various levels of "success" (e.g. Meltzoff and Kornreich 1970 - 75% effective, Luborsky et al 1975 - 60%, [See also Bergin 1971 Smith et al 1980]) and it seems that most psychotherapy has moderately positive effects, (see Garfield and Bergin 1986 for fuller review).

However, there are special problems of evaluating psychotherapy with ethnic minorities. Not only are they traditionally excluded from the talking therapies but are often are excluded from the research protocols altogether. As late as 1996 the National Institute of Health in America decided that it was only funding research that was truly representative - by including ethnic minorities and women in all funded research. Hence reports on the efficacy of psychotherapy with ethnic minorities are few and far between, and are either case history reports or more rarely a few ethnic minority patients within a larger evaluation of psychotherapy (e.g. Luborsky 1988). Their individual contributions to the outcome study are not separately evaluated (usually because there are so few of them). In the first case they are seen as exceptional results are seen as not representative of therapeutic work with ethnic minorities, or in the second, there is a loss of potentially positive results which would provide an impetus for clinicians to take on ethnic minority patients.

However, it is important to consider that the goals of therapy, and thus its evaluation, present special problems for patients and therapists of different cultures. Who defines normality? (Rosen 1962 cited Rosen 1967). Who defines an "acceptable change in personality"? (Parloff 1967). Do minority patients simply want the removal of distressing symptoms, as many psychotherapists argue? Does psychotherapy change the personality, or merely reframe presenting difficulties? (See Mahrer 1967, Wolberg 1967). Strupp et al (1969) note that concepts like cure, improvement are only meaningful in the broadest sense:- what constitutes this, who is to be the judge (patient, therapist, patients' family, outside observers), and they query how long the changes have to continue before they are considered "true" improvements .

1.17.3 Best Time for Evaluation

The most successful predictors of outcome were those based on reports during early sessions rather than before therapy started. Hence, taking on a patient who conformed to the YAVIS criteria (see section 1.9.3 would seem to be predictive of a good outcome. Yet they might not feel comfortable in a talking therapy, and hence it would only be after the first few sessions that it would be clear whether they would be able to benefit from the therapy. Correlations between end of treatment assessments and follow-up assessments tend to be high (Luborsky 1971), i.e. those who do well at the end of therapy continue the gains after therapy is completed.

1.17.4 Variables in Therapy Research

All evaluations of therapy are predicated on outcome, whether the research has been of the case history, process or outcome research. For example, therapists reports tend to reflect issues arising in therapy. From this they make a judgement whether their interventions had positive or negative effects on the therapy. They then propose changes (to technique or theory) that are necessary to "update" the theory (see Kareem and Littlewood 1992, 2000).

Remembering that the evaluation of psychotherapy is generally confined to neurotic patients (Rachman and Wilson 1980), which Cawley (1983) contrasted with the primacy of research into psychosis by psychiatry. However, even with this limitation, Beutler (1991) notes that the number of permutations which could usefully be carried out in psychotherapy research involving combinations of individual, family or group therapy, with different types of therapy e.g. psychoanalytic, psychotherapeutic, insight and nominal variables such as ethnicity (which itself is ill-defined - Reid 1989),

diagnosis etc., together with therapist variables (Shapiro et al 1989) runs to about one and half million possible combinations, which suggests the early hopeful view that soon relevant factors in the selection for therapy would be identified are some way off.

Muench (1968) also notes that such variables are difficult to measure as they are often covert, non verbal, internal and subtle, and others suggest a need to define goals operationally (Hart 1978), provide tools to measure these and define the nature of counselling (Volsky et al 1965). Cartwright et al (1963) argue that there is no conceptually valid way of assessing change (see also Koenigsberg 1985) and a single score cannot adequately reflect the changes in therapy.

However, despite the difficulties there have been an increasing number of evaluations of specific aspects of the therapeutic encounter including patient attributes (sociodemographic and therapeutic), therapist variables (sociodemographic and therapeutic), and therapy variables.

1.17.5 Patient Attributes

Beutler (1991) notes that over 175 different patient characteristics have been used by investigators over the years as relevant to outcome. There are real difficulties with this as they have weak associations with therapy theory, he refers to this as *happenstantial* (i.e someone happens to see an interactive effect). With this caution, the general trends will be discussed. It is interesting to note that for an "internal science" the variables with most written about them are sociodemographic factors. The reasons for this seem to be that

- most researchers tend to collect sociodemographic data as a matter of course.

- Early work showed little evidence that changes in technique had any effect on outcome, so other factors required investigating (Strupp et al 1973).
- Most psychotherapists only take on the white middle-classes, fulfilling the YAVIS criteria (see 1.9.3)

1.17.5.1 Ego Strength

Ego strength is a psychoanalytical measure of psychological functioning that has been used in several studies (Kernberg 1972, Malan 1976, Rosser 1987) and is a subscale of the MMPI (Barron Ego-Strength Scale). High ego strength is a positive predictor of suitability for psychotherapy. However as Lake (1985) notes there is no consistent definition of how it is identified, described or measured, with many clinicians using it synonomously with ego, self or identity. Lake (1985) suggests that ego strength can be thought of in terms of the ability to be self supporting, self sufficient, the capacity to form relationships (and deal with difficulties within these and losses within these) and maintain a realistic level of self esteem.

These findings were reiterated in the Vanderbilt study (Strupp & Hadley 1979) although expressed in slightly different terms (high motivation, ability to form good relationship early in therapy and relative absence of long standing maladaptive interpersonal patterns). They recognise, unlike others that "low ego strength" can be modified with work done at the beginning of therapy but this then requires long term therapy. Gottschalk et al (1967) contrast this with finding that patients with higher psychiatric morbidity fared best in 6 session (brief therapy) (see also Lake 1985).

Husby et al (1985) looked at slightly different factors and found at least one adequate "give and take" relationship during the patient's life, adequate contact with the interviewer during the assessment interview, problem-solving capacity and motivation for change were positive predictors.

All these findings imply that the ability to form relationships is an important factor in the positive outcome of therapy and patients are selected on this basis, as patients have to be able to form a therapeutic relationship (Fieder 1950).

1.17.5.2 Positive Predictors of Outcome - Some Patient Characteristics

Positive predictors of outcome include; adequacy of personality functioning, absence of schizoid trends, motivation, positive expectations, intelligence, initial anxiety, capability for deep feelings (Crown 1986, Kernberg 1972, Luborsky 1988), ego strength, good physical health, spontaneity, ability to share experiences, good reality sense, personal adequacy, ability to cope, general capacity for personality integration and lack of racial prejudice (Baron 1953), motivation for change, psychological nature of symptoms, introspective tendency, honesty, taking an active part in therapy and a desire to change (Sifneos 1979). Student status is associated with improvement, whilst professional people are more likely to complete therapy than the general population (Luborsky 1971).

1.17.5.3 Negative Predictors of Outcome - Some Patient Characteristics

Obviously the opposite qualities to the ones that are described in the previous section would be predictive of poorer outcome as are the more serious diagnoses (Luborsky 1971). People with flattened affect, unsurprisingly tend to do badly (Luborsky 1971).

1.17.6 Therapist Variables

Ironically some of the best evidence that psychotherapy works comes from studies of behaviour therapy, where psychotherapy has been used as a control group (Rachman and Wilson 1980). It is interesting to note that in most of these studies the

"therapist" was untrained or in training - it might be expected that if therapy works it will be the trained and experienced therapists who achieve the best results. This poses the question whether better results could have been achieved with well trained, experienced therapists.

Although the results on therapists' experience are contradictory with some studies (e.g. Bergin 1963, Luborsky et al 1971, Strupp and Hadley 1979, Luborsky et al 1988) showing that experienced therapists get better results than inexperienced ones, others (e.g. Strupp 1958) found the reverse. Recently Clemental-Jones et al 1990 showed that trainees under supervision produced good results (5 out of 11 best outcomes were by trainees under supervision).

However, in all these studies there is the implicit assumption that it is possible to measure skill by the number of years that a therapist has been practicing. This is, at best, an arguable assumption. A poor therapist may remain a poor therapist no matter how many years experience they have.

Moreover the patients that the therapists rated as more likeable, had a better outcome than others (Lorr 1965), leading to the suggestion that success is related to the personality of the therapist (Eissler 1943). Moreover patients who rated their therapy as successful, rated therapists as warm, attentive, understanding, interested and respectful. Patients rated by therapists as successful produced similar descriptions of their therapists, whilst those with poorer outcome reported more uncertainty about the therapists' attitude to them (Strupp et al 1969).

This is perhaps explained by the fact that "the relationship" is the basis of psychotherapy (Fiedler 1950) and that the ideal therapeutic relationship is based on empathy, rapport and understanding. Luborsky et al (1971) identified as important

empathy and similarity of patient to therapist (this has particular resonances for intercultural work). Rogers (1961) noted that therapists who showed the above characteristics had 90% improvement in their patients whilst those judged to show less had only a 50% improvement.

1.17.6.1 Ethnic Matching

Harrison (1975) showed that counsellees preferred counsellors of the same race, and Luborsky et al (1988) found similarity between patient and therapist was related to a good outcome. On the other hand, Jones (1978) showed that outcomes were similar for short- term dynamically oriented psychotherapy for cross-race and same-race dyads, and Miranda and Castro (1977) found that Mexican American bicultural/bilingual therapists (when matched similar patients) did not necessarily produce a good outcome, acculturation of the patient was a more potent predictor. Here the unacculturated patient would have a different worldview to the acculturated therapist. Unsurprisingly, ethnocentrism was found as a negative predictor in 2 out of 3 studies (Tougas 1954, Barron 1953; non-significant in Rosen 1954)

1.17.6.2 Therapist as Researcher

Luborsky et al (1975) found that in most studies it was the therapist who was the most common means of assessment, (the majority of their patients are seen by them as making slight to moderate gains). When the client assesses the therapy most forms of psychotherapy are 50% more likely to produce an improvement compared to no

therapy (Smith, Glass and Miller (1980 see also Howarth 1989), with little difference between techniques.

Feifel and Eells (1963) however found important differences in emphasis between the reports of the patients and those of their therapists. Therapists gave greater importance to insight and technique, whilst patients rated self-understanding and self-confidence as important. Given the inevitable bias, we need to use "independent" measures of well-being, and then see how these correspond with the opinions of both therapist and patient. Clearly everybody wants their patients to do well, this factor has to be taken into account in the area of inter-cultural work where so much seems to rest on the question "does it work?"

1.17.7 Therapy Attributes

Most "dynamic" psychotherapies take as their starting point psychoanalysis and develop their theories and therapies from this. Some deviating more than others from the central ideas. This presents difficulties in comparing results of therapy, the notion of "cure" depends on what you were aiming to do - symptom removal or rebuilding personality. There has been a gradual increase in the length of time an analysis takes from the short term work carried out initially by Freud and his colleagues (e.g. Studies in Hysteria, Breuer and Freud 1895) to the ongoing work reported in the various psychotherapy journals of several years of work. However, at the same time some therapists have shortened the time that therapy takes, and the brief (Malan 1975) or time limited therapies (Mann 1973) (see Malan, 1975, Sifneos, 1972, and Davanloo 1978), have become increasingly important. Some of this has financial

implications. Even within distinct schools of therapy, technique varies between therapists).

Those analysts committed to long term work criticise the short term school as causing patients to have "a flight into health", "transference cure" or in one case a "counter-phobic reaction" (Molnos 1986). However, most clinicians see patients for short term work (whether planned or otherwise) (Howard et al 1995)and most evidence has shown no difference between time limited and time unlimited treatments (Luborsky et al 1971).

This may be due to the fact that there is no consensus over the length of short term work, Garfield (1978) notes that the median number of sessions in short term work is six, and two thirds of patients have less than 10 sessions. In their review of brief therapy, Koss and Butcher (1986) say many clinicians recommend 1 to 6 sessions, with the upper limit for brief therapy being about 25 sessions, with therapists working around an 18 week session contract or less. Howard et al (1995) suggests that the median is about 15 sessions. For Malan (1975), short term is between 10-40 sessions, for Frank (1974) it is 3-6 months. Despite the overlap the consensus seems to be that long term (in psychotherapy) is between 6 and 18 months (cf. psychoanalysis where "long term" is considered in years).

Short term work aims to relieve symptoms (Wolberg 1977), enabling people to gain some control over their lives (Gustafson 1986). Some short term work combines psychoanalytic concepts - concentration on maintaining stability of "the setting", setting boundaries etc. (e.g. Gillieron's short term psychoanalytic approach (Molnos 1986), Nafsiyat intercultural therapy (Kareem 1992, 2000)). Because of its limited

nature, planned short term work is the basis of most research (notable exceptions include the Menninger Study, (Kernberg et al 1972, see also Luborsky et al 1971).

1.17.7.1 Time in Therapy

But is outcome necessarily improved by a greater length of time in therapy or the frequency of sessions? Evidence suggests that the frequency of sessions (once a week, twice a week or every 6 weeks) had no effect on outcome (Lorr et al 1962). Others have noted symptomatic improvement in half a therapy cohort after one assessment interview; with just under a quarter of these showing partial psychodynamic change (Malan 1975). Furthermore, Schlien et al (1962) noted that patients in time-limited work showed more symptomatic improvement after 7 of their 20 sessions than did a similar group, at the same stage in open ended therapy, although whether this was due to the different emphasis of therapists in time limited work (i.e. interventions, aim of therapy being symptomatic relief as opposed to work on personality, type of presenting problem) is not clear.

On the other side of the argument, Clemental Jones et al (1990) in a retrospective study, claim that people with poor adjustment/severe pathology and a bad childhood benefit most from at least 40 sessions. With the best results found around 60 sessions. Such childhood disruption as experienced by ethnic minorities may imply longer term work is appropriate. They also assert that people who get more therapy, benefit more, and they quote the Oslo study which notes that at a 2 year and 5 year follow up patients continued to improve significantly (the so called sleeper effect - Husby et al 1985). For unlimited psychotherapy, the longer the treatment the better the outcome (Luborsky et al 1988).

1.17.7.2. Dropout from Therapy

Some people "drop out" from therapy. From previous work for the "usual"[45] psychotherapy clients, it might be expected that up to one third of patients would refuse treatment at an initial session (Garfield and Kurz 1952; Rosenthal and Frank 1958 - cited Garfield and Bergin 1986), and up to 41% might not return after the initial assessment session. It might be expected that there might be attrition of patients (from all backgrounds) during therapy at a rate between 20 - 65% and about two thirds of patients might be expected to terminate their therapy before their 10th session (Foulks et al 1986, Garfield and Kurz 1952, quoted in Garfield and Bergin 1986).

Foulks et al (1986) note that cultural beliefs about illness were more important in initiation and termination of treatment than race, sex, demographic or diagnostic categories (one third of the group was non-white). Moreover they found that the more medical the patients' explanation, the better the patient at termination and the more visits made to their centre (i.e. the therapy was *emic,* and thus consistent with the patients' worldview).

However, for black patients (in the USA), results show more attenuation with up to 75% of patients only attending one interview (Kahn and Heiman 1978 cited Garfield and Bergin 1986), Black patients were shown to attend fewer sessions and terminate earlier (Sue, Mckinney, Allen and Hall 1974 cited Garfield and Bergin 1986), even after moves to increase ethnic sensitivity (Sue et al 1991, Yutrznka 1995). Is this the *latent importance of "speaking a common language"* (Parsons 1969)?

Paradoxically, Sue et al (1974) note that those patients who did not drop out from

[45] Young, White, Middle Class.

therapy became more engaged in individual therapy. However, in his report, there were almost twice as many black patients dropping out as whites (52% to 30%). Berrigan and Garfield (1981) suggest that premature termination (before 6th session) is related to low social class. This is supported by the Penn study (Luborsky et al 1988). However, as only one eighth of the patients in the study were "black" or "Oriental", they did not evaluate the effects of ethnicity, but age, sex or previous therapy was not related to premature termination. Of course, "premature termination" may be due to the patient having resolved what they wanted (Rosen 1986).

For Caccia and Watson (1987), 87% of those referred attended the initial assessment, for Hutton (1985) there was a overall 24% dropout rate, with a slightly lower (22%) rate for self referrals.

Long waiting time was negatively related to outcome, (Gordon and Cartwright 1954, Uhlenhuth and Duncan 1968); this has implications for waiting list controls, as it can not be thought of as a neutral no therapy situation (Luborsky 1971).

Somewhat surprisingly, previous analysis does not predict current outcome (Luborsky 1971). There seems to be little evidence that changes in technique have any effect on outcome (Strupp et al 1973).

1.18 Spontaneous Remission

The problem with using short term work as a focus for research is that, firstly psychoanalysts do not see it as reflecting their way of working and hence do not learn some of the interesting lessons that such research provides (including the range of people for whom psychotherapy could be an effective treatment option). Secondly, as the average duration of neurotic illness has been shown to be between one and two

years, such illnesses are the "usual" ones chosen for therapy (Sheppard and Gruenberg,1957), and critics such as Eysenck (1952) have suggested that cure may be due to spontaneous remission rather than therapeutic efficacy. On the other side of the argument there is evidence to suggest that psychoanalysis gets better results than would be expected by spontaneous improvement (Howard et al 1995, Shadish et al 1997).

However, are the spontaneous remission rates for ethnic minorities different? Moreover, the assumption that "spontaneous" implies "uncaused", is not tenable as people do not live in a contextual vacuum and "spontaneous remission" rates are likely to improve by sharing problems. Therefore, when considering the efficacy of "therapy" it is not talking of the effects of diffused psychotherapeutic processes which may occur in many, probably most, communities, so much as a specific additive procedure.

1.19 Contraindications to Therapy

Psychotherapy is seen by therapists to be good for most people (Smith et al 1977, Lesser 1979, Smith et al 1980, Andrews and Harvey 1981, Smith 1982, Manos et al 1984, Chadwell et al 1979), and this is why, Reisman (1971) argues, there is a lack of research. Although some authors would argue there are no contraindications (e.g. Carvalho 1986), Bergin (1970) pointed out if there was a potential for benefit (i.e. something changed) it could also change negatively. There are some studies that suggest that psychotherapy may be less helpful (if not damaging) to some people (Bloch 1982, cf. Freud 1927b).

Evidence suggests that people in treated conditions who do not seem to benefit from therapy, may have poorer outcome on review than if they had not been offered therapy (see McCord 1978). An "impossible" social situation is also identified as a contraindication (which has particular resonances in ethnic minority work, particularly therapy with refugees).

1.20 Summary

This chapter reviews some of the difficulties with providing adequate mental health care for people from ethnic and cultural minorities. It identifies issues in classification, access to care and diagnosis, together with the differing psychological views on the effects of migration. It attempts to draw together some of these findings to account for the differential treatment of ethnic minorities, whilst recognising the differences and similarities of experience of migrants and second and subsequent generations. The chapter reviews the little research on ethnic minorities in therapy and relates this research to other findings that may have resonances for intercultural therapy.

CHAPTER 2

THE NAFSIYAT INTERCULTURAL CENTRE

2.1 Overview

Nafsiyat was set up in North London in 1983, to provide community based "intercultural" psychodynamic psychotherapy for patients from diverse cultural backgrounds. The relevance of "intercultural" was derived from the fact that not only do the therapists work with cultures and ethnicities different to their own, but also that the therapists themselves came from a wide range of ethnic and cultural backgrounds themselves. "Nafsiyat" translates as "mind, body and soul" and is an acronym derived from Sanskrit, Persian and Aramaic. The choice of name was indicative of the therapy to be offered, a therapy that not only would have its frame of reference within the "inner world" of classical psychodynamic thinking, but recognised and took into account elements of the "outer" social and physical world (see 1.6).

The Centre's staff argued from the inception of Nafsiyat, that the therapy offered would be "emic" to the patients and that they would not be imposing a "western" treatment inappropriately. They argued that understanding the unique ethnic and cultural backgrounds of the patients, the patient's worldview, as well as grasping the meaning of their presenting symptoms based on this understanding (in the terms of psychodynamic language used in this thesis: the manifest and latent meanings, see 1.12.2), would lead to a successful and helpful therapeutic relationship.

2.2 Origins of the Centre

The motivation for the Centre began during the 1970s. A group of professionals (from a range of cultural backgrounds) working in the health and social services, recognised that ethnic minority patients were presenting with psychological problems that would be expected to respond to psychotherapy. However, they also were aware of the difficulties of placing patients in therapy due to the apparent reluctance of therapists to consider people from different ethnic and cultural origins as appropriate for psychotherapy. This, together with the fact, that therapy is a "rationed" resource (usually by ability to pay for therapy) meant that there was nowhere to refer such patients.

They also recognised that there were real difficulties for therapists. Their experience suggested that the differences in, for example, language, cultural expressions and metaphors and the way illness was expressed - typically "somatic expression" of psychological and psycho-social problems - meant that patients' needs might not be understood, and therefore appropriate psychotherapeutic treatment might not be offered (See 1.14.2. and Kareem 1992, 2000).

Therefore, the "Intercultural" service they developed, whilst grounded in traditional psychotherapy principles, also addressed the life experiences of the patients, racism, culture, ethnicity (see 1.2), the issues of migration, as well as the experiences of separation and loss which are fundamental to most (if not all) intercultural work (see 1.10).

When established in 1983, Nafsiyat had three main functions:

- Psychotherapy with adults, adolescents and children.
- Advice, support and training for other professionals working in primary health care, the social services and psychiatry.
- Case consultation for other professionals.

It was funded on 3 year joint inner city partnership funding. Initially patients were seen at the, then, Clinical Director's private practice premises. Moving from there to Archway (North London) and the following year into its current premises in Finsbury Park, North London, occupying the first and second floors above a shop on the high street of Seven Sisters Road, close to Finsbury Park Underground station. It recently has acquired the third floor of the building, increasing the number of clinical rooms by two. It is currently funded by Islington Council and the Camden and Islington Health Authority.

Nafsiyat was intended to replace the various "ad hoc" psychotherapy services that these professionals had been providing for minority groups. It was also anticipated some therapy would be in a patients' own language, hence the importance of training psychotherapists from different cultural backgrounds. The *retrospective* study indicated that most therapy was carried out in English. This does not preclude the importance of different languages in therapy, and perhaps reflects the unique nature of the Centre and its patients and the primacy of culture in therapy. In the early 1990's an intercultural therapy diploma was set up, and a couple of years later an M.Sc. was offered with University College, London. The diploma and M.Sc. has trained some of

the therapists currently working at the Centre, and as can be seen later (2.7) has contributed to the increase in the number of languages offered .

2.3 Theoretical Assumptions behind the Therapy

The therapy offered was primarily a form of dynamic psychotherapy described generally by the first Clinical Director, Jafar Kareem, as a psychotherapy "that takes into account the whole being of the patient ..... believing that for successful outcome of therapy, addressing these conscious and unconscious assumptions is essential" (see also 1.3). Understanding the "culture" of the patient included taking into account both the individual's personal experiences in the societies in which they were born and lived, the experience of the "migrant culture" of parents and grand- parents, and the way of life created by minorities in British society to maintain and develop their own identity, a way of life into which subsequent generations are born.

Nafsiyat intended to challenge many of the preconceptions which had been traditionally associated with conventional "psychotherapy" and "trans-cultural psychiatry": that ethnic and cultural minorities are unsuitable for psychotherapy; that payment is necessary for successful therapy (most patients do not have to pay); that it always requires long term commitment with regular, frequent attendance (Littlewood 1988b). It also required therapists to reexamine their own definition of cultural and racial issues as well as their personal way of working. All therapists are helped in supervision to work on their personal values, attitudes and beliefs and to understand how this impacted on their practice.

2.4 The Practice

The therapists at the Centre worked in a psychodynamic way. Although patients were not necessarily asked to use the "couches" available in each of the therapy rooms (unlike in some traditional therapies), some patients chose to do so. The major thrust of the therapy was to understand the patient's experience in his/her own terms, and the psychodynamic concepts of, for example, transference, countertransference, splitting, projection, projective identification, introjection etc. were used to facilitate this process. Some of the therapists had been trained primarily within a Freudian or Kleinian framework, but most worked eclectically. However, intercultural therapy recognises the inherent difficulties in technique and theory of the traditional schools, and the Centre regards exploring such difficulties (for example which concepts appear to be pan-cultural and which are specific) as an integral part of it's work. Moreover, it believes "cultural issues" can have an important positive contribution to the therapy (cf. Evans Holmes 1992).

As the therapy was brief and time limited, its aims were not to reframe the personality, but give relief from (often debilitating) symptoms, allowing the patient space to explore their experiences. So that they could understand the reasons for their current mental/emotional distress within the cultural context that they lived their life, and to provide a way of understanding and reflecting upon these experiences in order that patients could begin to deal with the problems in their daily lives.

2.5 Teaching

A major theoretical issue for the Centre was the importance of personal and shared culture in the development of mental distress and the significance of this in the therapeutic process. Nafsiyat's training of professionals was intended to emphasise the dynamic role of culture and the need to develop appropriate communication skills to work effectively with clients with backgrounds different from the professionals' own.

2.6 Staffing

During the period of the initial research (1986-1989), staff (from diverse cultural backgrounds) were managed in the day to day running of the Centre by Jafar Kareem (the late Clinical Director), the research continued until the final research patient left in 1992. As the founder of the Centre, at the time he was the only directly funded member of staff. An psychoanalytical psychotherapist, he had worked in the intercultural field in Austria, Israel and elsewhere in England. Other staff included analytically trained psychotherapists and psychiatrists, and counsellors with backgrounds in social work or clinical psychology. A child psychotherapist worked predominately with child and adolescent cases. Two psychiatrists provided psychiatric backup, assessment and advice, and a research psychologist (SM funded by the Department of Health) evaluated the service. There was provision for one full-time administrator/secretary (who provided administrative backup for the Centre) and for a part- time secretary. Two members of staff were registered for postgraduate degrees with the Department of Psychiatry at University College, London University, with whom close academic and clinical links are maintained.

The Staff maintains close training links with local mental health professionals and G.P.s and offers one day seminar programmes which take place in different venues throughout the UK In 1992 the Centre produced a book (Kareem and Littlewood (1992) *Intercultural Therapy: Themes, Interpretations and Practice;* A second edition will be published in 2000). Preliminary results of this research were published in 1989 (Acharyya et al 1989) and in 1992 (Moorhouse 1992, 2000).

2.7 Current Situation

By 1999 the Centre has expanded. Whilst the ethos is essentially the same, there has been an increase in the number of therapy (paid staff, students and volunteers) and administration staff to thirty-six (from fifteen in 1989); and whilst in the late 1980's eight languages other than English were spoken (Hindi, Urdu, Bengali, Sylheti, Punjabi, Spanish, Turkish, Greek and Malay); this had increased to nineteen in the late 1990's (Amharic, Cantonese, Farsi, French, French Patois, Ga, Greek, Hindi, Japanese, Kankani, Kurdish, Malay, Portugese, Punjabi, Somali, Spanish, Tigrinya, Turkish, Urdu). It must be remembered that these languages fluctuate with changes in staff.

2.8 Sociodemography

We find that there is consistency in the patient profile between years. For example, if we randomly select a year e.g. 1995 (the figures are based on the report for financial year April 1995 - March 1996), and the last report (based on the financial year April 1998 - March 1999) and compare the results, we find some differences and some similarities. As with previous years (cf. the Retrospective study), we find the majority (98% for 1995 and 71% for 1999) of patients were treated by individual therapy. The change in the latter figures reflects the addition of a family therapist and a group

therapist to the team. The ethnic breakdown of patients showed a difference. For 1995 the largest group (28.8%) were from the Caribbean, a further 22.7% from Asia, and 8% in 1995 being defined as Black British. There will be a proportion of patients from those defined in the "other" category who will be British born children (or grand children) of people who migrated, who for various administrative reasons were not categorised into the "Black British" category. For 1999 the largest group was the Turkish group (20.8%), followed by the African group (17.1%) and then the Caribbean group (12.5%). The Asian-born group made up 10.2 % of the population, and, similar to previous years the Black British group made up 8.8% of the group. This change, of course, reflects the patterns of migration and the current world situation, particularly war zones and the attendant refugee groups.

However, the two years show similarities with the majority of patients coming for therapy in their mid twenties to mid thirties (36.2% for 1995, 44.1% for 1999) and the sex ratio was 1.52:1 (women to men) for 1995 and 1.59:1 (women to men) for 1999 (see 1.9.2).

Residential similarities with previous years continue, with almost a third of patients (for both years) referred living in Islington (this is the single largest group for both years). A fifth came from Haringey (in 1995, by 1999 this had dropped slightly to a sixth), with nine other Boroughs in 1995 (and seven other Boroughs in 1999) referring to the Centre. This change reflects the annual funding changes and grants available to the Centre

There has been a change in referral patterns. In 1995 the single most common way of referral (approximately 36%) was self referral, with just under one fifth of patients coming via their G.P. (other referrers included Social Services and Hospital

Departments). By 1999 the commonest means of referral was via a G.P. (22.9%) with self referrals making up almost a fifth (19.6%) of the group.

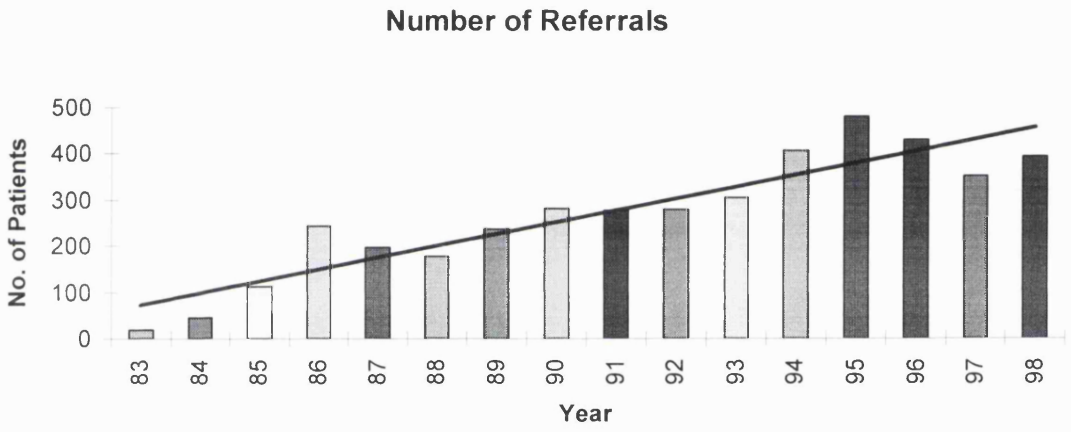
The differences in ethnic origin and referral patterns between the years may be just the normal fluctuations that occur in such Centres, depending on the "world situation". Alternatively it reflects the increased time given by the Turkish therapist. Such therapists are a "scarce resource" because of their linguistic skills. It is therefore, unsurprising, that G.P.s are referring such patients, as some may not be able to refer themselves (due to difficulties in writing English). The slight drop in individual work reflects the addition of therapists with skills in family and group work, and the fact that group work, where indicated therapeutically, is a cost effective solution to an oversubscribed resource.

A few patients pay: some arrange a payment for each session, rarely at the level of private therapy; some pay a small amount during their time in therapy. By 1999 the number of patients contributing had increased, although only a few were paying a fee for each session. Unlike private therapy this is usually dealt with by the administration staff, rather than through the therapist.

2.9 Referrals

During the lifetime of the Centre there has been a generally increasing number of patients referred annually to the Centre (shown by the regression line on the graph)[1].

Figure 2.1



2.10 Research Team

The research team comprised the Research Director, a South Asian male psychiatrist (S.A.) who had been previously trained in the administration of the P.S.E. In August 1986 a white, female research psychologist (S.M.) was

[1] The old method of recording was a count of the number of patients referred. A new method of recording was introduced in 1996 and since that time the count of the "number of referrals" refers to the number of patients who were referred and assessed at the Centre. This may explain the slight decrease in the number of patients seen in the last three years. There are always patients who are referred and who do not come to the assessment session.

employed initially on a part-time basis (17.5 hours per week) and over the final 17 months of the (D.O.H. funded) study was employed full time. The final three years the psychologist was employed sessionally. This team was supported by the Chairman of the Research Committee, an academic psychiatrist who provided external supervision for the project.

2.11 The Therapy Team

Twelve therapists were involved in the research, eight women and four men. Of the women, three had a first training in social work and five in psychology. Of the men, two had a first training in psychology, one in psychiatry and one was a probation officer. Eight were either psychoanalytic psychotherapists or in a psychoanalytical therapy training. One was in clinical psychology training, one was a psychiatrist and two were experienced social workers.

Table 2a

PROFESSIONAL TRAINING OF SESSIONAL WORKERS WHO TOOK PART IN THE RESEARCH

No	Ethnicity	Secondary Training	Current Occupation	First Degree/ Certificate
1	S. Asia	Psychotherapy	Clinical Director	Psychotherapy
2	S. Asia	Psychiatry	Research Director	Psychiatry
3	Caribbean	Psychotherapy	Senior Probation Officer	Probation
4	S.E. Asia	Clinical Psychology	Tavistock Clinical Trainee	Clinical Psychology
5	Greek-Cypriot	Child Psychotherapy	Child Psychotherapist	Social Worker
6	African	Social Work	Senior Social Worker	Nursing
7	Caribbean	Clinical Psychology	Family Therapy	Clinical Psychology
8	Caribbean	Social Work	Senior Social Worker	Social Work
9	S. America	Psychotherapy	Tavistock Clinical Trainee	Clinical Psychology
10	S. Asia	Psychology	Clinical Psychology Trainee	Sociology
11	UK	Educational Psychologist	Tavistock Clinical Trainee	Educational Psychology
12	UK	Counselling	Research Psychologist	Psychology

Table 2b

SOCIODEMOGRAPHIC INFORMATION ON SESSIONAL WORKERS

The numbering (No) is the same as above

No.	SEX	AGE	MARITAL STATUS	YEARS EXPERIENCE	ORIENTATION AS THERAPIST
1	M	>40	Married	>10 years	Freudian/Eclectic.
2	M	>40	Married	>10 years	Freudian/Eclectic.
3	M	>40	Married	<10 years	Freudian/Eclectic.
4	M	<40	Single	<10 years	Kleinian.
5	F	<40	Single	<10 years	Kleinian.
6	F	>40	Married	<10 years	Eclectic.
7	F	<40	Single	<10 years	Eclectic.
8	F	<40	Single	<10 years	Freudian/Eclectic.
9	F	<40	Single	<10 years	Eclectic.
10	F	<40	Single	<10 years	Eclectic.
11	F	>40	Single	<10 years	Kleinian/Eclectic.
12	F	<40	Married	<10 years	Eclectic.

For trainee therapists the decision to allocate them to particular school was determined not only by their training, but also by the orientation of their training analyst.

The ethnic origins of the therapists were, four were from South Asia, three from the Caribbean, one from Malaysia and a South American therapist. The child psychotherapist was a Greek Cypriot while two therapists were British whites (see tables 2a and 2b). Seven of the twelve therapists were younger than 40 years old.

2.12 Summary

This chapter identifies the service provided by the Centre, and its emphasis on short-term intercultural psychodynamic psychotherapy. It also provides some sociodemographic and therapeutic information on the therapy and research teams.

Chapter 3

OBJECTIVES OF THE RESEARCH

A *retrospective* study was carried out to define the parameters for the *prospective* study (Acharyya et al 1987). The methodology and relevant results will be briefly reviewed here. Both the *retrospective* and the *prospective* studies were funded by the Department of Health.

3.1 *Retrospective* Study

3.1.1 Method

The patients were selected by a *quasi-random* sampling technique. Three hundred and forty-six patients had been referred to the Centre in its first three years of work (1983-1986), the *Total* sample. A one in three sample was taken from the alphabetically arranged patient's files (this is considered a relatively robust sampling technique: see Yeomans 1968, Hannagan 1982). This sampling was continued until a test sample of 100 patients were achieved, 54 of these had been offered treatment by the Centre.

All these patients had been assessed and treated by the Clinical Director (the *Treated* sample). There are difficulties with this data as it may be biased towards the more severely ill patients. The Clinical Director's caseload reflected his seniority and experience and hence tended to include those patients with more difficult psychological

problems. For some of the measures there were missing values, in such cases percentages were worked out according to number of patients on whom there was information.

3.1.2 Results

3.1.2.1 Sociodemography (this relates to the *Treated* Sample (n=54), unless otherwise stipulated)

The psychotherapy offered by the Centre was focused on patients from cultures other than the majority white British population, and therefore it was considered important to try to identify, as accurately as the retrospective study data allowed, the cultural backgrounds of patients using the Centre. From Chapter 1 (1.2) it can be seen that identification of a person's "culture" is a complex task. However, twenty-two countries of birth were identified (the *Total* sample identified 54 countries of birth).

It had been anticipated that the overwhelming majority of patients would be migrants, because the therapy offered emphasised the *intercultural* aspect, focusing on culture and identity. Unexpectedly over a quarter (28.2%) of patients were born in the UK. Of those born overseas, 34.8% came to the UK before their 16th birthday. Just over half of the whole group (52.4%) had had separations from their families, a known and previously identified (see section 1.10) contributory factor to mental illness.

The results showed that the ratio of women to men was approximately 3:2 which appeared to suggest that the Centre was seeing a different population to that described by the psychiatric literature (but similar to other community surveys see 1.9.2). They tended to approach the Centre in their twenties and early thirties (63.4% of the total

came between the ages of 21 and 36 years)[1]. Just under half (41.2%) were married, with a slightly lower proportion of single (never-married) patients (37.2%).

Only 13.7% of the patients were unemployed, with just over a fifth (21.6%) being students. This result was surprising as a previous evaluation of the population had showed a high proportion of unemployed patients. However, it was thought that this change reflected the addition of a child psychotherapist to the team, together with changes in the social service provision.

3.1.2.2 Therapeutic Issues

The majority of the work was individual (87%), with the remainder family work. In the Total sample there was a slightly higher proportion of individual work (94.7%). This again reflected the therapist profile, the majority of whom were trained in adult individual work. The majority of the patients (71.4%) came for less than 24 weeks, just over half (53%) for 12 weeks or less.

The commonest way of referral was through a self referral (33.3%), whilst 27.8% were referred through their G.P.; 11 of the 54 had been to see other professionals about their problems, one having being referred to 12 (mostly medical) doctors. This, perhaps, reflects the difficulty of professionals in recognising psychological problems behind the somatic presenting symptoms. Prior to Nafsiyat, only 5 had had psychotherapeutic treatment.

[1] Fulfilling the commonly expected age range -see section 1.9.3)

3.1.2.3 Presenting Symptoms

Of those referred with severe mental disorders, 3 were referred with symptoms consistent with psychotic disorders, with a further 4 patients showing symptoms that were consistent with major affective disorders. Three were referred with culture/adjustment disorders, whilst 10 were referred with anxiety disorders. (This group had 31 missing values and reflects the fact that social work, probation and self referrals were not referred with a psychiatric diagnosis). 31.7% had suffered some form of physical abuse (there were 13 patients where this information was missing), while 5 of the 41 (12.2%) reported having been sexually abused.

When the Nafsiyat diagnoses were evaluated, using P.S.E. syndrome checklist criteria, it was found that 11 patients were referred with symptomatology consistent with schizophrenia, paranoid disorder, atypical psychoses and major affective disorder, and a further 13 patients had symptoms consistent with culture shock /adjustment disorder. It was hypothesised by the authors of the *retrospective* study (Acharyya and Moorhouse 1987) that culture shock and adjustment disorder are two separate entities, with culture shock being an extreme and immediate reaction to changes in culture, whilst adjustment disorder is the process following this reaction. Over a third (35.6%) were on medication when starting therapy. Five people were addicted to their prescribed drugs and a further five to alcohol, only one was dependent on an illegal drug.

This study presented a different group to those commonly expected to be in therapy, although there were similarities. They seemed to some extent to conform to the YAVIS

criteria in that the patients tended to be young, students and able to express themselves in therapy.

What is unique to this group is their life experiences, those of loss and separation from culture and from family and how this was experienced by the individual.. Culture shock on arrival (or sometimes after a period of time) and continuing adjustment disorder are potent pathogenic factors. The British born group reported that they approached the Centre to help them define their identity, to find their culture. The research supported the idea that difficulties in one generation can continue through to influence the subsequent generations (and hence the inherent difficulties with the DSMIV criteria- see 1.13).

3.1.3 Outcome

This group tended to present with high levels of symptomatology (although it should be remembered that although the criteria used for "diagnosis" were consistent with DSM. IV criteria, this was a retrospective evaluation so caution must be applied when considering the data), and seem to get "better" (defined by a reduction of symptoms as perceived by the therapist) with a short term psychotherapy. Just over half of these patients (53%) had 12 sessions or less, just over a quarter (28.6%) had longer than six months of once a week therapy. All of these patients were considered to have had a good (issues resolved, symptoms gone and better relationships) or moderate (most issues resolved, symptoms gone and increasingly better relationships) outcome, as defined by the therapist. In fact only 6 of the original 54 patients (11%) had, what the Clinical Director defined as a poor outcome (although in all cases there was some

improvement). These patients had not been able to resolve some of their problems and left therapy with some lingering symptoms.

However, it should be remembered that these results reflect the Clinical Director's caseload, a potentially more ill group, and hence a skewed population in research terms. It would be expected that in a sample that included other therapists' patients, the "good outcome" profile would be higher.

3.2 *Prospective* Study And Its Objectives

On the basis of this research the following objectives were formulated, by the research team in discussion with the therapists at Nafsiyat and the D.O.H.

- To evaluate whether ethnic minorities used the Centre.
- To evaluate whether patients conformed to the conventional sociodemography for psychotherapy patient profile (including the YAVIS criteria).
- To distinguish the specific issues relevant to therapy with ethnic minority patients
- To evaluate whether therapy was influenced by certain aspects of the encounter as defined by previous research, including ethnicity of therapist and language spoken, migration, separation.
- To evaluate the level of dropout from therapy.
- To identify the presenting symptoms of this group.
- To objectively evaluate the outcome.

3.3 Sociodemographic Hypotheses

3.3.1 The Patients seen at the Centre would come from a variety of ethnic and cultural backgrounds (see section 1.2, 1.9.1).

As the Centre provided therapy around cultural issues, it was expected that patients seen at the Centre would be primarily a migrant group experiencing cultural problems (see Chapter 1), or presenting their psychological problems in a culturally appropriate way, which might differ from that of the majority white population. It was expected, on the basis of the *retrospective* study, that the range of origins would be diverse and that a significant proportion of patients would be British-born ethnic minorities experiencing cultural / identity conflict. From the discussion in the introduction it was anticipated that there might be anomalies in allocation of "origins" (section 1.2). This would be explored in the research; in order to provide an insight into the patients' perception of their own culture and ethnicity. It was also expected, from a close evaluation of the caseload current at the time of the research, that the patients would be sufficiently proficient in English to complete their therapy, and the relevant research questionnaires, in English.

3.3.2 The patients at the Centre would conform to the expected sex ratio (see section 1.9.2).

The conventional sex ratio for the neuroses (the "usual" psychotherapy patients) is 3:1 (women:men). However, the *retrospective* study (and other community based studies - Caccia and Watson 1987 Hutton 1985), suggest that there is a closer ratio - the patient group at Nafsiyat showed a *referred* ratio of 1.45:1 (women:men). The research team expected the *prospective* study to show similarities with the *retrospective* study.

3.3.3 The patients at the Centre would conform to the YAVIS criteria (see section 1.9.3).

1. Age

Psychotherapy tends to be offered to young adults (conventional assumption), and this age range was confirmed in the *retrospective s*tudy results. It was expected that there would be a similar pattern in the *prospective* study with the majority being in their twenties and fewer patients being in therapy after the age of 40. Owing to this skew, other factors would be influenced, for example it might be expected that the majority of patients would be unmarried and perhaps some would still be in education.

2. Attractiveness

This factor is not considered in this study, although it is still reported in the literature (Helstone and Van Zuuren 1996). It is considered by the current author a function of the therapist's countertransference, and hence only valid in so far the therapist allows this to influence therapeutic decisions.

3. Verbal Ability

From hypothesis 3.3.1, where the assumption was that there would be a diversity of cultural origins, it might expected that people whose first language was other than English would be at a disadvantage linguistically, and hence the migrant group might be less successful in their outcome than those brought up in the UK.

4. Intelligence

From clinical work it was expected that most patients would be able to benefit from talking therapy, yet the concept of intelligence is one that is enshrined in the YAVIS criteria. It was decided by the researchers that, although they felt it might be a countertransferential issue for therapists (selecting patients who they considered to be like themselves), as it was often measured as a part of the (limited) research on therapy it was important to show that the patient group was one that did not fulfill expectations. Often in therapy research the notion of intelligence is measured by educational attainments. This is a limited measure of intelligence (those who have not high educational attainments may not necessarily be less intelligent), especially for the group of people who were seen at Nafsiyat; who might have been expected to have been discriminated against at school. Therefore it was expected only a proportion of the patients would have high educational qualifications[2].

5. Success

Given the particular problems experienced by migrant and British born ethnic minorities in employment, the assumption here was that this particular group would not be considered "successful" in terms of type of employment (if any - see *retrospective* study results) or in terms of their ability to pay for therapy, or other factors for example:- occupation, housing etc.

[2] As the research involved patients in giving time on top of their therapy to fill out questionnaires, it was considered inappropriate to extend this time commitment by adding intelligence questionnaires. This also obviated the problem of IQ tests's validity in other cultures.

3.3.4 The majority of patients at the Centre would live in Islington (see 1.1).

It would be expected that, as Borough of Islington supported the Centre through grants from the Health Authority and Borough, it would refer more patients than other boroughs (the service is free to those in Islington). As this service is unique, it was expected that the majority of patients would come from Islington but that patients from other Boroughs would be seen.

3.3.5 The patients at the Centre would be referred from a variety of professions and would self refer (see section 1.1, 1.15.1).

As referral agencies (especially G.P's) seem less accustomed to referring ethnic minority patients for psychotherapy it was hypothesised that the majority of patients would be self referred (see section 3.1.2.2).

3.3.6 The patients at the Centre would not be registered with a G.P. (see section 1.15.1).

From Rwegellera's (1980) work it was anticipated that many of the patients would not be registered with a G.P.

3.3.7 The patients at the Centre who referred themselves would show a different demographic profile to those who were referred through professional channels (see section 1.9.3).

It was hypothesised (from clinical work at the Centre) that there would be a difference in terms of sex and age between those patients who self referred (who would follow usual psychotherapy patient profiles) compared to those who came from different referral source

3.3.8 The patients at the Centre would not pay for therapy (see section 1.9.5).

It was expected that few patients would pay for their therapy, and hence this would not be a variable in this study (see also section 3.1).

3.4 Specific Cultural Issues In Intercultural Work[3]

3.4.1 The patients at the Centre would come from a variety of family backgrounds including extended families.

A commonly reported finding is that the extended family framework is a feature of some cultures. It was hypothesised that some patients would be living in extended family frameworks; however previous clinical work at Nafsiyat had suggested that patients tended to be living on their own or in more "nuclear" arrangements. It was,

[3] These hypotheses and the later results refer exclusively to the *treatment* group.

therefore, considered important to evaluate whether this patient group conformed to the traditional assumptions about ethnic minorities.

*3.4.2 **Patients at the Centre would be practicing a religion*** (see section 1.2, 1.10)

From a review of conventional assumptions, it was hypothesised that patients would be practising a religion and this would form an important part of their lives. This assumption had been challenged by the initial clinical work at Nafsiyat. Therefore, as religion may be a fundamental part of a person's understanding of their culture, such discrepancies between the clinical experience and the conventional assumptions needed to be identified and evaluated.

3.5 Psychological Characteristics that Affect Utilisation of Psychotherapy : Life Stresses

*3.5.1 **Many of the patients at the Centre would have had experience of migration*** (see section 1.10.[1]).

From a review of the literature it was hypothesised that migration would have psychological effects and from the *retrospective* study it was assumed that the majority of patients would be migrants.

*3.5.2 **The patients at the Centre would come from both rural and urban backgrounds*** (see section 1.10 [1]).

It was hypothesised from the literature that patients who had moved from rural to urban locations would fare worse "psychologically" than those who moved from urban to urban environments.

3.5.3 The patients at the Centre would have experienced racism and prejudice (see section 1.10 [2])

Because of the cultural backgrounds of the patiens, it was anticipated that most of the patients would have had experience of racism.

3.5.4 The patients at the Centre would have experienced many separations (see section 1.10.[3]).

From the *retrospective* study it was noted that thispatient group appeared to have many separations in their lives, it was hypothesised that this would be upheld in the *prospective* study.

3.6 Psychological Characteristics that Affect Utilisation of Psychotherapy : Psychopathology.

Presenting Symptomatology

3.6.1 The patients at the Centre would present with measurable symptoms (see section 1.11 and 1.13).

It was hypothesised that, despite the evidence in the literature, results from the *retrospective* study suggested that patients would present with symptoms consistent with psychological illness and this would be identified by the standardised measures (see also 3.1).

3.6.2 There would be differences in diagnosis between different professionals and the clients (see also section 1.11 ,1.13, 1.14).

It was hypothesised that there might be differences in assessment of symptoms between the patient, the referrer and the Centre (see also 3.1).

3.6.3 The standardised measures would yield comparable results.

It was hypothesised that the standardised measures, the General Health Questionnaire (Goldberg 1978, Goldberg and Williams 1988), the Psychiatric Symptom Checklist and the P.S.E. (Wing et al 1973, 1974a 1974b), would be able to be completed in English (see 3.3.1) and that they would adequately identify the levels of symptomatology, and be consistent between the measures (see respective manuals).

3.6.4 The patients at the Centre would present with differences in levels of symptomatology and this would decide whether a person was taken on for therapy (see section 1.17.5.3.).

It was expected that the severity of the symptomatology would influence whether a patient was considered suitable for therapy (i.e. more severe presenting symptoms would be seen as a contraindication to therapy - conventional assumption). The results from the *retrospective* study seem to provide a different view and suggested a need for evaluation in the *prospective* study.

3.6.5 The patients at the Centre would present with somatic symptoms (see section 1.14.2., 1.15.7).

It was expected that patients would be likely to endorse the physical/somatic questions on the questionnaires although it was hypothesised that this might vary between migrant and British born groups.

3.7 Outcome Measures

Outcome was measured not only "retesting" using the standardised measures but also using the more "subjective" therapeutic constructs.

3.7.1 It was expected that there would be changes in the rating of symptoms from the beginning to the end of therapy.

It is hypothesised that change in scores (when rating symptoms on the objective measures) demonstrates change in subjective experience of symptoms. Thus a

reduction in the scores demonstrates improvement (and vice versa). It is assumed that the use of three different scales would add to the credibility of the assertions (see respective manuals and conventional assumption) (see section 1.17).

3.7.2 It was expected that there would be a reduction in the levels of reported symptoms by the end of therapy.

It was hypothesised that for the majority of cases, there would be a reduction in the amount of symptomatology identified by the different measures by the end of therapy, i.e. the scores would be lower (see 3.1.2.3).

3.7.3 It was expected that therapist ratings of outcome would be accurate.

It was hypothesised that the therapists rating would be accurate and not under- nor over-estimate the amount of change (Feifel and Eells 1963 and see section 1.17.6.2).

3.7.4 It was expected that researcher ratings of outcome would be consistent with other measures.

It was hypothesised that this rating would be consistent with other ratings of outcome as it was based on the questionnaires.

3.7.5 ***It was expected that patients' description of outcome would be consistent with other measures.*** (see section 1.17.6).

It was assumed that the patients' view of outcome would be consistent with the other measures.

3.7.6 It was expected that many patients would fulfil the criteria of a good outcome (see section 1.17).

It was assumed that a high proportion of patients would finish therapy with a "good outcome".

3.7.7 It was expected that there would be sociodemographic influences on outcome (see sections 1.9, 1.10).

It was anticipated that some sociodemographic factors might influence outcome, but these had yet to be determined.

3.7.8 It was expected that there would be therapy influences on outcome (see section 1.17.6).

It was hypothesised that some therapeutic factors might influence outcome, but these had yet to be determined.

3.7.9 It was expected that there would be therapeutic issues relating to migration (see sections 1.6, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.15).

It was expected that there might be differences between British born and migrant patients in terms of various sociodemographic, therapeutic, presenting symptoms and outcome measures, similarly age might mediate the above results.

3.8 Therapy Issues : Patient Attributes

3.8.1 It was expected that there would be low ego strength among the patient group (see section 1.17.5.1.).

It was anticipated that this might be low in the patients seen at the Centre (conventional assumption about black and minority patients); however high ego strength is a positive predictor for good therapy and hence this needed to be evaluated.

3.9 Therapy Issues : Therapist Attributes

3.9.1 It was expected that patients would want a choice of their therapist.

It was anticipated that patients would want to have a therapist of a similar sex to themselves (conventional assumption).

3.9.2 It was expected that there would be an association between therapist training and selection of patients (see section 1.17.6).

It was expected that the more experienced therapists would see the more severely ill patients (see 3.1).

3.9.3 It was expected that there would be an association between therapist training and presenting problems of patients (see section 1.17.6).

It was hypothesised that therapists' skills would be matched with patients on the basis of the patient's presenting symptomatology (normal assessment procedure). Those with previous experience of therapy would be matched with a more highly trained/experienced therapist.

3.9.4 It was expected that there would be an association between therapist training and dependencies.

It was expected that the more experienced therapists would see the patients with dependencies (normal assessment procedure).

3.9.5 It was expected that there would be an association between therapist training and educational problems.

It was expected that the more experienced child therapists would see those with educational problems (normal assessment procedure).

3.9.6 It was expected that patients would request a therapist from a similar ethnic background to themselves (ethnic matching) (see section 1.17.6.1).

As the Centre is an inter- (not intra-) cultural, requirements for a certain ethnicity of the therapist was considered a therapeutic issue to be dealt with during the assessment; and it was thus hypothesised that patients would not necessarily be ethnically matched (Centre Policy).

3.9.7 It was expected that there would be few cases of sex and gender matching.

As the Centre did not automatically sex/gender match, it was hypothesised that women or men patients would not necessarily be sex/gender matched (Centre Policy).

3.10 Therapy Variables

3.10.1 It was expected that there length of treatment would be associated with severity of symptoms (see section 1.17.7.1).

It was assumed that more severe problems would require longer psychotherapy (conventional assumption see 3.1).

3.10.2 It was expected that there would be some dropout from therapy (see section 1.17.7.2).

It was anticipated that there would be a loss of patients from therapy, but how close this would be to the proportions discussed in section 1.17.7.2 was not known.

3.11 **Spontaneous Remission** (see section 1.18).

3.11.1 It was expected that there would be little evidence for spontaneous remission.

It was hypothesised that patients would present with long term problems and hence these would be unlikely to spontaneously remit without treatment, hence any change would be due to therapeutic intervention.

3.12 Summary

The above outlines the hypotheses for the research, as well as identifying the unique nature of the Centre. All the aims are based on research and the literature described in Chapter 1, from clinical work or from work in the *retrospective* study described at the beginning of this chapter.

CHAPTER 4

METHOD

4.1 Overview

The results of the *retrospective* study were unexpected, as they suggested that the Centre was successfully treating a group of patients normally excluded from mainstream therapy. However, the results of this study were based on retrospective data and thus a certain amount of caution had to be applied in the interpretation of the results. However, the data did provide evidence to support the research application to replicate the data, but in a prospective format.

As the *retrospective* study had identified the unique nature of the service and the patient group, an evaluation of several patients' experience of intercultural psychotherapy, their life experiences and their psychological "symptoms" before and after therapy, seemed the areas on which to focus this new study.

Therefore, an outcome evaluation was proposed to determine the effectiveness of Intercultural therapy - the *prospective* study. However, there were certain limitations in terms of comparison with other studies. So, for example, statistical comparison with other outcome studies was difficult, as the population and therapy were different to those commonly evaluated.

The researchers also wanted to describe the patients at the Centre, but the quantitative data did not give enough detail. To address this lack of information some qualitative data, in the form of case vignettes, was collected and is included as part of the results of the study (see Chapter 8).

4.2 Research Design

The results of the *retrospective* study suggested how to approach the *prospective* study: sociodemographic and therapeutic data needed to be collected, together with the results of standardised, "objective" measures of psychological functioning.

The research was designed in three phases, the development of questionnaires (section 4.2.1), piloting of them (section 4.2.3), followed by the prospective study (section 4.6).

A decision was reached by the research team to only research individual therapy. The small number of family referrals were excluded from the research, as comparison statistics might not yield comparable results. However that there may be similarities and differences between individual and family therapy results with this population suggests the need for further research. It was decided that the research would be based on 12 session contracts (as the *retrospective* evaluation suggested that this was an appropriate time scale).

4.2.1 Development of the Questionnaires

From a review of the literature (see Chapter 1), the results of the *retrospective* study (Chapter 3) and following a discussion with the Department of Health, the Clinical Director and the therapists at the Centre, a set of possible sociodemographic,

therapeutic and psychological issues were identified. From these issues a series of questions were devised. These were modified as the project developed to meet the needs of the research and the administrative procedures of the Centre (this included the addition of a feedback form - Research Form 7, Appendix 1).

It was decided that all the information collected would be analysed using the SPSS package (Nie et al 1975, SPSS 1987, Norusis 1988). Several test databases were produced (following Data Protection Act Guidelines) before the final version was accepted.

4.2.2 Control Groups

Forming adequate control groups is a dilemma in all psychotherapy research (see also A.P.A. 1982 for full review of this, and more recently Roth and Fonagy 1996). Following the difficulties of assigning ethnicity in the *retrospective* study, it was decided that it would not be possible to use a matched pairs research design, matching patients according to their ethnicity, in order to compare outcome. Similarly, matching on race or culture would also be difficult. However, as ethnic, racial and cultural background can be important factors in patient's presenting symtomatology (see 1.2., 1.11, 1.13, 1.14 1.15 and 1.16), ignoring this, and merely matching on age, sex and presenting problem could distort the results.

Moreover, to offer alternative therapies (i.e. to compare Nafsiyat therapy with an alternative therapy) would also have the same problem, the presence of ethnic, racial and cultural differences of both the therapist and the patient could introduce an

unknown and unidentified bias. Therefore the typical control group of "matched patients" was abandoned.

One could pose the question as to whether patients could have been matched with others from other Centres, or indeed whether more patients could have been evaluated. This research started from the premise that as many variables as possible needed to be controlled, as a commonly expressed concern amongst researchers is that, in therapy research, there are too many (uncontrolled) variables.

Apart from the linguistic and cultural difficulties in matching, outlined above, which obviated the matching of patients (remembering the difficulties experienced by the Menninger Clinic (1972) in matching their patients). There is also the added problem of whether intercultural therapy carried out in other Centres varies in form or content from the type of therapy carried out at the Centre. By limiting the variables one can provide a baseline from which other "intercultural" Centres can be evaluated. Questions can then be asked what is the same and what is different between each of the Centres.

In this research the following variables were kept constant

- Process of referral (written referrals, standard replies)
- Process of assessment (by one person)
- Process of therapy (in terms of place, length, forms to be filled out etc)
- Process of supervision (carried out by one supervisor)
- Process of research (same personnel)

- Constancy in understanding of intercultural therapy.

Other reasons also influenced this decision. As Nafsiyat is a voluntary agency operating from independent offices and is not funded for clinical work other than psychodynamic therapy; it was impossible to operate an alternative therapy design (e.g. psychodynamic versus behaviour therapy) for financial reasons. To send some patients to an alternative place for therapy (e.g. for behavioural therapy) was not considered an option ethically, therapeutically[1] or scientifically (it would introduce too many variables), and the problems of matching (outlined above) would also hold

Including other Centres in this research would have necessitated extra resources (in terms of reviewing therapy processes and training personnel in completion the research forms). In order to have constancy in research process, the research staff would have needed to have travelled to the other Centres to carry out the research. This was not feasible (in terms of time or finances).

An alternative way of matching is "waiting list control" groups. A review of the literature suggests that even where patients have been offered therapy, a proportion fail to turn up because they have explored various types of therapy and have taken up the first offer of help (Brandt 1964, see also 1. 17.7.2). Moreover an earlier attempt to recall Nafsiyat patients several months after therapy had finished, failed due to the high number of patients who had moved from their previous address. This suggested that

[1] There are therapeutic issues: if a psychotherapist decides that psychotherapy is the best option, how do they decide which alternative therapy to refer on to?

Nafsiyat patients have transitory living arrangements, and called into question the probable success rate of such a strategy (cf. Rosser et al 1987).

Therefore patients were their own control. This had the advantage of circumventing most of the problems outlined above and the ethical dilemmas posed by them. The A.P.A (1982) notes difficulties with this type of control group. These are related to the natural history of the disorder, in terms of the effects of treatment, spontaneous remission or the normal diminution of symptoms over time. As information on diagnosis and aetiology, duration and remission of mental health problems in an ethnic minority group is often criticised, it was difficult to provide comparative information. Therefore one measure of the effectiveness of therapy is to look at how long patients had been aware of their symptoms which indicates the chronicity (or otherwise) of the problem and hence provide some evidence to refute the likelihood of spontaneous remission.

Although the main thrust of the research was an outcome study, each group's emphasis was different. The schedules reflected this, with data being collected on sociodemographic (D.O.H. and researchers), symptomatic (D.O.H. and researchers), and therapeutic questions (therapists and researchers). As the organisation was small, it was impossible to commit large resources (time, money and extra therapy time) to the research. It was necessary to dovetail the research into the ordinary running of the Centre. A review of the referral procedure confirmed that a schedule format would be the most effective procedure, and hence the questions were designed so that research

information could be collected at the same time as therapy data. For example, during the assessment, sociodemographic details (such as age, sex) would normally be collected as well as referral source and reasons for referral, and hence collecting the additional information on ethnicity and gender of the therapist requested and allocated as well as the more specific information on patient ethnicity seemed appropriate to collect at the same time (see Appendix 1 for sample schedules and see Figure 4.1 below).

Figure 4.1 Detail of Schedule Presentation (see Appendix 1)

Title of schedule	Information to be Collected	Form Completed by/ Relevant Session
Case History **RF1**[3]	*sociodemographic diagnostic and therapy information*	**CD/**[4] *Assessment*
Psychiatric Symptom Checklist (PSC) **RF2**	*symptoms (psychological /behavioural)*	**CD** *Assessment*
Social History Form **RF4**	*cultural and demographic history*	**RP/**[5] *After Session 6 or Session 12*
Therapy Action Form **RF5**	*therapy goals and external links*	**PT/**[6] *After Assessment/ On Completion*
Therapy Profile Form **RF6**	*therapeutic issues and outcome*	**PT/** *After every 6 sessions*
Feedback Form **RF7**	*usefulness of therapy*	**Patient/** *On Completion of Therapy*

4.2.3 The Assessment Interview

This was the first meeting between the Clinical Director and the patient. Before this meeting the patient would have been sent a letter telling them that they had been referred to the Centre (or indeed that their own letter of referral had been received by the Centre) and offering them an appointment to meet the Clinical Director to "talk over some of the problems that you are experiencing at this time". In this letter they would also have been told that the Clinical Director's name was Jafar Kareem and they would

[3] RF1...RF7 indicates the number of the Nafsiyat Research Form, see Appendix 1. Research Form 3 was the research consent form which was normally completed at the assessment session.
[4] CD indicates completion by Clinical Director
[5] RP indicates completion by Research Psychologist
[6] PT indicates completion by Psychotherapist

have been asked to telephone the Centre to confirm (or change or cancel) the appointment.

Some patients would have been unaware that they had been referred to the Centre, others would have known they had been referred but have unsure of what psychotherapy was, and for others this referral would have been the end of a long journey through different medical and psychiatric departments. To some of the patients a psychological therapy was a completely new experience, although many, if not all, would have had the chance to talk to family or friends about their problems before arriving.

When the patient arrived for their assessment, they were given the opportunity to talk about the issues in their life that had brought them to therapy. The room they came to was a large room with a desk, a couch, two chairs and a small settee. The room had several pictures on the wall, which were clearly of a non-British origin. The patient could choose where to sit, the therapist choosing a seat that was appropriate to the one the patient chose.

No structure was imposed on the session, the patient was requested by the therapist to discuss or talk about whatever they wished. The patient knew that the person that they saw at this interview was a therapist, knew something of their background and why they were seeking help through the referral letter.

The therapist responded to their "material" in a psychodynamic way, clarifying some parts of the story and interpreting if appropriate. By the end of the session which lasted

between 50 minutes and an hour and a half, tle therapist would have been able to complete most of research form one and reseach form two (RF1 and RF2). Any unanswered questions were asked at the end of tle interview. It was at the end of this session that they discussed whether the patient would like to pursue therapy at the Centre and also the fact that the Centre was carrying out research. Patients were asked if they wished to be part of this research, after being told what the research entailed. Some gave an immediate response others responded later after they had left the session.

4.2.4 Piloting of Draft Questionnaires

The Clinical Director and therapists were given draft copies of their relevant schedules to complete on several past patients. The CD tested the two forms he completed at assessment session (the case history and psychiatric symptom checklist), and the two forms he completed as a therapist - the therapy action form (his assessment of the goals of therapy and outcome as well as any coordination with outside workers) and therapy profile form (progress in therapy), on some past patients. Therapists likewise completed their relevant forms - the therapy action form and therapy profile form on some of their past patients. The Research Psychologist tested out the social history form (which collected demographic and cultural details) on a series of patients who were returning to the Centre for six- week follow up of therapy.

Following this, a joint meeting between researchers, CD and therapists, discussed the schedules, their content, wording, omissions, spelling and layout errors, and together with feedback comments from the patients. This discussion lead to minor modifications.

A major concern of the therapists was that they (the therapists) might unconsciously try to elicit answers to the sensitive questions (such as sexual abuse) and that this might affect their way of working. The researchers emphasised the necessarily over-inclusive nature of the therapy profile form. They (the researchers) emphasised that the form was not intended as a guide to therapy process and that all questions would not be relevant to all patients. If information was not available at the time of completion, then, they were not to probe for it but to wait until it came up in therapy. Thus, if something was suspected by the therapist but had not been raised by the patient then it would not be noted on the schedule. However, when the second therapy form (identical to the first) was filled out at session 12, such issues might be picked up (but only if it had been raised by the patient in the intervening sessions). This method of recording was adopted as it was arguably the least intrusive to therapy.

4.3 The Pilot Study

The modified forms were piloted on a series of consecutive new patients in 1986 in a similar way to that of the proposed study. Therefore, at the assessment the CD completed the two forms indicated in figure 4.1, rated the psychiatric symptoms on a simple 5 point scale (rating absence (0) to severe symptoms (4)). He initially noted the symptoms that were reported spontaneously by the patient in the course of the interview. Towards the end of the assessment he was asked to prompt for those symptoms not raised by patient. He also asked patients to complete a General Health Questionnaire (60 version) (see Goldberg 1978).

The patient was then allocated a therapist who completed Part 1 of the therapy action form (the "goals" of therapy section) on taking on the case (patient group a). Due to time constraints, in order to pilot the second section (the outcome of therapy) was completed on different patients who were completing therapy (patient group b). They were assessed on whether the goals set at the outset of therapy had been achieved[7]. The liaison sections were to be completed if this was relevant to the particular patient. The therapy profile form was completed on the patients (from group a) after they had completed their first six sessions. The Research Psychologist completed the social history form on a series of patients who were in therapy with the Clinical Director. The Research Director carried out P.S.E. interviews on a series of new patients.

As there was concern about the use of standardised tests the GHQ-60 and the P.S.E. (see 4.4 below), the researchers considered it important that the patients' response to both these measures should be closely monitored. The patients in the pilot study were interviewed, not only about the "in-house" schedules, but also the standardised tests. From these discussions it appeared that there were few problems in understanding. For the GHQ-60 all patients piloted were able to understand and complete the questionnaire. Two issues were raised by these patients, firstly that of Q2 ("Have you recently been feeling in need of a good tonic"[8]), three of the patients felt some people might be unsure of what the question meant, even though they themselves understood it. One of the men queried question 25 " ("Have you recently been taking less trouble with your clothes"). He felt this would be more applicable for a woman, and only had

[7] The initial goals were the ones set by the assessor after the assessment, when the patient was handed over to the therapist.

limited applicability for a man. With these limited concerns noted, it was decided to proceed with the *prospective* study using the GHQ 60.

Patients contributed to feedback on the schedules by giving their comments on clarity, content, language etc. The questions asked were found to be, with slight modifications, clear and acceptable. The amended versions were again reviewed on past patients, although different ones to previously.

The feedback form (an evaluation of the patient's view of the therapy and treatment efficacy - see Appendix 1) was a later addition to schedules, and was piloted on a group of patients completing therapy early in 1988. Patients completed this at six week intervals. They posted the completed form to the Clinical Director, patients were assured of its confidentiality. In those situations where the Clinical Director was also the therapist the schedule was returned to the Research Director. This schedule was intended to provide information on the patient's own perception of the positive and negative aspects of therapy.

4.4 Standardised Measures of Morbidity

Discussion with the Department of Health in 1987 centred around the concerns they had about the robustness of the finding in the *retrospective* study that all patients in the study had symptoms rateable on formal diagnostic systems (DSM and ICD), and that a proportion of these patients had diagnoses of psychotic illnesses (11 out of 54 cases). Discussion with the Department of Health focused on whether this could be due

[8] Although one of the Caribbean therapists pointed out that "tonic" is well known in the Caribbean culture

to a low threshold for the perception of serious illnesses at the Centre, alternatively that many more patients than anticipated, were presenting with serious psychiatric illnesses. Another view was that patients present with symptoms consistent with serious illness although they are not, in reality, suffering from such severe illnesses (i.e. differential presentation). Therefore they wished to incorporate standardised measures of morbidity, despite the difficulties associated with such tests (described below), so that the results obtained from this study would be comparable with other studies.

4.4.1 History

The use of standardised psychological and clinical tests has a long history. Early tests were assumed to be relevant to all cultures. When people from different cultures failed to achieve scores comparable to the European white population on the tests, this was assumed to confirm their inferiority compared to western nations (see Butcher 1968, Flynn 1989, Rushton 1990). It soon became clear that tests only were discriminant for the populations on which they had been standardised. The notion of "ethnocentricity" began to be appreciated and the search for culture free tests began. Although suggestions have been made for culture free tests (e.g. the Rorschach: De Vos and Boyer 1989), there is no agreement about whether it is possible to create universal, culture free tests (Sears 1961, Lonner and Berry 1986).

In the light of these findings the researchers decided that two standardised tests should be used: one a self report schedule (the GHQ 60 - (see 4.4.2 below) and the second an interview schedule (the P.S.E. - see 4.4 below). To understand how patients presented

and would be recognised by Caribbean patients in a similar way to white British patients.

their illness and also to understand their demeanour at the assessment session, a simple checklist of different symptoms was constructed (PSC - see Appendix 1 and figure 4.1).

4.4.2 The General Health Questionnaire - (GHQ 60 Version)

In this study the General Health Questionnaire was used. It has been used worldwide, and has been found to be useful in reporting symptoms. These studies have produced some contradictory results but the consensus is that the GHQ60 is sensitive enough to pick up both psychiatric symptoms when presented either psychologically or somatically. Moreover, there have been many studies which provide comparative results. The GHQ60 is thought to be a better measure in non medical settings as it is better at correctly identifying those with psychological distress (Goldberg 1978).

The General Health Questionnaire was designed to be a self-administered screening test aimed at detecting psychiatric disorders in the community or non-psychiatric clinical settings. Goldberg and Williams (1988) note that the GHQ does not look at lifelong traits; but on two classes of phenomena: the inability to carry out normal "healthy" functions and the appearance of new and distressing symptoms. It aims to detect the boundary between "non-cases" (i.e. those without psychiatric problems) and "cases" (i.e. those with psychiatric problems) but primarily concentrates on detection of anxiety and depression. Although it was not originally designed to detect psychosis (Goldberg 1972, Goldberg and Williams 1988), it has been found that such patients are detected as "cases". This seems to accord with the notion that diagnostic schema are arranged in a hierarchical organisation (e.g. Wing 1976, Foulds and Bedford 1975, A.P.A. DSM1V 1994).

The GHQ 60 is the original and longest version, subsequent versions being subsets of the original. However in reducing the size of the questionnaire, the questions relating to somatic symptoms were discarded. This is important as somatic symptoms seem to be very relevant in the detection of illness in ethnic minority groups (Chan and Chan 1983, Goldberg and Williams 1988, see also 1.14.2).

4.4.3 Response Format

The response format follows the formula of "less than usual", "no more than usual", "rather more than usual" and "much more than usual". It has two possible scoring scales, one is a Likert scale assigning *0* to the "less than usual" response and incrementally up to *3* "much more than usual". Alternative there is a GHQ scoring procedure that scores the answers as *0* for the "less than usual", "no more than usual" responses, and *1* for the "rather more than usual" and "much more than usual" responses i.e. a bimodal response set. The overall misclassification between non cases and cases only drops by 0.7 per cent when using the more involved (Likert) scoring procedure (Goldberg and Williams 1988), and hence the GHQ scoring system was adopted for this research.

4.4.4 Culture Specificity

Goldberg reports that the test is culture specific - designed in London for detecting caseness in Londoners[9]. However, initial work showed that it worked well in

[9] Most objective tests have been standardised primarily on a white European population and thus have questions about their validity and reliability with other cultures. However, currently there is little alternative in terms of self-report inventories.

Philadelphia, and that the validity coefficients were not so different for Philadelphia blacks and whites. However, when the GHQ30 was used in Philadelphia two questions were changed, in place of "Have you recently been satisfied with the way you have carried out a task?", the question "Have you recently been feeling mentally alert and wide awake" was introduced. Also question 33 was replaced by question 16 from the GHQ60. Evidence is accumulating from various sources that the GHQ can be used in different settings, Goldberg and Williams 1988).

Some authors have suggested changes in threshold scores for different cultural groups (e.g. Harding 1976, Goldberg 1972) comparing the GHQ with other tests standardised in developing countries. However, as there is increasing evidence that there are differences in morbidity between the original culture and migrants from that culture, it may not be appropriate to change the scoring system as the new scoring have debateable applicability in the current context and may distort the results (Harding 1980). Finlay Jones and Burvill (1977) failed to find different scores by country of birth in their study in Britain.

While there is evidence that it may be appropriate to use different threshold scores for psychological measurement in other countries. However, with a migrant or British born population, British scoring baselines tend to be used preferentially. Debate continues as to the GHQ's applicability with non western peoples. The reliability of different threshold scores suggested for different cultures have not been established, and there have been no reliability reports of the GHQ in a British multicultural setting (with migrants and British born ethnic minorities).

4.4.5 Cases Overseas

The GHQ 12 was found to be equally effective as a detector of cases as the Self Reporting Questionnaire (SRQ-20 version- Harding et al 1980) used in developing countries (there was a correlation of +0.78 Mari and Williams 1985). Hodiamont et al (1988) carried out a comparison of the GHQ 30; those detected as cases were then interviewed using P.S.E. (Wing et al 1974a) and three other schedules. All the schedules correlated around +0.60 with each other, therefore there was very little difference to choose between them as case detectors.

In China, Cheng (1985) found that the GHQ 30 carried out on a community sample had a specificity (chance that a normal person will be assigned to no symptoms) of 94%, whilst the sensitivity (probability that a person with psychiatric symptoms will be scored as such) of 74% when rated against the Clinical Interview Schedule (both translated into Chinese). 30 items were then added to pick up common presentations of psychiatric morbidity - largely somatic complaints, and produced the Chinese GHQ 60, which lead to increased sensitivity (90%) and marginally reduced specificity (91%). In order to develop the GHQ 30, the somatic questions were removed from the GHQ 60 and this perhaps explains this result. Cheng and Williams (1986) conducted a discriminant function analysis and found that of the 12 best items, six were from the original GHQ 30 and the other six were from the new items. Does this confirm that psychiatric disorders around the world are variations on a common theme as Goldberg and Williams (1988) suggest, or is it that the studies are developed in the same cultural framework as the measures (and hence with a common conceptualisation of illness)

which are then projected on to the different cultures, and do show real deviations from the original culture?

4.4.6 Difficulties with GHQ

One of the difficulties of the scale is that it can pick up very transient disorders - those of less than two weeks duration - and potentially misses chronic complaints but Goldberg and Williams (1988) suggest that people tend to "cling on" to their concept of usual self as being without illness.

More recently Goodchild and Duncan Jones (1985) have suggested a modified scoring procedure (0,1,1,1, for negative items like feeling constantly under strain, and 0,0,1,1, for positive items like enjoying day to day activities), to pick up such chronic complaints (CGHQ). Goodchild and Duncan Jones (1985) claim it improves specificity from 76.4% to 80.2% GHQ:CGHQ; and sensitivity from 73.5% to 84% GHQ:CGHQ and correlation with the P.S.E. from +0.52 to +0.58%.

However, assessment by other workers on these results have produced contradictory evidence. Bellantuono et al (1987) in their study of Italian general practice found an improvement in specificity but not in sensitivity, whilst Cairns et al (1987) and Vazquez Barquero et al (1986) found no improvement in either coefficient. Surtees (1987) found that sensitivity improved between 0 and 25% on four samples and varied between an improvement of 1% and a decrease of 15%.

4.5 Research and the GHQ

The success of the use of the GHQ in a research setting depends on three factors:

1. The ability of the respondent to understand the questions.
2. The ability of the respondent to answer the questions.
3. The ability of the respondent to understand the response format.

The cut-off threshold of 11-12 recommended by the author of the GHQ was used in this context to distinguish those "with distress" and those "without distress".

Thus scores of:-

0-11 indicates no mental distress.

12-19 indicates distress that may get better without treatment.

20+ indicates distress that will not ameliorate without treatment

(But see section 4.4.4 for a fuller discussion of this)

(Goldberg and Williams 1988)

4.5.1 Translation of the GHQ

Goldberg and Williams (1988) note there are conceptual and practical problems when instruments are designed in one culture and translated for use in another (See also Gillis et al (1982) working with the P.S.E., Lyketsos et al (1979) working with the Foulds' DSSI, and Sen and Mari (1986) working with the GHQ). The GHQ has been translated into about 38 languages, with authors predicting that it is performing almost as well in other cultures (Goldberg and Williams 1988).

In this study the GHQ was not translated, as it was clear from the retrospective study that very few of the patients referred to the Centre had sufficient difficulty with English to be unable to complete the GHQ. In the current study only one person needed the GHQ to be presented orally by a Turkish worker in Turkish. It was decided to exclude this case from the analysis as it was thought that it might provide anomalous results as there was no possibility of "backtranslation".

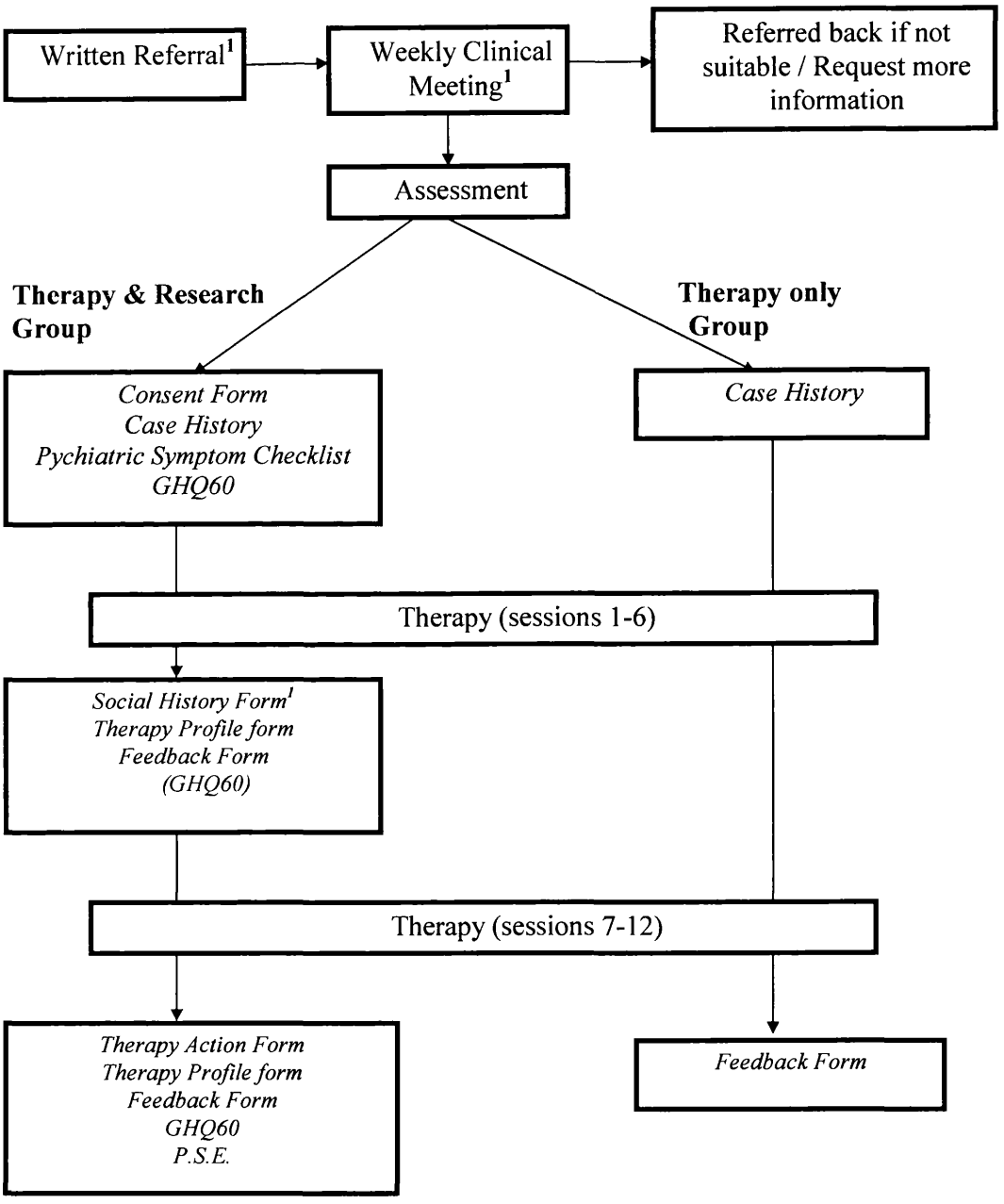
4.5.2 Introduction of the Present State Examination.

The other diagnostic instrument was the Present State Examination (9th Edition, Wing et al 1974a), a psychiatric interview schedule which had been standardised for different populations worldwide. The Present State Examination (P.S.E. - Wing et al 1974a) was suggested. This was agreed not only because it has been used worldwide but that also the Research Director had been trained in its use. This schedule includes the ratings of the presence or absence of 140 symptoms, it also incorporates a two-tier system so that there is a group of obligatory questions, and a group of questions which are asked only if the obligatory questions are rated positively (WHO 1973, Wing et al 1967, Wing 1976, Wing et al 1974a, 1974b). The results of the P.S.E (gathered and processed by Dr. Acharyya[10]) will be presented as comparative measures, comparing with the GHQ, although in this study they will not be extensively analysed.

[10] Dr. Acharyya has kindly let me use his data in this thesis.

4.6 The Prospective Study

Figure 4.2 **DESIGN OF PROSPECTIVE STUDY**



Only patients who consented to be part of the research at the assessment session became part of the study (see Appendix 1). It was stressed to all patients (at the assessment

session) that it was not compulsory to be part of the research, and if they declined this would not affect their being accepted for therapy at the Centre. It was also explained to them that they could withdraw from the research at any time and the time commitment was also explained. It was emphasised that the research was to monitor the effectiveness of the Centre not an individual's progress. The research followed the schedule presentation shown in figure 4.2.

After assessment (see figure 4.2) the patients were allocated a therapist who offered twelve fifty-minute therapy (usually weekly) sessions. At the end of the twelve sessions there was a reassessment by the Clinical Director, the therapist and the patient, and further time was offered if appropriate, usually negotiated in the form of a new contract for a specified number of sessions (see Figure 4.1 for details of the timetable of presentation of schedules).

Patients in the research were self selected, in the sense that they agreed to take part in the study. What is unknown is whether those who declined to take part in the research have a different profile to those in the study.

4.8 Changes to Research Design in Prospective Study

The RP as well as administering the social history schedule, also took a management role monitoring the patients' therapy to check relevant forms were being completed on time.

It became clear as the prospective research reached the nine months stage that the type of problem presented by some patients was more severe[11] than could be expected to be ameliorated in 12 sessions. This is consistent with the results of the *retrospective* study. The Centre therefore adapted by offering extra 12 session (or a smaller negotiated number) contracts to these patients. This clearly had implications for the research. It was decided by the research team at this stage to concentrate primarily on the change in symptomatology between the beginning and end of therapy, rather than a six weekly update. Some patients, if the original research plan had continued, would have filled out six GHQ60 forms and the effect of these multiple completions of the GHQ on measuring symptoms accurately (or on the therapy) was unknown.

Another anomaly was that some of the patients came for part of their first contract (for about 6-8 weeks) and then terminated their therapy. Several months later they came back and completed a second contract. This termination and later return to therapy may be an important issue in psychotherapy for people from some cultures. However, it did prove problematical from the methodological viewpoint. They were excluded from this study, although future research should look at this phenomenon.

4.9 Statistical Analyses

As the number of patients are relatively small, the statistical parameters required for a normal distribution were unlikely to be fulfilled, and hence precluded any parametric statistical analyses.

[11] By severe, I am referring to a quantitative measure of the number and severity of symptoms experienced

The researcher decided that nonparametric tests were, thus, the statistics of choice for the majority of analyses. As the results are from a single sample and the data is generally nominal (i.e. in categories rather than ordinal or interval), the Chi squared test of association is the most appropriate test to use on the sample (Siegel and Castellan 1988). Similarly although the GHQ results are ordered, the relationship between score of "1" and "2", for example, are not necessarily indicative of a doubling of distress and may only bear a relationship within a case (i.e. a person's "1" scores may relate to the same degree of distress) but not within cases (i.e. one person's "1" may indicate a different level of distress to another person's "1"), so again the Chi squared test is the most appropriate statistic.

4.10 Summary

This chapter reviewed the strategies employed in the both the *retrospective* and the *prospective* research, identifying problem areas (e.g. the use of standardised tests) and putting forward the solutions adopted in this research.

by patients. I am not necessarily implying the presence of psychoses in all cases.

Chapter 5

Sociodemographic Results

5.1 Patient Dropout (See Table 5a and Figure 5.1 and 3.10.2)

172 patients were referred to the Centre for therapy between October 1986 and October 1988. Five of these patients were not involved in the "normal" assessment procedure. Four patients were too vulnerable or ill to complete the initial questionnaires and therefore had to be excluded from the research altogether. Their assessments followed a different course, with several sessions of assessment (including one with the psychiatrist) and close monitoring of their condition. Their case history forms were completed, but the patients were very confused and hence were unable to give accurate responses to basic questions, e.g. those of age or where they were born, at the initial session.

That the most ill group were effectively excluded from the evaluation, clearly poses certain limitations on the conclusions that can be drawn. However, to include a group whose assessment followed such a different pattern (with no initial GHQ) would have produced results that were difficult to interpret, in the current research framework. A further one person was excluded from the assessment procedure, as he was under the misapprehension that the Centre staff could prescribe medication, and he did not want to have psychotherapy.

The remaining 10 patients did not arrive at their assessment session.

This left 157 (91.3%) patients who completed the assessment procedure (the *referred* group). Of these 25 patients were excluded, six were considered unsuitable for therapy, eighteen decided not continue and one was a one-off consultation (this group had only the case history schedule completed for them). This left a potential research group of 132 patients. These 132 patients were appropriate referrals and wanted to be considered for therapy. Therefore, as part of the assessment process, the case history and the psychiatric symptom checklist were completed.

Of these 132 patients, 113 patients were referred on for therapy at the Centre (19 patients had decided not to proceed with therapy after the process had been explained to them).

This means that two thirds of those originally referred (n=172) were seen for therapy and just under three quarters (72%) of those who completed the assessment procedure (the *referred* group: n = 157) were seen for therapy. This compares favorably with the dropout figures (discussed in 1.17.7.2), where it was shown that up to 75% of black patients attended only one therapeutic interview (see Table 5a).

Table 5a Table Showing Dropout from Therapy

	Total No. of Referrals	*Referred*[1] *Group*	Therapy
Total No. of Referrals	172 (100%)	----	----
Referred Group	157 (91.3%)	157 (100%)	----
Appropriate for Therapy	132 (76.8%)	132 (84.1%)	----
Therapy	113 (65.7%)	113 (72.0%)	113 (100%)
Treatment Group	52 (30.2%)	52 (33.1%)	52 (46.0%)
Comment	Just under 1/3 *referred* in Research Group	1/3 of those *assessed* in Research Group	Almost 1/2 of those in therapy were in the Research Group

5.2 Completion of Therapy

64 (56.6%) of the 113 patients in therapy completed 12 or more sessions. Of the rest, 19 patients had fewer than six sessions, 30 had six to eleven sessions[2].

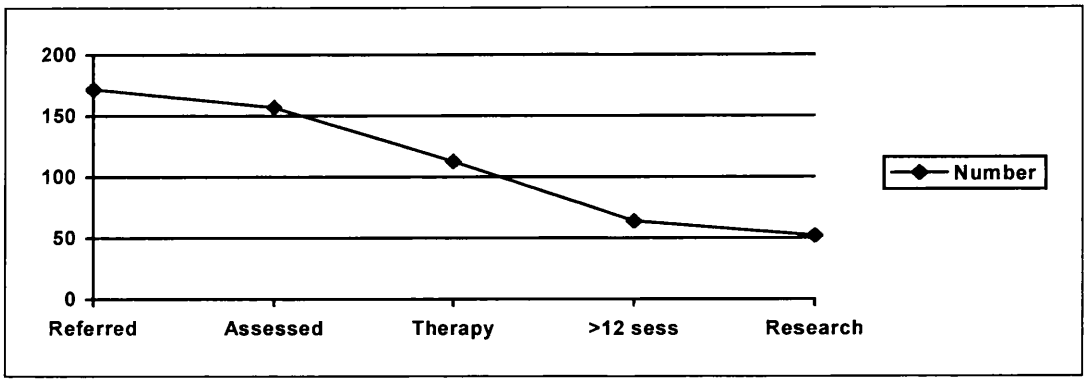
52 patients of the 113 were part of the research (The *treatment* group). Thus under half (52 : 46%) of those taken into therapy (113) completed the research protocol. Of the original 157, 30% completed the research. A further 38.9% of those assessed (157) had short term therapy (49 had less than 12 sessions, a further twelve patients had 12 or more sessions but had were not part of the research).

(See Table 5a and Figure 5.1)

[1] The *referred* group relates to those patients who turned up for their assessment interview and who completed the assessment procedure. This is the comparison group for the *treatment* group (who completed both their therapy and the research protocol) for the statistical analyses.

[2] It is not possible to know whether the patients who completed less than 12 sessions, actually completed their therapy and achieved what they wanted to achieve, or whether they dropped out of therapy because they either were unhappy with it or felt that it wasn't helping.

Figure 5.1 Graph to Show Dropout from Referral to Assessment



The graph shows the dropout from the original referrals to those in therapy. 30% of those referred were investigated in the research. A more accurate comparative group is the number of appropriate referrals who went on to therapy (n=113). The research sample was then a just under a one in two sample (n= 52 which is 46% of the 113). The fact that those who came for less than twelve sessions and a few of those who had more than 12 sessions were excluded from comparative evaluation, does pose difficulties in evaluation.

5.3 Agreement to be Part of Research (see Figure 5.2)

87 (of the 132) patients initially agreed to be part of the research and therefore completed the GHQ-60. After the P.S.E. assessment some were not considered suitable for therapy, and a proportion of those who completed the first two sessions, that of assessment and P.S.E. administration, subsequently failed to attend or complete therapy. A few were unable to see the psychologist to complete the social history

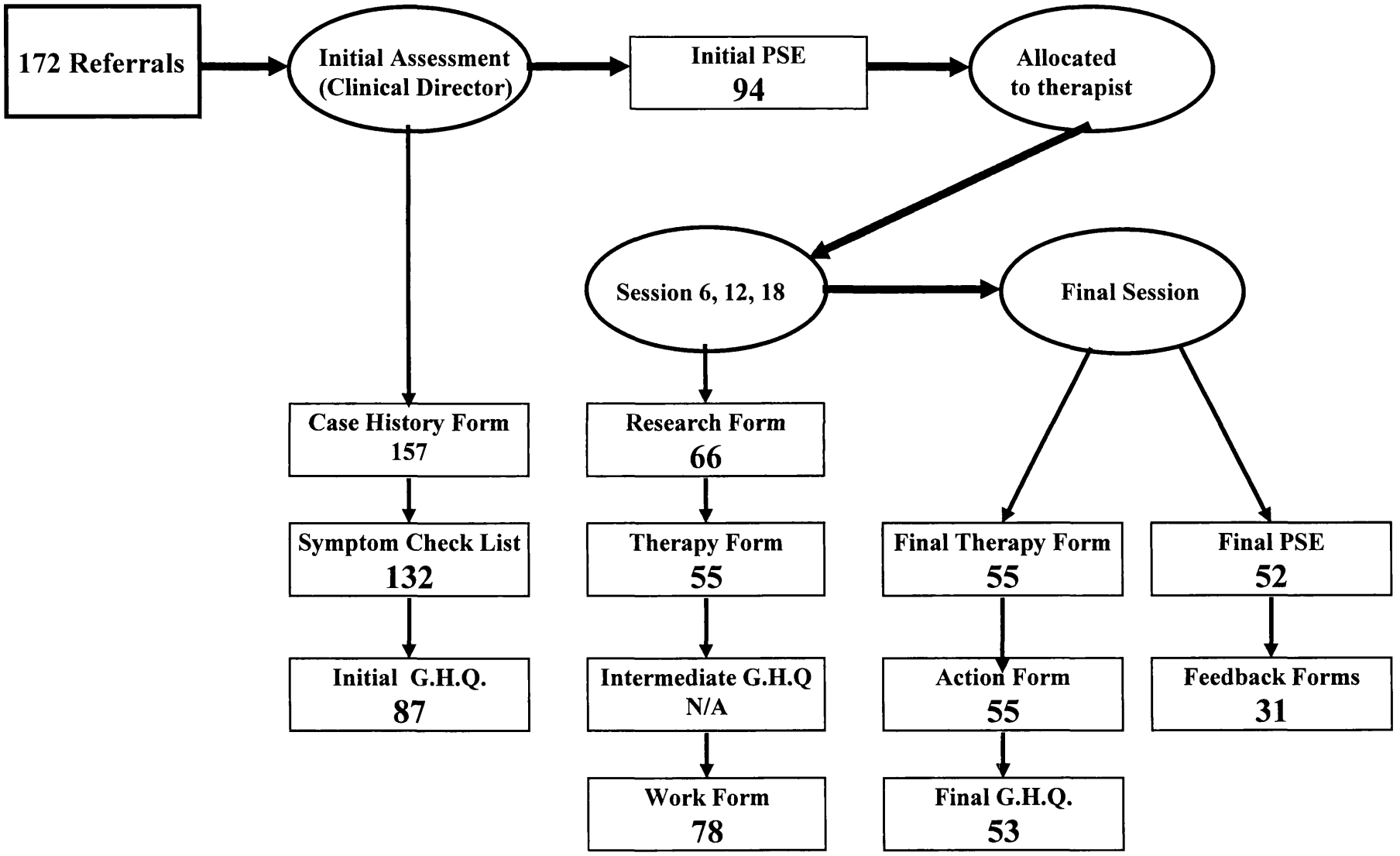


Figure 5.2: Patient Dropout

schedule and the second GHQ, although some patients completed their therapeutic contracts. The remaining group (n=66) who saw the research psychologist mostly completed their contracts (n=55). However, in a two cases, the patients were unable to stay to complete the final GHQ after the final session because of study commitments, a further person was unable to return to complete the final P.S.E. Leaving a final research group of 52.

However, the patients in the group who had 12 sessions or more (the group researched in this study) make up the largest single group. It might be expected that those who stayed for less than 6 sessions (here we might query whether some of these patients were true "dropouts" from therapy due to finding that the therapy was not appropriate for them) might have a different profile to those who stayed for 6-11 sessions (obviously this group were persevering and perhaps recognising the value of therapy). Both of these might have different profile to those staying more than 12 sessions. It was considered likely that from the *retrospective* evaluation the majority of patients would stay for at least 12 sessions (approximately 57% stayed for 12 sessions or more). This proportion was not as large as in the *retrospective* evaluation, but reflects the difficulties in the changing patient profile of a small organisation[1].

However, this group was not only comparative with the retrospective evaluation, but arguably, most accurately reflects the long term profile of patients at Nafsiyat. Still, in 1999, the majority of patients are offered 12 session contracts and it is expected that they will complete these, perhaps with the offer of a further contract of 12 sessions. As

[1] In a small organisation, small number of patients who show a different profile, disproportionately distort the results. e.g. if a few patients come into therapy and do not stay for 12 sessions, this will change the profile of the group.

this is the case, it was expected that the research group would have a representative range of presenting problems, and perhaps not be subject to the fluctuations in presenting symptoms.

It would, of course, be interesting to follow up patients who do not complete their contracts (was it because they found therapy inconsistent with their worldview? Did they find it difficult or painful to pursue? Did they resolve what they wanted within the few sessions they attended? Were they offered long term therapy elsewhere?). From patients spoken to informally, all these are possible factors, although they have not been followed up in this research.

5.4 Research Groups

Primarily two groups were evaluated in this research, the *referred* group (n=157) and those in therapy who agreed to be part of the research the *treatment* group (n=52). It should be remembered that the *treatment group* is a subgroup of the *referred* group .

5.5 Dropout from Research

Figure 5.2 shows the dropout from the initial assessment to the final *treatment* group in terms of the forms completed. Reasons for non-completion of forms included not wishing to be part of the research, inability to come at mutually convenient time to see either Research Director or psychologist or a decision that they did not want to be assessed by a psychiatrist (it should be remembered that some ethnic groups, particularly the Caribbean group, would be aware of the "misdiagnosis" issues

described in chapter 1 (1.15), and might feel that they were putting themselves in a vulnerable position if they saw a psychiatrist).

5.6 Sociodemographic Results

In this section the results of the different sociodemographic hypotheses proposed in Chapter 3 (3.3) will be evaluated, the *referred* group will be compared with *treatment* group to measure any particular differences between those who were referred and those taken on for therapy.

5.6.1 The Patients seen at the Centre would come from a variety of ethnic and cultural backgrounds (see 3.3.1)

As the Centre was set up to see patients from ethnic minorities this question is fundamental (see table 5b and figure 5.3).

Patients referred to the Centre were born in many different countries and cultures. For the *referred* group, the largest single group is the British born group (22.3%), and this is the largest group for any single country, but makes up only one fifth of the total. The next largest group are those born in the Caribbean, with one sixth (15%) born in Africa. A list of 51 Countries of Birth are noted, with patients defining their cultural origins in 61 different ways, this can be accounted for by those born in the UK describing their "cultural roots" or "ethnic identity" as for example *Black British* or in one case *African.*

Table 5b Geographical Origin of Patients

Geographical Area of Origin	Number of Patients	
	Referred Group (n=157)	Treatment Group (n=52)
Africa[1]	25 (15.9%)	5 (9.6%)
Africa (Asian)[2]	10 (6.4%)	5 (9.6%)
Caribbean[3]	31 (19.7%)	12 (23.1%)
Europe[4]	4 (2.6%)	1 (1. 9%)
South America[5]	1 (0.6%)	0 (0.0%)
Middle East and North Africa[6]	9 (5.7%)	5 (9.6%)
North Mediterranean[7]	9 (5.7%)	1 (1.9%)
S. Asia[8]	22 (14.0)	11 (21.2%)
S.E.Asia[9]	2 (1.2%)	0 (0.0%)
United Kingdom[10]	35 (22.3%)	12 (23.1%)
USA[11]	1 (0.6%)	0 (0.0%)
Mixed Race[12]	8 (5.1%)	0 (0.0%)

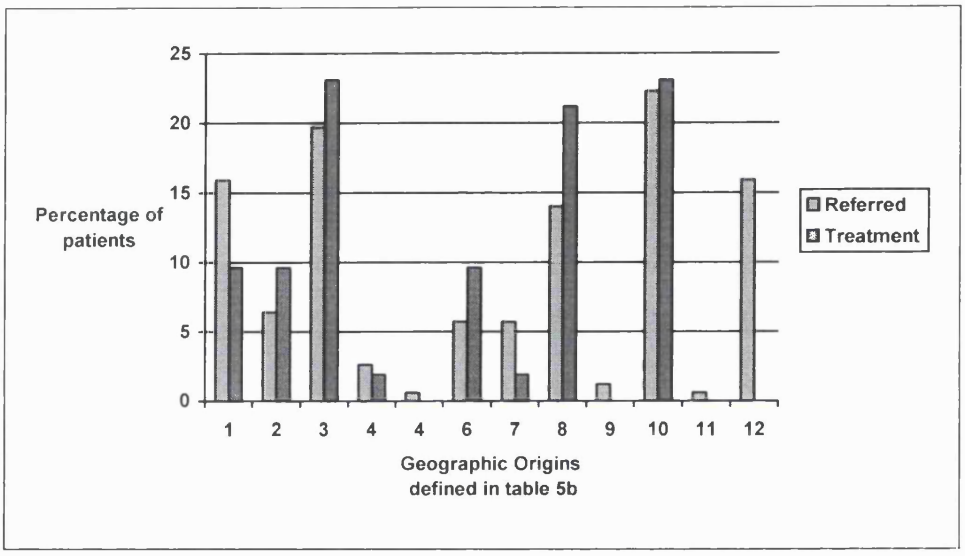
For some their origins are defined not where they were born but their cultural backgrounds (e.g. the "mixed Race"[13] "dual heritage" group), this was not followed up in the *referred* group, but geographical origin was defined in the *treatment* group (both

[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: Cuba.
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.
[11] U.S.A. unspecified States.
[12] Mixed Race - this group includes those whose Country of Birth was not noted, but details of their cultural origins were: they included those who were English-African, English-Ghanian, English-Nigerian, English-S.Lucian, English-Grenadan, English-Jamaican, English-Polish, English-Cypriot, English-Syrian, English-Mauritian, English-Pakistani as well as English-Mixed Race, and Sri Lankan-Italian
[13] At the time of the research, the term "mixed race" was the term usually used to describe people, and how people described themselves, from a dual heritage background. In the discussion of the groups the term "dual heritage" will be used, but the term mixed race will be kept in the tables as this was how the patients described themselves.

of these are important personal and therapeutic issues). Here we can see the influences of ethnic identity and ethnic origin as well as cultural identity.

Figure 5.3 Graph to show the Geographical Origin in the Referred and Treatment Groups

(N.B. the numbers refer to the footnote numbering of ethnic origin - i.e. 1 = African etc.)



For the *treatment* group again one of the largest groups is the UK group, but also the Caribbean group makes up 23.1% of the group. This implies that whereas for the UK group, a similar proportion of the group were prepared to be part of the research and in treatment, this was true of a larger proportion of the Caribbean group, alternatively that such groups were "more appropriate" referrals. The reverse situation seems to be true of the African group, fewer than expected were in the *treatment* group, a similar attenuation of numbers also occurred for those from the North Mediterranean, whilst S. Asia (see table 5c), the Middle East and North Africa increased their proportions.

Obviously there was an attenuation of "mixed race" patients to zero in the treatment group as we were looking solely at geographical origins.

It seems to the writer that this profile of patient origins is representative of Nafsiyat patients in treatment, with the UK, Caribbean and Asian born making up the majority of the Nafsiyat caseload. From Chapter 2 (Table 2a) it can be seen that this broadly mirrors the therapists' origins. It had been noted over some time that this relationship held (for some patients there was a need for therapy in the home language, for others it was for cultural reasons see section 5.13.3).

Political situations in different parts of the world caused fluctuations in the Centre's caseload and influenced the number of refugees from certain cultures. The absence of some cultures, for instance those from S. America, may not only reflect cultural emigration patterns, but also the limited amount of therapy available in Spanish. Of course, it may also reflect those cultures who do not feel that therapy is appropriate. This latter hypothesis seems unlikely to be working, as most ethnic groups are represented in the research group. Of course it may applicable to some patients.

Table 5c Differences between Country of Birth Statistics

Geographical Area of Origin	Change in Total Percentage of Patients Between *referred* and *treatment* groups	
Africa[1]	15.9% - 9.6%	-6.3%
Africa (Asian)[2]	6.4% - 9.6%	+3.2%
Caribbean[3]	19.7% - 23.1%	+3.4%
Europe[4]	2.6% - 1.9%	-0.7%
South America[5]	0.6% - 0.0%	-0.6%
Middle East and North Africa[6]	5.7% - 9.6%	+3.9%
North Mediterranean[7]	5.7% - 1.9%	-3.8%
S. Asia[8]	14.0% - 21.2%	+7.2%
S.E.Asia[9]	1.2% - 0.0%	-1.2%
United Kingdom[10]	22.3% - 23.1%	+0.8%
USA[11]	0.6% - 0.0%	-0.6%
Mixed Race[12]	5.1% - 0.0%	-5.1%

The minus sign in figure 5c indicates a loss of patients from *referred to treatment* groups. A plus sign indicates an increased percentage in the *treatment* group compared to the referred group.

[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: Cuba.
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.
[11] U.S.A. unspecified States.
[12] Mixed Race this includes those whose Country of Birth was not noted but details of their origins were: they included those who were English-African, English-Ghanian, English-Nigerian, English-S.Lucian, English-Grenadan, English-Jamaican, English-Polish, English-Cypriot, English-Syrian, English-Mauritian, English-Pakistani as well as English-Mixed Race, and Sri Lankan-Italian

The loss of certain ethnic groups may also be analysed on an individual level, perhaps the particular way of working was not appropriate for the individual, or that the presenting symptoms were not appropriate for intercultural therapy.

Table 5c indicates that patients from South Asia were more likely to stay in therapy and agree to be part of the research. In fact, in termsof origins, the results are greater than the 7.2% indicated in the table. This is because the S. Asian patients born in Africa also make up a greater percentage of the treament group than expected from the *referred* group. This can perhaps be undersood by recognising that the Clinical Director came from South Asia, and he was the person patients met at their first (assessment) session. Moreover, the psychiatrst who interviewed them (using the P.S.E.) was also from S. Asia. Thus perhaps patients from similar ethnic backgrounds found it easier to be part of the research. This perhaps also can be considered in terms of therapy being seen as being emic to the patients.

However, there was no association (χ^2 test of association) between Country of Birth and whether a patient was taken on for therapy, nor between whether a patient was a migrant and whether they were taken on for therapy.

Further analysis based on the other data collected on ethnicity yielded interesting discrepancies (Table 5d).

Table 5d Differences between Country of Birth and Ethnicity (1)

Geographical Area of Origin	Number of Patients		
	Treatment Group[A] (COB)	Research Schedule[B] (COB)	Research Schedule[C] Ethnicity
Africa[1]	5 (9.6%)	1 (1.9%)	7 (13.5%)
Africa (Asian)[2]	5 (9.6%)	5 (9.6%)	0 (0.0%)
Caribbean[3]	12 (23.1%)	8 (15.4%)	20 (38.5%)
Europe[4]	1(1. 9%)	0 (0.0%)	0 (0.0%)
Latin America[5]	0 (0.0%)	0 (0.0%)	0 (0.0%)
Middle East and North Africa[6]	5 (9.6%)	5 (9.6%)	4 (7.7%)
North Mediterranean[7]	1 (1.9%)	0 (0.0%)	2 (3.9%)
S. Asia[8]	11 (21.2%)	13 (25.0%)	19 (36.5%)
S.E.Asia[9]	0(0.0%)	0 (0.0%)	0 (0.0%)
United Kingdom[10]	12 (23.1%)	20 (38.5%)	0 (0.0%)

From these results we can see the differences. In this group, the country of origin question at the assessment session appears to have been answered, for many, in terms of *ethnic origin,* for others in terms of their country of birth. The research schedule

A This refers to the assessment Interview description of Country of Birth
B This refers to the Research Schedule description of Country of Birth
C This refers to the Research schedule description of Ethnicity
[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: The patient from Cuba was not in the treatment grp. This is added to allow comparison with Table 5b..
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.

Country of Birth question asked specifically which country they were born in, and this was clarified at the research appointment, while the Research Schedule "Ethnicity" question relates to their *ethnic identity*. Hence it can be seen that whilst 12 patients defined their country of birth in terms of the UK, in fact 20 people had been born in the UK. Hence we have a discrepancy of 8 patients.

Figure 5.4 Figure to Show the Different Descriptions of Origin and Ethnicity (For Groups Refer to Table 5d)

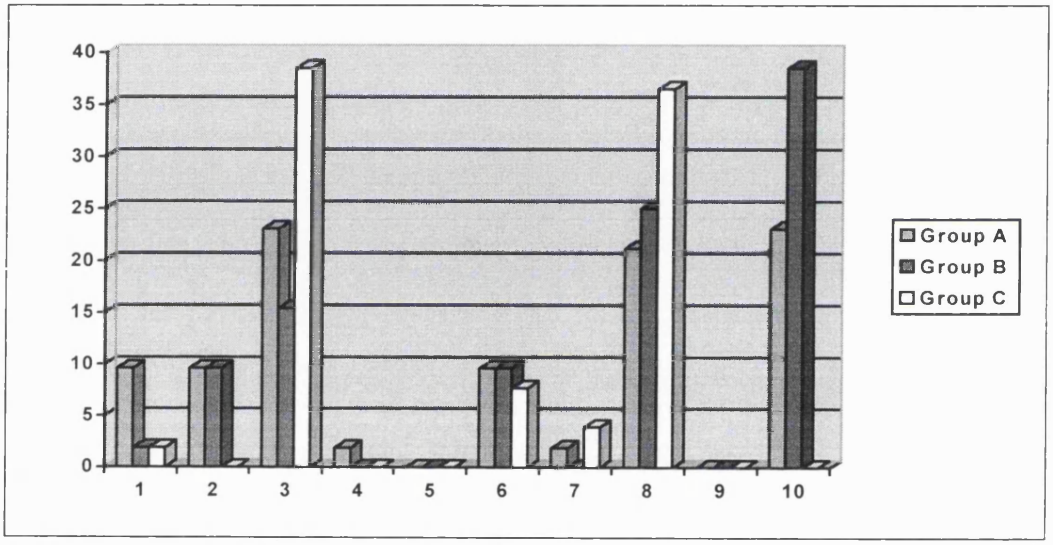


Table 5e Differences between Country of Birth Results

Geographical Area of Origin	Changes in Origin of Patients between Assessment and Research Interviews		
	Treatment Group[A] (COB)	Research Schedule[B] (COB)	Difference COB B-A
Africa[1]	5 (9.6%)	1 (1.9%)	- 4
Africa (Asian)[2]	5 (9.6%)	5 (9.6%)	0
Caribbean[3]	12 (23.1%)	8 (15.4%)	- 4
Europe[4]	1 (1. 9%)	0 (0.0%)	- 1
Latin America[5]	0 (0.0%)	0 (0.0%)	0
Middle East and North Africa[6]	5 (9.6%)	5 (9.6%)	0
North Mediterranean[7]	1 (1.9%)	0 (0.0%)	- 1
S. Asia[8]	11 (21.2%)	13 (25.0%)	+ 2
S.E.Asia[9]	0 (0.0%)	0 (0.0%)	0
United Kingdom[10]	12 (23.1%)	20 (38.5%)	+ 8

Difference A - B +/-10 which means that 10 people changed their Country of Birth, eight of them to the U.K.

It is clear that there are discrepancies between the groups. Four patients who had been previously designated as from the Caribbean were born in the UK, two African patients, one Turkish and one European patient were also born in the UK, whilst two patients who described their country of birth as African were born in India.

[A] This refers to the assessment Interview description of Country of Birth
[B] This refers to the Research Schedule description of Country of Birth
[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: The patient from Cuba was not in the treatment grp. This is added to allow comparison with Table 5b..
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.

How can we explain this? One explanation seems to be that patients are perhaps unsure where they were born, (and this may be a problem for some of the patients) but seems unlikely to be the whole answer.

The largest discrepancy happens around the UK country of birth (eight people gave alternative countries of birth). When the data is looked at in more detail it is found that three of the eight, moved from UK at a young age (less than one month after birth) to other countries. Therefore they spent most of the childhood and early adulthood in other countries, and hence would have been expected to have the same experience as migrants, when they returned to the UK. It is assumed that they would have the same experience of migration as other teenage migrants, as they had little experience of life in the UK. The remaining five people were born in the UK, and hence are categorised as UK born, even though they may have spent time away from the UK they can be considered to have been acculturated into the UK.

From the clinical work we know that identity is one of the struggles that our patients present with. These results seem to support the hypothesis that finding a ethnic identity is not an easy process and that even reporting your country of birth seems to present issues for patients. I think is perhaps well summarised by a patient I saw after the research finished (the Centre still uses a modified version of the case history form) and this patient said that "if I say that my country of birth is Britain, then it doesn't say who I am, that I'm from Barbados". So it seems that country of birth is a measure that causes some distress and confusion. Understandably cultural origin seem to be the single most important factor in this group.

It is interesting that two people initially reported they were born in Africa, on further evaluation on the research schedule it turned out they were born in India and were by

our definition *Africa (Asian),* yet they were obviously making a comment about what they saw as their ethnic identity/origin. If we put this into psychodynamic terms, we are looking at the unconscious processes: we know from Freud's work that our perceptions and our unconscious work in tandem; how we perceive the world is also predicated on our culture. In this group, with the different migrations of the different members and generations of families these identities seem to be more complex and seem less geographically and more psychologically based.

Table 5f Differences between Country of Birth and Ethnicity (2)

Geographical Area of Origin	Number of Patients		
	Research Schedule[B] (COB)	Research Schedule[C] Ethnicity	Difference COB-Ethnic
Africa[1]	1 (1.9%)	7 (13.5%)	-6
Africa (Asian)[2]	5 (9.6%)	0 (0.0%)	+5
Caribbean[3]	8 (15.4%)	20 (38.5%)	-12
Europe[4]	0 (0.0%)	0 (0.0%)	0
Latin America[5]	0 (0.0%)	0 (0.0%)	0
Middle East and North Africa[6]	5 (9.6%)	4 (7.7%)	+1
North Mediterranean[7]	0 (0.0%)	2 (3.9%)	-2
S. Asia[8]	13 (25.0%)	19 (36.5%)	-6
S.E.Asia[9]	0 (0.0%)	0 (0.0%)	0
United Kingdom[10]	20 (38.5%)	0 (0.0%)	+20

Difference A - B +/-26 which means that 26 people considered their ethnicity different to their Country of Birth, significantly none of those born in U.K. considered their ethnicity to be British.

The most striking result is that no-one saw their ethnicity as linked to the UK. In a similar way to the patient's comment described above, the majority of those who would

[B] This refers to the Research Schedule description of Country of Birth
[C] This refers to the Research schedule description of Ethnicity
[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: The patient from Cuba was not in the treatment grp. This is added to allow comparison with Table 5b..
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.

class their ethnicity as Caribbean were not born there. Likewise although only one person was born in Africa, a further five patients placed their ethnicity there.

A reverse situation happens for the *African (Asian)* group, all but one of the group placed their ethnicity within the Indian (*S. Asia)* category.

As a comparison, if we look at the original COB figures given at the beginning of their treatment (during the assessment session) and ethnicity described at the research interview, a similar pattern is found. Although as at least eight people failed to describe their COB as the UK (we are working from a 12 - not 20 - UK born figure) the differences seem less striking, but show a similar pattern.

Table 5g Differences between Country of Birth and Ethnicity (3)

Geographical Area of Origin	Number of Patients		
	Treatment[A] Group (COB)	Research Schedule[C] Ethnicity	Difference COB-Ethnic
Africa[1]	5 (9.6%)	7 (13.5%)	- 2
Africa (Asian)[2]	5 (9.6%)	0 (0.0%)	+5
Caribbean[3]	12 (23.1%)	20 (38.5%)	- 8
Europe[4]	1(1. 9%)	0 (0.0%)	+1
Latin America[5]	0 (0.0%)	0 (0.0%)	0
Middle East and North Africa[6]	5 (9.6%)	4 (7.7%)	+ 1
North Mediterranean[7]	1 (1.9%)	2 (3.9%)	- 1
S. Asia[8]	11 (21.2%)	19 (36.5%)	- 8
S.E.Asia[9]	0(0.0%)	0 (0.0%)	0
United Kingdom[10]	12 (23.1%)	0 (0.0%)	+12

Difference A - B +/- 19 means that 19 people considered their ethnicity different to their Country of Birth, again significantly none of those born in U.K. considered their ethnicity to be British.

If we look at the differences on all these charts (Tables 5e, 5f and 5g) we can notice that the biggest difference is, on the researcher's interview between COB and ethnicity. Two factors may have influenced this. Firstly the patient would have had several sessions of therapy and would have been able to explore issues about their origins and

[A] This refers to the assessment Interview description of Country of Birth
[C] This refers to the Research schedule description of Ethnicity
[1] Africa : Eritrea, Ethiopia, Ghana, Liberia, Mauritius, Namibia, Nigeria, S.Africa, Seychelles, Sierra Leone, Sudan, Zimbabwe, Black African (not specified).
[2] Africa (Asian): Kenya, Tanzania, Uganda, East Africa.
[3] Caribbean : Caribbean, Dominica, Guyana, Jamaica, Nevis, Trinidad, Afrocaribbean (born Caribbean).
[4] European : France, Ireland.
[5] South American: The patient from Cuba was not in the treatment grp. This is added to allow comparison with Table 5b..
[6] Middle East and North Africa : Iran, Morocco, Saudi Arabia, Egypt, Middle East.
[7] North Mediterranean: Greek Cypriot and Turkish Cypriot, Greece and Turkey.
[8] S. Asia : Bangladesh, Burma, India, Pakistan, Sri Lanka, Anglo Indian (born India).
[9] S.E.Asia : Malaysia and Singapore.
[10] United Kingdom: England, Scotland, Wales, Northern Ireland.

secondly the researcher was asking direct questions away from the assessment interview and therapy and explored answers thoroughly with the patient.

This is result in general supports the idea that ethnic identity is a composite variable it is not tied to country of birth but to perceived origins and countries where the person has grown up in.

Perhaps the differences can also be explained by looking at the question of country of birth as being understood and responded to as the patients need to identify with their origins (their ethnicity, their cultural roots) and create an ethnic identity, particularly those born in the UK We can perhaps say that for 26 people (table 5f) i.e. half the group, identity and origin may have been one of the factors that influenced their decision to come for therapy and perhaps influenced their choice of intercultural therapy. For others their country of birth was responded to as a definitive unchanging variable, where they were born. Obviously some patients were keen to get help at the Centre and perhaps felt that they might not get it if they said that they were born in Britain.[N.B.] Here we see the difficulties in assigning origin. In a similar way to gender, where physiological aspects are mediated by psychological aspects, origin is not only geographically orientated but is also culturally and psychologically mediated.

[N.B.] For research purposes, for those analyses where country of birth statistics may be considered to potentially have influenced assessment (e.g. being taken on for therapy), the number of British born is calculated at n=12 (the information available at the time to the assessor). Calculations involving migrant and the U.K. born are based on n=17 the number of patients whose country of birth was the U..K. The difference of three compared to the research schedule 4, table 5c (UK born = 20) is explained by the fact that three patients were born UK then returned to the Caribbean less than one month after birth. They migrated to the UK again in their early years.

5.7 Sociodemography

5.7.1 Did the patients at the Centre conform to the expected sex ratio? (see 3.3.2)

In the *referred* group the number of men referred was 58 compared to 99 women (women:men ratio was 1.7:1), whilst in the *treatment* group the number of men referred was 16 compared to 36 women (the women:men ratio was 2.3:1). There is thus some evidence to suggest that women were slightly "better" referrals or, at least, more likely to be in the research: 36.4% of them were taken on for therapy/research compared to 27.6% of men. Although the percentage of women was slightly higher there was no statistical association (χ^2 test of association) between sex and whether a patient was taken on for therapy.

5.7.2 Did the patients at the Centre conform to the Yavis criteria? (see 3.3.3)

1. **Age**

In the *Referred* group ages ranged from 17 - 57 years, The majority of patients come for treatment in their twenties and thirties (132 of the 157 people referred - 84% - were in this group), with the most common age being 26 years old. For men the age range was 19-57 years (mean age was 31 years), for women the range was 17-55 years (mean age was 30 years).

Table 5h Age /Sex of Referred Population

AGES	<19	20-29	30-39	40-49	50+	TOTAL
MEN	1	28	22	2	5	58
WOMEN	5	50	32	9	3	99
Ratio women men	5:1	1.8:1	1.45:1	4.5:1	0.6:1	1.7:1

The commonest age for referral was between 20-29 years of age. Remembering that we are selecting an adult population and child cases have been excluded. Of those under 19 years of age, more are young women. This skew happens again for those patients in their forties; of those in their fifties there is a slight skew towards men, perhaps reflecting some cultural issues (those of men, age and identity). There does not appear to be an association between age on referral and sex as the age/sex distribution is not statistically significant (chi-squared statistic 5.34: df = 4; sig = 0.25 n.s.).

For the *treatment* group, ages ranged from 19 - 57 years. The majority of patients come for treatment in their twenties and thirties (46 of the 52 people referred - 88.5% - were in this group), the most common age being 27 years old. For men the age range was 21-57 years (mean age was 34), for women the range was 19-46 years (mean age was 30). Therefore the Centre's patients came at the predicted ages, and hence this is a similarity between the Centre's patients and "usual" therapy patients. There was no significant association between age and whether a patient was taken on for therapy. However, as the patients who referred themselves or were referred were skewed towards the younger age group, then the hypothesis as to whether therapy is appropriate for an older age group could not be tested out.

2. **Attractiveness**

The Centre did not consider this an appropriate consideration in deciding on therapy (and perhaps, in this regard, it is different to other Centres). It can be thought of as a "countertransference", a feeling coming from the therapist. Hence such decisions are the responsibility of therapists, but one is left wondering whether black patients would be perceived by white therapists as appropriate for therapy (see Moorhouse 1992, 2000).

3. **Verbal**

One of the important factors in intercultural work is therapy in the home language if necessary, and the need to understand cultural metaphors in language. In the research all the respondents (remembering that one Turkish patient who spoke little English and was excluded from the research on this basis) were able to complete the GHQ in English. For 50% of the patients English was their first language (and hence we can surmise that referral to Nafsiyat was on the basis of cultural, not language) needs. The remaining patients (bar four) spoke one of 16 languages (Arabic, Ashanti, Bengali, Berber, Creole, Egyptian (Arabic), Eritrean, French, Greek, Gujerati, Hindi, Moroccan (Arabic), Punjabi, Sylheti, Tamil, and Urdu). The remaining four patients described themselves as being bilingual (Gujerati - English, Urdu - English, English - Patois, Gujerati - French).

4. **Intelligence**

Half of the treatment group had been in education beyond 18 years of age. 38.4% had left school at 16 or 17 years of age. In five cases patients had left education before the age of 16. 22 (42.3%) of the 52 had achieved post "A" level qualifications (20 in this country, 2 abroad). Although education is perhaps only a crude measure of intelligence, these results emphasise that half the patients seen at Nafsiyat were sufficiently intelligent to complete their secondary education and a proportion post "A" level. What it cannot show is, to what extent those who did not complete their education could have achieved. Two of the patients both had two degrees, one from their country of origin and one in the UK.

5. **Successful**

Implicit in the notion of "successful" is the ability of the patient to pay for therapy which is usually fee paying, leading to the reality that most therapy patients are middle class. At the time of the research the fees for private therapy were between £15 and £20 per session. The over-riding idea is that payment in some way provides an extra incentive for patients to turn up for sessions and complete the therapy contract. However (relatively recently) this notion has been challenged by the growth of NHS psychotherapy (most notably the Tavistock) and small therapy organisations. Nafsiyat, due to its funding was able to offer free therapy to Islington patients and had a series of grants which paid for patients from other areas. Hence it is unsurprising that 86.6% of the *referred* and 84.6% of the *treatment* group were taken on for free therapy, whilst the remaining patients paid a small donation ranging from a few pence to a few pounds. No-one was paying the full private rate.

There are other ways to show motivation and commitment to therapy. Clinical work has shown that patients will walk to sessions when they do not have money for public transport: An expression of motivation "par excellence".

It could be argued that these patients could pay for therapy. One of the key measures of economic status are the jobs people do and the type of housing occupied. The data for this was only collected on the *treatment* group.

Table 5i Current Full Time Job (see 3.3.7)

Administration	8
Media[1]	5
Owner/shop	2
Professional[2]	7
Semiskilled[3]	2
Skilled	2
Unskilled[4]	4

Only 30 (57.7%) of the group were in full time work, with a further 5 unemployed and 4 looking after children at home. Four were in postgraduate education and 6 worked part time. One was in secondary education and the remainder (2) were undergraduates. None of them considered themselves well off, the professional group were predominantly newly qualified and hence not earning enough to afford private fees.

Over half (29 people) of the patients were living in Council or Housing Trust accommodation with a further three people renting privately. Just under one third (30.8%) were living in their own or family owned home (either fully owned or with a mortgage), with the remaining 4 people either in student accommodation or work linked accommodation. The majority of home owners were single (9 of the 16).

The number of council tenants together with the lack of highly paid (or any) job, leads to the hypothesis that the majority of patients were unlikely to be able to pay for therapy, with only the 16 patients who owned (or were buying) their own home being "typical" therapy patients. The previous retrospective study had identified some transience in accommodation. However this group tended to show a quite settled pattern, for the 46 people who had details completed, 41% had lived in their home for

[1] Media = Musician, Actor, Writer, Journalist
[2] Professional = Social Worker, Nurse, Teacher, Interpreter
[3] Semi-skilled = Bus Driver
[4] Unskilled = Waitress, Shopworker and Porter

more than 4 years (one young person had lived at home for 15 years). 18 patients had been living in their current home for between 1 and 4 years, whilst only 9 had recently moved (and had been in their current accommodation less than 1 year).

5.8 Demographic data

5.8.1 Patients'Home Area (see 3.3.4)

In the *referred* group, 75 patients (47.8%) were living in Islington, with a further 17.8% living in other parts of North London. In total 94.9% of the patients came from London. The others (5.1%) came from Middlesex, Kent and Oxford. For the *treatment* group 25 people (48%) came from Islington, another 17.3% came from other parts of North London. The *referred* and *treatment* groups have a similar profile with almost half the referrals came from the local area, with almost two thirds coming from the neighbouring Boroughs. It should be remembered that some parts of Islington are geographically further away from Nafsiyat than areas in other boroughs.

5.8.2 How Patients were Referred (see 3.3.5)

The majority of patients in the *referred* group were self-referred (61.8%), with almost one fifth (19.1%) being referred by their G.P. (5 self-referrals heard of the Centre via their G.P.). Referrals by psychiatrists made up just under one tenth (8.9%) of the total. Social work referrals were small with only 3.2% of people being referred via them. The remaining seven percent of referrals come via psychologists (1 person), probation officer (1 person), other agencies (4 people), a medical consultant (1 person) and

college counsellors (4 people). Eleven people had heard of the Centre through a past or present patient at the Centre.

For the *treatment* group the pattern is slightly different, with (as with the *referred* group) the majority being self referred (57.8%) with 21% being referred via the G.P. and 11% through their psychiatrist. There was also a higher proportion of social work referrals (5.8%). Although, there are slightly more referrals from G.P.s, psychiatrists, and social workers, the change is too small to merit statistical evaluation. However, it is suggestive that referrals from these three sources are slightly more appropriate than from other sources (an alternative evaluation is that more of these groups agreed to be part of the research). But if the findings from the *referred* group where there were 9 different ways of being referred is contrasted with the *treatment* group where only six ways of referral were found: self, G.P., psychiatrist, social worker, agency, and educational counsellor, it suggests that self referrals are particularly appropriate for treatment (See 3.3.5).

5.8.3 Were the patients at the Centre registered with a G.P? (See 3.3.6)

It seems that contrary to previous research findings many of the patients at the Centre were registered with a G.P. What was concerning was the patient's worry about G.P.s knowing that they were coming for therapy. In the *referred* group, of those that chose to answer the question (106 people), 17 (16.1%) people did not want their G.P. to know that they were seeking help at a therapy centre. While for the *treatment* group, 7 patients (13.5%) did not want their G.P. contacted, and a further 14 patients said that they did not want their G.P. to be contacted initially, but accepted that if during therapy this became necessary they would discuss this again with their therapist (60%

of the patients said they didn't have any objection to the Centre contacting their G.P.). Hence it could be argued that 40% of this group were concerned about their G.P. knowing about their therapy.

Extending the notion of concern about the patient's G.P. knowing about their treatment, one can pose the question as to whether (if there was no self referral pathway) such patients would struggle with their psychological problems and would end up in hospital We must remember that the main arbiter of access to psychological services is the G.P. (Goldberg and Huxley's filter model 1980) and this route (obviously) only works if patients are registered with a G.P. and go to their G.P. when they are ill (see 3.3.6).

5.9 Demographic Profile of Self Referred Patients (see 3.3.7)

The majority of patients in both the *referred* and *treatment* groups were self referred. However the appropriateness of self referrals is a constant concern amongst professionals while, paradoxically, most private therapy patients are self referred. We can perhaps think of this as a class issue. Middle class patients are perceived to know and demand what they want, while working class patients are perceived to need to be referred and told what therapy to have. In a later section the therapeutic outcome for self referred patients will be discussed, in this section demographic issues will be reviewed.

The way patients found out about the service offered by Nafsiyat was diverse. For the 96 self referrals in the *referred* group the single largest group heard of the Centre through friends (25 people i.e. 26% of the group), of these, ten friends had been patients

themselves at Nafsiyat. A total of eleven patents had been recommended by ex-patients of Nafsiyat, the majority of the remainder heard via the media (16), through other agencies helping ethnic minority groups (eg. Roots) (15) or through leaflets sent out to various organisations (13).

For the *treatment* group of the 30 self referrals, 9 patients (30%) heard via friends (4 of these were ex-patients) A total of five patients had heard of the Centre via ex-patients. Again the majority of the remainder heard about Nafsiyat through leaflets (5), other agencies (5) or through the media (4).

5.9.1 Sex Differences in Referral Pattern

Table 5j Referral Source/Sex Patterns (For *Referred* Group)

Who referred	No. Men	No. Women	Total
Self	30 (51.7%)	67(67.7%)	97
Medical[1]	24 (41.4%)	22(22.2%)	46
Other[2]	4 (6.9%)	10(10.1%)	14
Totals	58	99	157

There appears to be a slight sex difference in the mode of referral, with more women self-referring and, although the number is small (5 women), all the social worker referrals were for women. For men the mode of referral seems to be from the medical route. The test of association shows that sex and self referral are weakly associated

[1] Medical = G.P.+ Psychiatrist+Psychologist+ Medical Consultant
[2] Other = Agency + College Counsellor +Social Worker + Probation

(χ^2 = 3.29, d.f = 1, significance 0.0471 before Yates' correction and 0.0695 after Yates' Correction).

5.9.2 Age Differences in Referral Pattern

Table 5k Referral Source/Age Patterns

Age	Self Referred	Other referrals	Total
< 19	3 (3.1%)	3 (5.0%)	6
20-29	57 (58.8%)	21 (35.0%)	78
30-39	30 (30.9%)	24 (40.0%)	54
40-49	6 (6.2%)	5 (8.3%)	11
50+	1 (1.0%)	7 (11.7%)	8
Totals	97	60	157

From this table it is evident that the usual age to self-refer is during a patient's twenties (59% compared with 35%): at all other ages patients are slightly more likely to be referred by another source (χ^2 = 13.93, d.f = 4, significance 0.0075). As private therapy is usually via self referral, this result explains the commonly reported finding that most therapy patients are in their twenties and thirties.

5.9.3 Payment (see section 3.3.8)

Only 17 patients paid for their therapy. Therefore, as expected this was not a major factor in the analysis, although there was an association with Country of Origin (see section 5.13.1).

5.10 Specific Cultural Issues In Intercultural Work[1]

There are common stereotypes and assumptions when thinking about ethnic minority people in Britain today, particularly those involving supportive extended families and close links with religion. Such assumptions contain a kernel of truth, and hence looking at them can not only help us understand our patients, but also challenge assumptions proven to be wrong. Deviations from such, also reflect the level of acculturation of patients to their life in Britain (and the concomitant integration, assimilation, cultural pluralism "choices" made by them).

5.10.1 Did the Patients come from Extended Families? (see 3.4.1)

The assumption that minority patients come from an extended family framework was considered. Several factors were considered to be key identifiers of an extended family framework. The first of these was whether people were living with their families. This was found not to be the case. The single largest group were those living by themselves (42.3%), whilst 26.9% were single parents. Only 16 people were living in a typical "nuclear" family, 5 with their partner and children and five with partners, the remaining six were living with close family. Moreover, the finding that in 39 cases, the person considered themselves head of the household with the concomitant family responsibilities (either due to living alone, or with children or elderly dependent relatives) was unsurprising after evaluation of the previous results.

This feeling of responsibility was echoed in the finding that the majority (47) of patients considered that they lived geographically "far away" from their close family (parents

[1] These results refer exclusively to the *treatment* group.

and siblings); only 4 patients felt that they lived "near" to families. However, the majority of patients (65.4%) did not keep close links with their country of origin, with only five having dependents there.

5.10..2Religion (3.4.2)

Another commonly linked variable is that of religion and different cultural backgrounds. Again a sizable minority, 20 patients, did not practice a religion and classed themselves as atheist or agnostic. A further 10 were currently not practicing their religion (Hindu, Islam, Catholic, Sikh and Protestant). Of the 22 patients who were practicing a religion the majority followed Islam (9), other religions cited were Hindu, Sikh, Roman Catholic, Protestant, Buddhist, Celestial Church, Baptist, Reorganized Church of Jesus and the Latter Day Saints. Two patients were currently involved with two religions. This separation into two religions may reflect the difficulties of resolving the two identities between the old and the new cultures. And perhaps the practicing of two religions represents a resolution of this, a form of cultural pluralism.

Both these results suggest that the original suggestion that some ethnic minorities live within a culture that is similar to their "home" cultures in Britain, may be the case for some, but not for the majority of patients seen in the research. There is, of course, the argument that such cultural "breakdown" of support structures may precipitate patients into therapy. The fact that there is such a breakdown argues for a therapy centre where such difficulties are recognised and therapy addresses them.

5.11 Psychological Characteristics that Affect Utilisation of Psychotherapy : Life Stresses

5.11.1Migration (3.5.1)

40 of the 52 patients had experience of migration. For seven of these people there was little free choice in emigration, as some were war refugees, other migrated because of political pressures or work permit difficulties. Of those that had migrated (40 patients), 13 (almost one third) had migrated by themselves, in a further 17 cases their parents had migrated first and they (as children) followed later (being left with family in the country of origin in the interim). Only 8 patients (20 %) had emigrated as a family (the remaining two patients were here as students). This supports the contention that the hypothesised migration pattern of family separations and reunions is a feature of ethnic minority migration.

A concomitant factor with migration is the change in economic circumstances post migration, only 10 patients (25%) reporting a reduction in their economic status, whilst 19 patients reported it staying about the same, the remaining cases were difficult to assign a group either because the patient didn't know what the economic status was before migration (i.e. the parents had migrated while the person was a child) or alternatively the parents had been students or just post qualification and hence there was no clear prior status.

5.11.2 Time in the UK

Table 5l Number of Years Patients have lived in the UK (based on n=17 for UK born)

A factor in acculturation will be how long the person has lived in the UK

Time in UK (yrs)	Number
<10	7
11-20	17
20-30	9
30+	1
Total	34 (1 missing value)

This shows that most of the patients are not new migrants, many have lived in the UK for many years, perhaps here there is a suggestion that such patients may have be acculturated into the U.K. and therefore demand the same treatment options. These results show that it is not only newly migrated patients who have problems. It poses serious theoretical difficulties (cf. the three month rule for "adjustment disorder" in the DSMIV), as it implies that there are long term effects of migration. It might be expected that might be particular problems, if patients came to the UK as children without access to psychological help. In adulthood they might choose to seek help with the unresolved problems of childhood.

5.11.3 Did the Patients at the Centre come from both Rural and Urban Backgrounds? (see 3.5.2)

Just under one fifth (19.2%) of the population came (or their families came) from a rural location prior to emigration. Two fifths (40.4%) had lived in a small town prior to coming to the UK, while a further two fifths (40.4%) had lived in a city. Hence about 60% of patients experienced a change from either rural or small town living to city dwelling when they came to London. Changes that have been implicated in deteriorating mental health..

5.11.4 Had the Patients at the Centre Experienced Racism? (3.5.3)

Two thirds (67%) of the research patients at the Centre have had experience of racism and prejudice during their lives. This research looked at both verbal racist abuse as well as physical attacks. Sadly, 33 people reported current experience of racism.

5.11.5 Had the Patients at the Centre Experienced many Separations? (3.5.4)

This is particularly pertinent to a multi-cultural population, especially in the light of Bowlby's (1977) work on "Attachment and Loss". Separation in this context means a separation from their family of weeks, months or years duration. Only 15 people reported no separations from family, perhaps most importantly (from a psychodynamic view); 16 people were separated from their parents whilst they were children less than 10 years old, and 8 people were separated from family between the ages of 10-20 years.

A further two patients reported being away from their siblings when they were young. Eleven patients had experienced separations but it was not noted at what age.

5.12.2 Age of Arrival in the UK (see 3.5.1)

We know that age of migration is very important (see section 1.10[1])

Table 5m Age on Migration (based on n=17 for UK born)

Age (yrs)	Number
<10	12
11-15	7
16-20	7
20+	8
Total	34 (1 missing value)

These figures show that at least 7 (13.5%) of the 52 people, came to the UK at an age where they could be expected to be vulnerable (i.e. in their early to mid teens).

5.12 Therapy Issues of Migrant and UK Born Ethnic Minority Patients

(This refers to the *Referred* Group).

This data will be reviewed in two ways, initially in terms of British-born compared to those born overseas and secondly comparisons between different "areas", Africa, the Caribbean etc.

It might be expected that there would be some associations between the UK born and migrant patients; however there were only two in this study.

5.12.1 Significant Sociodemographic Associations Between British Born and Migrant Patients.

Table 5n Significant Chi-squared Test of Association between Migrant and British Born Patients and Sociodemographic Factors

Comparison	X^2	d.f.	Significance
Age	15.12	3	0.0017*
Pay	12.03	2	0.0024*

Importantly there was no association between the two groups and either presenting problems and diagnosis.

Age

It is unsurprising that there is a marked association between age and whether a patient is a migrant or British born, given the pattern of migration:

Table 5o Migration and Current Age of Patient

Age (in years)	<19	20-29	30-39	40+	Total
British Born	3	25	7	0	35
Migrant	3	53	47	19	122

Hence it can be seen that none of the British-born patients are in the forties or older (due to immigration patterns) but even more interesting is the fact that the migrant group uphold the traditional view that most psychotherapy patients come in the twenties and thirties - 82% of them (100 patients).

Table 5p Payment and Migration

	Pay	Didn't pay	Not Noted	Total
British Born	9	26	0	35
Migrant	8	106	8	122
Total	17	132	8	157

Although the majority of patients didn't make a contribution, (only 10.8% paid), there was a greater proportion of the migrant group who did not pay (86% did not pay, compared to 74% of the British-born); this may have been due to their status as refugees or new migrants.

5.12.2 Comparison Between Patient Variables and Patient Birthplace

A series of comparative evaluations were carried out between Country of Birth and other information. This table is split into two because there was difficulty with concatenating Country of Birth into meaningful groups; for some results this left very large degrees of freedom[1], and hence less confidence in the significant results.

Table 5q Statistically Significant Test of Associations Between Country of Birth and Patient Characteristics

Comparison	X^2	d.f.	Significance
Sex	12.73	5	0.0260*
Referral Source	26.81	5	0.0001*

[1] For a small sample large degrees of Freedom imply that some of the "cells" in the chi squared evaluation are either empty or have small numbers in them. This affects the robustness of the statistical test. I shall use "large degrees of freedom" as a shorthand way of describing such a situation.

Those associations with large degrees freedom, but significant associations, were those between birthplace and age, payment, sex of therapist, ethnicity of therapist, and the referrers' diagnoses. However, the groups were large (the degrees of freedom were equal to, or greater than 15) and hence should be replicated with larger groups with similar birthplaces.

There was no association between the Country of Birth and the patient's presenting problems, whether the patient was taken on for therapy, the number of sessions of therapy nor how the patient heard of the Centre.

5.13 Therapy Variables

5.13.1 Was the Patient Offered Therapy?

As most therapists discriminate against non-Western European born patients it might be expected that there would be a statistical significance between whether the patient was offered therapy or not; however, there was no association between whether the patient was offered therapy and whether they were British born or migrants.

5.13.2 Request for Male or Female Therapist (see 3.9.1)

Table 5r Request for Male or Female Therapist

Sex of Therapist	Patients	
	Women (n=98)	Men (n=58)
No Preference	69	46
Female Therapist	14	1
Male Therapist	0	2
Not Applicable[1]	15	9

One of the objectives of the research was to identify specific factors that might influence the therapy, it seems that the request for a particular sex of the therapist is important, particularly to women, 14.3% of whom requested a woman therapist, whilst only 3.4% of the men requested a male therapist, perhaps reflecting cultural issues. A χ^2 comparison showed that there was a strong association between the sex of the therapist and the sex of the patient. (χ^2 = 9.75, d.f = 3, significance 0.0208). A further analysis between Country of Birth of patient and request for a particular sex of therapist was carried out which resulted in a highly significant result (significance = 0.0041), however, the degrees of freedom were large and this sheds some doubt on the findings, and will need to be replicated. However, since many women are brought up in cultures where certain "taboos" are placed on contact between men and women and what they may (or may not) discuss, it does not seem unreasonable to suggest that there would be a relationship between certain cultural groups and such requests.

[1] Refers to patients who were referred directly to the Clinical Director

5.13.3 Request for Ethnicity of Therapist (see 3.9.6)

It was expected from the outset that one of the reasons for coming to the Centre might be a wish to be counselled by an ethnically similar therapist (*intra-cultural* counselling). The very surprising finding was that in fact of the 157 patients who were monitored, only 14 (8.92%) requested a specific ethnic origin for therapist.

Table 5s Request for Specific Ethnicity of Therapist

Ethnicity of Therapist Requested	Number of Patients
Black	5(3.2%)
Afrocaribbean	2(1.3%)
Asian (Indian)	2 (1.3%)
Asian (Bangladeshi)	2(1.3%)
Turkish	2(1.3%)
Greek	1(0.6%)

Again, this is an interesting finding as it might be expected that an intercultural centre would be chosen for its ability to cater for different language groups, in fact the Black and Afro- Caribbean requests were for cultural reasons (i.e. an understanding of the life experiences of that particular ethnic group), whilst requests for Indian, Bangladeshi, Turkish and Greek therapists primarily reflected the need for a therapy in a particular language (as well as cultural issues). Therefore the majority of those requesting a particular ethnicity of therapist (4.5%) were due to language reasons.

A high correlation was obtained for the association between Country of Birth and request for a particular ethnicity of therapist (the significance was 0.0003) however the degrees of freedom were large, and the numbers in the group small, caution should be

taken in interpreting these results. However, from a non-statistical viewpoint, as the majority of the patients were requesting particular language skills and the rest particular cultural knowledge, it might be expected that there was an association between the two.

5.13.4 Birthplace in Relation to Therapy

An analysis of the patients' Country of Birth[1] and whether they were taken on for therapy showed no evidence to reject the null hypothesis that the two factors were independent at the 0.05 level. This indicates that there was no association between the two factors, and although the degrees of freedom were large (and hence there should be circumspection in interpretation) the fact that patients from many different countries were and are in therapy at Nafsiyat indicates that despite the statistical problems, there does not appear to be a selection of patients for therapy on the basis of Country of Birth.

[1] Country of Birth is one of the constructs used in the analysis. It is generally considered to be a "hard" construct (one that is not open to interpretation). This study challenges this notion.

5.14 Ego Strength (see 3.8.1)

Ego strength has been considered to be important in most therapy research. Primarily, this can be considered to be the ability to form relationships. In this research, 64% of the population reported that they had been able to form one or two long term close relationships. This leaves 36% of patients who were unable to maintain long relationships, 22% of whom had had a series of short term relationships and 14% who had not been able to form any relationships outside their families.

In psychoanalytic terms the ability to form new relationships can be predicated on the previous relationships within the family and current relationships with partners.

Table 5t : Familial Relationships

Relationship	Type of Relationship			
	Good	Fair	Poor	Ambivalent
Mother	13.5%	21.2%	32.7%	30.8%
Father	15.7%	17.6%	45.1%	23.1%
Partner[1]	3.9%	5.8%	15.4%	21.2%

From this table it will be clear that almost two thirds of the patients experienced a poor or ambivalent relationship with parents and partners (63.5% with mothers, 68.2% with fathers) and if those with no current partner excluded from the analysis, 19 people out of the 28 with a relationship -i.e. 67.9% - are experiencing a poor or ambivalent relationship.

[1] 24 people (46.2%) had no partner.

Such relationship difficulties may be predicated on the migration experiences of this group and experiences of separation and loss.

5.15 Practical Considerations

5.15.1 Times Available for Therapy

99 (63.1%) patients could make arrangements to come for therapy at any time, while the remaining 58 patients were evenly spaced in their preferences for morning, afternoon and evening sessions. Unexpectedly, only three patients (1.9%) specifically requested an evening session. This was unexpected, because in private work early morning and evening sessions are most requested to fit around people's work timetable. Unsurprisingly, 16 patients (10.2%) could come to therapy at different times on different days (understandable in the context of their working lives - usually shift work). Of course this poses problems for both sessional workers and private practitioners.

Chapter 6

Presenting Symptomatology

From the previous section it is clear that the Centre saw patients from diverse cultural backgrounds. In this chapter the symptoms patients were experiencing when they came to the Centre will be reviewed, in order to decide whether the Centre was just "treating the worried well". The different evaluations came from the patients themselves (through both the objective measures of the GHQ, the P.S.E. and their discussions with the Clinical Director during the Assessment interview - a *subjective* view), The Clinical Director's *quantitative* assessment (using the psychiatric symptom checklist) and his *qualitative* overview together with the referrers' assessment of the patient. All this information was collected prior to the patient being allocated a therapist.

6.1 The Referred Group

6.1.1 Presenting Problems - The Patients' View (see 3.6.2)

The commonest reason for seeking therapy was depression, with just under half of the patients reporting this (43.3%), indicating that patients had recognition of the psychological aspects of their illness. Twelve patients came to help with an 'identity' problem (7.6% of the total) and a further 7 patients came for help with 'cultural'

problems (unsurprising in the context of their problems in rationalising their COB and Ethnicity described in 5.6).

Of the women, 6 sought help at the Centre following a rape, while 4 women sought help to deal with the continuing effects of childhood sexual abuse, and a further 4 were looking for help to deal with the after-effects of physical abuse. This makes up 9% of the total.

6.1.2 Presenting Problems - The Referrer's View *(see 3.6.2)*

This is based on the *referred* group (n=157).

This category does not apply to those who self-referred[1] (this is for external referrers only). The referrers' perception of the problem experienced by the patient were allocated in order of importance of Problem1, Problem2, Problem3 based on the referral letter and any subsequent information provided. The three key symptoms for each of these groups (based on numbers of patients referred with this symptom) are noted below. As each symptom is recorded only once for each patient (i.e. depression will be scored as problem1 or problem 2 or problem 3), it is possible to add the numbers to get a total count of the number of patients presenting with each symptom to understand the patient profile (see table 6a below). Although such totals lose the referrers' consideration of the importance of each symptom, it does allow consideration of the types of problems presented.

[1] n=97

Table 6a Major Presenting Problems - The Referrer's View

Symptom	Problem1 (n=60)	Problem2 (n=51)	Problem3 (n=30)	Total (n=60)
Depression	25.0%	19.2%	3.3%	26 (43.3%)
Relationship Problem	10.0%	19.6%	16.6%	21 (35.0%)
Anxiety	13.3%	17.3%	0.0%	17 (28.3%)
Somatic	13.3%	7.6%	13.3%	16 (26.7%)
Coping	0.0%	2.0%	10.0%	4 (6.7%)
Identity /Cultural	1.6%	3.9%	3.3%	4 (6.7%)

A further four patients (6.7%) of the total were referred with psychotic symptoms.

Table 6b Presenting Problems - A Comparison

Symptom	Description of Problem		
	Referrer (n= 60)[2]	Patient (n=157)[3]	C. D. (n=157)[4]
Depression	26 (14.5%)	8 (1.7%)	51(10.8%)
Anxiety	17 (9.5%)	19 (4.0%)	13 (2.8%)
Somatic Problems	16 (8.9%)	16 (3.4%)	6 (1.3%)
Relationship (partner)	13 (7.2%)	51 (10.8%)	58(12.3%)
Relationship (family)	21 (11.7%)	106 (22.5%)	86(18.3%)
Coping	4 (2.2%)	29 (6.2%)	36 (7.6%)

Table 6b is based on details and information available and recorded at the assessment interview.

[2] As each of the 60 patients was rated on three possible "diagnoses", the table percentages are worked out on the basis of 60x3 (i.e. 180).
[3] As each of the 157 patients was rated on three possible "diagnoses", the table percentages are worked out on the basis of 157x3 (i.e. 471).
[4] As each of the 157 patients was rated by the Clinical Director on three possible "diagnoses", the table percentages are worked out on the basis of 157x3 (i.e. 471)

It is clear from Table 6b that there are two ways of perceiving a patient's problem either by looking at the cause or the result ("causes" e.g. those of relationships and coping, or the "result" e.g. depression and anxiety). Patients and the Clinical Director give primacy to the former, the referrers emphasise the latter (perhaps reflecting the fact that the majority of referrers are following a medical model of illness). The role of somatic problems is interesting as it appears that the referrers recognise that the somatic problems presented to them are a reflection of psychological problems. The question left unanswered is whether patients are presenting their illness somatically for cultural reasons (see Goldberg and Huxley 1980, see 3.6.5). It is interesting to notice that both the Clinical Director and the patient give more emphasis to whether the patient is able to cope than the external referrer, and that cultural and identity issues are given secondary importance by the referrer.

The single most important factor for these patients are those relating to family relationships.

6.2 Standardised Measures (see 3.6.1 and 3.6.3)

6.2.1 Psychiatric Symptom Checklist

This was devised at the Centre and rated on a four point scale which gives an impression of the patient at the first interview. It not only rated level of symptoms but also their type, for example mood could be "depressed", "elated" or "sad" (for a description see appendix 1).

Table 6c Results of Psychiatric Symptom Checklist

Symptom	0	1	2	3	Commonest Problem[5]
Mood	2	3	20	27	Depressed, sad.
Appetite	10	5	28	9	Decreased appetite
Thought Content	15	14	9	14	Worried Specific Event
Anxiety	1	5	7	39	Severe Anxiety
Phobia	24	7	12	9	About mental illness
Energy Level	15	5	17	15	Low energy level
Interest	19	5	11	17	Little interest/pleasure
Sleep	5	5	27	15	Sleeps Badly
Agitation	14	10	19	9	Increasing
Anger	1	2	5	44	Unable to express/ Very Angry
Suspicious	13	7	22	10	Increasing/Very Suspicious
Histrionic	35	8	8	1	Increasing
Withdrawal	15	11	13	13	Increasing
Ideas of Reference	44	2	4	2	Increasing
Unshakeable False Belief	40	4	3	5	Related to Past Experience
False Perception	35	3	11	3	Not described
Guilt	3	11	30	8	Specific to person/situation
Weight	32	7	9	4	Decreasing
Behaviour [6]	51	1	0	0	Avoidant
Verbally Aggressive	30	8	10	3	Generally (not against specific person)
Physically Aggressive	36	8	5	1	Generally (not against specific person)
Wandering	35	7	8	2	Happens Infrequently
Impaired Self Care	29	4	12	7	Mildly disheveled
Impaired care Child	39	3	7	3	Increasingly aware
Impaired Work	13	3	8	28	Increasingly aware/unable to work
Obsessional Rituals	51	0	1	0	One specific ritual
Threatening behaviour	48	3	1	0	Generalised
Suicidal	19	24	5	4	Thought about/Attempted
Impaired Concentration	31	7	9	5	Short concentration span
Clouding/ Consciousness	51	0	0	0	None recorded
Intellectual deterioration	40	4	5	2	Increasingly aware
Impaired memory	42	1	6	2	"Forgetful"
Obsession	36	5	9	3	Several

[5] Most common (numerically) reported description
[6] Uncooperative behaviour is noted here.

The above table allows more understanding of the type of patient seen at the Centre. Looking at the group (focusing on those with severe symptoms) it can be seen that the majority of severe symptoms cluster around those of anxiety (75%), depression/sadness (51.9%). 84.6% present with anger issues, either being unable to express their anger or alternatively feeling very angry most of the time. A significant number (53.9%) being increasingly aware of their impaired work performance (with some being unable to work.)

It was decided that if the total number of patients presenting a particular symptom (when moderate and severe symptoms were combined) was over 26 (i.e. half of the population) these results were particularly noteworthy. From this analysis it can be seen that many were having the concomitant symptoms of a lack of interest and pleasure in life, difficulties with sleep and weight loss. Half recognized that they were increasingly withdrawing from life and 61.5% were becoming more suspicious ("wary"). In line with psychotherapeutic work, 73.1% described guilt as an issue. From a review of the literature one might have expected that shame would have been a more important concept than the "western" notion of guilt. But this was not the case, which may have acculturation significance.

These results suggest that the high anxiety levels experienced by this group should lead to a good outcome (for in many research studies high anxiety is equated with good outcome). However, this table also shows that there was a proportion of the population that had more severe symptoms: those of false perceptions, unshakeable false beliefs, ideas of reference, and at least four patients were considered at a serious risk of suicide.

Although many reports have shown that therapists accurately record patients' symptoms, this study used two further ways of reporting symptoms. The General Health Questionnaire (a self report inventory) and the Present State Examination (administered by the Research Director).

6.3 Treatment Group (see 3.6.3)

6.3.1 The General Health Questionnaire

The General Health Questionnaire results were divided into the 3 groups recommended by the GHQ manual. the "not psychiatrically ill" (a score of <12), "those who might be expected to recover without any therapy" (a score of 12 19) and those "not expected to improve without therapy" (a score of 20+).

The initial GHQ showed that 7 people scored less than 12 on the initial scoring (6:1 women :men), 5 people scored in the 12 - 19 scale (3:2 women:men), 40 people scored 20+ (2:1 women:men). Therefore of the people who were taken on, only 12 people might be expected to get better without treatment. Ego strength, separations nor referral source were associated (chi squared test of association) with the initial GHQ score. It also seems that women were referred (or referred themselves) with fewer symptoms, or were less aware of their symptoms.

6.4 Differences between Symptoms and whether a Person was taken on for Therapy

The patients at the Centre would present with differences in levels of symptomatology and this would decide whether a person was taken on for therapy (see 3.6.4)

It might be expected that there might be a selection process for those who were taken into therapy. Following the research described in Chapter 1, it might be expected that some of the patients would be taken on because they had less severe symptomotology (the "worried well") and they would be considered more appropriate for psychotherapy, than those with many, severe symptoms.

6.4.1 Comparison Using the Psychiatric Symptom Checklist

A χ^2 test of association showed that only one of the psychiatric symptom checklist questions was associated with whether a person was taken on for therapy (χ^2 = 18.527, d.f. = 9, sig = 0.03), and that was of verbal aggression with a higher proportion (41%) of those in the *treatment* group showing this, compared to 30% of the *referred* group.

This has two ramifications, firstly that patients were neither chosen nor excluded on the basis of their symptoms. As reported before, those with more severe symptomatology were not necessarily excluded. The only exception to this were those who were verbally aggressive who, perhaps surprisingly, were more likely to be taken into therapy. This may be representative of a group who can express themselves and hence are particularly appropriate for a verbal therapy. Also the expression of anger might have precipitated seeking help, as patients would be very aware of this problem.

The second implication is that cannot be used as an allocating instrument as it does not discriminate between those taken into therapy and those not.

6.5 Comparisons Using the Initial GHQ Scores

Table 6d Comparison of Initial GHQ Score and Migrant Status

GHQ scores	Born/Raised UK[7]	Experience/ Migration
<12	0	7
12-19	2	3
20+	10	30
Totals	12	40

It can be seen that 83.3% of patients born and raised in the UK are in the group with severe symptomatology, whilst only 75% of those with experience of migration are in this group. None of the British born group come to the Centre with a low symptom score. So one can extrapolate that the life experience of being born and raised in the UK creates psychological problems.

6.5.1 Whether Taken on for Therapy

This comparison yielded more associations between the initial GHQ questions and whether a patient was taken on for therapy. The questions that yielded the significant associations at the 0.05 level were 4, 8, 9, 10, 13, 21, 22, 23, 24, 25, 27, 28, 30, 31, 32, 33, 34, 48, 49, 50, 52, 54, 56, 59.

[7] In this analysis the comparison is between those who have no experience of migration and who were born and raised UK and those who have experience of migration, even if they were born in the UK but migrated away and then back to the UK (see section 5.6).

Table 6e Comparison of Discriminating Initial GHQ Questions and whether Patients Taken into Therapy

Have you recently:	
Q4	felt that you are ill?
Q8	been afraid that you were going to collapse in a public place?
Q9	been having hot or cold spells?
Q10	been perspiring (sweating) a lot?
Q13	been feeling too tired and exhausted even to eat?
-Q21	been managing to keep yourself busy and occupied?
Q22	been taking longer over things you do?
Q23	tended to lose interest in your ordinary activities?
Q24	been losing interest in your personal appearance?
Q25	been taking less trouble with your clothes?
-Q27	been managing as well as most people would in your shoes?
Q28	felt on the whole you were doing things well?
-Q30	been satisfied with the way you've carried out a task?
-Q31	been able to feel warmth and affection to those near to you?
-Q32	been finding it easy to get on with other people?
Q33	spent much time chatting with people?
Q34	kept feeling afraid to say anything in case you made a fool of yourself?
Q48	had the feeling that people were looking at you?
Q49	been feeling unhappy and depressed?
Q50	been losing confidence in yourself?
Q52	felt that life is entirely hopeless?
Q54	been feeling reasonably happy, all things considered?
Q56	felt that life isn't worth living?
Q59	found yourself wishing you were dead and away from it all?

The minus sign indicates those questions where a "less than usual" response was associated with going into therapy.

The questions that are associated with being taken on for therapy relate to somatic questions (e.g. feeling ill, having hot and cold spells, perspiring a lot, feeling exhausted), panic questions (feeling that they were going to collapse in a public place), social dysfunction questions (managing well, doing things well, satisfied with way carrying out tasks, feeling warmth towards close family, easy to get on with others, spent time chatting with others) , anxiety and depression (felt afraid of making fool of self, feeling people looking at you, feeling unhappy and depressed, losing confidence, feeling life is hopeless, feeling reasonably happy), and severe depression (life isn't worth living, and wishing they were dead)

Table 6f Difference Between the Scores on the Initial GHQ Between the *Treatment* and *Non Therapy group*[8] (CGHQ scoring - see 4.4 6).

Question No.	% scoring >1		Difference > 10%[9]
	Therapy	Non-Therapy	
4	90.4%	79.4%	*
8	63.5%	35.3%	**
9	67.3%	50.0%	*
10	78.9%	61.8%	*
13	76.9%	79.4%	
-21	75.0%	73.5%	
22	96.2%	97.1%	
23	94.2%	91.2%	
24	69.2%	64.7%	
25	92.3%	82.4%	*
-27	84.6%	91.2%	
28	92.3%	97.1%	
-30	88.5%	97.1%	
-31	96.2%	87.5%	
-32	96.2%	94.1%	
33	94.2%	82.4%	*
34	90.4%	73.5%	*
48	78.9%	67.7%	*
49	98.1%	91.2%	
50	96.2%	91.2%	
51	88.5%	67.6%	**
52	86.5%	70.6%	*
-54	92.3%	88.2%	
56	76.9%	52.9%	**
59	76.9%	50.0%	**

The minus sign indicates those questions where a "less than usual" response was associated with going into therapy.

Using the Chronicity Scale scoring, it is clear that certain questions discriminated between those in therapy and those who did not pursue therapy. It seems that a much

[8] Non Therapy group is the group of individuals who completed an initial GHQ but were not part of the research

[9] * difference is between 10-20%, ** difference >20%

higher proportion of those taken on for therapy had increasingly felt that their life was not worth living, wishing they were dead, feeling worthless and more afraid of collapsing in public places (** rating).

Perhaps it is surprising that questions 57 and 60 which also relate to suicide did not discriminate between the two groups. However both of these questions specifically mention active suicidal behaviour (Q57 about the possibility that you might make away with yourself, Q60 the idea of taking your own life kept coming into your mind) rather than the more abstract (passive) feeling that life isn't worth living (Q56).

To a lesser extent those questions relating to feeling ill, having hot/cold spells, sweating a lot, taking less trouble with clothes, spending less time chatting to people, frightened of making a fool of oneself, feeling people looking at them and that life was hopeless also discriminated between the groups but at a lower level (* rating).

6.6 The Present State Examination[10]

The above results suggest that patients who are in therapy tend to have symptoms primarily of depression. The Present State Examination was used at the suggestion of the Department of Health, so that Nafsiyat clinical diagnoses could be made in a consistent way and were consistent with usual psychiatric practice .

When a comparison is carried out at syndrome checklist level for those in the *treatment* group it is found that there were

2 cases had Nuclear Syndrome (NS)

[10] Administered and evaluated by Dr S Acharyya, reproduced with his kind permission.

6 cases with Non-Specific Psychoses (NP)

2 cases with Hypomanic Syndrome (HS)

There were 42 cases with Simple Depression, one of Depressive Delusions and Hallucinations, and 46 cases with Special Features of Depression or Other Symptoms of Depression (the complete list of the P.S.E. results can be found in Appendix 2). Although this is not a diagnosis, it fulfills the criteria common to many psychiatric diagnoses. From this evaluation it can be seen that many patients present with serious syndromes and this upholds the earlier data regarding the seriousness of their illnesses and the primacy of depression.

6.6.1 Spontaneous Remission (see 3.11)

It has been argued that spontaneous remission accounts for many of the psychotherapy cures reported in the literature, although it is recognised that this only happens in cases where there is recent onset, commonly thought of as within a 2 year period. For this group the typical length of time the patient has been aware of problem is from 1 to 5 years, with 55.9% of patients being aware of the problem for longer than one year. (28.8% - 15 people- had been aware of the problem for 3-6 months, with 8 people - 15.4%- having been aware of it for 7-12 months).

It might have been expected that as patients had been aware of their problems for some time, they would have tried to get help for them. In fact 23 people had had no intervention (medical, psychological or other) for their problems.

A total of 14 patients had been in therapy before. Eleven had had previous psychotherapy and a further three patients had had counselling, and in two of these cases they were also taking prescribed drugs at the same time. Thirteen patients (in total) had been prescribed drugs (three of them were prescribed tranquilisers) and two patients had been offered social work support.

Of these 29 patients who had been offered help before, 25 did not feel it was useful nor helped their problems. While one patient was very enthusiastic about the earlier help, the remaining three felt it had only helped partially.

Interestingly, one patient had become dependent on one of the minor tranquilisers that had been prescribed, whilst a further two said they had become dependent on barbiturates. (Only eight patients had reported any dependencies and the remaining five patients said they had been dependent on alcohol).

6.7 Therapy Issues

6.7.1 Choice of Therapist (see 3.9.1)

As part of the assessment interview there was an initial evaluation, by the Clinical Director, as to what type of therapist a patient needed, or with whom they would work well. This assessment might be founded on the specific presenting problems, skills of the therapists, the personality of the therapist or might be for cultural or other issues. It could be argued that there was no selection of a particular therapist for a particular patient. Of interest is whether the training background of the therapist is taken into account by the assessor (in this case the Clinical Director) or whether this is not the case. For this particular patient group, other issues including those of ethnicity and gender of the therapist might also have influenced the choice of therapist

6.7.2 Therapist Training and Selection of Patients (see 3.9.2)

A comparison was carried out between therapist trained in analytical psychotherapy (BAP or overseas training in psychoanalytical psychotherapy), those currently training (Tavistock and other organisations), and other professionals with psychiatric, psychology and counselling backgrounds.

The trained therapists were seeing 33 of the *treatment* group, the trainees were seeing 4 of the treatment group and the remaining 15 patients were seen by the "other professionals".

6.7.3 Therapist Training and Presenting Problems of Patients (see 3.9.3)

Most of the trained therapists were allocated to patients with a secondary "family" problem ($\chi^2 = 13.61$, d.f = 6, sig = 0.03). It is probably fair to note that there was a weak association between the trained therapists and the patients' first (most important) problem with the majority of those trained being given those with psychological problems. Hence from these two results, it is possible to hypothesise that trained workers were likely to be given patients with both psychological and social problems, whereas trainee therapists and others were given patients whose major problem was social which was beginning to have psychological effects; i.e. the more ill patients were taken on by the more experienced staff.

6.7.4 Training and Previous Therapy (3.9.3)

Those offered psychotherapy before (11 patients) were more likely to be given a trained therapist (7 patients - 63.6%), however the majority (3 of the 4) of the trainees work was with patients who had had therapy before. This leads to the strong association (χ^2 = 13.35, d.f = 4, sig = 0.0097) that was found between these two factors. The present author can only recall one patient having been in individual psychoanalytical psychotherapy before.

6.7.5 Training and Dependencies (see 3.9.4)

Training was highly associated with whether the patient had been dependent on any substances (χ^2 = 28.47, d.f = 6, sig = 0.0001). This is highly significant, with 5 out of the 7 patients who had had dependencies being seen by trained therapists, the remaining two patient were seen by trainees. None had been seen by non psychodynamic therapists.

6.7.6 Training and Educational Problems (see 3.9.5)

This was a significant association (χ^2 = 17.37, d.f = 8, sig = 0.0265), with 3 out of the 4 patients seen by trainees being those with educational (college) problems. This is

understandable as one of the trainees was a child psychotherapist and the other was an educational psychologist.

6.7.7 Ethnic Matching (see 3.9.6)

The Clinical Director regarded the request for a particular ethnicity of therapist as a clinical issue and hence this was addressed during the assessment. Therefore only three people in the *treatment* group were recorded as having a need for a particular ethnicity, one was for language needs (they were allocated a Bangladeshi therapist), the second person requested a black therapist and was allocated an Afro- Caribbean therapist, and the third requested an Afro-Caribbean therapist and was allocated an Asian therapist (For this person, the choice of therapist was based on clinical need, as the initial GHQ score was high). It is interesting that the person who was given a language match, changed from a 20+ score on the initial GHQ to a "no symptomatology" (<12) on the final GHQ. The patient who requested a black therapist and was treated by an Afro-Caribbean therapist reduced their score between the first and final GHQ by 8 points changing from the 20+ group to the 12-19 GHQ group, as did, the person who requested an Afro-Caribbean therapist and was treated by an Asian therapist. So although there was ethnic matching in these cases the results are not as good as those achieved by intercultural therapy.

6.7.8 Gender Matching (see 3.9.7)

Only two patients in the *treatment* group requested a specific gender of therapist, one who requested a black woman therapist and was allocated to an female Afro-Caribbean therapist (This patient showed an 8 point decease in score between initial and final GHQ). The second patient requested a woman therapist but was allocated a male therapist and showed a good improvement going from the 20+ initial GHQ score to the "no symptomatology" group by the final GHQ. Again matching does not seem necessarily to predicate a good result, as a particularly good result was achieved by a "none-match" with the male therapist.

These results suggest that a careful initial assessment is fundamental. There are reasons to match sometimes, but there are real difficulties in matching patients and therapists (in therapy, as in research).

For those matched, there are expectations that the therapist will understand everything, have had similar experiences, and yet the reality in therapy may be very different. A Caribbean therapist from the East Caribbean will have very different experiences to a patient from the West Caribbean. This may be further compounded by different migration experiences and different family backgrounds. These will need to be addressed in therapy, and the patient may feel very let down if the therapist does not instantly understand their life experiences.

Chapter 7

Outcome Measures

Outcome was measured not only by "retesting" using the objective measures described in Chapter 6, but also using the more subjective therapeutic constructs. The problems of using objective tests to compare a multi-cultural group will be considered further in Chapter 9, but it will be noted that the results will be presented here comparing the changes in scores before and after therapy, with the assumption that change in numbers or rating of symptoms demonstrates improvement (or otherwise). It is assumed that the use of three different scales will add to the credibility of the assertions.

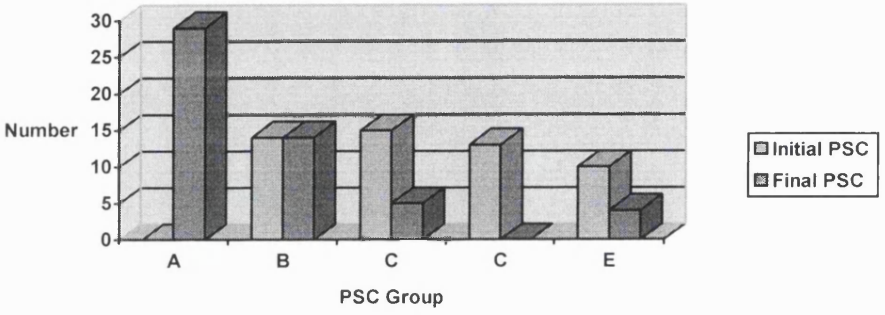
7.1 The Psychiatric Symptom Checklist (PSC) (See 3.7.1)

The results were divided into ten point intervals.

Table 7a Initial and Final PSC scores

	Number of Patients	
Scores	**Initial**	**Final**
0 –10 **(A)**	0	29
11 – 19 **(B)**	14	14
20 – 29 **(C)**	15	5
30 – 39 **(D)**	13	0
40 – 49 **(E)**	10	4

Figure 7.1 Initial and Final PSC scores



It is clear from the above figure that most of the patients decrease their symptoms according to this scoring. Two other issues arise: the first is whether any patients increase their scores between the initial and final Checklists (in one patient there is an increase of 5 points, and two patients have the same score); the second is what is the most common change in scores: the modal is 10-19 points (17 patients), while 14 patients change between 0 and 9 points.

7.2 The Present State Examination (see 3.7.2)

The final P.S.E. scores show a decrease in the severity and number of syndromes, of the two cases with *Nuclear Syndrome,* one changed from NS++ to NS?, the other no longer rated on this category, of the six cases with *Non-Specific Psychosis* only one stayed with the rating of *NP?* all the others no longer rated on this scale. Both of those with *Hypomanic Syndrome*, no longer showed evidence of this in their final evaluation (see Appendix 2).

For those with the syndrome of *Simple Depression* (42 at the initial assessment), only half (21) still rate on the second assessment, with the majority (12 showing a reduction in the syndrome), 8 showing a similar level and only one showing an increase in the syndrome (from *SD+* to *SD++* - patient number 20) .

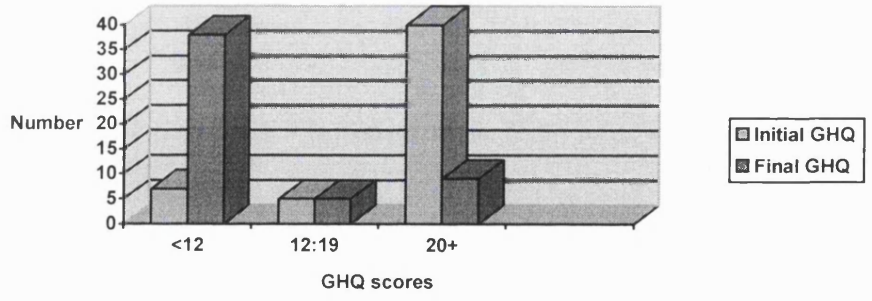
Moreover, the number of syndromes reported was reduced in the majority (51) of cases. The exception is again number 20.

7.3 The General Health Questionnaire (See 3.7.2)

Table 7b Change in GHQ-60 scores Before and After Therapy

	No symptoms *<12*	May Get Better Without Treatment *12-19*	Psychiatric Symptom *+20*
Initial	7	5	40
Final	38	5	9

Figure 7.2 Change in GHQ-60 scores Before and After Therapy



There was a noticeable change in the reported symptoms between the initial and final GHQ with now 38 people in the <12 group (27 women and 11 men), with five women in the 12-19 range and only 9 in the 20+ group (4 women and 5 men see figure 7.3).

From the previous discussion on the GHQ (section 6.3.1) it can be seen that there is a 2:1 women :men ratio in the 20+ group for the initial GHQ, but almost a 1:1 ratio for the final GHQ indicates that women decrease their symptoms in therapy more than the male group.

For those in the UK born group only one of the group increased their score from the initial to the final score, from the 12-19 range to the 20+ group: the other person who scored on the 12-19 range stayed in the same category after therapy. Nine patients changed scores from those in 20+ to a low (<12 score): the remaining person changed from 20+ down to the 12-19 scores..

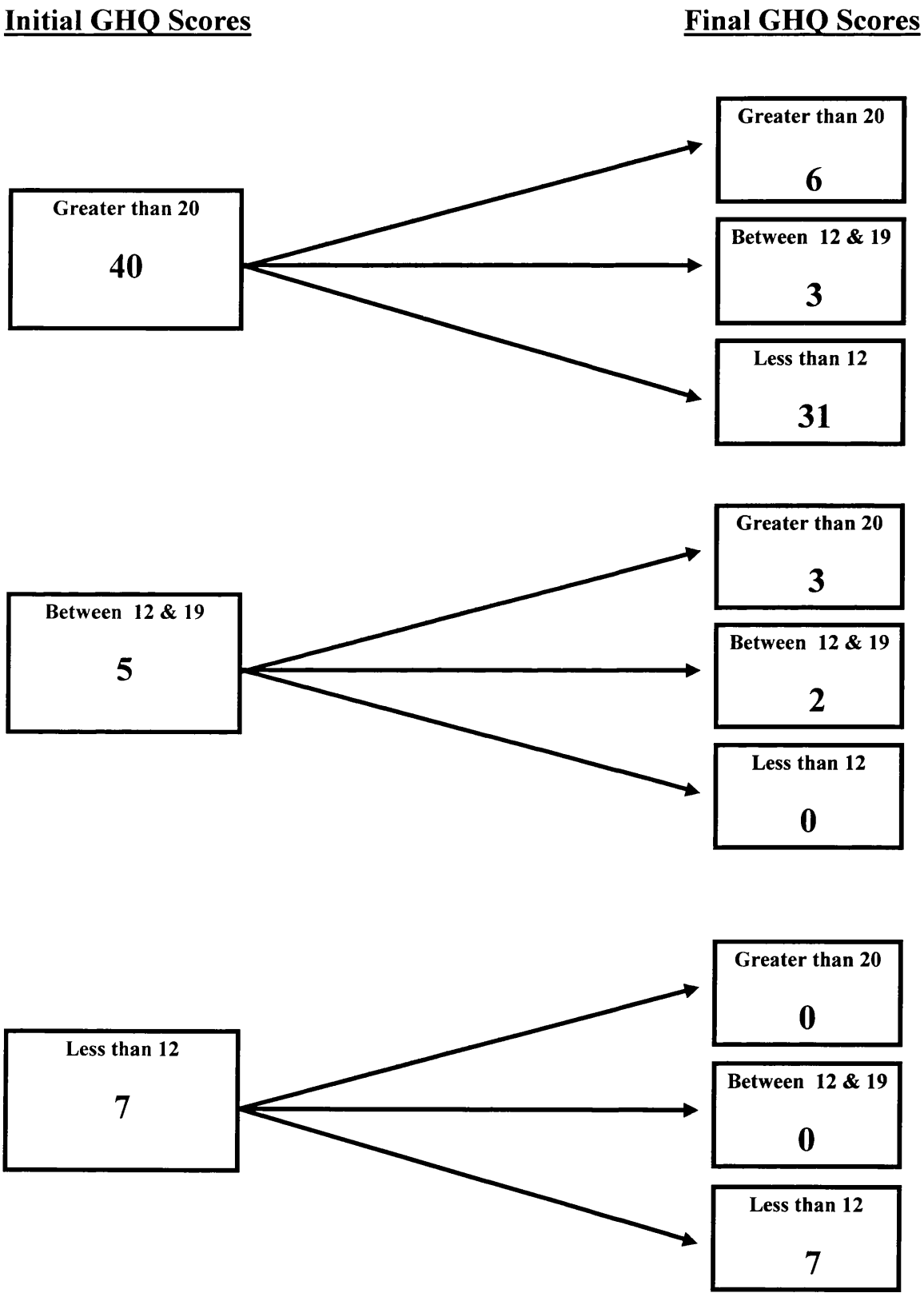
7.3.1 Ethnic Matching (see 3.9.6)

For those who were matched because of availability of therapist, because a particular therapist had spaces (6 patients who had described their ethnicity as Caribbean and 10 patients who had described their ethnicity as S. Asian), 50% showed a reduction of symptomatology from the 20+ to <12 group levels, whilst 79% of those who weren't matched showed such a reduction. This again suggests that ethnic matching is not an optimum therapy option.

7.4 Therapist Rating of Outcome (see 3.7.3)

22 patients (42.3%) were assessed by their therapist as having a good outcome, a further 7 patients had a fair outcome. As there is some fluidity in the language and some therapists were stricter in their assessment than others, it can be said that 29 patients (55.8%) of patients had a *positive* outcome. Only one person was considered to have a poor outcome. A further 11 patients had finished their therapy, but the

Figure 7.3 Comparison Between Initial/Final GHQ



therapist thought it was incomplete in some way, whilst a further 11 patients were considered to have improved but still in therapy at the end of the original research programme. Of these 11, 7 had moved into the good outcome group by the end of therapy and the extended research format.[1] From this we can extrapolate that 29 +7 (69%) of patients had a *positive* outcome.

There seems to be a slight sex difference in results, with 16 women and only 6 men in the *good* outcome group. Therefore a greater proportion of women than expected are in this group. The expected ratio is 2.3:1; this ratio is nearer 2.7:1. This ratio is largely upheld in the *fair* outcome group (5 women and 2 men - 2.5:1), in the *poor* or *finished but incomplete* the ratio is 1.4:1 (with 5 men and 7 women). Hence there seems to be a better outcome in therapy for the women. If we add on the later "finishers" (8 women and 3 men) we find that we have 24 women and 9 men in the *positive* outcome (ratio 2.6:1, women:men), which is still higher for women than expected.

7.4.1 Good Outcome (Therapist Defined) (see 3.7.3)

Of the twenty nine patients in this group, 20 women had a good outcome. 19 were in the 20-39 age group (see 1.9.3) and 1 woman was in her forties. Of the 9 men in this group, again the majority (7) fell in the 20-39 age range, only two were outside this range and they were both in their fifties. Nafsiyat patients seem to fulfill the age aspect of the YAVIS criteria.

For those with a *good* outcome there was a diverse range of origins described. Nine of those in the *good* outcome came from the UK (7 women and 2 men). Seven came from

[1] The later "finishers" (i.e. those patients who had long term therapy) are being kept separate (in some

the Caribbean (6 women and one man). Four patients came from Africa (2 women and 2 men), Four were African-Asian (3 women and 1 man). The remaining 2 women and 3 men came from different countries. Hence origin does not seem to be implicated in good outcome.

All three of those who had good outcomes and who were in their forties and fifties came from S. Asia.

7.5 Researcher Rating of Outcome (see 3.7.4).

There was a further evaluation of the outcome by the therapist, this was the description of outcome. The therapist wrote a detailed evaluation of whether the issues that had been presented at the outset of therapy had been achieved, this was rated by the researcher before any of the other outcome measures had been coded, and hence the researcher was blind to the other results. In this evaluation, 18 patients were rated as having a *good* outcome, 17 were rated as having a fair outcome and 6 were rated as having a poor outcome, again 11 were still continuing, but by the end of therapy, this 11 split into 7 with a *good* outcome and 4 with a *fair* outcome. Hence in total, 25 (48.1%) patients had a *good* outcome and 21 (40.4%) had a *fair* outcome. Therefore 88.5% of patients can be seen to have achieved most of the goals that were set at the outset of therapy.

7.6 Patient Description of Outcome (see 3.7.5 and Appendix 3)

33 of the 52 patients (63.5%) in the research group completed the *feedback form.* The groups were allocated to two groups those allocated to the good outcome group were ones who responded "yes" to whether they felt therapy had been useful *and* would

analyses) to illustrate the effect of the extra sessions.

recommend it to a friend with similar difficulties. If either of the questions were responded to with a "no" then this was classed as a poor outcome. Thirty patients were classed as having a *good* outcome, with a further three having a *poor* outcome.

7.7 Comparison of Different Outcome Measures (3.7.6)

Table 7c Comparison of Different Outcome Measures

Outcome	PSC	GHQ	Research	Patient	Therapist
Good	29	38	25	30	29
Fair	19	5	21	-----	11
Poor	4	9	6	3	12
Total	52	52	52	33	52

From these figures we see that the majority of each group is in the good outcome group. The lowest percentage is 25 of the 52 (48.1%) in the researcher rated group. Although this is a reasonable figure, it is lower than the other ratings of outcome. It is thought that this reflects the fact that, as therapy progresses, there may be some changes in the aims. Because as patients explore different thoughts and feelings, and reflect upon their problems, their understanding changes. Hence these changes would be available to both therapist and patient, but not the researcher who considered the change from the original goals. This suggests that external evaluation of therapy has inbuilt difficulties, and a lack of flexibility. This has ramifications and calls into question the use of such techniques in other psychotherapy research studies.

The results also show that the therapists are conservative in their assessment of outcome, with the largest number of patients allocated to the poor outcome (12) group.

7.8 Comparison of Different Associations Between Initial and Final Measures

Table 7d Comparison of Different Associations Between Initial and Final Measures

	Final GHQ	Initial GHQ	Diff[2] GHQ	Final PSC	Initial PSC	Diff[3] PSC	Outcome	
							Desr[4]	Thera-pist
Final GHQ	--	**sig**	**sig**	**sig**	NS	NS	**sig**	NS
Initial GHQ	**sig**	--	**sig**	NS	NS	NS	NS	NS
Final PSC	**sig**	NS	NS	--	NS	NS	**sig**	NS
Initial PSC	NS	NS	NS	NS	--	**sig**	NS	NS
Description	**sig**	NS	NS	**Sig**	NS	**sig**	--	**sig**
Therapist	NS	NS	NS	NS	NS	NS	**sig**	--

The two initial tests (the GHQ and PSC) are not significantly associated (χ^2 test of association), but the GHQ (Initial and Final) are significantly associated (χ^2 =16.72, d.f. =4, sig = 0.0022). The higher initial GHQ is associated with lower GHQ's on finishing therapy.

The final PSC is associated with the final GHQ (χ^2 =12.81, d.f. = 6, sig = 0.04), suggesting that scores on both questionnaires are related, (i.e. patients who get low scores on one questionnaire tend to get low scores on the other), and both the final PSC and the GHQ are associated with the researcher scored description of outcome (PSC and Description -χ^2 = 30.2, d.f. = 9, sig = 0.0004. GHQ and Description - χ^2 =12.87, d.f. = 9, sig = 0.04).

[2] Difference between initial and final GHQ
[3] Difference between initial and final Psychiatric Symptom Checklist
[4] description of outcome rated by researcher

Both the initial and final GHQ are related to the difference between the two scores (the initial GHQ χ^2 =29.38, d.f. = 8 , sig = 0.0003 and the final GHQ χ^2 =20.90, d.f. = 8, sig = 0.0074). This indicates that the change in these two scores are related, emphasising the change from the large numbers of initial high scores to the final low scores and vice versa. This was not mirrored by the PSC results: here there was only an association between the initial PSC and the difference in scores between the first and final PSC scores, perhaps because there was more of a spread of patients between "good" and "fair" outcomes than on other questionnaires.

The significant relationship between therapist outcome and description of outcome may be explained by the fact that both were described by the therapist (although the latter was rated "blind" by the researcher).

These results suggest that the different scales are rating different aspects. The GHQ is measuring minor psychiatric symptoms and life problems, the psychiatric symptom checklist is measuring a range of psychiatric symptoms, and therapists are measuring therapeutic change. However, these results emphasise the relationship between these scales, and also the need to compare the results from several different measures to gain a more complete understanding of the therapeutic situation..

Sociodemographic Influences on Outcome (see 3.7.7)

The final GHQ will be used as the primary measure determining good or poor outcome for comparative purposes. The reason for this is twofold: firstly it is an established *objective* measure and secondly it is associated with all but the therapists' rating of outcome (see section 7.8)

7.8.1 Was the Outcome Influenced by Migration Status? (see 3.7.9)

Outcome was not associated with migration. Migrant patients have statistically significant associations (compared to none migrant groups) only in those areas that would be expected: i.e. country of birth, age of arrival in UK, emigration issues, education in another country and first language. This latter aspect does suggest that the British born generally consider English as their first language which may be a slightly unexpected finding considering the ethnic/cultural backgrounds of this group.

7.8.2 Separations (see 3.7.7)

It is interesting to note that the final GHQ score was not associated with separations during the patients' life.

7.9 Did the YAVIS Criteria Influence Outcome? (see 3.7.7)

7.9.1 Age

Age was not associated with the outcome measures.

7.9.2 Intelligence

There was no association between final GHQ score (between good and poor outcome) and any educational variables.

7.9.3 Successful

There was no association between final GHQ score (between good and poor outcome) and any occupational variables.

7.9.4 Was Payment Associated with Outcome?(see 3.7.7)

Payment was not associated with any of the outcome variables.

7.9.5 Did Patient's Sex Influence Outcome? (see 3.7.7)

There were three significant associations with sex , those of description of symptom 1, description of outcome, and the ability to form new relationships.

In the first of these, the description of the first symptom, $\chi^2 = 8.01$, d.f = 3, sig = 0.045. From the results it seems that women tend to present with psychological (internal) problems, whereas the men present with "external" issues relating to family and identity issues. Taking account of specific pressures and stereotypes of ethnic minority men in Britain today, this result is probably unsurprising.

This links with description of outcome where the test of association is $\chi^2 = 8.02$, d.f = 3, sig = 0.045, fewer men than expected are perceived by the therapist to have a *good* outcome. This may reflect the external nature of the presenting symptoms, resolution of family problems involve other family members, and the internal issue of identity can be reinforced, by external reality and therefore more difficult to resolve. Moreover men have more involvement with the "outside world" through work. The ability to form new relationships is connected with this, but it is the women, not the men who seem more able to make new relationships (see 5.14).

7.9.6 Referral Source and Outcome

Self referrals were equally good or bad referrals compared to other referrals, in terms of outcome.

7.9.7 Ego Strength and Outcome (see 3.8.1)

Ego strength was not associated with outcome, 28 were considered easily able to form new relationships at the end of therapy; 24 still found this difficult, 7 of each group remained with a GHQ score greater than 12.

7.9.8 Ego Strength and Sex

The ability to form new relationships: (a facet of "ego strength") was strongly associated with sex with 66% of women considered able to form new relationships, whilst only 25% of the men were able to do this ($\chi^2 = 7.74$, d.f = 2, sig = 0.02).

7.10 Did Therapist Training Influence Outcome? (see 3.9.2)

A comparison was carried out between therapists trained in analytical psychotherapy (BAP or overseas training in analytical psychotherapy), those currently training (Tavistock and other organisations) and other professionals with psychiatric, psychology and counselling backgrounds.

The final GHQ was not associated with therapists' training. However, the difference between the first and second GHQ was highly significant ($\chi^2 = 26.90$, d.f = 8, sig = 0.0007, with 76.2% of patients with 40+ point improvement being seen by trained

therapists, the remaining 23.8% of those were from the other professional group (not the trainee group). Just under half of the patients of trained therapists showed an improvement of 40+ points. This supports the contention that more skilled therapists were seeing the more ill patients and also getting good results.

The final PSC was strongly associated (χ^2 = 14.04, d.f = 6, sig = 0.029), with trained therapists having more patients with fewer symptoms (64%) at the end of therapy, notwithstanding the higher number of symptoms they had at the beginning of therapy. (79% had scores of 20+ on the initial GHQ, compared with 100% of the trainee group and 66% of the "other" group). All groups do well, with few patients remaining high on symptom scores.

The fact that the final PSC is associated with training and outcome as described by the therapist, while the final GHQ is not, perhaps reflects the different aspects shown in the two outcome measures (symptoms versus life problems).

The fact that the trainees have a slightly anomalous response with 2 out of the 4 patients in the low group(<10) and the remaining 2 in the very high group(40+) as measured by the final PSC, also shows this, as on the GHQ scoring these four patients were all in the 20+ group initially and three out of the four were in the "no symptomatology" (<12) group at the end, and perhaps reflect a more conservative evaluation of their effectiveness as therapists.

7.11 Frequency and Duration of Sessions and Outcome (3.10.1)

The number of sessions was not related to outcome as measured by the final GHQ, however it was related to the Description of Outcome (rated by the researcher), and it

was highly significant ($\chi^2 = 17.16$, d.f = 6, sig = 0.0087), with 50% of those with 25+ sessions having a good outcome and remaining 50% having a fair outcome, whilst only 27.3% of those in the 12 sessions or less group had a good outcome; a further 40.9% had a fair outcome.

Of those who were continuing therapy at the end of the research, who were excluded from the first analysis, because their therapy was continuing, 7 had good outcomes and the rest had fair outcomes. Of these 11 patients, 5 had 2 years of therapy, 4 had 3 years of therapy, 1 had 4 years of therapy and 1 had five years.

This reflects the essential fluidity of therapy, where as the patient progresses through therapy, the number of sessions may increase (or decrease) as difficulties in the therapy (the treatment of symptoms and whether other issues surface) become apparent or are resolved. Such fluidity is essential if therapy is to be effective.

From this is seems that a lower number of sessions are less good for some and the more therapy the better for others. However the difficulty in interpretation of these results is that the ones who were offered more therapy may not be the most ill, but "better therapy patients" (and perhaps also the worried well); however there is only a weak association (at the 0.07 significance level) with the initial GHQ which suggests that generally the more symptomatic patients get longer therapy.

The number of sessions was also associated with the difference between the first and final PSC ($\chi^2 = 19.74$, d.f = 8, sig = 0.0113), This emphasises that the greater number of sessions increases the amount of difference between the first and second PSC; although good reduction in symptoms were found for all patients; the results were more variable for those having 12 sessions or less (based on the 113 patient group). Perhaps,

this also emphasises that the PSC was used as a focus for therapy, as the identified problems on the form were used as part of the "handing over" process between the assessor and the therapist.

7.11.1 Frequency of Sessions and Outcome (3.10.1)

Frequency of sessions was associated with first PSC ($\chi^2 = 23.21$, d.f = 12, sig = 0.026) but not with final PSC, showing that of those 75% of those with better ratings are seen on a weekly or twice weekly basis. This is understandable as the first PSC was at the assessment where such decisions as to frequency were discussed. However it seems that of the 5 patients with less frequent sessions 3 were in the high (40+) initial PSC group. The results of the final PSC and the final GHQ suggests that such spacing does seem to be less effective, in terms of symptom reduction.

Frequency of sessions was associated with the final GHQ. ($\chi^2 = 12.59$, d.f = 6, sig = 0.05), the results suggest that although weekly sessions are the optimum, 75% of those coming for weekly sessions end up in the "no symptomatology "group, whilst only 62% of those with less frequent sessions end up in this group.

Frequency was also associated with the final PSC with 82.9% of those in the lowest two groups (<20) being seen on a weekly or more frequent basis, again only 62.5% of those in the less frequent groups attained the same low scores.

7.12 Previous Psychotherapy (3.7.8)

Previous psychotherapy was not associated with any outcome variables, apart from being weakly associated with the difference between the two PSC's. The results tend to suggest that 6 of the 11 patients who had had therapy before changed their score by

more than 20 points, whilst only one person who had not been in therapy before managed to achieve the same level of change. This suggests that previous therapy may have provided some help in understanding the process of therapy, but had not reduced the symptoms.

7.13 Long Term Outcome

All patients left therapy with the knowledge that they could return to therapy, and most were seen by their therapist 3-6 months after completion. Although the Centre did not feel it appropriate to keep in touch after this session, 10 of the patients have been in contact with the Centre and are well, are achieving occupationally and have settled relationships, two have recontacted the Centre following a traumatic event and have been seen again for short term therapy. It can be assumed that most of the others would have been in contact should they have required help.

Chapter 8

Illustrative Case Vignettes

8.1 Overview

Some of the patients involved in the research (described in the previous three chapters) have been selected to illustrate some of the life histories and problems patients present with. It is included to help the reader understand interpretively the patients seen at the Centre and emphasises the cultural component of the presenting symptoms.

These case studies are not intended as detailed clinical histories. There are many reasons for this, however two major reasons stand out. Firstly there is the issue of confidentiality, all patients in the research were assured of confidentiality. The researchers were concerned that by giving much detailed information, the unique experiences of patients might identify patients to people who might know them. Some of the case studies were people who worked in the helping professions themselves and therefore there was a need to "disguise" their cases so they were not identifiable. Limited information is one way of disguising case histories, another is to change significant details. The former approach was taken so that there was little distortion of the facts, which would, of course, influence interpretation of the results.

Secondly, the author did not treat the patients herself (for obvious research reasons). By providing case vignettes an effort is made to give a detailed and balanced report of the case. However, there is selection of information and hence some parts of the therapy are emphasized and some are not. Therefore, if detailed information is provided by a third party, the interpretation may distort the actual experience of the therapy by patient or the therapist, thus providing erroneous information. The therapists felt that confidentiality was paramount, but agreed with the researchers that some limited information would be appropriate and helpful to understand the types of issues presented and the particular life experiences of their patients. So they agreed to provide brief resumes of their patients. This was on the understanding that the therapy was not compromised or identifiable. They gave brief overviews, in their own words, of their patients' backgrounds and presenting symptoms and outcome.

It was also agreed that detailed evaluation of therapy was not covered by the research agreement signed by the patients (the consent form) and so detailed discussion of their therapy would have contravened the agreement and therefore would have been unethical.

Hence a more detailed evaluation of the particular cultural aspects in this therapy is left for later evaluation after clear consent has been acquired.

However, despite these limitations the case vignettes do give some insight into the types of intercultural issues presented by the Centre's patients of both a social and psychological nature. However, even "external" problems can be addressed during an intercultural therapy encounter.

The vignettes also emphasise that the measures used to show improvement or otherwise during the therapy, need to be considered alongside the therapists closing summaries, to be sure that the therapy is effectively evaluated.

The GHQ was used to gauge the levels of presenting symptomatology.[1] Before and after GHQ scores are used to define three groups,

- Group 1: Those patients whose particularly high initial GHQ[2] scores reduced considerably during the course of therapy.
- Group 2: Those patients whose scores increased between the initial and final GHQ
- Group 3: The patient who scored 0 (no psychiatric symptoms) on the initial and final GHQ: someone who might not be expected to be taken on for therapy.

8.2 Group 1

All these three cases, began therapy with particularly high scores (scoring 60 on the GHQ, although none were consistently "end users", i.e. always marking the extreme ends of the scale). Their final GHQ scores all fell into the <12 (no psychiatric symptoms) level.

Patient A.

This woman, born in an Arab country, referred herself with an "identity crisis". She described this as an inability to reconcile the different cultural expectations of her,

[1] The therapists were not told the results of the initial GHQ (although the psychiatric symptom checklist was discussed with them on taking up the case).

between her "mother culture" and the British way of life. Issues of how she should dress and behave caused her difficulty and had precipitated a continuing depression. This lead her to have difficulty in concentrating on her postgraduate studies. She was behind in her study assignments, which caused her to seek therapy at Nafsiyat.

She was unable to make regular appointments at the Centre (because of her study commitments). Her appointments were arranged approximately fortnightly. She had 12 sessions in total.

Ms A was in her twenties when she came for her therapy. She had experienced many separations during her school life. She was educated in her home country as well as in Europe and America, although the rest of her family were still in her home country. She had a good relationship with her mother and a "fair" relationship with her father. She had, at the time of her therapy, no close relationship or partner but had a network of friends and acquaintances in the UK Despite being very depressed her therapist considered that she was able to relate well to others[3]

She felt unable to complete her academic work, but on the other hand felt she had to for financial reasons. Her therapist noted that she was very committed to therapy (never missing an organised session, always on time or early). She said that therapy had enabled her to understand the influence of the separations and cultural changes which had contributed to her depression and "identity crisis". Although the depression had not completely gone by the end of her sessions, she was able to complete her course and get a professional training.

[2] Luborsky (1988) suggests that rating scales can be a way of patients asking for help. High scores may reflect the urgency with which patients regarded therapy, and perhaps indicates the commitment and motivation for therapy.

[3] This would associate with high "ego-strength" described as a good predictor of outcome (see chapter 1).

Ms A wrote, some months after completing her therapy, that she was still deriving benefit from her therapy[4] and had found work in an allied field which she enjoyed.

Patient B

An African woman in her mid-twenties was referred by her G.P. She presented with acute depression which had lead to an inability to work. She was also becoming agoraphobic. At her assessment interview she related her current feelings of depression to the long term separation from her parents and her poor relationship with them as well as difficulties reconciling her role within the family and her responsibilities. Her parents remained in Africa whilst the rest of her siblings were in the UK

She described being sent to boarding school in England to complete her senior school education. She had lived in the UK since this time, with a short stay in another European country. She had a transient lifestyle having found it difficult to find long term lodgings (she had lived in 10 places in 3 years).

She stayed for about 40 sessions of therapy. Her therapist described the aims as helping her overcome the agoraphobia and depression, although the therapist felt she found looking at her problems "quite frightening" and this had extended the therapy beyond the normal 12 sessions. She was seen several months after her therapy finished. At this time she said that the therapy had enabled her to cope with her life. She was working and happy with her new job.

[4] This could be related to the so called "sleeper effect" described in Chapter 1.

Patient C

This young woman in her mid twenties referred herself to the Centre. She was born in Africa and described herself as a "black Asian" (she was an African born Asian), but she said that in England she referred to herself as "black" because of the political associations. She had come to the Centre in order to deal with a drinking problem that had started some years earlier. At her assessment she was described (by the Clinical Director) as looking very dishevelled and shaking all over. She was mostly concerned that although she had a degree that her drinking would preclude her getting a job.

She described a currently virtually nonexistent relationship with her parents but she was close to one of her siblings.

She came for 6 sessions following this assessment. In those six weeks she managed to get a job and this enabled her to keep her drinking under control. Although the therapist felt there was more work to do she decided to discontinue therapy[5]. She was told that she could recommence her therapy at any time. At this time her therapist reported that she had been able to make connections with her past life, her drinking was managed and that she had been able to form new relationships outside the family.

She wrote three months after the termination of therapy saying that she felt well, was doing well in her job and that she was able to control her drinking. She had decided against coming for any more therapy.

[5] Her final GHQ showed a reduction in symptomatology to the "no psychiatric symptom level". It perhaps a more conservative rating by her therapist, who of course was looking at more than just symptom removal.

8.3 Group 2

The next group of patients are ones where there was an increase in reports of symptomatology.[6]

Patient D

This woman in her thirties came to the Centre and initially completed the GHQ form with a score of 14. By the end of her therapy with her first therapist she had a score of 43[7].

Born in the Caribbean, she had lived with a stepfamily with whom she described a poor relationship. She left this behind and came to the UK in her teens to join her biological father. She had been sexually abused

She described her main symptom as depression, this was affecting her professional work. She had difficulties in controlling her weight which she attributed to the abuse.

She had found it difficult to work with her white woman therapist and expressed this to the researcher at her 12 session review. This was discussed with her therapist. Because of the therapeutic difficulties she was re-assessed by the Clinical Director and reallocated to a black Caribbean woman therapist[8]. She was able to work better with this therapist and reported on her feedback form, that her time in therapy had helped her and she felt positive about the effectiveness of her therapy.

For this client there were difficulties about her relationship to her culture. She clearly felt that she was being disrespectful to her culture when she talked about the difficult

[6] This may indicate the patient not recognising chronic symptoms, which are brought to awareness during therapy see Chapter 1.
[7] This increase in symptoms may occur in therapy due to the therapeutic process. Repressed material may come into consciousness making the patient "more ill" until the issues are resolved.
[8] This is one of the rare instances of "intra-cultural" counselling ("so-called" ethnic matching).

experiences that she had experienced in her life. She felt that she was being disloyal when she talked to the white therapist, and therefore needed a therapist from a similar background to be able to express the hurt and the trauma that had occurred in her life.

It appears that, for this client, intra cultural therapy was the most appropriate treatment. There are many definitions of intra cultural work and these generally talk about the benefits of cultural understanding that accrue from such work. Nafsiyat's training and experience of intercultural therapy has helped the organization (and the theory of intercultural work) to refine its definition of intra cultural work.

For those who feel alienated from white society, a white therapist, even one with none British origins, may cause the negative transferential feelings to be too intense. Therefore, a therapist from a similar background to the patient may diffuse these feelings to the extent that the treatment can continue. However, as with all work at Nafsiyat, the therapist not only looks for the similarities between their own and the patient's experience of the culture, but also those areas where differences occur. Nafsiyat would put forward the argument that all therapy is, to a greater or lesser degree, intercultural. Hence intracultural work at Nafsiyat always contains the intercultural (working with difference) element.

Patient E

This man in his mid-thirties initially completed the GHQ form with a score of 13. By the end of his therapy he had a score of 33.

He was referred by his G.P. for therapy for his depression. He said that he had felt a failure since he had not achieved any academic qualification. At the assessment, the Clinical Director, described him as an articulate man, working in a difficult job. He described experiencing racism at his work. The Clinical Director felt that this had exacerbated his depression. He had been in therapy for a year before he came to the Centre (for a different problem).

He came to the UK in his late childhood after being looked after by his grandparents in the Caribbean. His mother having come to the UK three years before his arrival, his father came three years prior to that. He described being unable relate to his father who he felt did not give him any guidance. He related his feeling about relationships, to this relationship with his father.

At the twelve session research review he expressed that he was having difficulties with his therapist. This was discussed with his (woman) therapist and the patient was again re-assessed by the Clinical Director and was reallocated to a male therapist.

This patient clearly had not related well to his white, woman therapist. The male therapist he was subsequently allocated to, whilst not being from the same culture, proved to be very effective. In this case the intercultural aspect was underpinned by this patient's relationships with women through his past experiences.

He felt unable to talk about the hurt, pain and vulnerability that his life experiences had caused him with a female therapist. In this case an effective treatment option was to provide a male therapist to alleviate some of the immediate concerns of this patient, allowing him space to talk about the issues of separation and loss that were central to

his seeking therapy. He was also able to explore the outer world reality of the racism that he was experiencing in his workplace.

At the end of this therapy he said that, although he recognised that he had not resolved all his issues, he felt that the therapy had been useful.

Patient F

In this case there were minor changes from an initial score of 2 to 8 on the final GHQ

An African woman in her mid-twenties, referred herself after hearing of the Centre through a friend who was a patient there. She developed pain throughout her body at the time of her menstruation, when she could not sleep. This had resulted in admissions to hospital. On several other occasions she had had to go into hospital because of severe weight loss. This she associated with the break-up of a long term relationship and examination stress.

She described herself as shy and was bullied at school, and, she said that although the school did not consider her academically bright, she had got a degree.

The family situation was fraught, but she noticed that when she lived away from her family, with friends her pain went away. She had decided to come to the Centre as she felt her physical symptoms were related to the family situation.

As family was very important to this woman she needed to express her conflict about her need to be close to her family and her difficulties within this environment. The intercultural aspects of her situation of the racism (bullying at school) and her westernization (her preferences for being with her friends rather than family) contributed to her referral to an intercultural Centre. She felt that her concerns about

her need to be part of her family and apart from them (a traditional versus an acculturated role) could be explored. She was seen by a Greek Cypriot therapist.

She stayed in therapy for 15 sessions, and her therapist noted at the end of therapy there had been a marked improvement in her symptoms. The therapist related this to increasing understanding of her anger towards her parents, with a concomitant wish to develop a better relationship with them, which in part involved her separating emotionally from them. The therapist noted that the increase in the GHQ was probably due to her increased awareness of her emotions, feelings and needs.

8.4 Group 3

The final case reported is one where there was no change in the GHQ scores before and after therapy (she scored "0" on both)[9].

Patient G

A Caribbean woman in her late thirties was referred by her G.P. She presented as a cheerful woman, although she had physical symptoms, her G.P. related them to anxiety in other areas of her life (including her current relationship).

She came from the Caribbean to the UK in her teens to join her parents who she described as people she "hardly knew" and which was an "awful experience". She said that she missed her uncle in the Caribbean who had brought her up and to whom she remained close.

She regarded the referral as one to help her understand why none of her relationships lasted very long, an early marriage lasted a few months, a second one in her twenties a few years. She associated the breakdown in her relationships as being related to closeness, when she became close to her partner, she made the relationship go sour so that it would breakdown. She felt very confused by this, but related it to anger with her father who she felt became distant and never visited her. She felt was also angry with her mother, who after an estrangement, is now close.

She stayed in therapy for 7 sessions on a fortnightly basis. Although due to changing work circumstances she had to finish therapy early (not staying for the full 12 weeks), the therapist felt that she had been able to make connections with her early experiences of separation and loss with her current relationship problems.

8.5 Comment

It will be noted that none of the above case studies are for British born ethnic minorities This is because the particular groupings chosen were generally for extreme change; none of the British born went from many symptoms to none (Group 1), only one increased their symptoms and that was by one point from 19 to 20 between initial and final GHQ).

The above analyses illustrate the some of the specific cultural experiences of migrants, the losses and separations (of country, family, language), as well as the difficult reunions. These case studies reinforce the long term effects of this. These quantitative results emphasise the need to be aware of the different "real life" experiences of

[9] This may indicate the patient not recognising chronic symptoms, which are brought to awareness during therapy see Chapter 1.

people from different backgrounds, and not just to focus on inner world problems without reference to their external reality.

CHAPTER 9

Discussion

9.1 Previous Psychotherapy Research Design

Psychotherapists have tended to treat few ethnic minority patients, and this is shown in the lack of research. That which does exist, tends to evaluate the "problems" of psychotherapy with ethnic minorities and presents them as poor therapy patients. Despite the few research studies, the notion that there are treatment problems with such patients is pervasive in the literature. However, research into all forms of therapy that encompass other than "usual"[1] patients, is more concerned in showing that such patients do not do well and identifying the sociodemographic and outcome measures that support this, rather than asking questions as: how can such patients be given "appropriate" therapy? Why don't they do well? What can be changed or added to the therapy to make it more appropriate?

The well-known large-scale studies which have explored several facets of therapy have tended not to use ethnic minority patients. The Menninger study patients were all white, middle class or upper middle class with high I.Q.'s (Wallerstein 1989), and the

[1] "usual" here refers to white, middle-class and professional

Penn study had only six "black or oriental" patients, with only one of the total sample being less educated than a high school graduate (Luborsky et al 1988) (see Table 9a).

The Sheffield Psychotherapy Projects (the first and second) had very stringent criteria e.g. they excluded those patients who had had their symptoms for more than two years (which leaves a query over spontaneous remission, i.e. would they have got better anyway?). They don't seem to have had any ethnic minority patients in their first study, while in the second study they note that the patients were "predominantly white Anglo-Saxon".

Such lack of clarity creates difficulties when comparing and contrasting population profiles, presenting issues and outcomes.

In America, the American National Institute of Health has issued guidelines identifying the need to incorporate all sections of the community in all research (Hohmann and Parron 1996). Yet such an initiative has not yet happened in the UK where it is well summarised in the second Sheffield Psychotherapy Project as "*No restrictions were placed on clients' racial or ethnic status, which is not routinely recorded in UK treatment settings*" (Shapiro et al 1994). It is unclear what this means, as the evidence suggests that ethnic minority patients are not offered psychotherapy, were there any ethnic minority patients in their research?

Table 9a : Comparison of Demographic Details of the Main Outcome Studies

Study	No. in Study	Men : women (%)	Mean Age Men : Women	Educated	Class	Minorities
Menninger	42	50:50	33:30	IQ 124 (mean)	Middle	None
Penn	73	40:60	26.3[2]	89% had had some college	Not noted but: 40% student	5 "black", 1 oriental
Chicago	540	32:68	25-35 median grp	90% had had some college	Not noted	Not noted
S Sue	13439	48:52	34.7	Not noted	77.7% were on *Medical*[3]	72.2% Non-white
Sheffield 1	40	57.5:42.5	40.7	72.5% post school qualifica-tions	Mostly Middle	Not noted
Sheffield 2	117	48:52	40.5	62.4% post school qualifica-tions	White collar profess-ional	Mostly White
Nafsiyat	52	31:69	31:30	33% post school qualifica-tions	A range of work	All Minorities

At the same time there has been an increase in the number of ethnic minority therapists in training. Such a change has allowed questions to be raised about the reliability of such "psychotherapeutic lore", and questions are beginning to be asked about whether

[2] no differentiation by gender
[3] People who qualify for this, have incomes close to the federal level of poverty.

therapists need to review their own technique and whether the theory and "lore" needs reviewing.

It is interesting to reflect on the fact that in the past, such ethnic minority therapists had difficulties in raising issues about race and the lack of ethnic minority patients in therapy with their training organisations. Often their concerns were "interpreted" in terms of *their* "problems with their ethnicity". The results of this study show a predominantly positive outcome from intercultural therapy; which suggests that such "interpretations" are, at the very least, incompatible with psychotherapy. Perhaps they represent a counter-transferential problem with the (predominantly) white training organisations. The problem itself is a conundrum, because if therapy organisations feel able to train ethnic minority people as therapists (as part of the training is a personal analysis), why are they so against treating ethnic minority patients?

The argument revolves around the perceived different cultural views of minorities. Those in therapy (e.g. therapists from ethnic minority backgrounds) are seen as more *westernised* (and more acculturated), more *psychologically minded* (perhaps fulfilling YAVIS criteria), and hence are *appropriate* for psychotherapy.

The usual psychotherapy patients are reported as young, middle class and intelligent (do ethnic minority psychotherapy trainee psychotherapists fulfill these criteria?) who have been acculturated into the particular cultural context of psychotherapy. The questions now to be asked are firstly whether there are any other young, middle-class and intelligent ethnic minority people (which, of course, there are), secondly are they acculturated into the culture of psychotherapy (or can they be so?) and thirdly is psychotherapy a effective treatment for them?

Research Parameters: Issues and Limitations

9.2 The Research Context

This history sets the scene. This research started from a different premise to that described above, therapists at Nafsiyat have always argued that psychotherapy is a particularly powerful therapy with ethnic minority patients, but that the culture of patient, therapist and therapy need to be recognised, defined and "worked through" during the process of therapy.

Psychotherapy for ethnic minorities in London was (and is) a scarce resource. Psychotherapy where the therapists themselves were (to a large extent) ethnic minorities was unique. Therefore despite some of the methodological difficulties it was decided to investigate the Centre without preconceived ideas about the groups using the Centre (for example, just choosing to investigate South Asian patients) nor preconstructed notions of those who would benefit from the service (following the YAVIS criteria) but to investigate the real users of the Centre i.e. "real" patients from different cultural groups and hence the "real" intercultural therapy as practised at Nafsiyat. All patients were offered the option of being the research and hence the only selection was on this basis.

One of the criticisms of psychotherapy research is that it either uses experimental conditions that are different to those used in therapy and so produces meaningless results, or that it affects the clinical practice to the extent that it compromises the therapy, again producing results that have limited practical relevance.

For the researchers, a key area of concern was the extent to which the research affected the clinical practice and how much did it accurately reflect the clinical practice.

The following sections discuss the issues and limitations considered by the researchers, particularly the relevance of this research design to the therapeutic context at Nafsiyat.

9.3 The Therapy Context

Therapists at Nafsiyat have interpreted their therapeutic "brief" widely, not rejecting those patients whose symptoms appear to be outside the remit of traditional therapy (see Chapter 1), and the high levels of presenting symptoms seem to support this. Patients were carefully evaluated during the assessment session, with attention being paid not only to the nature and severity of the presenting symptoms but also to the cultural world of the patient; and the effect of this on them and their presentation of their symptoms (the manifest symptoms and the latent meaning of these).

The assessment session can be considered an "experiential" session, where patients could experience a modified therapeutic session, to see if they wished to continue. Institutional psychotherapy varies from private therapy in this one important aspect. In private work the assessment is carried out by the therapist, so this allows the patient to see if they "like" the therapist.

9.4 Research Design :Aims of Therapy

One of the fundamental concerns of researchers is the definition of the aims of the research, as the design of the research is predicated on this understanding. Historically the distinction between psychoanalysis and psychotherapy has been blurred but is perhaps best paraphrased by the fact that "late" Freud believed that psychoanalysis was carried out for its own sake and if this caused the relief of symptoms this was a beneficial "side effect". The psychotherapies on the whole have addressed themselves

to dealing with the problems of improving life skills and (in the process) removing symptoms (i.e. "early" Freud).

The aims of therapy have been a source of contention since the beginning of therapeutic intervention. The early psychoanalytic prize competition (in 1922) to identify the relationship between theory and technique was never won (Burgoyne, 1996,personal communication). The notion of the aims of therapy predicated, as it is, on theory, has somehow been divorced from practice.

This aspect of psychotherapy is important. Patients come to the therapist to feel better. One of the moderators of this is whether the "symptoms" they present with go away. Howard et al (1993) have described this as the second part of a tripartite model, in which subjective well being, then symptoms, and finally life functioning improve sequentially.

The psychoanalytical view that presenting symptoms mask the core problem can be incorporated into such a model. If the presenting symptoms go away (and are not replaced) it implies that the "core issues" or the underlying pathology has been addressed and changed.

What therapists often criticise, in my view misguidedly, is how outcome criteria are evaluated. A fact that they tend to forget is that they themselves use criteria to decide when to finish therapy, as Freud (1937) says in "Analysis Terminable and Interminable" most therapists believe there is an end point, i.e. that analysis is terminable. How and when you decide this is predicated on the original aims of the therapy.

The aims of intercultural therapy were identified as primarily to reduce presenting problems and symptoms (reflecting a return to "early" Freudian notions discussed in the Chapter 1), together with the usual measures of "success" as defined by patients i.e.

feeling better and more able to cope with life. The research was predicated on this understanding, but further measures were added to reflect the complexity of the notion of *success* in therapy. A drop in symptomatology had to be coupled with an increase in the ability to form relationships and the ability to function in a better way outside the therapy.

The variables chosen for this research were ones that could be objectively measured and in effect argues against Muench's notion (1968) that psychotherapy variables are difficult to measure. What is difficult to measure is the interaction between them during the process of therapy.

9.5 The Research Design: Questionnaires and Therapy.

All those involved in this research (especially the researchers) considered the therapy primary, and thus the starting point of all research discussions was the need not to compromise either the patient's experience of therapy or the therapeutic process.

The naturalistic research design fitted into the normal procedures at the Centre although it meant extra work for the Clinical Director and therapists. Forms were filled out as part of the therapeutic review procedure and to provide extra information on clinical case notes, so it was reasonably cost effective.

It was interesting that the initial concerns of therapists about the in-house forms potentially influencing practice changed through the research: firstly to a stage where the forms were seen to just be there to be filled out ("going through the administrative hoops"), to the later stages of the research where therapists found them a useful adjunct to their normal monitoring of patients. Most finding the first two forms (see Appendix

1- the case history and the psychiatric symptom checklist) a useful introduction to the patient[4]. So the extra work involved for the therapists seems to have been offset by the benefits.

What was evident was that as the therapists were involved in the research they had a positive view of the research, perhaps because their concerns and opinions were listened to, discussed and acted upon appropriately by the researchers. This also meant that the research reflected their practice.

This is an important lesson for researchers to learn. If the research is seen to reflect and be helpful to the psychotherapeutic work, then the research will be perceived by therapists as useful. The usefulness of the forms is illustrated by the fact that they are still used, in a modified form, thirteen years later.

9.6 Research Design:Effect of Questionnaires on Clinical Practice

As has been discussed (in Chapter 1) therapists usually accuse researchers of seeking to alter their practice. There seemed little concern from therapists, and no evidence from patients, that this research was influencing or changing the process of therapy at the review workshops with researchers.

Some of the results produced apparently inconsistent responses (particularly the Country of Birth statistics), but all participants in the review workshop felt it important to report the exact responses of the patient at the assessment session rather than querying the response (hence the "mixed race" responses to country of birth), unless therapeutically there were reasons for an intervention. The net result being that the assessment session continued as though there was no research was being carried out;

[4] These forms were accompanied by a detailed case history from the Clinical Director.

whatever the patient wanted to talk about at the assessment was primary and respected, whether or not it corresponded with the research form.

This has face and criterion validity as this design mirrors normal assessment practice.

There was also a need not to impose or influence the discussions during therapy. The therapy profile form addressed this by only asking for answers to questions that had been discussed or reported in the previous sessions. This format worked very effectively, as therapists felt comfortable about using the forms (some finding it a useful way of clarifying their thoughts about the patient and the progress of therapy), and the patient's therapy seems not to have been distorted. The drawback, of course, was the fact some issues may have been missed out in the research. This seems to have been a negligible difficulty. It would be expected that after a thorough assessment and therapy most relevant issues would have been raised.

Of course some patients derived overt benefit from the research (see chapter 8) as they were able to discuss the problems they were having in therapy with the researcher and have this considered by the Clinical Director.

It can be seen that the research, to a large extent, reflected clinical practice and leads the researchers to have confidence in the applicability of the results.

9.7 Research Design: Number of Therapy Sessions

This research took a "black box" approach to therapy, looking at before therapy and after therapy measures, using the first assessment session as the "before". It also confirms the idea that the best time for evaluation is at an initial session. This is commonsense because anything may change if there is a lag between

therapeutic/research assessment and therapy starting. Most of the patients in this study waited less than six weeks to begin therapy, no one waited longer than 3 months.

All appointments attended were counted, missed appointments did not contribute to the final tally, and hence some patients might have come to 12 weekly sessions and missed four sessions, hence have been allocated a therapist for sixteen weeks. This may have influenced the results as some therapists argue that missed sessions are also working sessions. Even with these extra sessions, the work was predominantly short term.

The effect of these missed sessions is unknown, as sessions may indeed have been missed for therapeutic reasons (most usually because a previous session had raised uncomfortable feelings or brought back memories that had been forgotten: in analytical terms "repressed"). However, ethnic minority patients, like traditional patients, miss sessions because they are ill, because they have something arranged, and also because they have to work.

Some of the patients worked shifts and hence "regular" weekly sessions sometimes clashed with their work, this was also evidenced in their times available to come to therapy. Our patients will have special meetings to attend - court hearings about asylum procedures, advocate meetings etc.). This is an important factor as much of the intercultural therapeutic work is based on Council or Health Authority money. There is a need to acknowledge that absences can occur, and the budget organised to allow for these contingencies.

In normal psychotherapeutic practice sessions not attended are counted as part of the final tally of sessions. In this research we were measuring the amount of therapy (the "dosage") that people had and the outcomes based on this. Patients have different attitudes to therapy, some attend every session and others (for various reasons) are more

erratic in attendance. The researchers needed to adopt a consistent approach to the research and hence were faced with a dilemma. If the research was limited to 12 sessions some patients may have had 9 sessions of therapy, whilst others would have had 12 sessions of therapy work. The effect of these missed sessions is unknown.

Moreover, we cannot be certain of the outcome effect of missing session 2 or session 12 (of a 12 session contract). Although in absence of other information, therapists would interpret the former very differently from the latter.

Therapists try to understand the importance of missed sessions and interpret on the basis of this. They place meaning on the missed sessions (see above), but it is understood in intercultural work that some people cannot attend all their planned sessions or have to rearrange them. It is an assumption by the researchers that those who missed for psychological reasons would have a different profile to those who missed for practical reasons (e.g. work, asylum hearings). Hence the effect of such missed sessions is predicated on the "outer world" realities, as well as those which are part of their inner world.

It was also found that some people were having fewer sessions and some longer therapy than the initial 12 session contracts and this provided yet another variable.

It could be argued that people were getting more therapy than identified in the research. For those on a 12 session contract, those missing 4 sessions would have had 16 sessions in all (only 12 of the sessions being attended). Currently there is no reliable research on the identifying the "working" effects of missed sessions, nor any way of clearly

separating those missed sessions missed for external reasons and those for psychological ones. Some therapists would argue that all missed sessions have a psychological component. Therefore these queries have had to be left for later evaluation.

Hence a decision was made that this research would look directly at "active" therapeutic practice, the actual number of sessions of attended therapy sessions. Hence we chose to evaluate the therapy as the actual number attended as opposed to those that may have been planned. This has the advantage of eliminating the variables of which sessions were missed (i.e. early sessions or late sessions) and making a consistent method of measuring the number of patient sessions, based on observable, external criteria.An additional variable occurred for some patients. Due to work commitments (e.g. shift work) some people had their sessions on a weekly basis, but at varying times. The Clinical Director was able to do this as he was at the Centre several days a week, at other times training, attending meetings etc. However, as many therapists worked sessionally (usually one three-hour session a week), this was not always practical.

This variable session time also has therapeutic ramifications. The theory suggests that the therapy has to take place at the same time, in the same room, to be most effective. Arguably the *therapeutic optimum* is to minimise or exclude changes in room and times of appointments. This allows a therapist to pick up any subtle differences in the patient and not to have to consider whether the patient is reacting to the changes in the therapy situation (the outer world), and therefore to concentrate their effort on looking at other changes in the patient's life to explain the subtle differences. Although an alternative argument is that the such changes can bring into the transference, the way change is

experienced by the patient. However, this requires therapists to be very sensitive and "listening" for things that relate to the changes in the physical environment as well as in other areas of the patient's life.

Nafsiyat has always been innovative in its approach to therapy. Although the therapists at Nafsiyat recognize the need for boundaries, and work with some or all of the accepted boundaries (those of regular, usually weekly sessions, in the same room), this is not always a necessary part of therapy. In a small organization, with a unique patient group, there is sometimes a need for a change in practice to accommodate particular cultural or life experiences. For example, it is not unheard of for therapists from a particular cultural background that prohibits men and women being alone together, to have supervision from an opposite gender supervisor with the door left open (obviously in a room sufficiently isolated that the discussions cannot be heard).

Similarly Nafsiyat has also worked with the notion of a secure base for therapy. Hence as long as the important parameters are kept constant (at the same place, with the same therapist) other factors can be flexible. Obviously no-one is suggesting changing all the parameters (different times and rooms) at every session, but some variations can be worked with. This is not particularly radical, as therapists themselves cancel sessions for sickness or other reasons. Similarly in an organizational setting, therapists may choose (or have to) change rooms to see their patients.

Obviously such changes can produce unexpected effects in patients, but in intercultural therapy the therapist is open to thinking about whether the physical environment can be interpreted as a causal effect for these changes. However, all this is predicated on the

patient/therapist dyad being "secure" enough to cope with such changes, and deal with them within the therapy. It is an interesting future project to evaluate how necessary the accepted rigidity in therapeutic practice actually is, and to what extent psychotherapists "normally" deviate from this ideal.

9.8 Research Design: The Notion of "Short Term Therapy"

In Chapter 1 the intangibility of the term "short term therapy" was discussed. How long is short term? The majority of Nafsiyat patients came only once a week over a period of 0-24 sessions, which seems to fit in with the discussion of "short term" as described in the introduction (1.17.6). This seems a modest amount of therapy compared to the description of the years of analysis described in the literature.

However, although most therapy is measured in months (rather than years), there is an expectation by patients that psychotherapy is always long term. The reality of therapy is not necessarily "years on the therapeutic couch", but, for many, several weeks/months of work. From my therapeutic experience, this acknowledgement of the reality is often accompanied by relief by the patient. The prospect of long term work brings its own anxieties.

A more important research point is whether we are only talking about "short term work" or "short term, time limited work". The Centre does not offer open ended therapy. So a further variable has been introduced, the notion of a contract. Has this a therapeutic influence? Is it easier for patients to commit to a number of sessions? Luborsky (1988) found that there was little difference in outcome when time unlimited

work was compared with time limited work, which suggests that as contracts are administratively easier to manage (i.e. they have a planned end point), such a structure may be useful for organisations working to strict budgets. However, extension of these contracts should be also an accepted procedure, to deal with the changes that occur during therapy.

Perhaps if short term work aims to give symptomatic improvement; the results of Schlien et al (1962) are relevant, most symptomatic improvement was seen at session 7 for those who were having short term (20 session) therapy compared to open ended therapy.

However, there may be the issues if the contract is extended for a further number of sessions - does this lead to patients feeling more ill (hence the need for extra sessions) or more therapeutically *held*[5] *?* Is the idea of a contract only applicable to ethnic minority patients?

9.9 Research Design: Statistical Accuracy

The research group was, in statistical terms, quite small; sometimes it was necessary to statistically evaluate small groups, and hence caution must used in the interpretation of the results. Generalisation of these results to other treatment situations should be circumspect, as the sample was small and the treatment was specific. However, in terms of psychotherapy research, this survey involved detailed findings on "real patients" (significantly more than many studies).

[5] *holding* is a term used by analysts and therapists to describe the ability to support a patient during the process of working through the (sometimes) painful work of therapy.

9.10 Research Design :Use of Standardised Questionnaires

The GHQ, PSC and Therapy forms showed that patients presented with high levels of symptoms and were fully aware of the impact of their problems on their psychological health. The GHQ is a particularly important measure to review as this was a self-completed form, and reflected the patients' understanding about their psychological problems. The P.S.E. was presented in an interview format, and hence there was some flexibility for the research psychiatrist to clarify the patient responses.

An extra variable was introduced because patients not only needed to be fluent in English, but also be able to read and write it. They also needed to understand the GHQ questionnaire format. This obviously would affect the results of those patients unable to do this. However, in the research only one patient was excluded. This suggests that the Centre attracted a certain population, one that was sufficiently competent in English and "verbal" enough to complete the questionnaires. It has yet to be ascertained how representative this is of the ethnic minority populations in the Borough. Although common sense would suggest that as new generations are born in Britain (as immigration becomes more difficult) this will be increasingly be the population seen in all areas of the health professionals work.

In the early stages of the research the patients completed GHQs at six weekly intervals during their therapy. Apart from administrative difficulties, it became clear that some of the patients were staying longer than the expected 12 sessions. The (practice) effect of repeatedly completing GHQs became increasingly important and the effect of this was unknown- it might have interfered with the validity of the pre- and post-therapy results. Hence a decision was made that GHQ would only be administered pre- and post- therapy.

9.10.1 Use of Multiple Scales

Although the use of multiple measures was indicated by the research design, there are difficulties in using such a range of measures. It is clear that the emphasis changes between questionnaires, as the PSE is looking at psychiatric symptoms and the GHQ is looking at psychological self reported thoughts and feelings. There will also be a change of understanding of thoughts, feelings, emotions and symptoms between the beginning and end of therapy, which may be understood in terms of the following factors

- Timing may influence answers, Hence the need for consistency in the timing of the questionnaire completion, so that all the patients had the same experience of therapy before completing each questionnaire.

- There may be an improvement in symptoms after one assessment session (Malan 1975), and hence any measures given after this session may not reflect the symptom pattern at referral. Of course, the first interview with the referrer may also have the same therapeutic effect. Hence answers given before the assessment session will (or may vary) from those given after this session. The different questionnaires were completed at the assessment session, hence the results do not necessarily show the pattern of symptoms etc at referral.

- The questionnaires are measuring different aspects of a person (psychiatric, symptomatic and general psychological functioning), so that differences may reflect the different emphases of the different questionnaires.

- The assessment procedure was rigorous and the effect of this is unknown and may have influenced the results.

- With a group of patients with such diverse cultural and linguistic backgrounds there may be differential access to the helping professions and therefore the understanding of their "symptoms" may be different. One might expect some pre-counselling to occur at the assessment session, but that further understanding may be gained during therapy. Early results may reflect this lack of recognition of the symptoms, leading some patients to underreport their symptoms, on the early questionnaires. However, there was a high level of symptom reporting on the initial questionnaires and the influence of this variable may affect a small proportion of the research population, however this should be investigated in future research.

- However, high levels of symptom reporting may also reflect a wish to be taken on for therapy.

- Because patients had experience of filling out questionnaires, the later questionnaires may reflect a greater understanding of their symptoms. This would lead to higher levels of reporting on the later questionnaires. This gives us confidence in our therapy, when the later results show a reduction in symptoms

- One way of minimizing the over/under reporting phenomenon is to vary the timing of the presentation of questionnaires, however, a much larger sample would be required to provide meaningful results.

- Variation in symptom levels may also be created by the fact that different individuals administered the different questionnaires. However, the same professional administered the same questionnaires, therefore the results of each questionnaire across the patient group should be consistent.

- The exception is that final rating of the therapy was by the therapists. However, despite their training on the measure, there might be variations in the ratings given by different therapists (i.e. the initial ratings by the clinical director and final rating by the therapist may be subject to some variation).

- There is also a question as to whether different cultural groups respond similarly to questions about symptoms and whether such questionnaires are culturally constant across cultures. From our pilot study there seemed to be such constancy, but such cultural information needs to be researched more effectively by the authors of such questionnaires in the future.

- It was anticipated that by limiting the variables, the range of results obtained would offset some of the methodological difficulties.

Some of these methodological difficulties were addressed by keeping the timing of the different measures consistent, with, at least for those measures carried out at assessment, being carried out by the Clinical Director and research psychiatrist. In effect every patient has had the same "dose" of therapy at each stage of the assessment process and at each stage at which the quantitative measures are completed. Therapists were trained in the use of their measures and it was anticipated that the variation in PSC "scores" between therapists would be minimal.

9.11 Research Design: The Researcher Variable

The effect of having extra "sessions" with a researcher is unknown, and is left to future research to answer. In most therapy research, the therapist also tends to do all the research data collection. In this research it was considered it possible that this might create boundary problems.

In therapy, the use of boundaries is an important therapeutic tool, and boundaries are strongly emphasised in the psychotherapeutic practice. In order to obviate the therapists crossing therapeutic boundaries, therapists were not involved in the psychiatric and sociodemographic part of the research. Each patient was seen after the assessment session by the research psychiatrist to complete a P.S.E. and later by the research psychologist to complete the social history form. As the patients were talking about their "problems" at these research sessions, there may have been some impact on the therapy, although none was reported. However, future research will have to try to understand the role and effect of such non-therapeutic interventions (but see Chapter 8).

Moreover, having a white English female researcher may have also influenced answers to questions. The researcher, a trained counsellor as well as psychologist, did not identify any patient having problems with the questions or the questions being put by her, but there may have been. Therapists were asked to let the researcher know if any problems about the research were raised in sessions, but none of them did so. Although this does not preclude the possibility of problems, but is suggestive that such problems were not of primary importance.

9.12 Research Design : Development of Terms

The term "patient" is used throughout this thesis, whereas the research forms which were constructed in the early part of the research use the term "client". At the time this term seemed appropriate, although over the years since the forms were devised, "patient" tends to more accurately describe the population. Therapists tend to use the term "patient" preferentially, whilst counsellors tend to use the term "client". As the therapy is primarily psychodynamic in orientation, "patient" seems a more appropriate term.

Similarly the term "mixed race" was used in the early part of the research as this was the commonly used term for those now described as from "dual heritage" backgrounds.

Discussion of the Sociodemographic Results.

9.13 Dropout

Conventionally, ethnic minorities are excluded from psychotherapy because they are considered "poor risks", do not come forward for psychotherapy, fail to attend after the first session or drop out early in therapy. In this study, not only did patients put themselves forward for therapy (cf. the number of self referrals), the drop out rate was similar or better to other studies with "usual" psychotherapy patients.

Referral results are similar to those found by Caccia and Watson (1987) at a London based Counselling Centre offering a similar service which was not specifically aimed at ethnic and cultural minorities. Nafsiyat having a slightly better response (91%), compared 87% of those referred attending the initial assessment in the Caccia and Watson study.

From table 9b it can be seen that less than half of patients completed the research protocol and hence there may be questions as to the generalisability of the results (in fact 94 initial GHQ's were completed - a 17% drop from the 113 suitable patients, but because some people finished therapy before their 12th session and others were unable to complete all the research forms, only 52 patients were investigated).

Dropout is always a problem with therapy research unless, of course, a decision is made only to offer therapy to those who comply with research. However, psychotherapy research studies generally do not say how many of the treatment patients were approached and refused to be part of the research and thus it is impossible to say how well or otherwise this study compares to others.

Table 9b Table Showing Comparison between Nafsiyat Results and Previous Research Studies.

Sample	Number	Percent	Expected Result (based on previous research)
Referred	172		
Assessment	157	91%	
Suitable for Therapy (cf. no. Assessed)	113	72% (113/157)	Expect 1/3 not to turn up; for ethnic minority patients up to 75%.
Suitable for Therapy (cf. no. referred)	113	66% (113/172)	Expect 41% not to turn up.
Research	52	46%	Studies don't tend to identify research proportion

From previous research, it might be expected that 33% of traditional patients would refuse treatment at their first session, and 75% of ethnic minority patients might be expected only to attend one session. It can be seen that Nafsiyat dropout figures are better than this with 91% of prospective patients turning up, and only 28% of patients not continuing. This is consistent (but slightly better) with other community based centres, well within the 20 - 65% dropout of "usual" therapy patients, and well below the 75% dropout of ethnic minority patients cited by Sue. Of the 113 suitable referrals, 64 patients were still in therapy at the 12th session (i.e. 57% were still in therapy) which refutes the assertion that two thirds of patients may terminate their therapy before the 10th session (see 1.17.7.2).

The result generally reflects the accuracy of the assessment by the Clinical Director. Patients did not fail to turn up after their first session, they chose not to continue after assessment (an active rather than passive approach to therapy).

Such results impact on the notion that ethnic minorities cannot use psychotherapy and that they should not be offered such help. The results suggest that more research needs to be carried out to find out why other Centres are unable to keep patients in therapy. Further work is required to identify the relevant components of the therapy experience at the Centre. However, it would seem to be a common sense assumption that because of the Centre employs therapists from range of cultures and the clinical work is headed

up by a non majority culture therapist, the environment created at the Centre is more emic to the patients and hence more comfortable. Further work needs to be carried out to identify the components that make up the good practice at the Nafsiyat Centre

9.14 Early Terminators

Forty-nine patients (43.4% of those in therapy) completed less than 12 sessions of therapy. The question here is how many of the 19 patients who had 1- 6 sessions were happy with their therapy, and how many of those having 7-11 sessions were happy? Future research has to address this as this might skew the proportion of successful and unsuccessful therapy patients.

The reasons for dropout are usually discussed in terms of patients not being understood or helped during their visits i.e. true "dropout". The Nafsiyat therapists asserted that, for the vast majority of *early terminators*, there was some gain from therapy and perhaps some did not need 12 sessions.

Without objective measures of these assertions it is impossible to ascertain the effect of brief interventions, but as Malan (1975) has noted, psychotherapeutic change can occur even after one session. The reasons for patients deciding not to continue, will be left as a question which will require investigating in future work. It is a complex problem and, because of the sensitivity of contacting patients after they left or finished therapy, there would need to be careful consideration of how such a survey would be carried out.

Researchers also need to develop ways of contacting those who do not complete therapy to find out their reasons for dropping out. Such research is particularly sensitive and requires support for the patient. Research will need to be set up to answer the question as to whether people drop out because they have achieved what they want from the therapy or whether they found the therapy unhelpful and the reasons for this. Because

of the potential sensitivity of such questions such research would need to be carefully monitored.

Future research should also consider which variables are most related to dropout. Possible variables include age, gender, cultural background, urban/rural upbringing, requesting psychotherapy rather than being referred, whether psychotherapy is emic or etic to the patients' worldview and the effect of the cultural distance between the culture of the therapist and that of the patient. Moreover, the variables should not only be considered on their own, but the interrelationships between variables should also be analysed.

9.15 Ethnicity

Psychotherapy is usually not an option for ethnic minority patients with psychological problems. It is clear that part of the problem is a lack of psychotherapeutic understanding of the problems experienced by ethnic minorities, together with the inability of traditional psychoanalytic/psychotherapeutic theory to provide a basis with which to understand a psychic reality of these patients.

The notion of an intercultural therapy centre is predicated on the idea that patients would come from a variety of cultural backgrounds, and not only reflect the particular backgrounds of the therapists. The *retrospective* study showed that many different ethnic/cultural groups were represented.

There are many different ethnic minority groups in Britain. Some will have been born in the U. K.; others will be migrants who have experienced the stress of moving from

one country to another; some may have been in the UK for many years and some may be recent migrants. It was important to identify, not only whether the patient caseload was predominantly migrant or not, but also whether new migrants approached the Centre more than people who had lived in the country for many years.

The assessment profile showed a great variation in ethnic backgrounds, with approximately one third of the treatment and one fifth of the referral groups being British born. The reason for British born patients seeking help from a cultural service, appears to be explained either by the strong sense of cultural identity upheld by this group, or, alternatively the need to discover their cultural identity. It represents the difficulties of living with two (or more) cultures and shows the difficulty of balancing the contradictory cultural views.

From clinical material, many are seeking their "roots", some patients having been brought up in an appropriate traditional way and have had, for many years experienced a dual lifestyle both Western and "traditional". The patients at Nafsiyat (both UK born and migrant) present with life styles that argue for acculturation via cultural pluralism (the orthogonal model described in Chapter 1), rather than assimilation or integration.

For some the difficulties with which they present (particularly identity), relate to this sense of duality and the difficulties of maintaining their traditional roles with western notions. For others, the fact that they are living a lifestyle different to their culture, often due to circumstances beyond their control, is a problem. Hence the inherent duality of a culturally sensitive service, yet one based on western psychoanalytical concepts is perceived as a way of dealing with this (perhaps the *etic* psychoanalytical concepts are actually only *etic* when interpreted through a western "gaze". When it is interpreted through an intercultural view they become *emic*). Other psychotherapy

centres may be perceived by patients as white and middle class where their life experiences of prejudice, racism, separation, loss and migration may not be acknowledged. Patients may also fear they are being disloyal to their community and this feeling might be enhanced at a centre where the workers are all white and felt to be potentially judgemental.

One of the most important findings for this research (which has implications for other research) was that country of birth was not found to be a consistently recorded measure. At assessment, the *treatment* group was similar to the *referral* group (in terms of country of birth). When the research psychologist saw the patients during therapy, the Country of Birth statistics changed. This seems to be due to the effect of therapy, as all patients had had a least one assessment session and six therapy sessions by the time that the researcher saw them. This can be perceived as a positive effect of the therapy.

At assessment, many of the patients had identified country of birth with what they perceived as their country of origin and this seemed to be tightly related to their "ethnic identity" (a psychological entity). One of the major changes was the "loss" of "African" patients, who turned out to be British born, usually with Caribbean parents. Moreover, some patients when asked about their country of birth responded with "mixed race" which emphasises the need to define themselves in terms of their perceived ethnic origins/cultural origins. It also emphasises this group's lack of identification with the UK - it is perhaps significant that no-one stated that ethnicity was British.

There seem to be five possible explanations.

Firstly, their ethnic identity influenced their origins to themselves and their response to the Clinical Director. It may also account for why they approached a culturally

sensitive service and perhaps reflects their eagerness to be taken on. This is an *identification* with a culture.

Secondly, it may reflect a different world view that is "ancestral" where a person traces their ancestry back to a country, rather than the western notions of more immediate familial relationships.

Thirdly, identity confusion may be a symptom of the illness.

Fourthly it may reflect the effects of racism.

Fifthly, ethnic identity is in a continual process of development and reworking, in the adult, as in child, even without therapy. The fact this is a "process" indicates the appropriateness of a psychotherapeutic intervention.

The results could be interpreted as suggesting that patients are at the *dissonance* level in Helms's model or at the *working through* stage of the Ruiz model. In both models identity is fragmented at this stage, and there is confusion about group identity, but there is recognition of the problems this is causing. Hence the reason they attempt therapy.

A particularly important further research project would be to "measure" which stage patients are on Helms model (and similarly on Ruiz's model) when they begin therapy. As therapy proceeds further monitoring could be carried out to see whether there is a change in their levels, perhaps leading to a greater understanding of how this occurs. The theory behind both models implies that as there is a resolution of ethnic identity conflicts, a more realistic sense of self and others occurs. For some people in therapy this might indicate an end point for therapy, depending on their presenting symptoms. It would be interesting to see whether a particular stage of conflict resolution at

assessment is indicative of whether a patient continues therapy or whether they dropout, and whether outcome is influenced by this measure.

Also it would be a valuable piece of research to find out if the models do work in a practical situation and if psychotherapy can influence the process of change through the levels on either or both models.

A possible query is whether patients felt they would not be taken on for therapy, if they "provided" a "British" country of birth.

If we use the concept of *culture* as a learned set of ideas and behaviours, then in this research, patients were not only referring to their culture but also to their "ethnic identity". This emphasises both the psychological aspects of identity, identification and the notion of self, as well as the difficulty of providing questions that are unambiguous.

This is similar to the notions of "gender" and "sex". Sex refers to a set of physical characteristics that define men and women. However, some people who have physical characteristics which define them as men, feel psychologically more feminine and vice versa, this is where the notion of gender is important. It is the psychological space within which people live their lives - a "psychic reality".

Where there are differences from the majority culture, such psychic realities take on a "loaded" value. This is experienced as positive only if the majority regard the difference as positive. Where the majority view the difference as negative the view of oneself can become distorted.

This composite identity, that of patients' perceived origins, and their families' origins and their own country of birth, race, culture and religion, need to be explored in the

context of future research and more immediately in therapy. In patients who are ill this may be part of their presenting problem or may confound the presenting problem.

9.16 Understanding Ethnicity in this Context

When we talk about culture, we are talking about learned values, attitudes and beliefs, passed from one generation to the next (this may be more complex in bicultural patients), whereas many minority patients come with a sense of identity that is based on identification with another group either on the basis of visible or political factors, or on the notion of their "roots". Hence "African" for the Caribbean group.

When talking about "ethnicity" or "ethnic identity" or "ethnic origin" we are talking of a psychological construct, not a social construct. It has, of course, social implications, and is not a "hard" construct" (it bears little relationship to geography or external cultural origins) and it could (potentially) change over time. It is not the same as internal culture - which is influenced by the countries and cultures that the family as lived in - although it can be related to this.

As it is a product of identification, this can be either positive or negative: positive aspects include identification with, say, Africa - recognising an historical link with the past, As a result of racism there may be a need to identify with a positive ethnic image. The negative aspects include feeling rejected by parents as *"too black"*[6] perhaps resolving this with an alternative identity.

Therapists should heed that these difficulties (for the researcher) are mirrored in the patients themselves and this is an important part of the therapeutic presentation (12 people presented with identity issues at assessment). The current author is aware of

several patients where the patient is not sure where they are born (some of whom hold dual birth certificates). Alternatively the discrepancy may come to light when patients start therapy and begin to actively seek out their origins. Obviously such discrepancies may be important in a patients' understanding of "self", "identity" and "culture"[7].

It seems important from the results presented here to make the distinction between the British-born and migrant ethnic minorities. As a way of circumventing the problem, the current writer thinks that the question "were you born in Britain?" would yield more consistent responses, but will still not help in those cases where patients are unsure where they were born, nor for those for whom identity and identification are important issues. Alternatively such questions could be left to the end of therapy where such dilemmas should have been worked through.

The discrepancy in identifying "where you belong" emphasises not only the difficulties in identifying birthplace from what should have been a straightforward question, but also poses the question as to whether, if these differences occur in research in a small organisation, is there any reason to assume that it won't happen in other situations?

This is not only a problem for Nafsiyat. Many statutory bodies now use ethnic monitoring in many aspects of their work, and if the current research is replicated simple "ethnic origin" or Country of Birth (Origin) questions may lead to an underestimation of the numbers of British-born ethnic minorities. This finding had also been raised by the C.R.E., although they separate the overestimation of some groups and the underestimation of others (see Chapter 1).

[6] Patients (particularly Caribbean and S. Asian individuals)frequently describe how their fairer siblings were treated better than they were. Leading them to the conclusion that they were "too black"(cf. Hawkes 1997).

[7] Moreover the therapists' own understanding of their culture, race and ethnic identity and any confusions therein may surface during the therapy.

This should alert us to thinking more carefully about the questions we pose to patients in psychotherapeutic research (and in other spheres of social, psychological and psychiatric research). From these results any information collected at assessment may be biased by the illness, distress, and for some, disorientation experienced at the time of assessment.

The result of this discrepancy has important ramifications for future research. No longer is it appropriate to use terms such as ethnicity and country of origin as necessarily specific constructs but, as this research highlights, ones that are weighted by family background, where you are born, where you have lived and other psychological experiences.

One possible strategy is for researchers to consider more carefully and give primacy to the processes of acculturation and enculturation. Within these two concepts, which are part of a complex psychological adjustment, lies some of the answers to the question of what is self and how self identity develops.

Understanding better how these processes occur, what influences certain identifications and what actively works against such identifications could lead us to more appropriate ways of therapy. How people negotiate the, often competing, demands of these two processes and deal with the cognitive dissonance engendered by two opposite responses to the same situation will help elucidate the complex psychological processes that occur in migrant and subsequent generations.

Helm's model is useful as it describes a process that occurs in the acculturation process that occurs in a white majority culture. This is an extra level of complexity because acculturation occurs in the presence of another cultural group, and hence the person not only develops within a family cultural framework and within a external cultural

framework, but also there are the additional burdens of negotiating racism. All this impacts on the sense of self and how inner psychological culture is defined and this impacts on where you feel you belong.

Further research needs to address our limited psychological knowledge about encultuation and acculturation, what affects the processes in individuals and how does this impact on the assimilation-integration-cultural pluralism debate.

9.16.1 Ethnic Matching/Gender Matching

Country of birth on the questionnaires seem to bear little relationship to the culture within which the client lives their life. In practice, professional agencies usually refer clients to us hoping for a therapist from the same background (the so called "ethnic matching"), as determined by where the patient was born or by the referring agents perception of the clients' culture. This may be as vague as "Asian" (see also Spitzer 1989).

It was expected that patients offered the therapist of their choice (by sex or by ethnic origin) would be more successful in therapy (see Chapter 1).

Although request for a specific ethnicity of therapist was only recorded in a small percentage of cases, it should be remembered that Nafsiyat aims to give a cultural services accepting different cultural beliefs. The fact that this was considered a clinical issue in this setting is important; as is the fact that patients were most likely to be given a "ethnic minority" therapist anyway.

Only 3 patients were allocated their choice of ethnicity of therapist, two of whom would be considered to have "good" final GHQ scores. Of those ethnically matched

(with Caribbean or Asian therapist) by virtue of the fact that a therapist had spaces; had slightly poorer final GHQ, scores than those who were having "inter-cultural" work.

It is difficult to explain why "intracultural" seems to be less effective, although this may be an artefact of the data as numbers are small. Obviously the therapists are trained in intercultural work, and hence may be better at working with difference. From clinical experience, some patients when given a therapist who is similar in culture to themselves, expect the therapist to understand everything, and to have had similar experiences to themselves.

From this research it is very clear that culture is experienced in a uniquely individual way. Perhaps one of the difficulties in intracultural work is the fact that a Nigerian therapist may *look the same* as a Nigerian patient, but may have a completely different cultural background. Outwardly a good match, but not if they come from different tribal backgrounds, nor if one and not the other has migration experiences. The presumed similarity, and the expectations that go along, with this will be shown to be false during the therapy. Thus an overt match may not in effect be a match. Of course, for those who are not following a "traditional cultural" route through life, such intracultural matching may exacerbate the feelings that originally belonged to their difficulties within the family, they may feel the therapist may be judgemental and this again might influence outcome.

Both of these situations need careful *intercultural* handling by the therapist.

However, there is one situation where intracultural work seems to be of benefit. There are a comparatively higher proportion of South Asian patients who went on for therapy. Was it because the professionals that they first met at assessment - the Clinical Director (and for some, the Research Director) - were from India an influence in this process?

We can see from Table 5b that 14% of patients in the *referred* group were from S.Asia, whilst a higher proportion were in the *treatment* group (21.2%), a substantial increase of 7%. We could adjudge this to be evidence of some selection, although if we look at the same table (5b) we find that those from the Caribbean also showed a (lower) percentage increase of 3.4% (from 19.7% to 23.1%). In Table 5f we find an increase to 36.5% of patients with an ethnic identity of S. Asian. Obviously this includes those patients born in countries other than those in S.Asia, whose ethnic identity is S.Asian.

Here it seems that ethnic matching may have value for those who are similar to the assessor, in this case S.Asian, in terms of perhaps of language (although there are many different S.Asian languages and the Clinical Director spoke three) and cultural metaphor, or just feeling comfortable with someone from a perceived similar background. From clinical work it seems that it is only after the first few sessions of therapy that differences become apparent.

Can we argue that the effect of *intracultural therapy* is effective but only at an initial meeting? This is an interesting and important hypothesis for future work.

It also begs the question as to whether a white English therapist working with a white patient is therapeutically the optimal arrangement? The traditional research suggests similarity between patient and therapist as essential - could this be only at the assessment session?

In the research group, only two women had requested a female therapist, the one who was matched with a woman therapist showed improvement, but their was a significant improvement in the woman patient who was seen by a senior male therapist. A limitation of this result is for some patients (brought up in certain cultures), a female

therapist would be required in order to maintain their cultural rules; this would not be seen as a clinical matter.

Developing the notion that there are differences between intra- and inter- cultural work as well as between intra- and inter- gender work should be a priority, as this has important implications for clinical practice. Clinicians and researchers need to look at whether there are certain therapy or sociodemographic variables that predicate a better therapeutic experience or outcome in an inter- or intra- cultural/gender therapy. The further question is whether there are strategies that can be developed by therapists to diminish the negative effects of a intra-cultural therapy if inter- cultural is indicated and vice versa.

9.17 Racism

It is clear that this psychic reality is predicated on external (real life) problems of ethnic minorities in Britain today. These real life problems are experiences that are both currently occurring and have occurred in the past. It is possible to argue, in a similar way to the "theories" of sexual abuse, that experience of racism (of "racial abuse") has long lasting effects. This is because they are based on personal attack. Such attacks are mediated by skin tone, and are not based on any action or comment or anything that the person can control. The experience of racism leaves patients feeling very vulnerable and long lasting emotional effects.

It was anticipated that most of the patients would have had experience of racism and this would have to be addressed in therapy. Just one third of patients had no experience of racism which left a majority who had. When asked about current racial problems, 63.5% had current experience of racism. The two major types of racism experienced

involved (a) physical attacks on self or property which may or may not have involved injury and (b) "the usual" verbal taunts. It is worrying to report that one fifth of patients (10 people) reported previous physical attacks, whilst 3 patients had recent experience of such attacks, perhaps we can relate this to the identity (and coping) problems as well as the high level of symptoms presented by this group.

These results also point to the particular life experiences that are focused in the "outer" real world and their influence on the "inner" world (as in racial attacks).

Of course, there are therapeutic issues if their therapist is white (or from a culture previously linked with oppression - remembering some patients are escaping persecution). Transference is an important part of the process of dealing with such experiences. An integral part of intercultural therapy is the overt acknowledgement of the reality and the feelings of both participants of the therapeutic encounter. Here clearly the external world's effect on the internal psychic reality is clear, and should be acknowledged and dealt with in the "safe environment" of therapy.

Specific Cultural Issues In Intercultural Work[8]

9.17.1 Individual Culture

For this group an important issue is their own internal (psychological) culture. In this research it was difficult to unravel the culture within which patients live their lives. Many ethnic minorities are understood (by professionals) outside this context (e.g. migrants are often seen in the cultural context of their home country which may or may not be applicable, certain rituals are assumed for certain cultural groups which again

[8] These results refer exclusively to the *treatment* group.

may or may not be applicable). The levels of difference from that home culture are often not identified, nor are the levels of assimilation, integration or cultural pluralism or acculturation. Conversely, when they present with mental health problems, these are usually diagnosed outside the context of their culture, referenced to a white majority population, and outside the context within which they live their daily lives (e.g. the experience of prejudice). A suggestion for defining the psychological nature of culture and ethnic identity was put forward in the introduction to incorporate the various (cultural, racial and ethnic) inputs.

Although culture is important for patients it is equally important for therapists too (Freud's intercultural analyses cf. Kardiner 1977). An important (but sadly neglected) facet of training is to ask all participants (both white English and professionals from cultures) about their understanding of their "mother" culture. Participants on such courses begin to recognise the fluidity, and essentially individual understanding, of their respective cultures. Evidence suggests such training enhances knowledge about stereotypes and influences peoples future practice, it was clear that the training that Nafsiyat carried out with local professionals (G.Ps, social workers and psychiatrists) influenced the appropriateness of their referrals.

9.17.2 Traditional Culture?

The simple answer is that the majority of the patients did not fit comfortably into the accepted ethnic minority roles. From the literature (see chapter 1) the researcher expected that many of the migrant patients would keep close links with their country of origin (e.g. with family) and many would have a first language other than English and

maintain their cultural values and religion, including using traditional healers (only a small number had sought such help).

One of the presentations of the extended family is that the concept of different generations (grandparents, parents, siblings) living in one household, does not appear to have been confirmed in these results. What is more likely for this group is that there is, for some, an extended family network, but due to studying, work, etc. this is a geographically extended family.

The closeness of the links appears to be difficult to ascertain, especially since many of the migrants migrated many years ago Just under half of the patients (from both groups) were living alone, with a further 14 people living on their own with their children. In the majority of cases their families were living away. Patients maintain close links with their families but they are not physically living with them (the effect this has on the so called "protective" value of extended families is unknown). For others the break-up of the extended family may be the reason for seeking help.

Hence as patients do not appear to be living in traditional extended family groups (accepting that extended family frameworks are not universal for all ethnic minorities). It appears that the concept of extended family is one that needs to be clarified in future work,. This of course emphasises that ethnic minority groups are not the homogeneous groups that are often described in the therapeutic literature, but essentially individual people who have similarities and differences with people from a similar cultural background and similarities and differences from people from different backgrounds. However, it would be expected that the similarities would be greater in the former rather than the latter situation.

9.17.3 Traditional Patients?

The group of patients seen at Nafsiyat are similar in some ways to traditional psychotherapy patients (YAVIS criteria) but in others they are very different. Similar to many reports the patients tend to be young (the peak age for referral is 20-35 years, with a slight skew towards women in the under 20 age group and for men in the over 50 age group. The mean age of referral for men was 34 (treatment) 31 (referred) and for women it was 30 in both groups), with a fewer number being referred or referring themselves after the age of 40 years.

Similar to most therapy (community based) studies the ratio for the referred group was approximately 1.5:1, (the Salford and Camberwell registers note a ratio of approximately 1.5:1 see Bouras 1983, and Caccia and Watson (1987), but the ratio of those in treatment was 2.3:1 (women:men) This suggests that the commonly quoted figure of 3:1 or 4:1 is an overstated the ratio and may or may not applicable to community based psychotherapy/counselling services. It is of course very different to the first Sheffield Psychotherapy Project, which surprisingly, had more men than women (Shapiro and Firth 1987, Shapiro et al 1994) perhaps because of their stringent population requirements.

However Pollitt (1977) suggests that if depressive illness is considered solely, then it is twice as common in women than men, as we know from these results the major presenting problem is depression, and this may explain the different ratio.

Similar to other therapy patients (from the literature many patients in orthodox treatment tend to be graduates/students, perhaps because much psychotherapy research is carried out at universities with student patients) over a third had been educated post "A" level, either in the UK or in the country of origin (or elsewhere). However, there

were variable academic backgrounds with just under two-thirds having only school level qualifications or none.

Although academic achievement is not a test of intelligence (because patients without academic qualifications are not individually necessarily less intelligent, and may reflect the limited educational opportunities available to ethnic minorities), it is interesting to note that the skew in this data is for a minority of graduates/tertiary education students.

Just over half of the patients were in full time work. This often used as a measure of ability to pay. However most of those in "professional" occupations (7) were just post-graduation and would be unable to afford private therapy, and this is reflected in the figures that show that just over half of those in work had stayed in their longest job for two years or less. Only 12 had been in jobs for longer than 3 years. This may be partially explained by the age skew of the treated group, but it does not satisfactorily explain the results. Issues of discrimination in the work place need to be given greater prominence in work related research.

Just under a fifth of the patients were unemployed; however it is not clear whether these patients are more ill because of this, or whether they unemployed because they are ill. The direction of the link is unable to be teased out in this study although it may have been mediated by the decline in economic status on coming to Britain reported by 10 patients (19.2%).

Perhaps we can suggest that one or more of the following hypotheses may be in operation for those seeking help at the Centre:

a) Nafsiyat has a particular patient group, that is distanced from their culture and family perhaps evidenced by the fact that few migrants are recent migrants. Certainly the difficulties over assigning ethnicity described above would support this.

b) Nafsiyat is seeing a more *westernised, psychologically minded* group (certainly the results of the GHQ would support the latter understanding). Perhaps the fact that most of the therapy was carried out in English suggests that this is a new group, a different one from that seen in hospitals who need interpreters. However, in the last two years there has been increasing pressure on the Centre to provide therapy in more languages; this is particularly acute in terms of Turkish, Somali and some of the languages of Eastern Europe (the Centre currently has a Turkish speaking therapist).

c) This is the changing profile of ethnic minorities in Britain.

d) There is a ethnic minority "middle" class that has some of the same beliefs (and fulfil the YAVIS criteria) as the white group and hence request similar treatment (psychotherapy).

e) As psychotherapy is available in many different cultures now, we can talk of cultural psychotherapy i.e. therapy is not necessarily a *western* treatment exclusively. Therapy, in the global sense, is not referenced to the white cultural groups and standards (one could argue here that this is an ethnocentric statement), but there is increased use of therapy in home cultures. There are, of course, still class/caste (i.e. ability to pay) issues in the rationing of the service. One might also argue that as senior therapists (in Britain) tend to be white people; there may be less access for minorities due to some senior therapists' ingrained beliefs.

f) That the loss of the extended family/ support structures/culture (including religion language)/ or the compromises of living in Britain today, has caused illness. If this is the case it is interesting they have chosen a western treatment. This implies that there is an element of acculturation, this is further supported by the length of time the patients

in this study have been in Britain (although length of time does not necessarily reflect acculturation).

g) That being an ethnic minority in Britain today causes its own stresses; such stresses have psychological results.

All of the above merit further investigation in their own right.

9.18 Life Stresses

9.18.1 Migration Issues

Migration has psychological effects (see Chapter 1). Migration is not a unitary phenomenon, and is experienced individually by each individual. Such issues will have influences on the material presented in therapy and may affect the therapeutic relationship. It might be expected that patients who had migrated would be in poorer psychological health and would therefore make up a larger proportion of the population. This was borne out by the results.

However, the biggest single group was the British-born group, followed by the African and the Caribbean. This gives a interesting insight into the two major hypotheses on mental health and migration (the selection and the social causation models). As only two patients reported psychiatric illness in their country of origin, this group tends to refute the selection model. Perhaps the social causation is a believable explanation because of the real life problems that they experience. Further British-born black people seem to suffer the same degree of "racism" in their birth country as migrants; about two-thirds of the population reported that they had suffered harassment. This suggests that the alienation felt by the population born in Britain, the feeling of being "rootless" is a similar experience to that of migration.

It also lends credence to the notion that migration may have long term (generational) effects and the effects of the rootlessness are not only a function of racism, but also the historical legacy of the experience of migration(s) of the family. This research shows that age at migration, moving from a rural/small town location to city has effects (60% of this group had such experiences). Also how and why people migrate (as only 4 people in this study had actually been forced to emigrate it is difficult to ascertain the effect of forced emigration in this study) will affect the experience and the results.

Most research concentrates on the effects of migration in the short term, neglecting the long term impact on patients (cf. Bavington 1992). Future research should address the long term effects of migration on people to evaluate whether there is an initial (or perhaps delayed) "culture shock", whilst there is a potential for "adjustment disorder" in the long term.

This experience (adjustment disorder) will have effects. Many ethnic minority people wish to go back to their home country on retirement. It is assumed that this will be an easy process. However, it may not be. The feelings associated with original migration to Britain may be relived, which may be very traumatic. This is coupled with, the sometimes unrealistic, expectations of home make the process potentially painful. This can leave individuals in a cultural limbo - unsure of where they belong. There needs to be consideration on how this process can be managed appropriately. This needs to be considered as this will become more common because of the age skew of migrants.

Again this emphasises the limitations of our knowledge of the long term effects of migration, and need to understand it more fully, this research suggests further hypotheses. For example what is the effect of migration in the long term/ What is the effect of an administratively extended process for asylum seekers? Should the notion

of short term effects of migration be considered as part of a process which may be life long? Can we psychologically prepare people who wish to return to their home country for the process of going back and what should this entail?.

From a therapeutic point of view only two factors were significantly associated with migration: age and payment. Migrants more likely to pay (although this was a small number) and, given the pattern of migration, the British-born tended to be younger. However there were no associations between the UK born and migrants on other sociodemographic data, and perhaps most importantly whether they were taken on for therapy.

9.18.2 Separation and Loss

The effect of separation and loss in migration is key. Caribbean immigration has had a pattern of parents coming to Britain followed by children, the question is why did we not see any parents in therapy, only patients who as children (one third of the patients) had experienced this. Perhaps it is due to the more limited immigration opportunities now, and the fact those children are now adults.

It is interesting from a clinical viewpoint, that many adults seek help when their own children are at the same age that they were when they either experienced moving from one country to another, or when another traumatic event happened to them.

Of those on whom there was information, almost three-quarters emigrated by themselves (72%), with only 8 people emigrating as a family. A high proportion 35.3% came during their early adolescence (see Elliston 1985), with its reported effect on mental health, but a further fifth of the group came at less than 10 years old and a further fifth came during their late teens. Only just under a third had been separated from family for less than three months. 30% had been separated from their parents for more than three months during their early childhood (less than 10 years old) whilst 15.4% had been separated in their teens. 19% had been separated from their family during their childhood. This group have experienced a series of losses and separations during their lives, it would surprising if such major life events did not affect psychological health.

But such separations also mean that the child was usually left with another member of the family. What seems consistent from the reports of my patients is that this person often became "the mother" and there was not only the initial separation from the birth mother, but a subsequent one from the person who was bringing them up "at home[9]".

The making and breaking of bonds during the migration process perhaps explains the later relationship problems these people have, with only a tenth of the total being married, and only 5.8% of this group claiming a "good relationship" with their partner. Patients have poor and ambivalent relationships with their parents, they have difficulties in making close friendships and difficulties in closeness with partners.

But we also have to consider what role, such disrupted family life had for the child. Does it correlate with the fact that a quarter of the female patients report sexual abuse or

[9] "Home" is a very important identifier of the psychological culture of the patient as the patient will refer to "home" and it is important for the therapist to be clear where the person is referring to, particularly in the case of multiple migrations.

rape? It seems that, for some individuals, the family did not function in a protective way and did not offer them the expected support.

But it also has another effect. Migration (either internal or external) and the feelings associated with it (such as abandonment) may be acted out in the therapy.

What this research could not look at was the effect of separation from the home culture - the loss of culture, religion, language, customs, values, beliefs and friends on the individual; that is a question left open for future research, but from clinical work this seems, for some, almost as important as separation from significant members of the family.

What we do not know is whether the results for this group of patients is different to other people from the same cultural background. Do they have the same experiences of separation and loss? In other words has this group experienced more separations and losses and hence such experiences are implicated in mental and psychological problems. Information needs to be gathered so we can gauge how different the social experiences of our patients are compared to those who are not seeking help and are more psychologically robust.

These results presents the group as a rather complicated mixture of the "traditional" and the "western". But they do not easily fit into the "usual" therapy patients nor to traditional expectations of ethnic minorities, perhaps the most interesting finding is that psychotherapy worked effectively with the majority of this group. The fact that they had the similar experiences, which gave rise to similar presenting symptoms, is a consideration for future research.

Key Sociodemographic Issues in Research

To summarise the key sociodemographic issues which affect how and why people seek out intercultural therapy, and suggest categories for future research programmes:

The variables of origin and ethnic identity. Both of these terms, which may be interchangeable for some (e.g. "both my ethnicity and my origins are African, I was born in the Caribbean, my culture is Caribbean") or may reflect different aspects of "self" ("my origins are Greek, my country of birth is Britain, my culture is Greek-Cypriot[10], my ethnic identity is British Greek-Cypriot,"), affect view of self and appropriateness of therapy. Where people place themselves, their "self", is self selected and in fact is part of the internal "psychic" reality.

[10] Although how much the Greek-Cypriot culture is influenced by living in Britain will be an aspect to explore - i.e. how similar is "Greek Cypriot culture" in Cyprus, similar to "Greek-Cypriot culture" in Britain (or Greece).

Table 9c: Factors Influencing Ethnic Identity

Ethnicity is not only experienced externally but also internally. This study emphasised that *Ethnic Identity* is a psychological (rather han purely sociological) concept with a composite nature, which encompasses:

- Race
- The *geography* of where people are born anc where they grow up.
- The *geography* of where parents or grandparents were born
- Places where family has lived (if there have been internal or external migrations, age of migration may also play a part in definition of ethnicity),
- Language
- Religion
- Colour[11]
- Culture[12]
- Family Life

a) Family Experience. Rituals around birth, child rearing, achieving adulthood [remembering that *adolescence* may have limited applicability to non western people (but cf. Graham and Rutter (1985) and Rutter and Hersov (1985), although there is increasing evidence that migrants may adopt *adolescence* after living in cultures where the concept] and dying

b) Family constellations, other members of the family fulfil the same roles in different cultures (see Abel and Metraux 1974). The role of the father may be different (cf. Lacan's notion of the "name of the father").

Social factors such as age, occupation, class, education, gender, sex, and whether from an urban or rural background, may also influence this self representation.

[11] Here I am referring to the notion of different members of the same family being "darker" or "fairer" than each other, and the psychological effect of this (cf. Hawkes 1996).

[12] Culture plays a vital role in maintaining the family links with home country. It seems to the current author that on initial migration it operates in a way not dissimilar to the transitional phenomena described by Winnicott (1992). It is thus surprising that such psychoanalytical symbolism has not been investigated by psychoanalysts. This has implications for some patients there might be particular therapeutic help that would be more appropriate than others.

The fact that many minorities have experienced deprivation in housing, education, employment and health care and often overt and covert prejudice (or racism), also needs to be factored into the research.

Table 9d: Factors Identifying the Stresses of Migration

For the migrant[13] population as well as the above, there is:
a) The stress of dislocation and adjustment.
b) Change in cultural expectations
c) For some, change in language/religion.
d) For some, isolation and alienation.
e) The difference between the "expectations" of their new life and the "reality" of it.
f) Age on migration.
g) Length of time in the UK.
h) Rural/Urban changes.
i) Migration as family unit or not.
j) Whether culturally unique in the current place they are living.

[13] We must remember the complexity of migration, particularly the fact that the current migration may be part of a series of internal (rural to urban or vice versa) and external (to different countries) migrations.

Table 9e: Factors Identifying the Experiences of UK born

A British born group[14] may experience
a) a split between being born into a society and being made to feel apart from it.
b) The struggle to integrate their cultural origins and expectations with British society. Sometimes the protective value of extended families may turn into battles of great intensity (Rack 1982).
c) Integration of family language and English.
d) The different and sometimes conflicting cultural rules.
e) Living with the negative experiences (in some cases the depression) of the migrant generation (Robertson 1977).
f) For dual heritage patients there will be extra issues around the cultures of both their parents and the culture currently living in (cf. Tizard 1992).
g) Generational/historical effects of migration

Such factors would give an "impression" of the experiences of the ethnic minorities in Britain today.

Opler (1959) writes "...there is enough constancy in transmission of culture to speak of normative patterns in every cultural scene"; this view needs to be reassessed in the light of migration to understand which parts of the original culture are closely followed and which elements are discarded and why, are they similar for similar ethnic groups on migration, are they universal of migration and if so why.

9.18.3 The Research Group and New Migrants

The research group was not made up of many recent migrants (accepting that now immigration is more difficult). At the time of the research, the research population was

[14] This is dependent on the type of adjustment of the individual in comparison with the family.

skewed towards the longer term "older" migrants needing cultural understanding. Recently this has changed due to the changes in staff, and the many more languages available (see 1995 figures in Chapter 2). In the future the Centre may see more recent migrants; perhaps due to the arrival of different cultural groups, some of whom will come as refugees. Such patients may have difficulties with therapy in English; with the clinical work skewed towards more recent migrants and their particular psychological experiences and therapeutic needs.

This begs the question as to whether, at the time, new migrants were not approaching statutory/voluntary services (we know migrants and UK born patients hear of Nafsiyat from different sources), or are not being referred on?

It would be interesting to identify any differences between new migrants (in this country less than two years) and older migrants, to see if their symptom presentation was different or whether their experience of therapy or outcome was different.

9.19 Ego Strength

Most of the positive predictors for improvement were not descriptive of the Nafsiyat population; i.e. the qualities describing "high ego strength" did not adequately describe patients. The ability to form good relationships is usually one of the factors in high ego-strength. This group do not seem to show this.

Perhaps that there may be different predictors for ethnic minority patients, but it seems from Kernberg et al (1972) that for those with "low ego strength" (descriptive of this group) a combination of supportive work and psychoanalysis yields the best results.

This perhaps best describes the form of therapy at Nafsiyat; although such short term work contradicts the Strupp and Hadley (1979) argument that those with "low ego strength" need long term work (whilst their definition of "long term" needs to be clarified). This group also had a series of broken relationships through migration, and current difficulties with their relationships and other life experiences which we can assume leads to low ego strength. One would hypothesise that if these life experiences were worked through in a supportive way, learning about self and relationships via the therapeutic relationship and therapy, such results would be explicable. The fact that our patients, although with overt and debilitating symptoms - and symptoms consistent with serious mental illness - seem to "get better" with short term work implies that their illnesses are either more socially based, or psychologically more transitory than the current diagnostic schemas allow for.

9.20 Discussion of Sociodemographic Results

As the Centre served the local area, most of the patients lived locally. But it also got referrals from many different areas and this suggests that there is a need for a Centre with such cultural therapeutic experience, but also the need for training, so that appropriate therapy can be offered in other areas.

This is perhaps illustrated by the concatenation of the number of ways of being referred from the referred to the treatment group (suggesting that the training that was given by the Nafsiyat staff to local G.P.s, psychiatrists and social workers was effective, as these groups of referrers were more prominent in the treatment group).

Referral agencies are less accustomed to referring ethnic minority patients for psychotherapy, and the self-referred patients have always been an important referral group. Evidence seems to be accumulating that self-referred people in community based centres are equally as good or as bad referrals in terms of commitment to therapy. It is notable that the proportion of self-referrals was highest in the treatment group, hence perhaps suggesting that they were in some ways "better" referrals, more motivated and having accepted that they need help. Moreover, they were neither better or worse patients in terms of outcome.

9.21 Demographic Profile of Self-Referred Patients

Most self referrals occur in their twenties, whilst the for other referrals the majority occur in the twenties and thirties (three-quarters of all referrals occur in this range) with more than twice as many women referring themselves compared to men.

The results of this study highlight the fact that self-referrals tend to be women in their twenties, who neither present their symptoms differently nor get either better or worse outcomes than the "professionally" referred patients. This is an interesting finding which perhaps explains a profile found in the psychoanalytical literature; that of the majority of patients being young and women. As most psychotherapy is on the basis of self-referral, and this tends to be skewed towards younger people it might be expected that more women would be in psychotherapy, this may then be seen as an artefact of the population seen in psychotherapy and certainly merits further investigation.

For all referrals, "word of mouth" is important; just over a quarter of self referred patients in the referred group hearing about the Centre via a friend, with eleven of these patients hearing via an ex-Nafsiyat patient.

These results emphsise the need for the information available to patients to be clear and accessible, so that patients can make informed choices as to whether they wish to refer themselves for therapy.

They also show that patients who have been in therapy value that experience, to the extent that they will suggest to their friends that Nafsiyat is a place they could seek therapy.

9.21.1 Registered with G.P.

Although recent literature suggests that many ethnic minorities are not registered with a G.P. this was not borne out by the results of this study. Although the largest group of patients were self-referred, nearly all of them were registered with a G.P. What was most striking was the number of people who do not want their G.P. to know that they are attending the Centre. Worries are common in this area, perhaps in relation to the doctors' reaction to their mental ill health. One might hypothesise that the patient felt that if their doctor was told he or she might react differently to the patient, seeing the person in terms of stereotypical ideas of black mentally ill patients.

In order for therapy to be accessible to all, this response of patients to their GPs has to change, so that GPs are seen as part of the process of finding suitable help for psychological problems. One way forward is for doctors to be more proactive in emphasising the confidentiality of their service to patients from minority backgrounds. However, any future research should investigate the needs and wishes of patients from different backgrounds from the GP service.

Discussion - Presenting Symptoms[15]

9.22 Presenting Symptoms

For just under half of the patients this was their first experience of mental illness, of the remaining group the majority had been suffering from depression, with just over half (52%) having been treated previously, two thirds of whom had found the treatment unsuccessful . But contrary to expectations 24% had been offered psychotherapy before (all of which was considered unsuccessful to a greater or lesser extent; although they generally improved more in therapy at Nafsiyat than those who had not had therapy before) and a further two had had counselling.

Several authors have queried whether some diagnoses of psychoses in ethnic minorities are safe, suggesting that florid presentation is not necessarily predictive of psychosis (Littlewood and Lipsedge 1989) and also questioning whether some diagnoses should be changed to diagnoses of less severe illnesses (e.g. depression) (Littlewood and Lipsedge 1979). This research seems to suggest that the particular life experiences of ethnic minorities influences presentation of symptoms.

Caccia and Watson (1987) used the modified GHQ28 and similarly found high scoring with over 80% scoring above the cut off score and 47% in the "will not get better without treatment" score. Nafsiyat percentages were 87% and 77% respectively, suggesting that Nafsiyat was seeing proportionately more patients who would not get better without treatment.

[15] See Appendix 1 for copies of research forms

This relatively high scoring may also be explained by the commonly expressed finding that some ethnic minorities do not seek help until their need is great, For example in a study by Bouras et al (1983), twice as many West Indians came to the attention of mental health professionals in a walk-in clinic in Lewisham through the crisis intervention team than through the walk-in service, whilst for other ethnic minorities the ratio was slightly reversed (1:1.3 crisis team:walk in centre).

Interestingly although the initial GHQ scores were high there was change in scores after therapy and this therefore indicates that high scores on the initial GHQ is not a contraindication to therapy.

That there were higher initial GHQ scores in the treatment group than the non-treatment group (a proportion of the referred group completed an initial GHQ) implies that perhaps the GHQ scores can be seen, as Luborsky (1988) has suggested, as a way of asking for help as well as the recording the "pain" the patient feels. Perhaps the self-knowledge that their symptoms needed treatment also motivated the group to go into therapy - they couldn't ignore the symptoms judging by their answers on the GHQ.

Somewhat surprisingly a higher proportion of UK born patients scored above 20+ threshold on the initial GHQ than migrants. This again suggests that life for the UK born ethnic minorities creates difficulties. The commonality of experiences in the social environment must be a factor here as the range of origins were diverse and so biological/cultural explanations seem difficult to support.

Those with high somatic presentation tended to be taken on for therapy (primarily recognising this as way of expressing psychological problems). It can be argued that the number of patients scoring highly on the initial GHQ questionnaire could be thought of in terms of the hypothesis of 'hysterical overlay' (illness behaviour). But the

psychiatrist also rated them highly on psychiatric illness. So perhaps alternatively, the specific life issues of ethnic minorities may have influence on the degree and type of presenting symptoms.

This section of research needs to be replicated with a larger group of patients, so that the similarities and differences between the cultural groups can be identified. Moreover, more detailed information on the impact of issues relating to minority ethnic groups, such as identity, acculturation, enculturation, separation, loss as well as experiences of racism could be related to their psychological presentation.

9.23 Presenting Symptoms and Therapy Patients

Primarily, like traditional therapy patients, ethnic minority people present with depression, anxiety and problems with their relationships with others. Women seem primarily to present with psychological problems, men with external problems. From clinical reports, it does appear that in the initial stages of some of the patients' illness, an identity crisis precipitated a reaction which resulted in the type of symptoms being presented.

Obviously for some patients the initial assessment session was an important time to discuss identity issues (12 patients presented with this as a problem at the assessment session), whilst others presented with family or relationship problems. The number of patients who reported coping problems is consistent with other studies, as often the inability to cope is the motivation to seek help.

Identity crises were twofold. The most common was the cultural identity problem, where a patient feels unable to know what culture they belong to; this was

understandably presented more often by dual heritage ("mixed race") patients. The second precipitating factor was one where sexual identity was the focus of the problem. Moreover it was noted that identity problems were presented slightly more often by men, and may reflect the different cultural roles expected of them.

The notion of identity is one that merits large scale research in its own right. The difficulties presented by the patients in this study in finding their identity is mirrored in people from different cultural backgrounds outside the therapy situation, As described earlier we need to identify key components of "identity" how they impact on the individual. The models suggested in the introduction (1.2.2) could be used to faciltate the research process by providing a baseline "measure", but more information is required to dissect the process further, so that therapy most effectively addresses these issues that are of fundamental importance to our patients.

9.24 Spontaneous Remission

One of the potential arguments was that the centre was seeing the worried well (Eysenck's hypothesis that there is a spontaneous remission over a two year period). Although, the GHQ and P.S.E. show high rate of symptoms - in the case of the GHQ at a level of the chances of recovery from the illness without psychological help being low (Goldberg 1978, Goldberg and Williams 1988) this does not fully address the problem of spontaneous remission.

Although there is no clear evidence as to whether spontaneous remission is actually "spontaneous" i.e. without external help, the evidence in this study was that many people had been aware of their symptoms for between 1 year and 5 years. This suggests

that if Eysenck's hypothesis is correct, for this group of patients only a small proportion would then be expected to get better spontaneously.

However, the work on spontaneous remission has largely been restricted to "neurotic" illness, and the population included in the treatment group could not be easily identified within this framework. Although[16] the vast majority of patients (46 out of the 52) had special features of depression and other symptoms of depression, and 42 patients had simple depression which would qualify them within the major category N+ of the Catego. It is fair to state that there have been criticisms of the P.S.E. and the Catego programme in terms of its categorisation of affective disorders. Authorities such as Winnokur (1979), Pollitt (1965) and Paykel (1971,1979) would describe these symptoms (in fact even more so when they occur in combination) as indicative of severe forms of depressive illness. Furthermore, they would suggest that such types of depressive illness do not show early, spontaneous remission.

Outcome[17]

9.25 Standardised Measures

All standardised measures showed a considerable decrease in symptoms on completion of therapy. On the GHQ there was a change from 40 patients in the severe symptoms group (20+) to 38 in the low (or no) symptom group. The PSC equally showed a decrease in symptoms with 29 patients in the good group by the end of therapy (0-10 rating). These results taken together show the efficacy of the treatment.

[16] The PSE data was analysed by Dr Acharyya.
[17] See Appendix 1 for copies of the forms, and Appendix 2 for PSE results and Appendix 3 for patients' views on therapy,

On the P.S.E.: there were three cases where the scores had gone to "no symptoms" from having had all three of the depressive syndromes. In all other cases (bar three) there was a marked reduction in the number of syndromes rated including all cases of psychotic ones. Only one had possible non-specific psychosis both initially and finally; all other cases with initial psychotic syndrome did not rate on any psychotic syndrome on the final P.S.E.

The final GHQ related to most of the other scales and hence was used as the main "outcome measure". Each scale was measuring a different aspect: the GHQ was measuring symptomatology; the P.S.E - psychiatric symptoms; the psychiatric symptom checklist - individual therapeutic/psychological variables and therapists' evaluation of outcome (on RF6) - overall therapeutic issues. Although the initial GHQ was not scored before the end of therapy, it was available in the file. The therapists used the psychiatric symptom checklist as a pointer to therapy, it is interesting to note that the number of sessions they gave was associated with the initial GHQ score.

It also argues that, as there was close correlations between the different objective measures, with the final GHQ being related to most of the outcome measures, the number of measures could have been reduced to just the GHQ. In this study the therapists were shown to be measuring different issues in their assessment, and hence to get a balanced picture both the therapist reports and those of the GHQ would need to be reported.

9.26 Considerations about Standardised Measures

9.26.1 Chronicity

It could be argued that problems the patients present with have not changed, and thus are scored as "same as usual" on the final GHQ (Goodchild and Duncan-Jones 1985): however this argument may be opposed by the overall consistency of the final GHQ scores with other outcome measures in this study.

9.26.2 Endusers

It could also be argued that the patients were using the ends of the scale, i.e. just responding to the "less than usual" or "more than usual" ends of the scale. This did not happen in this study. The results show that people were responding to the questions not the position of the answer. Again the overall consistency of reports also argues against this hypothesis.

9.26.3 Language and GHQ

Although there was some variability in fluency in English, all but one patient were able to complete the GHQ in English. The fact that only one of the research patients had difficulties in completing a complicated form raises questions as to how typical the group was in terms of representing "typical" Nafsiyat patients - and did this indicate that Nafsiyat was available to all sectors of ethnic minority communities?

At the time the majority of Nafsiyat patients had their therapy carried out in English, but a proportion were referred to the Centre with particular language requirements. Similarly at that time, the Centre had therapists who spoke many of the major South

Asian languages, therefore it might have been anticipated that there would be a higher proportion of patients in therapy compared to other ethnic groups; there were.

There is a query as to whether there might potentially be many Asian women wanting to be seen for therapy who do not speak English and who do not approach the Centre. This issue has been recently taken up by the Tavistock Clinic, they have set up an outreach centre for Bengali families. Further research into this and other ethnic minority's language needs is urgent.

9.26.4 Continuation of a Patient After Assessment

This is obviously an important area as it not only covers those who are offered therapy but those who also pursue therapy. It is interesting as the data suggests that certain questions on the GHQ differentiate between those who seek therapy and those who do not continue after assessment. It seems that those with more acute symptoms seem to have continued (e.g. those who reported feeling ill etc.). Which fits in with the earlier results which suggested that those with higher scores were more likely to go into therapy.

From Nafsiyat's point of view it would seem appropriate to carry out a more detailed investigation of why this should be, and whether this can be seen as a clinical matter to be addressed. It might also address the idea of the *early terminators* - perhaps they felt "better" and this influenced their decision to leave therapy.

9.26.5 Standardised Measures Overview

It was anticipated that the measures used would not be totally "culture free", but that the results obtained from the standardised test would be would be consistent with other studies using the same research tools (see chapter 1). As there was equally high

reporting on the P.S.E., it does not appear that a new "cut off" score is necessary in this study, but that may be appropriate if the GHQ is to be used as a clinical instrument.

As other authors have noted, the level of presenting symptomatology is high; it was hypothesised that the standardised measures would adequately identify the level of distress of patients, and certainly they all measured high levels of distress, despite emphasising different aspects. There were differences in scores between the first and final GHQ results and that final GHQ was associated with other measures.

Both the GHQ and the P.S.E. showed high levels of reporting and this can be explained in one of six ways

- They represent true level of illness, recognised as psychological by patient.
- The patient overestimates their symptoms in order to get therapy.
- There is a higher threshold for ethnic minorities
- There is a lack of understanding of the questions by the patient.
- High level of symptoms are recorded for relatively low mental ill-health, the symptoms reported reflecting different levels of reporting in different groups.
- A way of asking for help

The first explanation is appealing because all other measures show high levels of reporting (all patients were seen by a psychiatrist). If current thinking on the exacerbation of ill health due to a psychological response to prejudice is then added to the equation, then perhaps it might be hypothesised that "recovery" is swifter with some of these patients, and hence the comparatively large reduction in symptomatology after relatively short interventions..

The research argues that each of the questionnaires was measuring different aspects of the problems presented by the patient. Statistically the most consistent measure was the final GHQ, which showed similar trends to the other outcome measures. This is interesting not only because the GHQ looks at symptoms but also life experiences, and hence suggests that studies that just use symptomatic improvement as a measure will miss some of the improvements (or otherwise) in other areas. It implies that the final results are comparable and therefore all were measuring low levels of symptoms at the end of therapy (i.e the success of therapy). This supports Howard's (1995) tripartite model that there is a sequential improvement in functioning.

Discussion - In -House Measures[18]

9.27 Differences in Diagnosis

The fact that there were changes in emphasis between the professionals' diagnoses between referrers and Nafsiyat, and also between those of the "professionals" and the patient raises many questions. The differences seem to be due to the changes of emphasis with the Clinical Director, a therapist, at the assessment interview looking at the cause and effect of the problem as well as its symptom, the referrer, when referring to Nafsiyat, emphasising the symptomatic profile. Of the professional diagnosis, it seems that the Nafsiyat diagnosis at assessment was most reliable, as it was closely more associated with other measures, particularly that of the patient.

[18] See Appendix 1

9.28 Differential Expectations

Feifel and Eells (1963) draw our attention to the different emphases in description of outcome between patients and therapists. These results seems to have been confirmed by this study with the patients reporting generally lower levels of symptomatology on the "psychiatric" measures (P.S.E., GHQ and the Psychiatric Symptom Checklist), whilst the therapists appear very conservative in their global outcome score, but willing to acknowledge achievement of goals.

9.29 Therapist Rating of Outcome

Therapist outcome indicated that 55.8% had a good outcome; a further 21.2% had a fair outcome; on the final GHQ scores, 73% people had scores of less <12, a further 10% had scores between 12-19 and only 17% had scores of 20 or above. This emphasises that therapists are quite conservative in their assessment of patient improvement, and perhaps emphasises that the therapists' assessments do not overestimate improvement as has been suggested by some authors, and that they can be used as a reliable (if conservative) therapeutic indicator.

It should be remembered that therapists see their patients (usually) weekly for the duration of their therapy, and hence know their patients very well. One of the reasons that may account for the lower "good outcome" figures from the therapists is their composite understanding of the patient. They may feel that although the presenting symptoms have gone away, a vulnerability to future psychological problems still exists. This potential vulnerability will be factored into their assessment of outcome.

9.30 Patients' Description of Outcome

From a patient's view of therapy, 90% of those that replied (30 patients), recorded a good outcome. This study is unusual in that it tried to measure outcome, based on the patient's experience. Most previous studies have relied on the therapists' view of outcome and this has lead to difficulties in interpretation of results.

The measure used to record the patients' view of therapy was a short simple measure, which although it lacked some sophistication in terms of recording precisely the

difficulties and strengths of therapy, did have a simple measure of "success". It might also be argued that most people who had committed to their sessions and completed them would be "happy" with their therapy. The argument then returns to how many of those that remained in therapy after the initial assessment but who did not complete the forms, were "happy" with their therapy. It is possible to suggest that, as 38 people had GHQ scores of less than 12 at the end of therapy, a significant proportion of these 38 should have been happy with their outcome.

Therapy Variables

9.31 Length of Treatment

Although the retrospective study had suggested a good "short-term" period was 12 weeks The findings from the study suggest that for some short term work is effective and all that is requested or required. It became increasingly clear that, for some with high levels of morbidity, this could not be the only option. For example a twelve session contract for a patient addicted to lorazepam for five years did not seem

appropriate, nor did it seem appropriate to envisage it for a patient who has been "hearing voices" .

It must also be recognised that the Centre was providing a unique service; where else could professionals refer patients for whom cultural sensitivity and psychotherapy were required? The fact that some patients presented with symptoms which could be treated by long term psychotherapy, but which required cultural understanding to make sense of the symptoms, left Nafsiyat therapists in a dilemma of whether they could offer effective treatment.

Overall, the results seem to refute Clemental-Jones et al (1990), in that for a significant number only short term work is offered (although it is recognised some patients do need and receive long term help). However, it seems that all therapy has a natural history and hence needs have to be identified and work has to be flexible enough to cope with this.

As the more severe problems would require longer work, it was anticipated that there would be a correlation between presenting problem and the length of therapy, which seems to be borne out by the finding that the number of sessions was associated with initial GHQ (the higher this was, the higher the number of sessions). When confronted with a highly distressed person, it would be expected that a therapist would offer such patients longer therapy. The number of sessions was also related to the final psychiatric symptom checklist (lower scores for greater number of sessions), outcome as described by achievement of goals by the therapist (rated by the researcher) was better for greater number of sessions, and there were bigger changes between first and final psychiatric symptom checklist scores.

Howard et al (1986) also note that psychotherapy can be considered in terms of a "dose" model, where the more therapy you have the better you will be (in their terms

53% of patients improve after eight sessons, 74% after 26 sessions and 83% after 52 sessions). The Nafsiyat work tends tc suggest, that although medium, short term, weekly therapy is optimum, other frequeicies do only marginally worse.

Future research needs to look at differiig lengths of therapy, identifying the different pathologies and aetiologies which need greater of lesser therapeutic intervention. It can be argued that, for this patient groip, short term work is indicated. For example the isolation and loneliness of migration,the alienation from the new society or the after effects of a racist attack. However many patients present with complex life histories; many separations, some of whom have been sexually or physically abused and hence longer term work is necessary.

9.32 Choice of Therapist

Trained therapists have generally had long training analysis or therapy. The variables associated with trained therapists were: the type of presenting problems; difference in G.H.Q scores; being more likely to be given patients who had been in therapy before; who had poor relationship with partners. a better final psychiatric symptom checklist score; and being more likely to see patients with addictions, educational problems or significant bereavement. This suggests that trained therapists saw more ill patients. However, they did not necessarily offer patients long term therapy nor were the number and frequency of sessions related to their own training background.

9.33 Sociodemographic Influences on Outcome

9.33.1 Culture and Outcome

The culturally different backgrounds of the patients did not seem to interfere with the effectiveness of the therapy. Although there were differences between the migrants and the UK born, almost all patients gained some benefit from the treatment. That there was a difference between migrants and UK born patients was an interesting finding as the results suggested that very few of the migrants had come to the UK recently, and hence the initial suggestion that migrants who came to this country many years ago would be similar to those born in this country appears to be contradicted. Further studies with the different groups need to be carried out to identify these issues.

9.33.2 Outcome and Age/Sex/Payment

Age was not related to initial/final GHQ score, therapist outcome nor number or frequency of sessions. Sex was associated with therapist's description of outcome (fewer men are perceived as having good outcomes) and the ability to form new relationships (women being perceived to be more able to form new relationships at the end of therapy)

A small minority paid for their therapy, and the results showed a high level of symptom reduction across several different measures for most patients. There is, therefore, no evidence to suggest that they had a better or worse outcome than those who did pay. This suggests that payment is not a therapeutic issue, but merely a social one.

It might be expected that patients who finish their therapy contract have a better outcome. By definition those in the treatment group completed therapy; nothing can be said about those patients from the referred group who failed to complete therapy. However, those in the treatment group that did not complete their contracts (in terms of staying for twelve sessions), but who together with their therapist decided that they wished to finish therapy had a slightly worse outcome than those who completed their therapy contract.

9.34 The Study Findings

From the results presented here, it can be concluded that the study has provided some clear findings and hypotheses for future work:

(a) People from ethnic and cultural minorities (both migrant and UK born) request therapy, need it, use it and benefit from it

(b) The final GHQ score was closely associated with most of the other checklist/outcome measures.

(c) It appears from the results that, although there were differences in the discriminatory questions, the GHQ was picking up cases. The high level of reporting on the initial GHQ may indicate "asking for help" as opposed to clinical morbidity. It also suggests that the communication, conceptualisation, and the translation of manifest psychological symptoms from a western European baseline is possible, although the latent meaning and hence treatment may be different. Other results also suggest some patients may be suffering from psychotic symptoms. Whether these are of a brief acute psychotic nature or are part of the constellation of symptoms around depression would need future investigation. Equally, whether the high level of reporting by the migrant group may be equated with the "hysterical overlay" described by Rwegellera, and this seems a fruitful area for further research.

(d) The research tends to refute the selection and higher morbidity models of causation of mental illness, as the majority of migrants in this study had been in the UK for many years, and had not had illness in their country of origin. It seems to support the

social causation model and (due to the high levels of racial harassment reported) may be linked to overt prejudice.

(e) The length of time that patients had lived in the UK suggests that culture shock as currently defined did not apply to them. It may be that apart from the initial "culture shock" there may be long term effects ("adjustment disorder"). From clinical work these effects re-emerge around culturally significant times (puberty, marriage, childbirth, retirement and death), when the difficulties of migration, settling etc. become important. This, of course, does not concur with the current definition of either adjustment disorder in the D.S.M. IV or culture shock in the I.C.D.9

(f) Many patients show Elliston's vulnerability factors, they came to Britain in early to mid teens, came from rural backgrounds, and did not come with their family.

(g) This study suggests that ethnic minorities do present with depression, as many of the patients presented with P.S.E. symptoms of depression and anxiety. As described in the introduction most "transcultural" work has been carried out on psychotic illnesses, and it is thought that some of the misdiagnosis may be an overdiagnosis of the psychotic illnesses and an underdiagnosis of depression.

(h) It is difficult to measure acculturation with the migrant population, but one would suspect that it would be the "most westernised" who would approach the Centre, again leaving the query that perhaps there is a "hidden morbidity" in ethnic minority communities, some ethnic minority people will only be seen when the illness is acute and unable to be contained in the family. Perhaps the increasing number of professionals with relevant language skills will encourage such patients to seek help early. Moreover, following the numerous television programmes on misdiagnosis, overrepresentation of black patients in mental hospitals, has lead ethnic minorities to

being wary of "the System" As Nafsiyat is not associated with hospitals it is perhaps seen as "safe".

(i) There seems little support for the concept of pseudorejectors (Brandt 1964) in this group, as the Centre is unique it would have been difficult for patients to find alternative help, although the time waiting for therapy may have deterred some (waiting time is a negative predictor of outcome).

(j) Similar to Craissati's findings in South India, many of the patients presented with culturally appropriate issues, such as those around arranged marriages.

(k) As Nafsiyat offers free (or low cost) therapy and produces good outcome. The role of payment, which is usually related to commitment to therapy, has to be re-evaluated[19].

(l) Therapy is short term, this needs to be evaluated against therapy which is open-ended, and/or long term and/or more than once a week. Questions which need to be focused on include: is long term (whatever this means see Chapter 1) intrinsically "better" than short term work? Is it better for some patients with some presenting symptoms? Also what is the influence of setting a limit on therapy (Freud (1909) found it useful and productive in his work with the "Rat man").

(m) In intercultural therapy, the ethnicity issues will arise, with different "weightings" in different contexts with different patients (particularly in the transference). Therapists need to understand the concept of ethnicity as an important part of the concept of self, researchers need to be more complex in their thinking.

[19] Some Nafsiyat patients are economically poor and will walk to sessions; it is not unheard of for the therapists to give money for the bus fare home.

(n) Language: although in this study all patients spoke English, some of them had to learn English on arrival in Britain and hence had initially experienced difficulties with employment as well as locating health care (including therapy) in their own language. The Centre relied on the linguistic skillsof the current staff; languages were offered which changed with change of staff. This had certain ramifications. The first was that if language was offered that was a "scarce resource" then many professionals referred patients whether or not they were suitable for psychotherapy as this enabled some "treatment" to be offered to that patient.

Secondly, if a language was offered that the patient spoke, then that patient was automatically referred, even though for some patients the language offered was associated with previous oppression (examples of this include a Turkish therapist working with Kurdish patients), this obviously has implications for therapy.

Thirdly some languages have never beer able to be offered, because no suitably qualified therapists from this linguistic group had applied to join the team. This is a problem particularly for the new immigrants from Eastern Europe and some of the African countries. The cost of therapy training in terms of finances and time is prohibitive.

Moreover, it is not unusual for bilingual patients to bring a dual sense of self. Greenson (1949) notes that language is closely related to culture, he reports that the mother tongue is the bearer of unresolved conflicts and the new language offers the opportunity of a new self portrait, old and new images coexist. The same arguments can, I believe, describe the whole process of migration (whether or not a new language is learnt).

(o) Therapists need to identify the issues in such an encounter and understand the transferences, it could be argued that the notion of the therapist speaking the language of a previous oppression could be applied to white therapists working with black patients (who have experienced racism from white people).

9.35 Conclusions

The notion that psychotherapy is only helpful for western European patients, patients from other parts of the world not being helped by it, appears to be refuted. Contrary to orthodox psychotherapy arguments and reports (see Campling 1989), intercultural psychotherapy improved levels of symptoms in a group of people from diverse ethnic and cultural backgrounds (including those who were British-born). This group (unlike other "usual" psychotherapy patients) present with high levels of symptoms and a long history of them, many of whom were living and brought up in non-nuclear families (either extended families or single parent families). They are not affluent (as measured by current jobs, housing and the inability to pay for therapy), and have poor relationships and many losses and separations, due to migrations and extended family frameworks.

That such a heterogeneous population showed improvement in their well being, suggests that the old "YAVIS" preferences should be abandoned (at least with this population) and replaced with a more careful differentiation of positive predictor variables (symptomatic, life experience, social situation etc.). It also suggests that notions of "cure" have perhaps to be predicated on more than one measure.

It should be remembered that this research, although based on a "real" clinical population in a "real" therapy situation, has provided only a first step to understanding the practice of psychotherapy with ethnic minority. It has provided many interesting observations on the population studied, however in order to dissect the process further, replication of the results in different settings should be carried out.

What the research has demonstrated very clearly is that some of the ideas that therapists have about suitability for therapy in terms of ethnicity, psychological symptoms and life situation will now have to be replaced with clearly researched information about suitability. It is no longer appropriate to discriminate on certain global characteristics, as clearly a much more sophisticated analysis is required.

Patients from ethnic minority backgrounds have been shown to do well in therapy at Nafsiyat and this should require of therapists to review their prejudices about taking on such patients for therapy.

Chapter 10

Theoretical Implications for Research and Practice

In this chapter, on the basis of this research, some of the factors found to contribute to the success of cross cultural therapeutic and research work will be discussed, together with some of the issues that were considered during the research process.

10.1 Research and Psychotherapy

The aim of this research was to evaluate the clinical effectiveness of intercultural therapy. Research into psychotherapy has always been controversial. On the one hand, the research provided by therapists (case history reporting) is condemned by researchers as not being scientific, and research by researchers is condemned by therapists as not reflecting their clinical practice (see Wallerstein 1999).

This split has an historical basis. Therapists tend to view psychotherapy as being proven (cf. Freud's response about psychoanalysis to Saul Rosenzweig *the abundance of reliable observations on which the propositions rest makes them independent of experimental verification* quoted in Talley et al 1994). What they consider important is modifying their technique to be optimally helpful, hence their interest in case histories.

Researchers are still debating the basic premise of the effectiveness of psychotherapy and what this is predicated on (therapist, patient or therapy variables). This, of course,

becomes more an issue (over and above the ethical one of providing appropriate treatment) when health insurance companies fund such treatment. Such companies want hard data on the effectiveness of therapy. They want to know the proportion of people who get "better".

10.1.1 The Therapist as Researcher

Historically, case history and process reporting has provided the basis of research into psychotherapy and analysis. Other approaches to research in therapy have been considered by therapists as, at best, irrelevant; and at worst intrusive and damaging to the therapeutic process. They argue that data collection effectively alters the practice and produces results which bear little relationship to the practice.

However, similar concerns could be put forward about case history reporting. What is seemingly ignored by therapists is, that when writing up a case history report to illustrate a theoretical point, not only are the *relevant* illustrative material of a session or sessions selected, and thus by definition other aspects of the encounter are ignored[1] (which may have validity implications); but also that if the therapy is on-going then the effect of writing up a case history may influence the outcome of therapy, "intruding" on the therapeutic process[2]. The choice of material may influence the selection of material for interpretation, concentrating on some aspects and de-emphasising others - i.e. not the free floating attention advocated by Freud.

[1] Freud is often accused of being selective in his choice of material for his case histories and his reporting of the success of analysis (see Webster 1996)
[2] This selection may also contain an element of countertransference.

Perhaps their arguments could be also voiced in relation to case history reporting?

This emphasis has provided anecdotal evidence of success, but has not answered the two major questions: does it work and how does it work?

10.1.2 Researchers and Therapy

Researchers have tried to carry out structured research, those with scientific validity, but have found difficulties. Studies of effectiveness of therapy have tended to select either patient groups, (e.g. students, professionals) or particular sociodemographic groups (e.g. those fulfilling the YAVIS criteria) or focused on particular problems (again usually those known to be effectively treated with psychotherapy e.g. the neuroses) (see Garfield and Bergin 1986), so that variables are kept to a minimum.

There are problems in this approach. For example, presenting symptoms and their different aetiologies. A person may present with depression, this may be due to one of any number of reasons, or it may be perceived by the professional as something endogenous that has no external trigger. Thus comparing treatments of depression may produce contradictory results.

Studies on the variables in the therapeutic "encounter" have encountered technical difficulties. For example, defining the basic baseline techniques of any given therapy, matching subjects on sociodemographic variables, matching for the length of therapy, type of symptoms, experience of therapists, and also how success is defined etc (particularly as this study demonstrates the diverse nature of the patients seen for intercultural therapy, and the diverse origins of the therapists themselves). To reduce

the possible variables, some studies have focused on one aspect of therapy. Solutions have included manualised therapy designs and student volunteers, some of whom were paid or got credits for their studies by participating.

It is increasingly obvious that therapy is a complex interaction, so that deconstruction to its constituent elements is difficult which does not make experimental evaluation straightforward.

Therapy is predicated on a number of factors relating to the style of therapy, the attributes and life experiences of the therapist and the attributes and life experiences of the patient and how they relate to each other in therapy. Since every therapeutic interaction is unique it is difficult to set experimental conditions, such as matched controls (particularly in intercultural work where identity, culture, race and ethnic identity may cause difficulties and changes during the therapy as in this study).

Technique may vary with different patients with the "same" presenting issues for various reasons, and such flexibility is an important function of the therapeutic process, one that allows maximal use of technique. But such fluidity is contrary to the experimental method as conventionally understood.

The research reported here suggests that the researcher needs to have several years of therapeutic experience, as this enhances the relationship between the external research and the therapy. Therapists can see that their needs and concerns are understood. It also allows for a different therapeutic understanding of the results of standardised psychological tests, in what is, an unusual setting for the use of such tests.

This research also emphasizes that researching real therapy must be the goal, as the least arguable of all the criticisms that have been levelled by therapists at research, is that research tends not to use real therapy, real therapists or real patients. Do the results of such studies, at this stage of knowledge, help us to understand therapeutic practice. Some would argue that they do, e.g. Tuckwell (1999). My own view is that the use of "standardised clients" helps to tease out therapists' "blind spots" e.g. their unconscious reaction to racial identity (as in the Tuckwell research cited above), but they do not help us to understand how this aspect can be hidden in real patients and therapists in real therapy. Perhaps there is a need to return to the ideals of meta-analysis and combine of the results of many "real life" therapy studies.

10.2 Research and Intercultural Therapy

Research in this area, and understanding of its complexities by therapists and researchers, is vital, and currently misunderstood (See Beutler et al 1996, Aldiverez et al 1996). Hence, the greatest challenge for therapists, administrators and researchers is to provide relevant research, which should reflect the experiences of real patients in real therapy.

The difficulties of retaining ethnic minorities in psychotherapy research should be an urgent concern and this needs to be addressed by all researchers. This study had significantly less people "dropping out" of therapy and this suggests that ethnic minority patients are not necessarily poor therapy or research "subjects". Perhaps the fact the research was carried out at a Centre, which acknowledged cultural issues helped to reduce the drop-out. This suggests an increase in ethnic minority researchers would

also help this process (Hohmann and Parron 1996), as would an increase in the number of ethnic minority therapists.

So what are the areas to consider from this research? Five areas from this research seem pertinent.

- How to collect relevant sociodemographic details, to provide categories that correctly represent the identity of ethnic minorities in Britain today?
- How to understand the high level of presenting symptoms: are they equivalent to the white British population or do they represent something else? For example racism might be one area which might be expected to have an impact on mental health.
- Should we think of different thresholds for the standardised measures: do we need new measures to reflect a minority group? Certainly it would be useful on the GHQ to have details of why people felt "unable to cope".
- Why do migrants seem to present differently to the UK born? It would be expected that, as there was such a range of cultural backgrounds of the migrant group, that such a consistency would not be found. Researchers have suggested that eventually the symptom presentation may conform to the UK born group. Can we think in terms of common experiences of this group - of "culture shock" and "adjustment disorder" (remembering that most of this migrant group came to Britain many years ago)?
- Why do the British born approach the Centre? We need to define their reasons. Are we seeing a new *westernised, psychologically minded* group? If we understand this, then adequate service provision can be given to all patients in all areas of psychological help.

10.3 Summary of Limitations to the Current Study

This study looked at real therapy and therefore there are several limitations to the study.

- It is a small sample. Although large by psychotherapy research standards, it is tiny in comparison to most research.
- There was some dropout and this may have influenced the results.
- Because of the sample size, all statistical results should be regarded as suggestive of success, but not conclusive proof.
- The researcher was white and female, and this may have had an effect on answers at the research interview.
- It is biased towards those who were taken on into therapy, who stayed in therapy and agreed to be part of the research. It can make no judgments as to whether this research group is significantly different from those normally seen in therapy.
- It only looked at short term work. In psychotherapeutic terms - very short term. Many studies have shown that long term work can have more benefits: we did not investigate this in this research.
- There were no control groups either by demographic variables or alternative therapy options. There are individual responses to therapy which contraindicate using matched control groups. My discussion on the problems of matching ethnicity (both origin and

identity) also effectively preclude such a strategy and by implication, call into doubt the use of such matched controls.

- As "ethnic matching" is (and was) considered a clinical matter, the research only investigated intercultural work, and only provided evidence on intracultural work coincidentally. The research did suggest that intracultural work did not seem so effective (apart from at assessment); however this was not rigorously tested. A different therapeutic population (and different therapists) may have produced more positive results.

- There were significant problems in the assigning of ethnicity, race and culture, from patients own descriptions. This lead to difficulties in assigning patients to different ethnic groups. Although this provided interesting points for discussion and points for future research, it did cause some difficulties in assigning to groups and hence some interpretation was inevitable.

- The research assumes the threshold scores suggested by Goldberg for the GHQ are predictive of the groups he assigned them. Likewise for the P.S.E., it is assumed that the cluster of symptoms are descriptive of the syndromes assigned to them. There may be different thresholds and symptom clusters for different ethnic groups. The sample sizes of the different ethnic groups precluded further investigation.

- It only looked at "before therapy scores" and "after therapy scores" and treated the therapy as a black box. Therefore it did not look at the process of therapy and that might have explained some of the anomalies.

- There was no provision for a post-therapy research interviews to gain insight into the patients view of therapy, and this might have provided more information on those patients who did not return their post-therapy "feedback" forms.

- There was no 2 year or 5 year follow up to see if the gains made by the patients continued.

- As the research was based at a psychotherapy centre it was not considered appropriate to offer alternative therapies to compare outcome. The research did not use different forms of psychotherapy (e.g. Gestalt, Integrative or existential psychotherapy), manualised therapy designs, nor make physical changes to the therapy e.g. by restricting the number of sessions.

These limitations do not invalidate this first attempt at intercultural therapy research, but they should help to develop this area of research, so that future work can properly investigate the issue raised.

10.4 Psychotherapy: The Clinical Practice

Freud himself was personally very well aware of cultural issues, and clearly used a different technique in psychoanalysis with his European training analysts and his American ones (see Kardiner 1977). But currently psychotherapy seems encapsulated within a *western* framework. This seems to be a reflection of the "usual" therapists (white and middle class) and their acculturation to their culture which in Britain, is enmeshed in a Western European/North American worldview.

The clinical practice of psychoanalysis in a cultural perspective is in its infancy. Therapy does not exist in a cultural vacuum, and Freud placed his "psychology" in a social-cultural context (Freud, 1913,1939) drives (instinctual trends) are *modified by individual experience* (Horney 1939). Whether this is in fact instinctual or based on other factors may be controversial, what is not in dispute is the fact that individuals modify, select and adapt it in different ways. Culture is often one of the predicators of this. The controls imposed by a given society (either socially and culturally) impacts on the individual and this can have psychological effects.

10.5 Intercultural Therapy: The Clinical Practice

The research at Nafsiyat showed predominantly "good" results. This begs the question as to what has been added to psychodynamic psychotherapy to make it appropriate to ethnic minority patients?

Therapists have to remember we are all *enculturated* into our particular society; there are many different beliefs and values worldwide that provide cultural context to the particular life experiences of different cultures. The process of "making it" in a new society with cultural values often in conflict, or alternatively the experience of prejudice, provides a situation that is likely to cause, at the very least, conflict within the difficult "balancing act" that is maintaining an identity. Such difficulties can lead to mental ill-health and breakdown. We must also remember that separation from family, home culture, language, food and rituals etc. and the loss and sadness that this engenders may also be part of mental breakdown. Yet when we try to make it "better" we often use tools devised within our society. We use (in psychotherapy) our interpersonal skills: skills that have been honed within our society and which reflect our view of the world.

The notion that it is possible for a therapist to "divorce" a patient from their cultural heritage, the values and attitudes by which they live their lives, is counterproductive and unethical. Similarly, it is not possible to "divorce" a therapist from their cultural heritage. What is required is for both parties to acknowledge the differences, to be able to understand each other's worldview. Where misunderstandings occur, and are not

addressed in the therapy, therapy becomes a sterile exercise. Usually, in these cases, the patients choose to leave their therapy.

10.6 Intercultural Therapy: Therapists' Practice

It is important to reflect on the differences between white therapists and therapists from other cultural backgrounds. The author asked the therapists what differences there were in their technique when used at Nafsiyat and that used elsewhere. The non- white British therapists worked similarly with similar patients with similar difficulties. They always, in effect, work inter-culturally. Some of them felt their own therapy was incomplete, and felt elements of their experience could not be fully explored (Kareem 1992, Batten 1990). This seems to not support Heimann's (1950) suggestion that analysts are in touch with their unconscious; when it comes to culture they seem unable to recognise and deal with the cultural aspects.

White therapists noted the following differences when working interculturally (see table 10a on the next page).

Table 10a Issues for White Therapists

White therapists cited as important to understand issues of

- Racism[3] and prejudice
- Acknowledgment of the differences in culture between themselves and the patient and the inherent power relationships.
- Possible stereotypical ideas
- Curry's (1964) concept of "pretransference".
- Differences in "outer reality" for black and ethnic minority patients (see Evans Holmes 1992): racism is not only part of the patient's perceptions and experience and this external reality informs the unconscious.
- Difference in presentation of symptoms
- Room layout

[3] It might be expected that there would be subtle differences in expression of prejudice from the majority population, experiences dependent on whether the person is non-white, linguistically different or culturally different or various combination of these (a differential hierarchical racism).

10.7 Intercultural therapy: The Theoretical Background

Was the therapy "emic" for the patients, a culturally appropriate treatment?

Part of the answer is the issue of feeling understood, of recognition of the particular life experiences that bond ethnic minorities together (those of separation, loss and prejudice), of providing a safe place in which to deal with the pain of rejection and loss (of country, of culture for some patients, of family and for most the rejection of being black (or an ethnic minority) in a white society.

In order to provide this safe place the therapist has to also deal with the rejection and the loss (which may be played out quite overtly in the therapy, for instance by rejecting the therapist or the therapy). In fact an *emic* therapy, in my opinion, is *emic* when it recognises the particular worldview of the patient, e.g. the daily reality of racism, different cultural "norms" , their identity etc. and allows that to be brought into the therapy: in Freud's terms it can be remembered, repeated and worked through (Freud 1914). Then and only then, can the therapy be seen to be "emic".

Some patients do not wish to see someone from their own background for many reasons: the community finding out that you are seeking help; wanting to talk about difficulties in cultural identity which they feel might be prejudiced by seeing someone from the same culture who they may feel may not be able to view the culture dispassionately; or unfortunately, patients might perceive black therapists as less qualified than white therapists.

But each therapy is unique between therapist and patient. But there are fundamentals.

- Transference/Countertransference.
- Working with the unconscious.
- Verbal therapy as well as "body language".
- Boundaried relationship (times, payment etc.).
- Interpretation

Therapists have to *acculturate* their patients to the culture of therapy. Therapists have to explain what will happen during the therapy. Therapists also need to acculturate themselves to their patients: listening to the cultural voice of our patients, listening out for the "colour coded" or "culturally coded" messages which are usually the way by which therapists find out what they represent to patients in therapy. Therapists also have to listen to their own coded messages, remembering that Britain is not a equitable society. These issues should not only be picked up by therapists, but the feelings engendered in therapists should also be a focus for supervision.

10.8 Intercultural Therapy: Personal Therapy/Supervision

What is different in intercultural therapy is that it requires therapists to review their own understanding of their own culture. In order to help others with their identity and cultural issues, therapists need to be aware of their own cultural "blind spots": those

aspects of self where their understanding of "life as it should be" clashes with other cultural understanding.

Therapists' own training has to contain components which review this important aspect of the self. It has always been assumed that this would be part of personal therapy, a prerequisite for all recognised psychotherapy courses; however, this is not always overtly identified. Perhaps because of the usual similarities between analyst and training analysand (white, middle class etc.), these "blind spots" are not teased out, and I believe in some cases there is a potential for counter-therapeutic collusion between the analyst and analysand.

By this I mean that I may think I know what it feels like to be a white, middle class, female therapist. If I am in therapy with someone similar to myself I may believe that their understanding of "white" "middleclass" "female" and "therapist" are the same as mine - but are they? There is a potential for confusion where both participants believe they understand each other because they seem similar, but there is difference (here similarities are maximised and differences minimised). This assumed understanding is maintained until analyst and analysand are noticeably different, in terms of race, colour, culture, religion, language. Here the differences have to be acknowledged. This leads to a therapeutic relationship where the emphasis is on difference, and similarities are minimised.

The way of working at Nafsiyat is one of intercultural work, where the cultural context of psychotherapy is recognised together with the notions of culture, ethnicity, race, country of birth, and origins. This means that professionals will need to reflect on their

own understanding of their own "self", working with difference (and similarities) but not making assumptions.

Table 10b Therapist Issues

Hence all professionals should be clear in their own minds about:

- Their cultural milieu - how they define their own culture, ethnicity, race, country of birth, and origins? Why do they "choose" these particular groupings?
- How these grouping affect and define their notion of "self", what other factors do they incorporate to define themselves?
- How their cultural milieu affects how they carry out therapy; is there flexibility in their approach to accept and attend to different worldviews?
- Do they "fit in" with British society, in which ways are they similar to, and in which ways are they different to the "traditional" British society? How does this affect them, and what differential factors do they use (e.g. class, language, religion etc.)?
- In which ways are they similar to, and in which ways different to, their patients (both British and ethnic minority)?
- Why they choose to work with ethnic minority patients, or why they choose not to work with ethnic minority patients.
- What does the term "cultural difference" mean to them? Can it be applied to their white English patients? For instance class differences can be considered to affect the cultural milieu that patients live their lives[4]?
- Can they attend to discussion of racism in therapy? For both British and ethnic minority therapists there is a need to recognise and deal with the transferences/countertransferences caused by this fact. This is not only a social problem, it will engender an emotional response in the therapist.
- Acknowledgement of different life contexts, hence in therapy, different cultural, familial and ethnicity issues need to be untangled from the presenting symptoms, to understand their contribution (or otherwise) to the symptomatology seen.

[4] I am talking about a notion that all therapy works with difference and hence is, in this sense, "intercultural". Patients will have differences from their therapists even if they are ethnically matched, e.g. white English patients will have differences from their white English therapists. Hence my argument that intercultural therapy is actually just good therapeutic practice.

10.8 Conclusions: Intercultural Therapy, Theory and Practice

In essence intercultural therapy as practiced at Nafsiyat has several different features than previous attempts in cultural psychotherapy:

1. It assumes that a increasing proportion of the professions are themselves from minority ethnic backgrounds. This allows all the therapists space to explore their assumptions about other cultures.

2. It does not necessarily "ethnically match" patients and therapists, such intracultural therapy can be difficult as the assumption is that the therapist will know all about the culture. This can only be achieved by very close matching in terms of language, religion, ethnicity, age at migration as well as socioeconomic status of therapist and patient (and perhaps other unknown factors) which is currently an impossibility. Nafsiyat would argue that in fact patients and therapists from different cultures can work well together as (in the sessions) assumptions; on both sides can be challenged.

3. With a multi-cultural staff the Centre can adopt intercultural supervision a vital part of the therapists learning situation. This is similar to the technique of a therapist representing the patients' culture in the therapeutic situation. Moreover, for white workers this is a healthy inversion of the normal power relationships and allows change and growth.

4. It adopts a theoretical stance which is similar to that proposed by Sue (1991) in that the therapist has to decentre themselves from their own cultural background. For just as Freud's theoretical stance was particularly related to his Jewish origins (Roith 1987), so many therapists adaptations relate to their cultural origins.

5. It recognises that patients may present mental health problems in a different way to a white British population but does not regard this as an insurmountable difficulty, using the patients' knowledge of their own culture (together with the therapists' knowledge) to understand the meaning of the illness. The extent to which the patients' problem will be framed in terms of a western framework (whether or not the therapist is white) depends on the patient; this will determine to what extent the therapeutic encounter is intercultural.

6. The very fact that the staff are from ethnic minorities allows some modelling by the patient.

7. The issue of power in the relationship (the therapist having power due to profession, but also perceived to be more powerful if white) can be diffused if both participants regard it as an intercultural encounter.

8. For minority professionals it is an opportunity to explore issues unfinished in their personal therapy and perhaps to use this in more successful work with their own patients.

There is a need for changes in training courses for therapists/ researchers and other helping professionals. All professionals need to be aware of the complex life experiences of minorities and their high levels of symptoms; their difficulties but also

their potential. This will enable them to feel competent to work interculturally, and they can begin the slow process of "decentring" their clinical practice.

It also challenges researchers to find ways of evaluating the complex nature of the life experiences of people from ethnic minorities and suggests that more effort must be made to translate research and clinical findings into appropriate service provision.

Further therapeutic (and research) work with ethnic minority patients should identify them as suitable patients and provide a change in prevailing attitude about therapy for them and a concomitant improvement in the quality of care for all patients. My argument throughout this thesis has been that intercultural practice is simply good therapeutic practice.

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Appendix 1 Schedules Used in the Research

Nafsiyat Research Form 1

Case History Form (confidential)

Research Number .....

Date of Form Completion (DD/MM/YY) --/--/--

Date of Referral --/--/--

Client's surname (or family name) .....

Client's first name(s).....

Client's Address.....

.....

Telephone Number .....

Date of Birth --/--/--.

Country of Birth .....
(as defined by client)

If couple or family in therapy, please note the forenames and dates of birth of the other family members under the relevant headings

Forenames	Date of Birth
.....	--/--/--
.....	--/--/--

Client's Home is in
- Islington
- North London
- North west London
- North East London
- North West London
- South West London
- Other .....(please specify)

Paying Client? Yes / No

Name of G.P. .....

Address .....

.....

Telephone Number .....

Can we contact the G.P? Yes / No

Brief summary of the presenting problem (note dates, length of time and description of problem)

.....

.....

.....

Person who advised patient to come to the Centre .....

Relationship to Patient Self/Spouse-Partner/Parent/Son-Daughter
Other Family
Other

If self referred -How did they hear of Nafsiyat?

.....

If referred - Referrer's Name .....

Referrer's Profession .....

Referrer's Address .....

.....

Telephone number.....

Referrer's perception of problem (if not self referred, quote from the letter)

.....

.....

.....

Date of First Therapy Appointment --/--/--

Prefer Male/Female Therapist?

Times available for Therapy?.....

Presenting Problem Summary Sheet code

0 = no problems
1 = First (major) problem
2 = Secondary problem
9 = not known/not available

(1) Emotional Stress

Family problems
Relationship problems
Coping problems
Bereavement

(2) Behavioural Problems

(3) Mood disorder

(4) Specific Mental Disorder Categories

Psychotic symptoms
Neurotic symptoms

(5) Practical Social Problems

Housing
Financial
Unemployment
Legal Problems

Nafsiyat Research Form 2

Psychiatric Symptom Checklist (confidential)

Code 0 = no symptoms
1 = mild symptoms
2 = moderate symptoms
3 = severe symptoms

Date of Form Completion (DD/MM/YY) --/--/-- Research Number .....

	Code	Description
Mood	.....	.....
Appetite	.....	.....
Thought Content	.....	.....
Anxiety	.....	.....
Phobia	.....	.....
Energy Level	.....	.....
Interest/Pleasure	.....	.....
Sleep	.....	.....
Agitation	.....	.....
Anger	.....	.....
Suspicions	.....	.....
Histrionic	.....	.....
Withdrawal	.....	.....
Ideas of Reference	.....	.....
Unshakeable False Belief	.....	.....
False Perception	.....	.....
Obsession	.....	.....
Guilt	.....	.....
Weight	.....	.....
Behaviour		
Uncooperative	.....	.....
Verbally Aggressive	.....	.....
Physically aggressive	.....	.....
Wandering	.....	.....
Impaired Self Care	.....	.....

Impaired Care of Children	.....	.....
Impaired Work	.....	.....
Obsessional Rituals	.....	.....
Threatening Behaviour	.....	.....
Suicidal Attempts	.....	.....
Impaired Attention/Concentration	.....	.....

Cognitive

Clouding of Consciousness	.....	.....
Intellectual Deterioration	.....	.....
Impaired Memory	.....	.....

Presenting Problems (note dates, length of time and description of problems)

(a) As presented by client

.....
.....
.....
.....

(b) As perceived by Clinical Director

.....
.....
.....
.....

Notes on completion of research questionnaire 2. Please read this in conjunction with DSM IV - N.B. there may be cultural or gender issues in each category).

Mood This is not an emotion. It is a quality or tone of emotion. Therefore it is a spectrum - moods rather than mood. Ranges from euphoria/elation to despair and depression and other emotion in between. Note not only the score but also the type e.g. "elated".

Appetite Record any gain or loss, which is different to a person's everyday appetite.

Thought Content Any current preoccupations that a patient presents to you. Note not only the score but also the preoccupation e.g. "with death".

Anxiety. This is a Western term. By this it is meant the quality of peace of mind or lack of it. Anxiety is not only a inner restlessness, but can present as a state of over-arousal. It may have a somatic component such as palpitation, butterflies in the stomach, burning sensations, nausea, feeling faint etc. Note not only the score but also any somatisation e.g. "nausea".

Phobia. An irrational fear of something, record phobia and degree of distress.

Energy Level. How active or otherwise a patient feels, are they able to complete their daily activities? This should be assessed with reference to a person's normal level of energy or capacity to perform a normal, everyday, work routine.

Interest/Pleasure. How much interest does the person have in outside activities? Do they feel able to meet friends/family/acquaintances? Are they enjoying life? Record with reference to how they perceive themselves "normally"

Sleep. Quality and quantity of sleep. Record if suffer from insomnia? Note if they have difficulty going off to sleep or do they wake early in the morning?

Agitation. At the assessment can they sit calmly? Do they appear in an agitated state? Record impressions of level of agitation.

Anger. Do they describe difficulties controlling their temper? Can it be seen in the assessment? Is it directed at any specific person. Record level (3 = very angry) and details.

Suspicions Do they describe suspicions about other people or about other people doing things to them? Record details and level (0= no suspicions).

Histrionic Do they appear hysterical or overdramatic at the interview? Are they behaving in an irrational or unusual manner? Record details and level (0= none).

Withdrawal Do they appear withdrawn, quiet, reserved, uncommunicative? Is this shyness or does it seem to reflect some psychological problems? Record details and level (3= very withdrawn).

Ideas of Reference Do they seem to think people are talking about them? Record details and level (0= none).

Unshakeable False Belief Do they seem to be having delusions, believing that something is happening when it is not? Record details and level (0= none).

False Perception An illusion, which is a misidentification. are they seeing things in a different way to reality? Record details and level (0= none).

Obsession Does the person seem to have thoughts that are repetitive and intrude despite the persons resisitance to them? Are they about a person, an action or place. Record details and level (0= none).

Guilt Do they seem to worry about things that they have done (or not done) that are causing them to feel guilt or shame. Perhaps there is a cultural element in this? Record details and level (0= none).

Weight Are they over- (or under-) weight for their height? To what degree? Record details.

Behaviour

Uncooperative. Are they fully part of the assessment interview? Are they forthcoming about their problems? Do they seem happy to be in therapy? Record details and level (0= cooperative).

Verbally Aggressive At the assessment do they seem angry? Do they raise their voice- is this appropriate? Do they describe situations where they have been aggressive? Record details and level (0= not aggressive).

Physically Aggressive At the assessment do they seem angry? Do they appear to be physically aggressive - this is not appropriate, can it be contained in therapy? Do they describe situations where they have been aggressive? Record details and level (0= not aggressive).

Wandering Purposeless physical wandering - this is an action not in mind. Record details and level (0= none).

Impaired Self Care Are they looking after themselves? Has this changed recently? Record details and level (3= very impaired).

Impaired Care of Children Are they looking after their children? Has this changed recently? Do we have to talk to social worker? Record details and level (3= very impaired).

Impaired Work Are they able to work well at work, are there difficulties? Has this changed recently? Record details and level (3= very impaired).

Obsessional Rituals Are they acting out repetitive behaviour patterns - e.g. washing their hands? Record details and how obsessional they are (3= very obsessional).

Threatening Behaviour Are they showing this in the session (or outside). Record details and level.

Suicidal Attempts How attempted, for what reason, how many, at what ages and how recently? Record details.

Impaired Attention/Concentration Are they able to concentrate, or has this changed recently? Is there a reason for this? Record details.

Cognitive

Clouding of Consciousness Is this due to a medical condition, drugs/alcohol? Consult G.P.? Record details.

Intellectual Deterioration Loss of ability to perform certain mental tasks? How recently? Any reason why? Consult G.P.? Record details.

Impaired Memory Loss of Memory, Short term/long term memory loss? How recently? Any reason why? Consult G.P.? Record details.

Nafsiyat Research Form 3

Consent Form (Confidential)

To be filled in by the client at the first interview with the Clinical Director, if agreement is given to take part in the Research Project

Research No.....

Consent to act as a subject in the Nafsiyat research Project

Client's Name.....

Date --/--/--

1) I hereby agree to participate in the research study at Nafsiyat.

2) I understand that Nafsiyat will answer any questions I may have at any time concerning the research.

3) I understand that I may terminate my participation in the research project at any time.

4) I understand that the information given shall be treated in the strictest confidence.

May we contact your G.P.? Yes / No.

Are you prepared to be interviewed at a later date? yes / No.

Signature.....

Date--/--/--

Nafsiyat Research Form 4

Social History Form (confidential)

Date of Form Completion (DD/MM/YY) --/--/--

Research Number .....

Personal Details of Client

Sex M / F

Age .....years

Marital Status Married/Single/Separated/Divorced/Widowed/Engaged/Cohabiting
Other
Age at First Marriage (if applicable) .....years
How many Times married .....
Length of Present Marriage .....
Length of time cohabiting .....
If Couple or Family in Therapy, please note the forename(s), Sex and Ages of Other Family Members under Relevant Headings

Forename(s)	Sex (m/f)	Age (in yrs and Months)
.....	.....	.....
.....	.....	.....

Dependants - Children

Under 5 years old	.....Boys	.....Girls
Between 5 & 10 years	.....Boys	.....Girls
Between 11 & 15 years	.....Boys	.....Girls
Aged over 15 years	.....Boys	.....Girls

Dependants - Elderly Adults Number.....

Relationship to Client Mother/Father/Spouse's Mother/Spouse's Father
Other Family (please specify).....
Other (please specify).....

Clients living arrangements Flat/House/Maisonette

How long have you been living here .....years .....months

Is it Council/Private Rented/Own/Shared Mortgage/Other.....

Who does client live with Spouse, Cohabit/Parents/Other Family...../ Hostel /

Digs/ Other.....

Is the housing in good condition Yes / No

Have you generally moved to better accommodation? Yes / No

If No, Why?.....

Brief description of Housing (How many people share facilities, share bedrooms etc.)

Ethnic group.....

Country of Birth.....

Current Citizenship.....

Other Countries where client has lived

Country	Arrival (year)	Departure (year)
.....	.....	.....
.....	.....	.....
.....	.....	.....

Father's Country of Birth.....

Mother's Country of Birth.....

Age of Arrival (of Client) in U.K.....

Mother Tongue.....

Fluency in English Good / Fair / Poor

Religion .....

Religion Practicing/ Non Practicing

Family Structure (this question relates to all those members of the client's household and other relatives that the client perceives as part of the family)

Living Together (in U.K.)
Head.....

Living Away from UK
Head.....

Client's dependants in Country of Origin (include ages, sex and relationship to client)
.....
.....
.....
.....

Economic Status (this question relates to the client's economic/work status, of if the client is a minor or it is family therapy then the question relates to the head of household and/or other earning members)

.....
.....
.....
.....

Works Full-Time / Part-Time / Other

Economic Status in Country of Origin (criteria as above)
.....
.....
.....
.....

Has Economic status changed since coming to the UK? Yes / No
Father's Occupation before ..... Now .....

Mother's Occupation before ..... Now .....
Who emigrated.....
Was there a free choice to emigrate? Yes/No
Where did your family live in the country of origin Rural / Small Town / City / Other.

Do you maintain No / Distant / Close Links with your (or your family's) Country of Origin?

Education

Age of Leaving school < 14 yrs / 15 yrs / 16 yrs / 17 yrs / 18+ years

Completed Primary Education	Trade training course
Secondary Education	.....
Tertiary Education	Apprenticeship

Dates	Course
.....	.....
.....	.....
.....	.....

Relevant History
Medical History in Country of Origin

Illness (& year occurred)	Treatment	Time in Treatment	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Medical History in UK

Illness (& year occurred)	Treatment	Time in Treatment	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Psychiatric History in Country of Origin

Problem(& year occurred)	Treatment	Time in Treatment	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Psychiatric History in UK

Problem(& year occurred)	Treatment	Time in Treatment	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

In general has your health changed over the last 5 years
Is it? Much Better / Better / Same / Worse / Much Worse

Have you ever sought help from a religious practitioner Yes / No
If Yes
.....

Family History
Medical History in Country of Origin

Illness	Name of Patient	Year	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Medical History in UK

Illness	Name of Patient	Year	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Psychiatric History in Country of Origin.

Illness	Name of Patient	Year	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Psychiatric History in UK

Illness	Name of Patient	Year	Outcome
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Are Medical Illnesses openly discussed in your family? Yes / No
Are Psychiatric Illnesses openly discussed in your family? Yes / No

Occupational history

Longest period of time in work over the last 5 yrs .....yrs ..... months

What type of work do you usually do .....

Professional/Managerial/Semi- Professional/Skilled/Semi- Skilled/Unskilled

Jobs	Dates	Problems
.....	.....	.....
.....	.....	.....
.....	.....	.....

Generally why do you change jobs?
Promotion/Changing Area of Work/Location of
Job/Redundancy/Fired/Dissatisfaction/Emotional Difficulties/Illness/ Other

General satisfaction with work Good / Fair / Poor
What Job would you like to do if you could
.....

Social History (give short description of problem(s) with dates)
In Country of Origin

Close Friends Many / Few / None
Acquaintances Many / Few / None

.....

In UK

Close Friends Many / Few / None
Acquaintances Many / Few / None

.....

Family Problems (give short description of problem(s) with dates)

Now.....
.....
.....

Before.....
.....
.....

Problems with Housing (give short description of problem(s) with dates)

Now.....
.....
.....

Before.....
.....
.....

Racial Problems (note any harassment)

Now.....
.....
.....

Before.....
.....
.....

Legal Problems (give short description of problem(s) with dates)

Now.....
.....
.....

Before.....
.....
.....

Since your last visit to the Centre has any thing significant occurred
Emotional Problems Family / Relationship / Bereavement.
Practical Problems Housing/Financial/Occupational/Unemployment/Legal /Other

Continue overleaf with anything client wishes to add or expand upon. Plus any comments on session from researcher.

Nafsiyat Research Form 5

Therapy Action Form (Confidential)

Date of Discussion (DD/MM/YY) --/--/-- Research Number.....

Primary (or Key) Therapist .....

Management/Action plan (note relevant information and specific goals - if any)

.....
.....
.....
.....

Outcome on completion of Therapy (write in details)

.....
.....
.....
.....

Name of Therapist .....

Date...../...../.....

Liaison Arrangements - if any

.....
.....
.....
.....
.....

Other Services Involved - if any (note the date of the beginning of the agency's involvement)

Name of Agency	Date	Type of involvement
.....	...../..../.....	.....
.....	...../..../.....	.....
.....	...../..../.....	.....

Further Action

..... Date ...../..../....

..... Date ...../..../....

..... Date ...../..../....

Review Research Number.....

Follow up report by professional (if appicable)

.....
.....
.....
.....

Name of professional .....
Date ..../..../....

Follow-up Report from Referring Agency

.....
.....
.....
.....

Name of Referring Agency.....
Date ..../..../....

*Follow-up from Client/Couple/Family (note whether quality of life has improved, in what way, do they think this due to Nafsiyat or has their life situation changed which has altered their lives, was it a function of the psychotherapy that they received enabled them to change their lives etc.)

.....
.....
.....
.....

*

* This question was replaced by the feedback form

Nafsiyat Research Form 6

Therapy Profile Form (Confidential)

Please circle relevant research category below
Not in research
First Appointment
Follow-up Number 1 2 3

Research Number .....
Date of Form Completion ../../..
Form completed by .....

Date of first appointment at Nafsiyat..../..../....

Therapist.....

Is Therapy Ongoing? Yes / No
If Therapy Completed, Date of Last Appointment ...../...../.....
Number of Weeks Involved in Therapy at Nafsiyat ..... Weeks
Number of Sessions.....
Average Frequency of Sessions (e.g. 1 per week/ 1 per month etc.)
.....

Description of Symptoms/Problems.....
.....
.....
.....

For how long has client been aware of problem?.....months

If therapy completed, what was the outcome? Good / Fair / Poor.
Description of Outcome .....
.....
.....

If Therapy ongoing, What stage has it reached?.....
.....
.....
.....
.....

Has Client been offered psychotherapy before Nafsiyat? Yes / No

What type of Help has been offered in the past? (include psychotherapy, drug treatment, etc.)

Agency	Type of Help	How Long did Help Continue	Client's View (did it work?)
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Has the Client been addicted to any Substance(s) Yes / No
(include prescribed drugs, other drugs, alcohol and solvents)

If Yes, What substances were these?

Name.....Taken for.....months in 19...

Name.....Taken for.....months in 19...

Name.....Taken for.....months in 19...

Has the client suffered any abuse (sexual/abuse) Yes / No

If Yes, who was the other person involved, and what happened?
.....
.....
.....
.....

Has the client suffered any separation experiences Yes / No
If Yes, What was their nature?.....
.....
.....

Has the client suffered any Bereavements Yes / No
If Yes, at what age did this happen to the client .....years
What was their relationship to this person?
.....
.....
.....

Relationships
What is the client's relationship with his/her Mother

Good / Fair / Poor / Ambivalent

What is the client's relationship with his/her Father

Good / Fair / Poor / Ambivalent

What is the client's relationship with his/her Spouse/Partner

Good / Fair / Poor / Ambivalent

Is the client able to relate well to Boy (Girl) friend / Cohabitee / Spouse / No Relationship?

Is the Client able to form new Relationships? Yes / No

Since the age of 16 years has the client had
One long relationship (heterosexual/homosexual)
2+ Long term relationships
Many relationships
Few relationships
No sexual relationships
No relationships

Further comments
.....
.....
.....

Has the client got a confidant Yes / No
Relationship to Client Spouse / Cohabitee / Iarent / Sibling / Family / Friend
other.....

Depth of trust in confidant No confidant
Difficulties withconfidant
Open relationship

Educational Problems
Has the client ever shown School Phobia
Truancy
Other Educational Problems

Please give a brief description of the problems
.....
.....
.....
.....

Sexual Problems
Has the Client ever suffered any sexual problems?
.....
.....
.....
.....

Has Client ever had any
Miscarriages/Stillbirths
Abortions
Children who have died
Children adopted

No. of Children who have died

0 - 4 years
5 - 9 years
11-14 years
15-19 years
20+ years

Which culture does the client adhere to?

.....

.....

.....

Below are the categories that the client was initially evaluated on (at their first interview at Nafsiyat. Please circle the symptomatology that was present at their initial interview and also note any important information.

Code 0 = no symptoms
1 = mild symptoms
2 = moderate symptoms
3 = severe symptoms

Abnormality of:	**Code**	**Description**
Mood	.....	.....
Appetite	.....	.....
Thought Content	.....	.....
Anxiety	.....	.....
Phobia	.....	.....
Energy Level	.....	.....
Interest/Pleasure	.....	.....
Sleep	.....	.....
Agitation	.....	.....
Anger	.....	.....
Suspicions	.....	.....
Histrionic	.....	.....
Withdrawal	.....	.....
Ideas of Reference	.....	.....
Unshakeable False Belief	.....	.....
False Perception	.....	.....
Obsession	.....	.....
Guilt	.....	.....
Weight	.....	.....

Behaviour

Uncooperative	.....	.....
Verbally Aggressive	.....	.....

Physically aggressive	.....	.....
Wandering	.....	.....
Impaired Self Care	.....	.....
Impaired Care of Children	.....	.....
Impaired Work	.....	.....
Obsessional Rituals	.....	.....
Threatening Behaviour	.....	.....
Suicidal Attempts	.....	.....
Impaired Attention/Concentration	.....	.....

Cognitive

Clouding of Consciousness	.....	.....
Intellectual Deterioration	.....	.....
Impaired Memory	.....	.....

Below are the categories that the client was initially evaluated on (at their first interview at Nafsiyat. Please circle the symptomatology that is now present and also note any important information.

Code 0 = no symptoms
1 = mild symptoms
2 = moderate symptoms
3 = severe symptoms

Abnormality of:	**Code**	**Description**
Mood	.....	.....
Appetite	.....	.....
Thought Content	.....	.....
Anxiety	.....	.....
Phobia	.....	.....
Energy Level	.....	.....
Interest/Pleasure	.....	.....
Sleep	.....	.....
Agitation	.....	.....
Anger	.....	.....
Suspicions	.....	.....

Histrionic	.....	.....
Withdrawal	.....	.....
Ideas of Reference	.....	.....
Unshakeable False Belief	.....	.....
False Perception	.....	.....
Obsession	.....	.....
Guilt	.....	.....
Weight	.....	.....

Behaviour

Uncooperative	.....	.....
Verbally Aggressive	.....	.....
Physically aggressive	.....	.....
Wandering	.....	.....
Impaired Self Care	.....	.....
Impaired Care of Children	.....	.....
Impaired Work	.....	.....
Obsessional Rituals	.....	.....
Threatening Behaviour	.....	.....
Suicidal Attempts	.....	.....
Impaired Attention/Concentration	.....	.....

Cognitive

Clouding of Consciousness	.....	.....
Intellectual Deterioration	.....	.....
Impaired Memory	.....	.....

Below are some problems that may have occurred since the last time you completed the therapy form which may have influenced how the client is feeling at this time. Could you circle the appropriate categories or if the category has not been included. Please add the relevant information under "other".

Presenting Problem Summary Sheet	code	0 = no problems 1 = First (major) problem 2 = Secondary problem 9 = not known/not available

Emotional Stress

Family problems.....
Relationship problems.....
Coping problems.....
Bereavement.....

Practical Social Problems

Housing.....
Financial.....
Unemployment.....
Legal Problems.....
Other.....

Any other relevant Information not covered above (include any further information on relationships, friend, psychological problems, psychosocial problems, social problems, medical problems, educational problems etc.)

.....
.....
.....
.....

Nafsiyat Research Form 7

Feedback form (confidential)

For the Attention of Clinical Director only

As part of our aim to improve the service offered by Nafsiyat it is important for us to look at the service we are offering not only from our own point of view but getting information from our clients. Therefore we hope you will find time to complete the following form for us.

Name.....

Address.....
.....
.....

Number of sessions you came to Nafsiyat .....

Do you find the therapy difficult Yes / No

If Yes, in what way?
.....
.....
.....

Do you feel that they therapy was useful Yes / No

If No, why was this?
.....
.....
.....

Would you recommend it to a friend with similar difficulties?

If no, why not?
.....
.....
.....

What were the good points about therapy

.....

.....

.....

What were the less good points about therapy?

.....

.....

.....

signature (optional).....
Date --/--/--

Please return to Nafsiyat
278, Seven Sisters Road,
Finsbury Park,
London N4

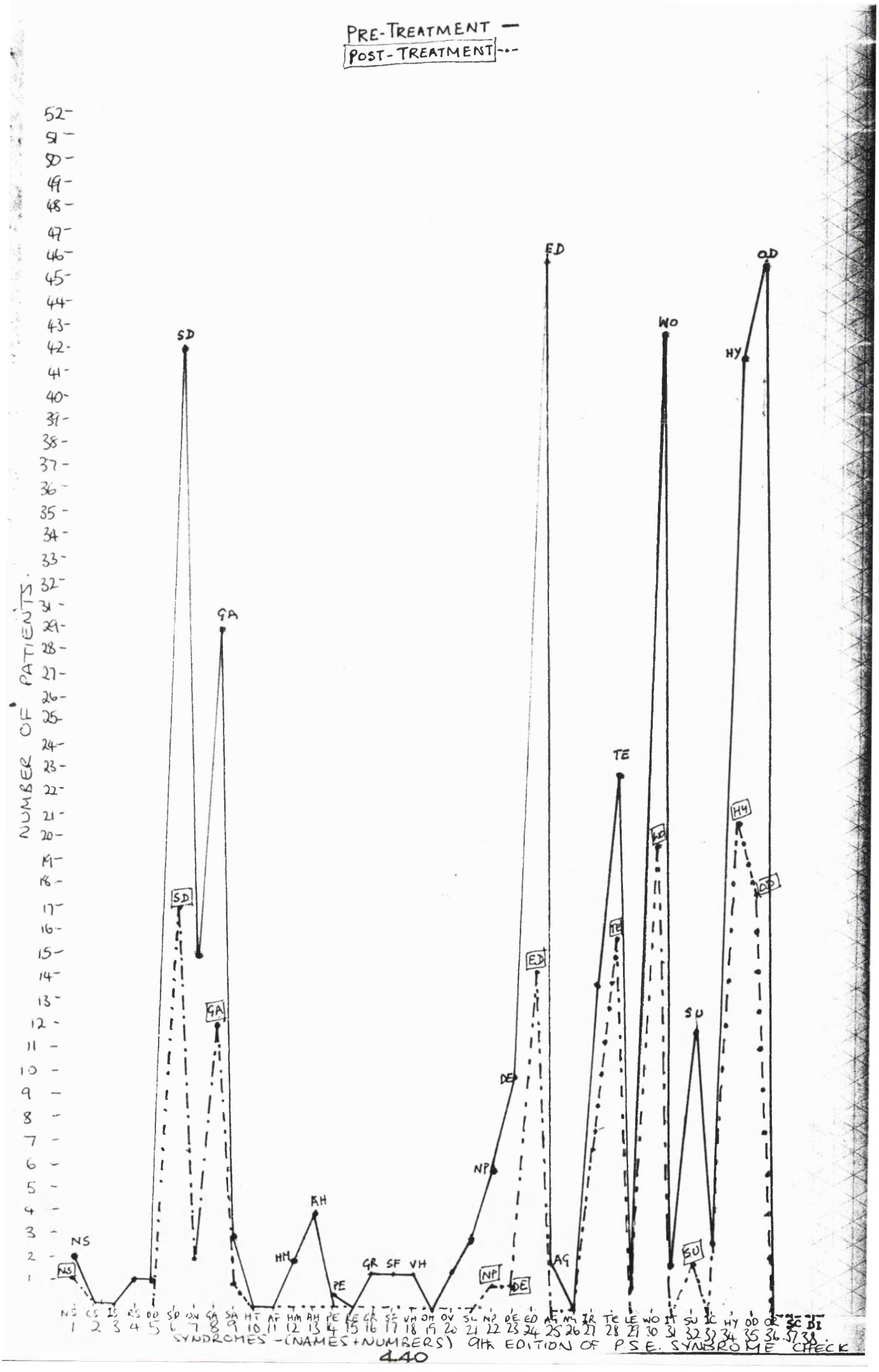
Appendix 2: PSE RESULTS

INITIAL P.S.E. RESULTS.

1. HY+ WO++ GA++ SD++ ED+ OD+ DE++
2. HY+ WO++ TE++ GA++ SD++ ED++ OD++ IR+ ON++ DE++
3. HY+ WO++ TE++ IR+ GA++ SD++ ED+ OD++
4. HY+ WO++ TE++ GA+ SD++ ED++ OD++
5. WO++ TE++ LE+ IT+ SU++ GA+ SA+ SD++ ED++ OD++
6. HY+ TE+ WO++ IR+ GA+ ON+ DE+ SD++ ED++ OD++
7. TE+ IR+ SD+ NP+
8. HY+ TE++ WO++ IR+ GA++ SD++ ED++ OD++
9. HY+ WO++ TE++ GA++ SD++ ED++ OD++ AH+ PE+ NP+
10. HY+ WO++ TE+ GA+ SD++ ED++ DE+
11. HY+ WO++ TE++ SD++ ED++ OD++
12. HY+ WO++ GA++ SA+ SD++ ED++ OD++
13. HY+ WO++ GA++ SD++ ED++ OD++ DE++ ON+
14. HY+ WO++ SD++ ED++ OD++
15. HY+ SU++ WO++ SD++ ED++ OD++
16. HY+ WO++ GA++ SD++ ED++ OD++ ON+ DE+ NP?
17. HY+; WO++; GA++ SA+; SD++; ED++; OD++; TE+; IR+
18. HY+; IR+; WO++; AH+; GA+; SD++; ED++.
19. HY+; WP++; GA+; OD++
20. HY+; WO++; GA++; SD+; OD++
21. HY+; TE++; WO++; IR+; SD++; ED++
22. HY+; GA++; SD++; ED++; OD++
23. HY+; WO++; GA++; SD++; ED++; OD++; ON+
24. HY+ TE++; SU++; WO++; IC++; GA++; ON+; SD++; ED++; OD++
25. HY+; TE+; WO++
26. GA++; HY+; WO++; TE+; IR+; SU+; SD++; ED++; OD++
27. IR+; SU+; ED++
28. HY+; WO++; SD++; ED++; OD++
29. GA+; SA+; SD++; ED+; OD++
30. TE+; WO++; IR+; SU+; SD++; ED++; OD++
31. TE+; WO++; SU+; IR+; SD+; ED++; OD++
32. HY+; WO++; GA+; ON+; ED++; OD++; DE+
33. HY+; WO++; OD++; DE++; NS++
34. HY+; TE++; WO++; GA++; ON++; SD++; ED++; OD++
35. HY+; WO++; ON++; SD++; ED++; OD++; DE+; NP?
36. HY+; WO++; GA++; SD++; ED++; OD++; ON+; DD++
37 HY+; WO+; SD+; ED++; OD++
38 TE+; LE+; SL+; WO++; SD++, ED++; OD++
39 HY+; WO++; IR+; SU+; SD++; ED++; OD++, ON+; NS++
40 HY+; WO++; TE++; GA++; SD+=; ED++; OD++; ON+; DE+
41 TE++; SU++; SD++; ED++; OD++; NP+, AH+
42 HY+; WO++; GA++; SD++; ED++; OD++; ON+; DE++; NP+
43. TE++; WO++; SU++; IC++; ON++; AG+; SL+; SD++; ED++; OD++
44 HY+; TE+; IR+; GA++; SF? AH+; SD+; OD++; HM++, VH+; ON+; OV+
45. HY+; TE++; LE+; WO++; IC++; SD++; ED++; OD++
46. HY+; WO++; GA++; SA+; SD++; ED++; OD++; ON+; IR+; SU+
47. HY+; WO++; IR+; SU+; SD++; ED++; OD++
48 HY+; TE+; OV++; SD++; ED++; OD++; RS+
49 HY+; WO+; GA+; SD++; ED++; OD++; HM?; ON++; NP+; GR?
50 HY+; IR+; GA+; ED++; OD+
51 HY+; WO++; SD++; ED+; OD+
52. HY+; WO++; IR+; SU+; SD++; ED++; OD++

FINAL P.S.E. RESULTS.

1. HY+; TE+; GA+; SA+
2. WO+; GA+; ED+
3. WO+
4. HY+; WO++; TE++; GA+; SD++; ED++; OD++
5. TE+; WO++; ED++
6. WO+; SD++; OD+
7 SD?; IR+
8. GA+; SD+
9. WO+; TE++
10. WO+; TE+
11. TE+; SD+; OD++
12. HY+; SD+; OD+
13 GA++; ED+; OD+
14. HY+; WO+; SD+; ED+
15 WO++; TE+
16. SD+; ON+; NP?
17 HY+; WO+; OD+
18. NO SCORE
19. GA+
20. HY+; WO++; IR+; TE+; SD++; ED++; OD++
21. TE+
22. HY+
23. HY+; WO++; GA++; SD++; ED++; OD++
24. HY+
25 HY+; WO+
26 NO SCORE
27. IR+
28 WO++; TE++; GA+ SD++; ED++
29. HY+; TE+
30. HY+; SD+
31 WO+; IR+
32. HY+; WO++; GA+; ED++; OD++; DE+
33. HY+; OD+; NS?
34. HY; TE+
35 NO SCORE
36. WO++; TE++; GA+; SD+; OD+
37 HY+; SD++; ED+; OD++
38. NO SCORE (?)
39. HY+; SD++
40. HY+; GA+; SU+; SD+; ED+; OD+
41. TE+; SU+
42. HY+; SD++; ED++; OD++
43. TE+; OD+
44. ON++; WO+; SD+
45. WO+; IR+
46. NO SCORE
47. HY+; WO+; GA+; ED+; OD+
48. TE+; SD+
49. HY+; WO+; SD+; ED+
50. IR+; GA+; OD+
51. HY+; IR+; OD+; ED+
52. SD+


PRE-TREATMENT —
POST-TREATMENT ---
NUMBER OF PATIENTS.
SYNDROMES - (NAMES + NUMBERS) 9TH EDITION OF P.S.E. SYNDROME CHECK
NS CS IS RS OD SD ON GA SA HT AF HM AH PE RE GR SF VH OM OV SU NP DE ED AG MM IR TE LE WO IT SU IC HY OD OR SC BI
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38
SD
GA
ED
TE
WO
HY
OD
SU
NP
DE
AH
HM
PE
GR SF VH
AG

Appendix 3: Patients Comments on Therapy

These results were collated from patients who were in therapy using the Nafsiyat Research Form 7 (see Appendix 1).

91% who replied said that they had found the therapy useful and would recommend it to a friend with similar problems. I have selected 3 questions which seemed the most revealing and commented upon

- *What were the good points about therapy?*
- *What were the less good points about therapy?*
- *Any other comments you would like to add?*

What were the good points about therapy?

- I could sort out my ideas and see more clearly.
- It was non-judgmental.
- I could share my pain.
- I learned how to like myself, to feel good about myself and be constructive.
- I understand myself better.
- I had time for myself and space to talk.
- It was important that the therapist understood cultural issues.
- It gave me courage to face my problems.
- I began to see patterns and deal with them.
- It improved my confidence - now I value myself.
- I can think more clearly.
- No more drugs.
- I could relate to my therapist.
- My therapist guided my understanding.
- My therapist was supportive and understanding.
- I was able to look at things I didn't want to look at.
- It clarified things, I wasn't mad.
- Helped my self esteem and my courage.
- I had no-one to talk to before Nafsiyat.
- I wasn't made to feel ashamed of my circumstances.

- It was a confidential service.

What were the less good points about therapy?

- Inflexibility of appointments, several patients commented on this.

  Their reasons were

  Picking up children from school, nursery or childminder.

  Having a demanding job that made it difficult to attend appointments.

  Or working shifts.[1]
- Only having one session a week.
- Only having short-term therapy.
- The long journey from home to the Centre.
- Stigma of mental illness outside.
- No quick solutions.
- Not a crisis centre - it would have been nice if I had been able to come to

  the Centre when I felt in crisis, without having to make appointments

[1] Although the clinical director and the child psychotherapist had some flexibility in changing appointment times as (a) they worked longer hours and (b) they had their own consulting rooms. Other sessional worker

Any other comments you would like to add?

- Nafsiyat - an excellent service.
- I've had therapy before, but I'm working harder here.
- I'm indebted to Nafsiyat.
- Thank you for your support - I hope you keep on doing the same for many more people.
- The therapy was useful. I do hope the Centre continues to provide positive help to people from similar cultural backgrounds.
- I believe I've developed inner strength from doing it.
- Jafar Kareem is a treasure!
- I am very pleased that I found Nafsiyat and feel very privileged to have "got in".
- In general I found the therapy very constructive and encouraging and felt greatly reassured by the caring staff.
- The Centre is doing fantastic work.
- I found the therapy really useful.

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could not be so flexible and there was the difficulty of the shortage of rooms which made changing times difficult.

Appendix 4: Training

I have used the following Exercises, modified from the originals with different groups of professionals. The "crib" notes in the first are to obviate against the difficulties white people have when presented with the "what is your culture?" question. These exercises help students to understand their cultural heritage and how it impacts on their lives and view of the world.

Exercise 1 (modified from Lago and Thompson 1996)

Can we come up with working definitions of Race, Culture and Ethnicity?

Which of the terms do you find most relevant to you and why?

To help you think about this, try to introduce yourself in cultural terms.
One person speaks for three minutes on their cultural background, the other person listens without interrupting. Then at the end of the three minutes the listener feeds back the salient points. the partners then discuss what was missed out and why. Reverse roles and repeat.

Think of your own background.

- Where would you place yourself in each of the categories (*Race, Culture* and *Ethnicity*)?
- Think about where were you born.
- What are the backgrounds of your parents?.
- Where did you spend your childhood?
- Which countries have you lived in?
- Which country feels like home?
- Significant people, places, and/or events which define your cultural identity.
- Think about how that cultural (or racial or ethnic) background has been helpful and how it has been unhelpful in your life.
- What other social and other factors influence your notion of cultural background?

Exercise 2 (Arnold 1999 - Nafsiyat Training)

Another important part of intercultural therapy is the notion of being a minority within a majority culture. Therapists can begin to think about their own experience of being different.

One person speaks for three minutes on the following, the other person listens without interrupting. Then at the end of the three minutes the listener feeds back the salient points. the partners then discuss what was missed out and why. Reverse roles and repeat.

Think of a situation in which you were a minority?

- How did it feel?
- How did you act?
- What did you think?
- Has it had any lingering effects?

Both these exercises aim to help course participants to think more personally about difference and what it means to them and to others in the group. From there they can begin to think about the implications of culture on their professional practice as therapists/doctors/social workers.