THE UNIVERSITY OF HULL

Learning from refugees and asylum seekers: experiences of distressing suspicious thoughts and accessing mental health support

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by

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Overview

This portfolio has three parts: a systematic literature review, an empirical paper and appendices. This thesis aims to explore the experiences of psychological distress and accessing support for refugees and asylum seekers, from the perspectives of service users and staff who work with them.

Part one: Systematic Literature Review

Part one contains a systematic literature review, exploring the experiences of refugees and asylum seekers who access therapy, from the perspectives of service users and staff. A systematic review of five databases was conducted and ten papers were selected that met the inclusion criteria. Thematic analysis identified fifteen analytical themes, divided into supportive, hindering and neutral factors. Conclusions and clinical implications are discussed.

Part two: Empirical Paper

Part two contains a qualitative empirical study, exploring the experiences of staff working with refugees experiencing distressing suspicious thoughts. Seven staff members working with refugees experiencing distressing suspicious thoughts were interviewed using semi-structured interviews. These were analysed using interpretative phenomenological analysis, and three superordinate themes were developed: working in broken systems; the social self, and self-identity and its transformation. These each contained three-four subthemes. Overall, this research highlights the critical role staff play in the systems of refugees experiencing distressing suspicious thoughts. The role of cultural, societal and community influences on this therapeutic relationship are considered.

Part three: Appendices

Part three contains appendices that support both the systematic literature review and empirical paper. This includes a reflective and epistemological statement, which considers the role of the researcher.

Total word count: 39, 610

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Part One: Systematic Literature Review

This paper is written in the format specified in the journal

Clinical Psychology Review

Please see Appendix M for submission guidelines

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The experiences of adult refugee and asylum seekers accessing psychological therapy: A Systematic Literature Review

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Abstract

Refugees and asylum-seekers are more likely to struggle with their mental health than comparative populations, but less likely to seek mental health support for this. Previous reviews have explored the experiences of refugees and asylum-seekers who access mental health support, integrating the views of adults, children and adolescents. This review is the first to specifically focus on the experiences of adult refugee and asylum seekers who access psychological therapy. Ten qualitative studies from five databases were assessed for quality using the NICE quality checklist (NICE, 2012) and then synthesised thematically (Thomas & Harden, 2008). Fifteen analytical themes were created, separated into supporting, hindering and neutral factors. The results suggest factors that support and hinder therapy are complex, however understanding that therapy occurs in a wider cultural/ community context allows therapists to attend to language, cultural needs, practical needs and the support they need as staff, in a cyclical manner. Implications and recommendations for future research are discussed.

Keywords: refugee; asylum seeker; mental health; systematic review; psychological therapy

Introduction

There is no universal definition, but The United Nations High Commissioner for Refugees (UNHCR) defines a refugee as "an individual who has fled from their country of origin due to a well-founded fear of being persecuted on the grounds of race, religion, nationality, membership of a particular social group or political opinions" (United Nations High Commissioner for Refugees, 2020 ,page 3). Alternatively, asylum seekers are defined by the UNHCR as "an individual who is seeking international protection… whose claim has not yet been finally decided on by the country in which the claim is submitted" (United Nations High Commissioner for Refugees, 2005, page 441).

Refugees and asylum seekers are more likely to struggle with their mental health than comparative populations. A systematic review of 29 studies, including 16,010 adult war refugees five years or longer after displacement (Bogic et al., 2015), found that these individuals were more likely to struggle with their mental health than the general population. They were roughly fourteen times more likely to have been diagnosed with depression and fifteen times more likely to have been diagnosed with post-traumatic stress disorder (PTSD). However, there was a large variance for participants in these studies in terms of countries they came from, where they were resettled and how long they had been resettled for. This may mean the figures are not representative of all refugee populations. There was significant statistical heterogeneity between included studies, with up to 40-fold differences in prevalence rates of mental health difficulties, suggesting prevalence rates of mental health difficulties may vary greatly between groups.

A more recent review of 26 studies attempted to account for statistical heterogeneity by using sub-group analyses and found that refugees and asylum seekers were more likely to

experience depression and PTSD than the general population. Rates of anxiety and psychosis were similar to the general population (Blackmore et al., 2020). However, sub-group analyses were not always possible to run and mental health difficulties were measured using western Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD) criteria. This may mean non-Western expressions of mental health, such as somatization (Biswas et al., 2016), were not taken into account. This increased prevalence of mental health difficulties has been linked to a multitude of factors, including exposure to traumatic experiences, poor socio-economic factors after migration, difficulties with language, discrimination, lack of social support, and isolation, amongst others. (Bogic et al., 2015; Hynie, 2018).

Despite this increased prevalence of mental health difficulties amongst refugees and asylum seekers, use of mental health services is low relative to need (Satinsky et al., 2019). Potential barriers to access include accommodation within services (particularly lack of interpreters/ appropriate language services and difficulty scheduling appointments); difficulties around trusting staff, particularly where there was a lack of ethnic minority staff; a lack of awareness of mental health services and what they can support with; professionals lacking awareness of how physical symptoms can indicate mental health difficulties; stigma towards mental health and help-seeking, and differences in understanding of mental health difficulties and who could help (e.g. certain communities preferred to visit a Sheikh for help with de-possession or go to traditional healers) (Satinsky et al., 2019). This may vary for refugees resettled in non-European countries, as this review focused on European countries.

Previous research has explored the effectiveness of specific mental health interventions for refugees and asylum seekers that do attend mental health services. Eye movement desensitisation and reprocessing therapy (EMDR) has been found to be effective in reducing depressive symptoms (Turrini et al., 2019) and symptoms of post-traumatic stress disorder

(PTSD) (Thompson et al., 2018). Outcomes for the effectiveness of narrative exposure therapy (NET) and cognitive behavioural therapy have been mixed (Thompson et al., 2018; Tribe et al., 2019; Turrini et al., 2019).These reviews are helpful for understanding the effectiveness of specific interventions. However, they focus largely on symptom reduction rather than considering the experiences of service users or which aspects of the interventions or therapeutic space are useful.

Three reviews have explored the experiences of service users accessing mental health support. Demazure et al (2021) conducted a systematic literature review exploring the experiences of children and adolescent refugees. Karageorge et al (2017) conducted a systematic literature review exploring the experiences of child, adolescent and adult refugees and staff who worked with refugees. Duden et al (2020) built on this review by conducting a qualitative evidence synthesis review. This explored what adolescent and adult service users, and psycho-social professionals, viewed as positive/ helpful and negative/ hindering aspects of mental health support.

Positive therapist qualities were mentioned in all reviews, including kindness, good listening, mutual understanding and reciprocal learning. Duden et al (2020) explicitly named the therapeutic relationship as a positive aspect. The experience of initial distrust towards services and the importance of taking time to develop a trusting relationship was also a central theme in all reviews. Culture and language was commonly mentioned, with Demazure et al (2021) finding that children and adolescents often had stigmatised views around accessing mental health care, and language barriers made the therapeutic process difficult. Cultural sensitivity was viewed as important, with insensitivity being damaging to the therapeutic relationship (Duden et al., 2020; Karageorge et al., 2017).

Specific interventions were mentioned as part of an 'ambivalent' category in the Duden et al (2020) review, including talking therapy and trauma exposure. Demazure et al (2021) highlighted the importance of activity-based interventions. These were not mentioned in other reviews, suggesting these may be more relevant to children. Themes around support structures for psycho-social professionals, the difficulties associated with missing mental health care structures, external instability, and the impact of the work on psycho-social professionals arose in Duden et al (2020)'s review. This may be due to the inclusion of staff members' voices in their data collection.

A theme within many of the aforementioned reviews is the differences in participants included, with heterogeneity in their home and host countries and the length of time they have been resettled for. This may impact on the results as certain themes may only be relevant to certain groups of refugees or asylum seekers.

The previous reviews have either looked only at the experiences of children or have combined the experiences of adults and children/ adolescents. The current systematic review is the first to focus solely on the experiences of adult refugees and asylum seekers. This is important as adults are at a very different developmental stage (Berman, 2001) and are likely to have different stressors, such as those related to caring for dependents, looking for a job, and paying bills. This is likely to impact what they require from therapy. Moreover, services in the UK are generally separated into adult and child, so it was deemed useful to explore the experiences of adults, so these findings can more easily be applied to adult services.

The current review aggregates qualitative data from both adult refugee and asylum seekers who have accessed psychological therapy, and mental health professionals working with refugees in this setting. Psychological therapy in this paper includes any type of work with a trained professional that aims to help people understand or cope with difficulties with

emotions or mental health (NHS, 2022). It is notable that this definition comes from the NHS website and constructed within a Western framework, making it historically and culturally specific (Burr, 2015). What is considered as psychological therapy may differ in other cultures and countries. The views of both staff and service users are included, as an initial scope of the literature found a limited number of papers speaking to service users about their experiences.

Alongside only including adults, this review provides an up-to-date understanding of refugees' experiences, as several studies have been published since the aforementioned reviews (Duden et al., 2020; Karageorge et al., 2017) and are included in this study. An updated review was thought to be particularly important due to the current political climate making it likely that there will be an increased number of refugees and asylum seekers displaced around the world. The recent war in Ukraine has seen the fastest mass fleeing of people globally since World War II (Dumore, 2022).

It is hoped that this review will encourage mental health professionals working with adult refugees and asylum seekers to attend to the aspects of therapy that are commonly seen as helpful or hindering in the therapeutic work and adapt their practice based on this. It is hoped that managers and service providers may attend to what they can do on an organisational level to support the therapeutic work. This will support with ensuring services are more trauma-informed, through using one of the core principles of trauma informed care around integrating the views of individuals with shared experiences into the service (Trauma-Informed Care Implementation Resource Center, 2021). Currently many psychological interventions are designed by, or tested on, white-British people (Hendriks et al., 2019). It is hoped that by aggregating data from refugees and asylum-seekers with varied backgrounds we can develop a better understanding of whether interventions are helpful, or what adaptations may need to be made.

This study aims to explore the experiences of adult refugees and asylum seekers who access mental health support/therapy, from staff and service user perspectives. The research question is:

'What do adult refugees and asylum seekers, and mental health professionals find supportive and hindering in the experience of psychological therapy?'.

Methods

Search Strategy

A literature search was completed of the electronic databases Academic Search Premier, CINAHL Complete, MEDLINE, APA PsycArticles and APA PsycInfo, facilitated by the EBSCOhost search engine, up to and including December 2021.

Search Terms

Search terms were generated through discussions with supervisors with knowledge in the field, the researcher's own clinical experience, and scoping searches, which prompted consideration of alternative terms. Search terms were finally reviewed by a third party experienced in conducting systematic literature reviews. Inclusion and exclusion criteria are presented in tables 1 and 2. The final search terms were:

Refugee* or "asylum seeker*" or displaced **(title)**

AND

Experience* or perspective* or view* or perception* or attitude* or satisfaction or qualitative or interview* **(all fields)**

AND

Therap* or intervention* or counsel* or psychotherap* or psychosocial **(title)**

The limiters ‘academic journal’ and ‘English’ were applied to ensure studies were peer reviewed, of high quality and written in a language that the researcher could understand.

Study Screening and Selection Strategy

Tables 1 and 2 show the inclusion and exclusion criteria for articles included in the review.

Table 1

Inclusion criteria for articles to be included in the review

Inclusion	
Qualitative studies with a clear qualitative methodology.	To ensure studies are exploring the experiences of refugees/asylum seekers and staff members who work with them.
Refugee/ asylum seeker has participated in at least one session of psychological therapy or staff member has had at least one therapeutic session with a refugee/ asylum seeker.	This review explores experiences of psychological therapy specifically.
Participants in the study are adult (18+) refugee or asylum seekers or staff who work with adult refugees and asylum seekers.	It was seen as important to only explore the experiences of adults as they are likely to be at a different developmental stage to children and adolescents (Berman, 2001) and therefore have different expectations of therapy. Moreover, services in the UK are

	often commissioned to provide care to just adults or children/ adolescents so looking at just adults will help to advise the best support for specific services. The cut-off of 18 was used as this is the age at which individuals are considered adults in the UK and when individuals will move into adult services.

Table 2

Exclusion criteria for articles to be excluded from the review

Exclusion	
Psychological therapy did not involve interaction with a mental health professional (e.g., was conducted through an app).	This research aims to help mental health professionals understand their role and what they can do to make therapeutic work more helpful. Exploring interventions that do not include this human aspect did not seem appropriate.
Intervention was psychosocial/ not specific to mental health.	This study was exploring experiences of psychological therapy and psychological interventions specifically.
Studies not available in English.	To be readable by the researcher.
Studies were not published in an academic journal.	To ensure the papers were of high quality and high scientific rigour.

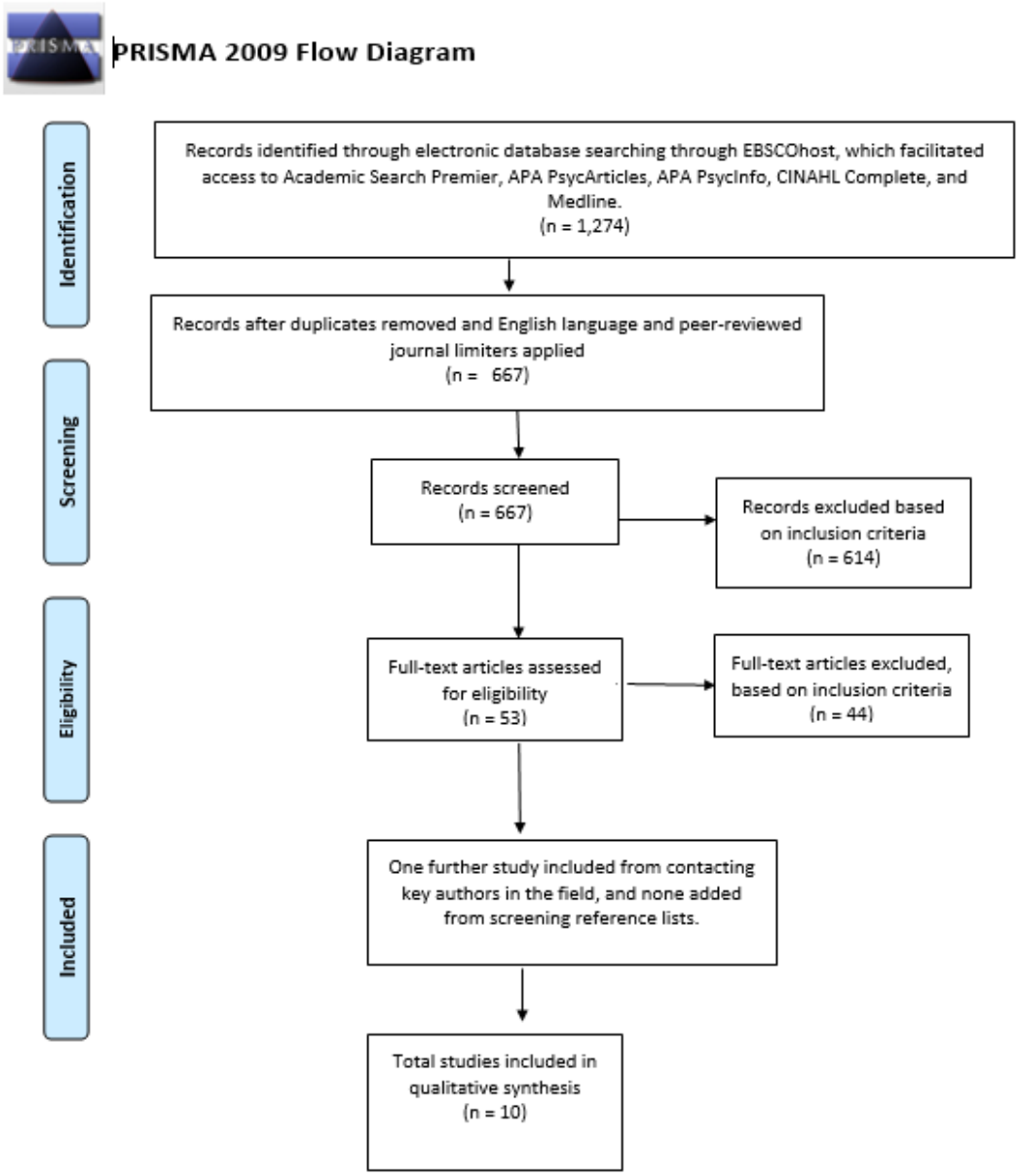
Article Selection

The search produced 1,274 results. This was reduced to 667 once duplicates were removed and English language and peer-reviewed journal limiters were applied. The titles and abstracts of these articles were reviewed using the inclusion and exclusion criteria. At this stage 53 articles were selected that met the inclusion criteria and the full-text versions were reviewed. Following reading of the full texts 42 articles were excluded, leaving nine articles. The researcher contacted the authors of two of these papers that did not make clear whether staff worked with only adult refugees (see appendix F). A hand search of the reference list, using the same inclusion and exclusion criteria, yielded no further papers. The researcher contacted key researchers in the field, and this resulted in the inclusion of one further paper.

Figure 1 shows the process of article selection

Figure 1

PRISMA diagram of included studies (Moher et al., 2009)



Quality assessment

The quality of studies included in the final review were evaluated using the NICE quality appraisal checklist (NICE, 2012). This was chosen as it is specifically designed for evaluating the quality of qualitative studies, giving each study an overall score of ++, + or – based on 14 criteria. It is a well-established tool and goes into sufficient depth.

Following scoring (see appendix E), an overall score of ++, + or – was assigned to the paper, based on the number of positive scores given (e.g., 'appropriate', 'clear', 'rich'). The overall assessment is somewhat subjective and states that 'most' of the checklist should be fulfilled to meet the criteria of '++' and 'some' to meet the criteria of '+'. The researcher therefore assigned values of 8/14 'positive' scores for ++ and 5/14 for +, unless the conclusions were likely to alter due to an area not being fulfilled. No papers were excluded based on this quality assessment.

One higher rated paper (++) and one lower rated paper (-) were selected for peer review by a trainee psychologist blind to the original ratings. A 65% agreement rate was reached initially. Where there were disagreements on ratings, the reviewer and peer reviewer discussed this until 100% agreement was reached. Due to the low initial agreement rate, the remaining papers were reviewed by the principal researcher using the criteria the researcher and reviewer had decided between them for the previous papers. Following this review one further higher rated paper (++) and one lower rated paper (+) were selected, and the peer reviewer reviewed these, blind to the original ratings. In this case an 86% agreement rate was reached, with disagreements being minimal. Due to the high degree of agreement reached in this part, the remaining papers were assumed to be reliably rated and no further papers were peer reviewed.

Data extraction

Data were extracted using a bespoke data extraction form. This form was developed by considering what information would be useful to have when completing the review and examining existing data extraction forms. Please see appendix C for details of what information was collected through this form.

Data analysis and synthesis

The data were analysed and synthesised using thematic synthesis (Thomas & Harden, 2008). This method was chosen as it is appropriate for analysing and synthesising qualitative research. Thematic synthesis centres participants' voices by analysing all information that is labelled 'results' or 'findings' in the text, paying particular attention to direct quotations. This was felt to fit with the social constructionist epistemology of this paper, as it does not look for one truth. Instead it recognises that our understanding of the world is constructed through thought and the conversations we have, and are likely influenced by our culture and the point in history we are in (Burr, 2015).

Prior to starting the analysis, the primary researcher engaged in a reflexive interview. Reflexivity is important when synthesising qualitative papers, as generation of analytical themes can be "dependent on the judgements and insights of the reviewer" (Thomas & Harden, 2008, page 7). Engaging in a reflexive interview allowed the researcher to become aware of how her own ideas and interests impacted on the synthesis (Hertz, 1997, as cited in Finlay, 2002). She used a reflective diary throughout this process to continue examining her own views and their impact on the synthesis. This can be seen as increasing the "moral integrity" of the researcher and supports with the validity of the synthesis (Kvale, 1996 as cited in Finlay, 2002).

Each article was printed and coded line by line according to its meaning and content. The thoughts or opinions of interpreters were not coded, as this review focussed on the opinions

of service users and mental health professionals. As each study was coded, the researcher added to her 'bank' of codes and developed new ones where necessary. Once completed, the researcher checked all text that had a code applied for consistency of interpretation and added additional levels of coding where needed. This created a total of 77 codes. The researcher then analysed these codes to look for similarities and differences. She grouped them together, applying new codes to capture the overall meaning of this group. This resulted in fifteen analytic themes. The research questions were used to create analytical themes that answered these, 'going beyond' the original data. This process was repeated until the analytical themes were abstract enough to encompass all data. An additional grouping of 'neutral' factors was developed, as many descriptive codes did not relate to helpful or unhelpful aspects of therapy. During this stage the primary researcher took the themes to research supervision, with three clinical psychologists experienced in this type of analysis. Themes were discussed, including how the researcher arrived at these and how her own preconceptions and ideas may have impacted on the development of them. This resulted in triangulation, through each researcher bringing their own understanding of the data (Finfgeld-Connett, 2009). Data was also triangulated through the inclusion of data from multiple sources and through analysing the data using multiple theoretical frameworks (Finfgeld-Connett, 2009).

Researcher's Position

The first author is aware that using thematic synthesis creates the possibility of subjectiveness within the review. She is aware that we all have different lenses through which we view the world, which are influenced by a number of factors, including our age, culture and upbringing. For this reason, it is important to be explicit about the lens of the first author to understand how this can impact on themes developed.

The first author was born in England and has been living here since birth, meaning she has been brought up within white Western structures. She is aware of the privileged position she is in as a white-British woman, and how this privilege may mean she attends to some themes and does not pay enough attention to others. For example, white-Western structures value individualism, which may mean she ignores themes related to collectivism or community. The author's privileged position means she has not experienced discrimination or racism and may attend to these things less during analysis. Her white-British background may also mean she attends less to cultural context and language differences.

The first author is a 24-year-old female, which also influences her lens. This review focuses on the experiences of adults, from 18+. Being at the younger end of this spectrum may mean she pays more attention to themes related to this age group and less attention to factors that can facilitate or hinder therapy for older adults. Her experiences of being female may mean she pays less attention to gendered stigma around mental health.

The first author's role is a trainee psychologist, and she prefers to work in a person-centred way (Rogers, 1959). This means she may have been drawn to themes around empathy and having unconditional positive regard for the client, whilst potentially paying less attention to medical understandings of experiences.

These biases were addressed through triangulation, which included research supervision with three clinical psychologists, using a research diary to reflect on biases and participating in a reflexive interview with one research supervisor. This allowed her to reflect on her previous experiences and how these may have influenced her relationship with the research topic and decisions through the process of developing the thesis. For further information about the researcher's position, please see the full reflexive statement in appendix A and epistemological statement in appendix B.

Results

Characteristics of included studies

All included studies were published between 2007 and 2021 (see table 3 for an overview of studies). Across all studies, 104 service users (refugees and asylum seekers) and 25 mental health professionals were included. Mental health professionals included psychologists, social workers, psychotherapists and in two studies individuals who self-defined their work as psycho-therapeutic, due to the context of there being no formal licence to carry out therapeutic work in Brazil (Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021). Interpreters' views were included in two studies, but these were excluded from the analysis. This is due to this review being focused on views of mental health staff and service users specifically. The study included 8 male, 35 female and 13 staff members of an unknown gender between the ages of 23 and 61. The ages were not specified for 17 staff members.

Service users were between the ages of 18 and 61, with one study only giving the mean age of participants, which was 51.23 (Mitschke et al., 2017). Service users were made up of 69 men and 34 women. Participants had been in the host country for between 0.5 and 20 years, however Mirdal et al (2012) and Mitschke et al (2017) did not provide this information. Service users had fled from an array of countries, including Iraq, Sudan, Zimbabwe, Afghanistan, Burundi, Burma, Congo, Rwanda, Bhutan, Syria, Iran, Kurdistan, Chechnya, Ingushetia, Bosnia and Lebanon. Zehetmair et al (2019) listed the continents they fled from, which included Sub-Saharan Africa, the Middle East and South Asia.

Studies were conducted in a variety of geographic locations, including Brazil (n=2), Denmark, Germany (n=2), England (n=2), Sweden, the United States (n=2) and Wales.

All studies used semi-structured interviews to collect data, however the data analysis method was diverse, with interpretative phenomenological analysis (IPA) (n=2), grounded theory

(n=1), inductive content analysis (n=1), descriptive phenomenology (n=1), content structuring qualitative analysis (n=1), qualitative phenomenological approach (n=1), thematic analysis (n=2) and thematic analysis alongside consensual qualitative research (n=1) used.

There was variance in research aims, with some studies explicitly exploring experiences of engaging in therapy in general (Al-Roubaiy et al., 2017; Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021); some exploring experiences of a specific therapeutic intervention (Mitschke et al., 2017; Vincent et al., 2013; Zehetmair et al., 2019) and some exploring specific aspects of therapy with refugees and asylum seekers, such as beliefs about illness (Bartholomew et al., 2021) and experiences of therapy with interpreters (Hanft-Robert et al., 2021; Mirdal et al., 2012). These were all appropriate to include as the staff and service user had worked together in a therapeutic way, however the variance in what studies looked at may have influenced the themes created.

Table 3

Characteristics of included studies and quality ratings

Study title, author(s) and years of publication	**Research aims**	**Participant demographics**	**Recruitment setting**	**Study design**	**Qualitative method of analysis**	**Key findings**	**Quality rating score**
Iraqi refugee men's experiences of psychotherapy: clinical implications and the proposal of a pluralistic model (Al-Roubaiy et al., 2017)	To explore how psychotherapy can address the needs of a specific client group (Iraqi men) at a specific stage in their lives (later stages of exile- at least five years after	• Ten adult male Iraqi refugees – who had lived in Sweden for at least five years. • Aged 21-51 • Participants had been psychotherapy	Iraqi Cultural Society/Association in the city of Malmo in southern Sweden.	Semi-structured interviews	IPA	• Participants found it helpful to "get things off their chest", therapy provided symptom relief and they felt interacting with the therapist helped to transcend marginalisation.	+

being granted asylum)	clients at some point during this time. • Seven unemployed, one had a university degree and eight had below average incomes • Had been in Sweden between 5 and 20 years.		• Therapist micro-aggressions, difficulty disclosing, therapists forcing their political opinions on clients, lack of cultural competency and lack of therapist transparency were all seen as negative.

Asylum-Seekers' Experiences of Trauma-Focused Cognitive Behaviour Therapy for Post-Traumatic Stress Disorder: A Qualitative Study (Vincent et al., 2013)	To consider the acceptability of trauma focused CBT (TFCBT) for asylum seekers with PTSD by exploring their experiences of this treatment	• 8 participants • Ages: 19-42 • Sex: 4 male and 4 female • Country of origin: Sudan (x2), Zimbabwe, Afghanistan, Burundi (x2), Iraq • Time in UK (years): 0.5-10 • The median number of therapy sessions	Three outpatient services offering specialist treatment for PTSD and one primary care service. All services offered CBT involving TFCBT and were in different regions in England and Wales.	Semi-structured interviews	IPA	Themes included: • Importance of the therapeutic relationship. • Experiences encouraging engagement in therapy such as hitting rock bottom, getting things out, trust in the therapist's professional expertise, trust in the therapist's personal sincerity, being pushed whilst respected and seeing signs of progress. • Experiences hindering engagement: uncertainty about the future, perceived powerlessness, difficulty of	+

		received was 8 (range 7–20). • The median number of TFCBT sessions was 3 (range 2–10).				trauma focused therapy, lack of progress, negative consequences of accepting • Conflict of staying where you are vs engaging in therapy. • Regaining life: considering life over death and looking towards the future. • Losing oneself- failing personal expectations and going against cultural norms.	
Listening to refugees: How traditional mental health	To assess the mental health needs of refugees from Burundi,	• 30 recently resettled refugees from Burundi, Burma, Congo,	Large metropolitan city in the Southwest United States that annually	Semi-structured interviews	Grounded theory	• Group program structure ○ Social support in a group	+

interventions may miss the mark (Mitschke et al., 2017)	Burma, Congo, Rwanda, and Bhutan recently resettled in a large, metropolitan city in the Southwestern United States. Specifically focusing on helpfulness of a peer centred and culturally competent mental health transition	Rwanda and Bhutan • Mean age: 51.23 • 12 male, 17 female • 3 employed, 25 unemployed • 22 married, 8 not • 13 no education, 14 primary education, 2 higher education	resettles roughly 10% of refugees to the United States.	○ Mutual aid in a group ○ Empowerment • Program content ○ System navigation ○ Literacy and language ○ Sense of place ○ Advocacy-interactions with employers, medical or social settings ○ Counselling-relationship building, trust, prioritising

	intervention program.					problems and needs. o Ethnic-specific differences between what was important for different refugees o Frequency/duration and location of sessions	
Stabilizing Techniques and Guided Imagery for	To gain a deeper understanding of what the refugees experienced when taking part in group	• T1 had 16 participants, T2 had 9 and follow up had 26. In total they	Refugee state registration centre in Heidelberg-Kircheim, Germany.	Semi-structured interviews conducted at three	Inductive content analysis	• Internal and external motivations for attending the group. • Other group members helped due to normalisation and peer	++

Traumatized Male Refugees in a German State Registration and Reception Center: A Qualitative Study on a Psychotherapeutic Group Intervention (Zehetmair et al., 2019)	therapy in which stabilising techniques and guided imagery were practiced. Research questions were: 1. How do the participants perceive the group concept focusing on stabilising techniques	conducted interviews with 30 out of a possible 46 participants who attended the sessions. • All participants had either applied for asylum in Germany before or were in the middle of the process during intervention. • Age range: 18-42	time points, after the first (T1) and fifth (T2) group therapy session and two weeks after participants had attended the group session for the last	support, however there was some mistrust. • Atmosphere of the therapy room, familiar structure and instructions were valued. • Support from the therapist was valued. • Participants noticed emotional, physical and cognitive improvements through attending the group. • Participants found practising the techniques difficult.

	and guided imagery? 2. What do the participants achieve while practising the guided group sessions on the one hand, and during self-practice on the other hand?	• All male • Participants came from Sub-Saharan Africa (n=23), Middle East (n=3) and South Asia (n=4) • Left home country between 2014 and 2017 (one had no information about this)	time (follow up)

	3. What inhibiting factors and difficulties are experienced in group-practice and self-practice?						
Integrating Cultural Beliefs About Illness in Counselling With	To explore the meaning mental health providers ascribe to integrating cultural	• Mental health providers were conceptualised to include psychologists,	Participants were recruited from various resettlement or immigrant/ refugee	Semi-structured interviews conducted over	Descriptive phenomenology	• Presenting concerns, stigma and expectations- exploring practical issues and being aware of why refugees and asylum seekers may attend	++

Refugees: A Phenomenological Study (Bartholomew et al., 2021)	illness beliefs into mental health care for refugee individuals. Research question: What is the meaning that mental health providers give to their integration of cultural illness beliefs into counseling services they provide to individuals from	social workers, counsellors. An interpreter working with counsellors was also included but data from her was excluded in this study. • Two men, six women • Ages 30-52 • All participants were from the US • Most participants identified as	support agencies throughout the US.	phone/ Skype	therapy, facilitators and barriers were seen as useful. • Centring diverse explanations of distress- importance highlighted of understanding the definition of "mental illness" depending on the specific community, including supernatural/ magical explanations. • Shifting the work to connect- importance highlighted of centring the client and adapting to their way of working.

	refugee communities?	white, whilst one identified as black and one Asian				• Language as barrier and opportunity- awareness of differences between clinical/ diagnostic language and language clients may use; importance of interpreters; creating shared understanding.	
Therapeutic Alliance in Interpreter-Mediated Psychotherapy from the Perspective of Refugee	To identify factors that are required for building and maintaining a trusting therapeutic alliance in the triad from a patient perspective.	• 10 refugees • 4 women, 6 men • Age range 18-61 • Participants from Afghanistan, Syria, Iran, Iraq, Kurdistan,	Northern German institutions and bodies specialising in the therapeutic treatment of people with a migration or refugee background	Semi-structured interviews	Content-structuring qualitative analysis	• Interpreter as a bridge of communication with the therapist. • Accurate translation on a linguistic and emotional level is key for building a trusting relationship.	++

Patients: Results of Qualitative Interviews (Hanft-Robert et al., 2021)	Chechnya and Ingushetia • Had fled to Germany between 2.5-6.5 years	and private practices	• Impartial appreciation and compassion is important. • Presence of a second unknown person. • Lack of professionalism is hindering. • Continuous presence is useful. • Creating a clear division of roles is useful. • Non-verbal expression of appreciation, compassion and understanding. • Sensitivity to client-interpreter compatibility is helpful.
			Curative factors +

Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment (Mirdal et al., 2012)	To study how traumatized refugees, their therapists, and their interpreters perceive both curative and hindering factors in psychological therapy	• Four female senior psychologists. • 16 refugees (seven men, nine women) who had undergone psychotherapy terminated from 6-20 months prior to the interview. • Ages of refugees ranged from 31-55. • Countries of origin of	Two centres for the rehabilitation of traumatised refugees in the city of Copenhagen.	Semi-structured interviews	Qualitative phenomenological approach	• Relationship between therapist, client, and interpreter. • Ordering chaos and finding meaning. • Psycho-educative interventions and counselling. • Events external to the therapeutic process and living conditions. • Transdisciplinary interventions and co-ordination. Hindering Factors

		refugees: Iraq, Bosnia, Lebanon, Afghanistan.				• Severe co-morbidity and lack of motivation. • Diverging goals. • Over/under-involvement of the therapist/ interpreter. • Factors external to therapy.	
The experience of working with refugees: counsellors in primary care (Century et al., 2007)	• To explore counsellor's perspectives on working with clients in primary care settings. • To identify current practice	• 13 counsellors, counselling psychologists, clinical psychologists or psychotherapists working in a range of primary care or	Primary care settings in North London.	Semi-structured interviews	Thematic analysis	• Limitation of resources in primary care settings. • Language difficulties meant interpreters were often used, however they were viewed as a "necessary but burdensome tool". • Culture- importance of approaching the clients with	+

	among such counsellors and the difficulties encountered by them.	community settings in North London with considerable numbers of refugees and asylum seekers.				as few assumptions as possible and to obtain cultural background knowledge. • Practical and psychological needs were important to consider. Counsellors had varying and strong needs about how much they should get involved with this. • The emotional impact was strong and sometimes mirrored how the client feels.	
Psychotherapy with refugees—Supportive and	• To focus on the experience of psychotherapists	• 18 participants • Aged 23-60	Brazil	Semi-structured interviews	Consensual qualitative	• Patient context: clients often have unmet basic needs which take priority over attending	++

hindering elements (Duden & Martins-Borges, 2020)	who work with refugee patients in the Brazilian context. • Research question: what do psychologists who conduct psychotherapy with refugees in Brazil perceive as supportive and hindering elements in their work?	• 3 men and 15 women. • Participants had worked as a therapist for between 1 and 30 years and with refugees for between 1 and 9 years. • Participants worked with refugee patients in their private practices, in spaces provided	research and thematic analysis	therapy. Discrimination and integration difficulties can also impact this. • Therapist context- resource limitations, working alone and not having enough training hindered therapy with refugees. Being supported through supervision and multi-disciplinary teams was helpful. • Patient: mistrust was hindering, whilst the client's resilience and strength and desire to talk about suffering was supportive.

	by universities, by a hospital or by NGOs. • 14 participants treated refugees on a volunteer basis and did not receive any form of payment for their work. • Participants self-defined their work as being clinical and psychotherapeutic as there is no	• Therapist: feeling powerless was hindering, whilst being aware of one's own culture, awareness of the client's culture and context, authentic interest in the client and self-awareness were helpful. • Relationship: bonding could be difficult due to mistrust. There is a high risk of becoming over-involved and boundaries are important. • Setting: lack of interpreters was seen as hindering, whilst flexible workspace, group and co-therapy were helpful.

		formal licence to practise psychotherapy in Brazil.				• Approach: stepping outside the psychotherapeutic realm, focusing on client strengths, using non-verbal methods and addressing client identity was helpful. • These factors were linked across levels.	
Psychologists' perspectives on providing psychological care for refugees in Brazil (Duden	To investigate the perspectives of psychologists working in psychological services for the care	• 14 psychologists were interviewed. • Aged between 26 and 61 • Ten women, three men	Brazil	Semi-structured interviews	Thematic analysis	• Experiencing the psychological care: working beyond psychology; psychological therapy with refugees is new in Brazil; personal closeness.	++

& Martins-Borges, 2021)	of refugees in Brazil. Research questions are: 1. How do psychologists experience the working process with refugee clients? 2. What do they see as negative aspects or barriers in the psychological work?	• Worked as a psychologist for between two and 38 years and with refugees for between one and 20 years • Five participants attended refugee clients in NGOs financed by the church, three worked in international NGOs, three worked in	• Negative aspects and barriers-psychological care of refugees as an emergency situation; xenophobia and racism; lack of mental health structures; missing competencies and experience; fatigue. • Positive aspects: resilience and transformation; gaining new perspectives; making a difference. • Facilitators: flexibility and openness; authenticity and warmth; support structures; providing safe spaces and working with groups;

3. What do they see as positive aspects or facilitators in the psychological work? 4. What do they see as necessary changes to better the psychological care of refugees in Brazil and ultimately	community outreach projects of their universities, two worked voluntarily with refugees and one worked in an institution financed by the state.		transparency; high tolerance for frustration.

	refugee clients'
	mental health?

Quality of included studies

Overall, the majority of studies in this review were of good quality, with five studies receiving the highest rating of ++ (Bartholomew et al., 2021; Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021; Hanft-Robert et al., 2021; Zehetmair et al., 2019) and none receiving a rating of –.

Three studies did not include a clear research aim or question (Mirdal et al., 2012; Mitschke et al., 2017; Vincent et al., 2013). All studies made clear why they were including refugees and/or asylum seekers in their sample, aside from Mirdal et al (2012) who did not clearly explain why they were including refugees as opposed to anyone who had experienced therapy with an interpreter.

Generally, studies gave a clear rationale for using a qualitative approach, however one study (Hanft-Robert et al., 2021) had aims which could have fitted with a quantitative approach and did not clearly explain why a qualitative approach was more appropriate.

The role of the researcher was poorly described across studies, with only two giving a clear description of their role (Bartholomew et al., 2021; Hanft-Robert et al., 2021). Three studies did include reflexive statements within the article (Bartholomew et al., 2021; Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021) and two encouraged reflexivity through the use of research diaries (Century et al., 2007; Vincent et al., 2013). However, in general there was limited explanation of how the research was explained to participants.

Data analysis was systematic and rigorous across all but one study (Century et al., 2007), where there was limited description of how the themes were reached. Data were rich in the majority of studies, however three included limited quotations (Al-Roubaiy et al., 2017; Hanft-Robert et al., 2021; Mitschke et al., 2017), making it difficult to assess whether the conclusions were fitting.

There was limited reference to ethical issues across studies, however most included studies referenced consent processes and anonymising of data. The exceptions to this were Mitschke et al (2017) and Zehetmair et al (2019) who did not mention anonymity and Bartholomew et al (2021), who did not refer to consent processes or anonymity in the write up. Five studies failed to mention whether the research had been assessed by an ethics committee (Al-Roubaiy et al., 2017; Bartholomew et al., 2021; Mirdal et al., 2012; Mitschke et al., 2017; Vincent et al., 2013).

Quality in relation to purpose of review

The quality of studies in relation to their relevance to the review question was also considered. Four studies explored refugee and/or asylum-seeking adults' experiences of therapy either from the service user or mental health professionals' point of view (Al-Roubaiy et al., 2017; Century et al., 2007; Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021). This fits closely with the aim of the review, to explore the experiences of refugee and asylum-seeking adults who attend psychological therapy. These studies may be of the best quality in relation to the study aims.

Three studies explored the acceptability of a specific intervention for refugee and asylum-seeking adults (Mitschke et al., 2017; Vincent et al., 2013; Zehetmair et al., 2019). This may have somewhat biased themes generated, as studies explicitly explored experiences of these interventions. This may mean themes related to these interventions appear more frequently in the results.

One study explored a specific aspect of mental health support, namely the experiences of mental health professionals who integrated cultural beliefs about illness into their counselling (Bartholomew et al., 2021). Although they explored positive and hindering factors in relation

to this, it may have created more codes related to cultural beliefs and understandings of mental health.

Finally, two studies explored supportive and hindering factors when the therapy included an interpreter (Hanft-Robert et al., 2021; Mirdal et al., 2012). This is likely to have created more codes related to interpreters, which may have created some bias in the results.

Factors

Fifteen analytical themes were created, separated into supporting, hindering and neutral factors. These are summarised in tables 4, 5 and 6.

Table 4

Supportive themes

Analytic Theme	**Descriptive Themes**	**Representative Studies**	**Who mentioned them?**
Fostering a trusting therapeutic relationship	Valuing the therapeutic relationship	V, Mis, B, Z, Mir, D(a), D(b)	Both
	Listening, validating, respect, empathy and genuine concern	AR, V, B, Z, HR, Mir, C, D(a), D(b)	Both
	Self-awareness, boundaries and authenticity		Both
	Facilitating trust	B, HR, C, D(a), D(b)	Both
	Empowerment, encouragement and perseverance	V, Mis, B, Z, HR, Mir, D(a)	Both
	Witnessing and being believed	V, Mis, C, D(a), D(b)	Both
	Normalising distress and how it might present	V, C, D(b)	Service users
	Collaborative	V, Z, Mir	Both
	Curiosity	B, C, Z, Mir, Mis D(a), D(b)	Staff
	Flexibility	B, C, D(a)	Staff

	Welcoming, safe and accessible physical setting	B, C, D(a), D(b) Mis, B, Z, C, D(a), D(b)	Both
Attuned to client's language and culture	Non-verbal communication	HR, C	Both
	Shared language and understanding	AR, B, D(a), D(b), Z, Mir	Both
	Interpreters (including family/ communication technologies)	B, C, D(a)	Staff
	Therapist acknowledgement of interpreter role and relationship	B, HR B, C, D(a), D(b)	Both Staff
	Cultural interest and understanding		
Focus on staff support and wellbeing helps them to stay focused on the client	Staff support	D(a), D(b)	Staff
	Supervision	D(a), D(b)	Staff
	Staff techniques to manage distress	D(a)	Staff

Support with adjustment to host country	Practical questions and support	AR, V, Mis, B, Mir, C, D(a), D(b)	Both
	Advocacy		Both
	Support with culture and systems of host country	Mis, D(a), D(b)	Both
	Connection with external services and community	Mis, Mir, D(a) Mir, C, D(a), D(b)	Both
Specific interventions	Managing emotions	AR, Mis, B, Z, Mir	Both
	Relaxation and connection to the present moment	Z, Mir, D(a)	Both
	Creative techniques	C, D(a)	Staff
	Psychoeducation	B, Mir	Both
	Cognitive and behavioural techniques	Mis, B, Mir	Both
	Working with systems	B, Mir	Both
	Trauma processing	Mir	Staff
	Body centred techniques	Z, Mir, C	Both
	Talking as cathartic	AR, V, Z, Mir	Service users
	Medical model as helpful	V	Service users

Value of multiple perspectives	Value of groups	Mis, D(a), D(b)	Both
	Mutual support in groups	Mis, Z, D(a), D(b)	Both
	Shared ideas and responsibility in group	Mis, Z, D(a)	Both
	MDT working as helpful	B, D(a), D(b)	Staff
Personal and therapy-specific progress supports engagement	Positive changes in personal circumstances support engagement	Mir, D(a)	Both
		V, Z	Service Users
	Signs of progress as motivation to continue	V, D(b)	Both
	Regaining identity and life through attending therapy		

Table 5

Hindering themes

Analytic Theme	**Descriptive Themes**	**Representative Studies**	**Who mentioned them?**
Negative appraisals of mental health struggles/ therapy	Shame and stigma	V, B, HR	Both
	Hopelessness	V, C, D(b)	Both
	Perceived lack of progress impedes engagement	V, Z	Service users
	Thoughts, feelings and physical experiences hinder engagement	V, Mis, B, Z, Mir	Both
		AR, V, Mir	Both
	Therapy seen as not helpful or harmful		Service users
Power struggles	Perceived powerlessness of therapist/ therapy	V, B, Mir, C, D(a)	Both
	Power differences between therapist and client	D(a), D(b)	Staff
	Perceived powerlessness of client		Both

	Mistrust (client and therapist mistrust)	AR, Mis, B, Mir, C, D(a),	Both
	Lack of boundaries/ getting overly involved	D(b)	Both
	Unclear expectations or not clarifying role	AR, V, Z, HR, C, D(a)	Both
		Mir, D(a), D(b)	
		AR, B, C, D(a)	
Unpredictable	Uncertainty	AR, V, Z, Mir, C	Both
circumstances	Home environment unsuitable for recovery	Z, Mir, C	Both
	Personal experiences of discrimination and lack of social	AR, V, HR, C, D(a), D(b)	Both
	contact	Mir, C, D(a)	Both
	Bad news and events outside of treatment		
Limited	Lack of mental health structures	D(a), D(b)	Staff
resources	Lack of resources	C, D(a), D(b)	Staff
	Lack of staff training and support	C, D(a), D(b)	Staff
	Inaccessible or negative physical environment	Mis, Z, D(a),	Both
	Limited number of sessions and time limited	Mis, Mir, C, D(a)	Both
	Working with refugees as new and difficulty adapting	D(a), D(b)	Staff

Cultural and language barriers	Therapist lack of cultural sensitivity	AR	Service users
	Therapist lack of cultural knowledge	AR, C, D(a), D(b)	
	Cultural differences	V, B, C, D(a)	Both
	Cultural norms and understanding of mental health	V, B, Mir	Both
	Language barriers	Mis, B, Mir, C, D(a), D(b)	Both
	Interpreter difficulties	B, Mir, C, D(a)	Both
	Interpreter impact on therapeutic relationship	B, Mir, C	Staff
			Staff

Table 6

Neutral themes

Analytic Theme	**Second Order Descriptive Themes**	**Representative Studies**	**Who mentioned them?**

Shifting motivations	• Hitting rock bottom and desperation as motivation to attend therapy	V	Service users
	• Ambivalence about engagement in therapy/ deciding whether to engage	V, C, D(a), D(b)	Both
Reliance on therapy	• Difficulty of implementing interventions without therapist/ group	V, Z	Service users
	• Difficulty of endings	V, Z, C	Both
	• Relationship as a buffer for isolation/ feeling marginalised	AR, V, Mis	Service users
Therapist influences the work, and the work influences the therapist	• Boundaries	C, D(a), D(b)	Staff
	• Therapist gains new perspectives	C, D(a)	Staff
	• Therapist life and work experience influences therapy	C, D(a)	Staff
	• Client work has an impact on therapist	C, D(a), D(b)	Staff

Key

AR= Al-Roubaiy et al (2017)

VJ= Vincent et al (2013)

Mit= Mitschke et al (2017)

B= Bartholomew et al (2021)

Z= Zehetmair et al (2019)

HR = Hanft-Robert et al (2021)

Mir = Mirdal et al (2012)

C = Century et al(2007)

D(a) = Duden & Martins-Borges (2020)

D(b) = Duden & Martins-Borges (2021)

Supportive Factors

These themes describe what service users and staff viewed as supportive of the therapeutic process. Seven analytical themes were developed, made up of 40 descriptive themes.

1. ***Fostering a trusting therapeutic relationship***

Clients and mental health professionals across all studies (see table 4) mentioned the importance of fostering a trusting therapeutic relationship or the skills that therapists used to foster this. It was seen as important for the client to be listened to, believed and empowered but for the therapist to also maintain boundaries and normalise their experience. One asylum seeker summarised the importance of building trust by showing genuine concern for them:

> *"So as the time goes, she, you know, I could say anything to her without getting, you know, without even minding about it, but if she had, if she had not won my love, some of the things, it's not easy to talk about it, you know. So that's the way, you know, she made me feel that surely, she's a good, she's a good person, she's a friend, she's concerned with my life." (Vincent et al., 2013, p585).*

The importance of this relationship was echoed by mental health professionals, with one explaining:

> *"Most essential of everything is the bond. Without the bond established, the therapy does not occur." (Duden & Martins-Borges, 2020, p410).*

A large part of maintaining this bond was the ability to be flexible within the interactions, which was highlighted in six studies:

> *"Being stiff as a counsellor with your boundaries doesn't work. You're on your own- you have to think again. All these ethical decisions are approached anew- there are no rules." (Century et al., 2007, p36).*

2. *Attuned to client's language and culture*

Service users and mental health professionals across eight studies stressed the importance of being attuned to the service user's language and culture, whether this was through using interpreters, additional non-verbal language or just being interested in their culture. One service user explained that non-verbal language was more important at times than verbal communication:

> *"I've learned from experience to watch the therapist to see if she can grasp my problems, I can see it in her face. Every now and again it doesn't matter if you don't understand the language. It's the facial expressions and appearance, gestures, that say so much." (Hanft-Robert et al., 2021, p6).*

Sometimes non-verbal language was felt to be more useful, even when the mental health professional and service user spoke the same language:

> *"I felt that there were no words I could say, because the horror of her story was so unbelievable. She wouldn't understand anything complicated and words seemed to be so trite. Perhaps at that point I would just touch her arm, just to let her feel that I was there with her." (Century et al., 2007, p35).*

However, many service users and professionals felt that having an interpreter was important, both for supporting with language differences and providing cultural support at times. Two studies spoke about how important it was for the therapist to acknowledge the interpreter and clearly define roles within the session:

> *"My therapist said 'you're here to see me, so we'll look at each other, and the interpreter is just here to help us understand each other's words' […]. 'Later on, the interpreter helped,*

when I looked at her she always signalled to me that I should look at the therapist, she nodded like this with her eyes and head towards the therapist.'" (Hanft-Robert et al., 2021, p5).

Interest and understanding of the client's culture was also seen as crucial when working with this client group. This involved taking time to learn about the client's culture and acknowledging how important the client's culture may be to them:

"Culture is very important. It [might be] all these people have to hold onto. I think that, yes, you learn from the client, but you have to be prepared to do some work so that you can understand." (Century et al., 2007, p32)

3. Focus on staff support and wellbeing helps them to stay focused on the client

The importance of staff wellbeing and support, and its impact on being able to effectively support the client, was mentioned by mental health professionals within two studies (Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021). These studies were both of high quality, suggesting reliability of the theme, however the studies were both conducted in Brazil, suggesting this theme may be more relevant to psychological work in this country.

Staff support and wellbeing included developing personal strategies for managing distress created through the therapeutic work, but also receiving support from other professionals. One participant emphasised the professional's role and agency in seeking out this support:

"Two things [facilitate the work], it's therapy and supervision. Supervision is more common in clinical work, but you can do it formally or informally with someone else. Exchange an idea with other psychologists about some issues in order to get an idea of referral, exchange experiences. This helps you to organise yourself" (Duden & Martins-Borges, 2021, p16).

4. ***Support with adjustment to the host country***

Although building a therapeutic relationship was crucial, all but two studies highlighted the importance of providing clients with practical support around adjustment to the host country. These studies mentioned that it was impossible to work therapeutically when clients were worried about their physical safety and circumstances:

"Trying to meet some of those basic needs up front so they can see that our role is to be helpful and support them- and also, as their therapist, I know if their basic needs aren't met, we're not even going to get to the emotional, psychological needs." (Bartholomew et al., 2021, p713).

Practical support was demonstrated in a variety of ways, from teaching clients about the culture of the country, to supporting them with systems, to advocating for the client on a wider level. One professional highlighted how even small acts can make a big difference:

"We went to a supermarket with him, just to teach him about what kinds of foods to buy." (Mirdal et al., 2012, p16).

Multiple studies referred to the importance of connecting with external services and the community to support service user's adjustment.

5. Specific interventions

Professionals and clients in all but two studies (Duden & Martins-Borges, 2021; Hanft-Robert et al., 2021) mentioned interventions that were helpful for the clients. These were mostly psychological, ranging from psychoeducation and relaxation strategies to individual skills such as cognitive and behavioural skills, to wider systemic interventions. Using simple

techniques to manage emotions was mentioned in multiple studies. One study (Vincent et al., 2013) referred to the importance of the medical model as an intervention.

Some studies focused specifically on what was helpful for clients who participated in a particular individual/ group intervention, so understandably these techniques were mentioned more commonly in these studies. For example, Zehetamair et al (2019) evaluated a stabilisation and guided imagery group and participants commented:

"If you do this training it is good because I feel. Even when I do it, I feel. Like my body is pulled down, I am becoming normal." (Zehetmair et al., 2019, p7)

Longer term, reprocessing work was also seen as helpful by professionals in Mirdal et al's (2012) study but was not mentioned by service users. One professional explained:

"In the beginning, he talked about images from the camp. Later about the trauma, but they were still fantasies. Much later he re-experienced the horror during therapy. After that, things changed." (Mirdal et al., 2012, p15).

The cathartic act of talking in itself was mentioned across four studies, only by service users.

"Emotionally I felt better by simply letting out all these thoughts, talking about these feelings." (Al-Roubaiy et al., 2017, p466)

This may suggest a difference between staff and service users, with staff being more focused on specific therapeutic techniques, whereas service users finding simply talking helpful.

The importance of specific interventions as a whole is a reliable theme, due to being present in multiple high-quality studies. However, some descriptive themes such as using a medical model and trauma processing were only found in studies with a slightly lower quality rating, suggesting these may not be as reliable.

6. Value of multiple perspectives

The value of multiple perspectives was mentioned in four studies, mostly in reference to groups but also in relation to the value of multi-disciplinary team (MDT) working. Two of the studies that referred to groups were evaluating a group intervention (Mitschke et al., 2017; Zehetmair et al., 2019) whilst in the two other studies mentioning groups, this topic was brought up spontaneously (Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021).

Some service users mentioned how working in groups linked to their cultural values around supporting others:

"The first thing for these groups, which made me happy, was that they said we would be helping our neighbours and friends who have some conflicts… This is how we grow in our country; we were advising and helping our neighbours and friends with their conflicts." (Mitschke et al., 2017, p593).

For others, having support within the group helped reduce their feelings of loneliness and isolation, both at the time of the intervention but also in a wider sense:

"It helped me very much because sometimes I feel lonely, but when I am in group I don't feel alone." (Mitschke et al., 2017, 593)

"But since I started in this group, sometimes I feel happy when I'm with the people […] but I see the differences: since I started this group I know how to speak to the people; how to get close to the people […] When I want to get close to them, I will get close to them, talk to them, to chat, we do some joking. You know." (Zehetmair et al., 2019, p7).

Staff viewed working with other staff members and therapists as supportive, as it counteracted their feelings of being overwhelmed. This allowed for sharing of different perspectives on the clients, influenced by their different lenses.

7. Personal and therapy-specific progress supports engagement

Participants in five studies mentioned how perceived 'progress,' both in their personal life and as a result of therapy, supported them to continue engaging with therapy. One participant described this process:

> *"I started maybe feeling a bit of difference. That's when I force myself. 'You have to go. No, be strong, go and they are helping you.' So I end up going." (Vincent et al., 2013, p586).*

Positive changes in personal circumstances, such as finding a job, accessing better living conditions or moving into a better financial position were also viewed as facilitating the therapeutic process (Mirdal et al., 2012).

Overall

The majority of themes within the 'supportive' category were present in almost all studies, suggesting the lower quality of some studies did not significantly impact the results. The exception to this was the descriptive theme of 'value of multiple perspectives', which was only mentioned in four studies, and 'personal and therapy-specific progress supports engagement'. However, these both included results from multiple high-quality studies, suggesting these categories were still reliable. It is important to note that two included studies were explicitly evaluating groups, which may have increased the likelihood of the theme around the importance of multiple perspectives.

Hindering Factors

These themes describe what service users and staff felt hindered the therapeutic process. Five analytical themes were generated, made up of 28 descriptive themes.

8. Negative appraisals of mental health struggles/ therapy

Participants in nine studies mentioned the impact that negative appraisals of mental health struggles, or therapy itself, had on engagement. Participants described sudden negative memories, pain, or exhaustion experienced during sessions as being difficult. Perceived lack of progress impeded engagement and participants described this in a number of ways, including continuing to have nightmares or continuing feelings of shame. These themes were mainly mentioned by service users.

Mental health professionals in two studies (Bartholomew et al., 2021; Hanft-Robert et al., 2021) and service users in one (Vincent et al., 2013) described how shame can impact accessing therapy:

"It makes me feel like I'm weak, like, you know, I'm not a strong person. 'Cause if I was then I wouldn't be needing […] someone else to help me deal with what's happened to me."

(Vincent et al., 2013, p587).

This can be exacerbated by cultural norms around mental health in the refugee's home country, which are referred to in the 'culture and language barriers' theme. This could include perceptions that attending therapy means you are "crazy" (Bartholomew et al., 2021, p715).

Service users in three studies mentioned thoughts around therapy being unhelpful or harmful:

"Actually, if anything, this experience could have potentially harmed me […] it could have destroyed me had I gone on to do more sessions with this person." (Al-Roubaiy et al., 2017, p487).

Interestingly, the reasons for why this therapy was unhelpful or harmful were often not given, but participants described feeling very strongly that it was unhelpful/ harmful.

Power struggles

Participants in all studies mentioned the powerlessness of the client, therapist, therapy, or power differences between therapist and client, that hindered therapy. Mental health professionals across multiple studies mentioned how powerless they felt when faced with the volume of client's struggles, particularly when they had limited resources and time with the client:

"and you think, oh my God where do I start, you feel powerless, you feel helpless sometimes. You think "how can I help this person who has so many problems in all areas of their lives?" (Century et al., 2007, p29).

The therapist's perceived powerlessness was also seen as a barrier by service users, for example some service users felt that the therapist's lack of control of their asylum status hindered therapeutic engagement (Vincent et al., 2013).

The difficulty of maintaining clear boundaries with a client group who have such complex and diverse needs was discussed mainly by staff, who were mindful that having too tight or loose boundaries could disempower clients. Staff members mentioned that service users often had high expectations for what they could get from therapy, and this could be difficult to manage:

"They will ask for everything. Everything is always denied. The doors are so closed, so when you open one, the person thinks she will find everything in there. So, it's not easy." (Duden & Martins-Borges, 2020, p409).

Some staff felt that this created a pull to get overly involved, which could create dependency within the therapeutic relationship (Duden & Martins-Borges, 2021). They also mentioned interpreters breaking boundaries or becoming emotionally over-involved with the client, which impacted on the therapeutic relationship within the room:

"I have a feeling that they [the interpreter and the patient] met privately" (Mirdal et al., 2012, p18).

Mistrust also acted as a large barrier and stopped some clients from feeling able to explain exactly how they were feeling. This was sometimes linked to past traumas they had experienced and sometimes linked to cultural barriers, such as the therapist being from the host country:

"Since she was Swedish I had to know what to avoid basically. I mean I could not really tell her everything I was thinking." (Al-Roubaiy et al., 2017, p467).

Some staff also mentioned mistrusting clients, which created a barrier for creating a therapeutic relationship. This could include feeling like they were fabricating experiences to receive financial support.

9. Limited resources

Limited resources, in terms of lack of mental health structures, time-limited therapy, lack of staff support/ training and the therapeutic environment not being suitable was seen as a

barrier across six studies but was mentioned much more frequently by staff than service users. In the studies conducted in Brazil (Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021), there was a specific focus on lack of mental health structures, which had a large impact on staff's mental wellbeing:

"I think it becomes very obvious and very bleak, the unpreparedness that Brazil has for receiving immigrants. So, I felt myself hitting walls, everywhere I ran there was a wall […] so it's very tiring, it's exhausting." (Duden & Martins-Borges, 2020, 408).

However, in studies conducted in European countries and the US (Century et al., 2007; Mirdal et al., 2012; Mitschke et al., 2017; Zehetmair et al., 2019) the focus was on how difficult it is to conduct effective therapy when sessions are time-limited. For example, Century et al (2007, p28) mentions that 'pressure arises for counsellors because the refugee experience must be managed within the usual timeframe and this is generally acknowledged as 'only scratching the surface.'' Other studies mentioned that when clients are experiencing so much distress and difficulty a psychosocial approach is needed:

"One weekly session is not enough. Persons who are so heavily affected need more psychosocial support." (Mirdal et al., 2012, p19).

10. Unpredictable circumstances

Staff and clients in eight studies referred to unpredictable personal circumstances that hindered engagement, such as uncertainty about asylum status, financial difficulties, experiences of discrimination and racism, and destabilising home environments. These constant worries and lack of control over their personal circumstances made it difficult to focus on therapy:

"You cannot concentrate on anything if you are constantly afraid you could be sent back at any time." (Mirdal et al., 2012, p19).

Some participants felt that speaking about their psychological state was useless when they had practical problems at home that felt more pressing:

"It is terrible not to be able to buy things the children need. It is terrible to see them growing up in poverty. Then it is no use to go to a treatment. It makes me feel very desperate." (Mirdal et al., 2012, p20).

11. Cultural and language barriers

Cultural and language barriers were mentioned in all but three studies (Hanft-Robert et al., 2021; Mitschke et al., 2017; Zehetmair et al., 2019), with multiple service users mentioning the stigma around attending mental health settings amongst their cultural group:

"You are ok if you haven't got any problem, Afghani people is happy with you. If you have problem, like me, they make a joke, […] they call me all the time, "you mad, you mad" and I'm very sad." (Vincent et al., 2013, p588).

Spiritual understandings of mental health also meant that some service users were reluctant to engage in talking therapy due to concerns about the consequences this could have:

"One should not wake up the demons (dijinns). There are things one should not talk about. It makes you feel worse." (Mirdal et al., 2012, p19).

Staff members could find it difficult to adapt to these different understandings of mental health and struggled to adapt their interventions accordingly. This could also be difficult when refugees and asylum seekers used language to describe their experiences that staff members were not used to:

Carrie suggested that her clients from the Burmese community had "heard of depression" but "would just usually call it sad".' 'Corina, who works with ethnically similar communities

as Carrie, alluded to the common expression "thinking too much" in her work with clients who have refugee status.' (Bartholomew et al., 2021, p714).

Staff members' misunderstandings and preconceptions about the client's culture also created barriers, particularly when the staff member seemed to have a negative view of the culture:

"He had already asked about my sisters and the liberties that they perhaps don't have or how oppressed my mother might have been. Mind you, all this was in the form of questions." (Al-Roubaiy et al., 2017, p466).

"She did not really come across as someone who knew about our culture. She just seemed to have this negative view." (Al-Roubaiy et al., 2017, 467).

Language barriers were seen as particularly difficult by staff. Some staff members found that their more diagnostic language and their clients' language were often incongruent (Bartholomew et al., 2021). Staff attempted to overcome these barriers by using interpreters, but this could often create its own difficulties:

"Counselling through an interpreter is tremendously difficult and takes forever and as a counsellor you find yourself working in the most peculiar ways." (Century et al., 2007, p30).

<u>Neutral Factors</u>

Some data did not fit into the 'supportive' or 'hindering' category but reflected the processes that were involved in delivering therapy with refugee and asylum-seeking clients.

12. Shifting motivations

Staff and service users in four studies highlighted how participant's motivation for therapy could change over time and impact on engagement. Participants in Vincent's study described initially attending therapy after hitting "rock bottom" and experiencing ambivalence when attending therapy. This was highlighted through the conflict of whether to accept or reject new perspectives:

"Up 'til now I didn't know if it's 100% helpful or not because I do sometimes cancel the appointment with her [therapist]. Just I had a strong feeling to, to stop come here and sometime I feel like and sometime I ring her and say "can I make an appointment with you?" so it's like levels of feeling and I don't know for how long I will see her." (Vincent et al., 2013, p586).

13. Reliance on therapy

Service users in two studies (Vincent et al., 2013; Zehetmair et al., 2019) alluded to a reliance on therapy, that can be difficult to adjust to once therapy ends. Particularly they mentioned the impact of losing the therapeutic relationship:

"I'm suffering now because our sessions came to an end just last month and I feel like I am forbidden from meeting or seeing someone who I really, really admire and love and need." (Vincent et al., 2013, p587).

Staff members also spoke about being impacted by the end of therapy (Century et al., 2007), which could be seen as relating to the 'powerlessness' they often spoke about feeling when working with this client group. This was often exacerbated by having to adhere to a set number of therapy sessions, rather than being able to finish when they felt this was appropriate:

"It's not that I think the short-term work is irrelevant or unhelpful but it just can be painful to finish and with these particular clients it just adds to how painful it is- leaving people who are desperate for help." (Century et al., 2007, p29).

Service users also spoke about how difficult it could be to practice techniques without the support of the therapist:

"When I try to do the exercises on my own I don't concentrate. So normally, when the therapist did the exercises for me and for the group I felt changes. When I do it on my own I don't feel that relaxed." (Zehetmair et al., 2019, p7).

14. Therapist influences the work, and the work influences the therapist

Six studies acknowledged the therapist's role, including how their personal and professional experiences could impact on the work and the impact that this work had on them. This was only mentioned by staff.

Three studies (Century et al., 2007; Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021) acknowledged the impact of the work on staff, including positive experiences of gaining new perspectives and more difficult experiences, as described here:

"Sometimes it's really profound, agonising! The torture- going into details; things I've not heard of before- never imagined! Or you might have read about it but once you've got someone sitting in front of you- it's happened to them or friends or family, it's a completely different thing." (Century et al., 2007, p34).

Duden et al (2020) mentioned that when the therapist brings their own experiences into the work this can create overidentification and blur boundaries. Therapists also mentioned bringing their own style that they had developed over time into the work:

'I think it is very difficult to think what would be helpful for a refugee client as opposed to any other sub-group or full group of clients, because the usual kind of therapeutic stance is applied throughout and I don't feel that my attitude or techniques or style wavers from one group to another.' (Century et al., 2007, p28).

Summary of themes

Although the themes were separated into facilitating, hindering and neutral, there was a large overlap between categories. The most common theme related to fostering a trusting therapeutic relationship and some of the other themes could be seen as contributing to this. Participants highlighted the importance of being attuned to the client's culture and language, and cultural and language barriers were also seen as hindering to the therapeutic process. Seeing progress in their mental health through attending therapy was facilitating whilst negative appraisals of mental health struggles or therapy, including lack of progress, was hindering. Participants also spoke in more neutral terms about the internal battle around attending or not attending therapy.

Staff focused on barriers related to limited resources and lack of staff support that was understandably not picked up by service users. Alternatively, service users drew attention to the negative appraisals of therapy. This suggests that overall staff and service users had similar understandings of what helped and hindered therapy, but there are some differences.

Discussion

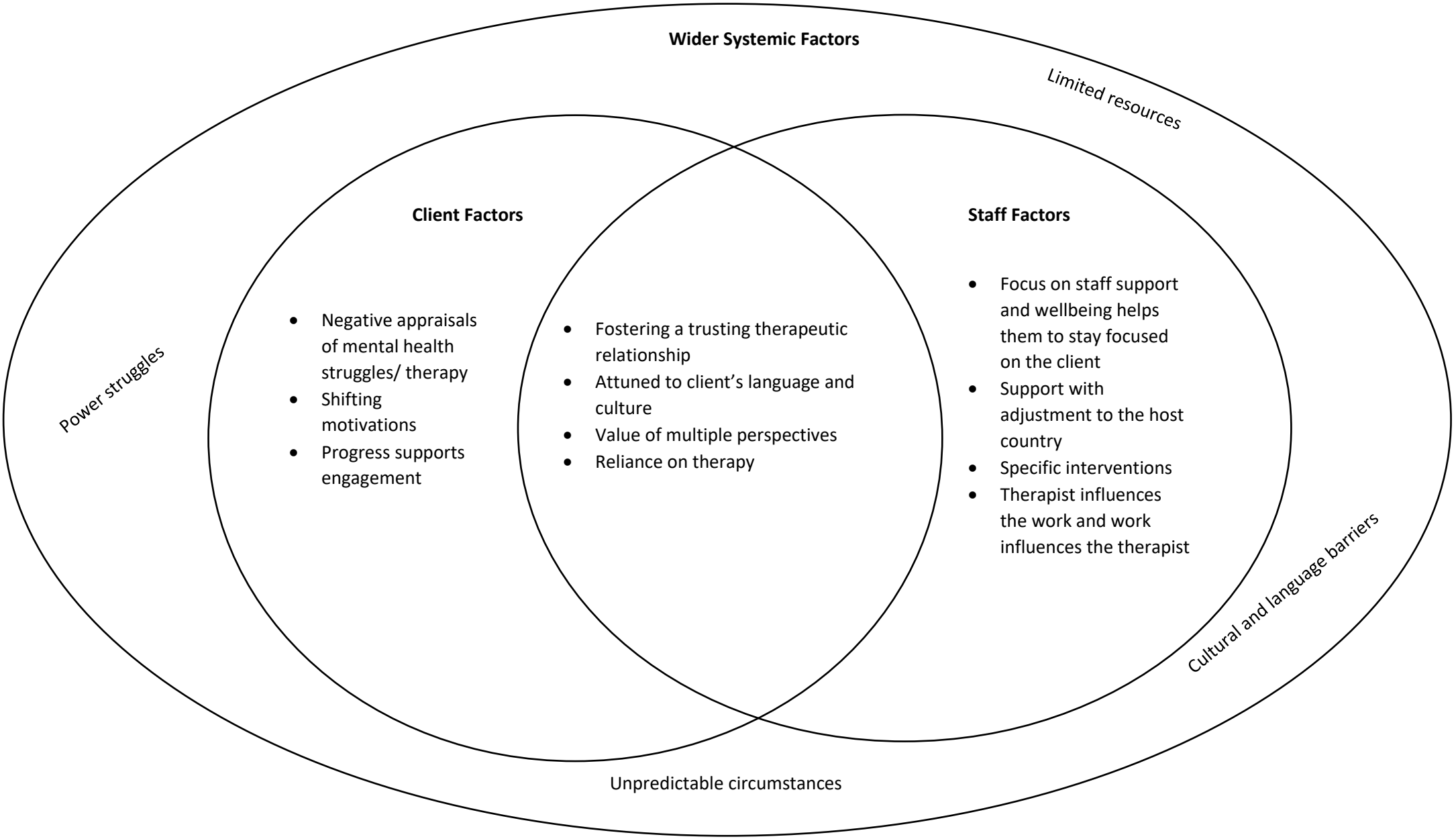
The aim of this review was to explore the experiences of adult refugees and asylum seekers who access therapy from staff and service user perspectives, particularly focusing on

supportive and hindering factors. During analysis, a third category of ‘neutral’ factors was developed as some themes did not fall into supportive or hindering.

Overall, this analysis created a complex web of factors related to the client, therapist, relationship between them and wider society (see figure 2) that supported or hindered adult refugee and asylum seekers engagement with therapy. Although some themes were similar to previous reviews, some new themes were developed that may be more related to adult experiences. This included the importance of attending to power struggles, developing attuned communication, and having therapy in groups. These are further summarised below, including clinical implications.

Figure 2

Diagram representing the themes generated as relating to client, staff, and systemic factors

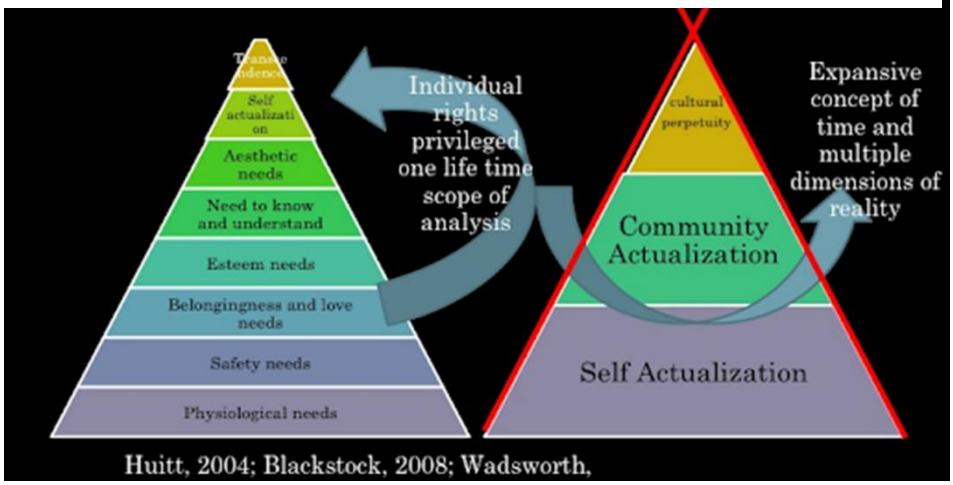


Overall, seven analytic themes were developed for ‘supportive factors’, five hindering analytic themes and three neutral analytic themes.

Initially the themes generated in this review appeared to fit within Maslow’s Hierarchy of needs (Maslow, 1943). Supportive themes around supporting with adjustment to the host country appeared to fit with the physiological needs that make up the foundation of the hierarchy. Fostering a trusting therapeutic relationship, and the value of multiple perspectives appeared to fit with the love and belonging needs. This could suggest that is important for staff to attend to the needs lower down the hierarchy before they can support clients to access their esteem and self-actualisation needs. However, when examining the remaining ‘supportive’ aspects and the ‘hindering’ aspects these seem to move away from the importance of individualistic aspects and focus on culture, language and how society shifts across time. Figure 2 also demonstrates how the client and staff-related factors can be understood within a wider systemic context. It was therefore felt that the Siksika (Blackfoot) way of life, that it has been suggested Maslow’s Hierarchy of Needs was based on, may be a better way of understanding the themes generated in this review (Heavy Head, 2018). This focuses more on multi-generational community actualisation (Blackstock, 2011) and connection to place (Heavy Head, 2018), which are valued above meeting individual needs. Figure 3 shows these differences in more detail.

Figure 3

Maslow's Hierarchy of Needs Compared to Blackfoot Ideas (Blackstock, 2014, as cited in Ravilochan, 2021)



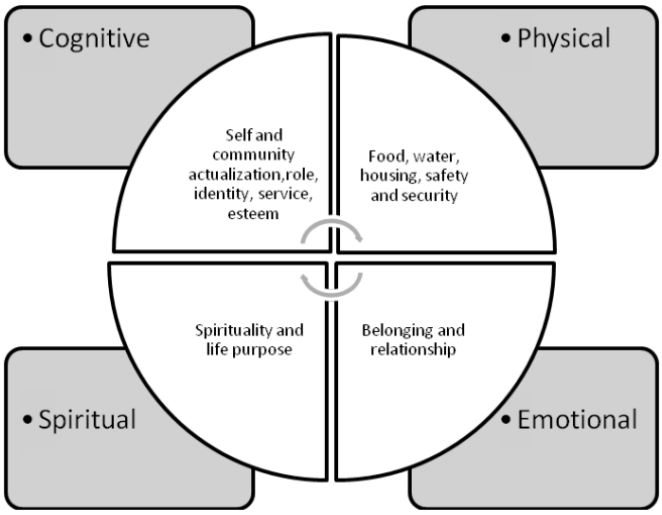
The first analytic theme of fostering a trusting therapeutic relationship was mentioned in all studies. Understanding this through the Blackfoot community's ideas that individuals are innately self-actualised (Heavy Head, 2018) allows us to see the therapist's role as decentred, which provides them space to connect with the client and appreciate the client's wisdom about what would be helpful. The importance of the therapeutic relationship is supported by Duden et al's (2020) review, which found that "therapeutic relationship and trust" was a key helpful aspect in the therapeutic process. This also fits with the general literature around the therapeutic relationship, which suggests it is the most important factor for improving client's psychological wellbeing (Horvath, 2001). The second theme of being attuned to client's culture and language supports this, suggesting that when the therapist steps back and attunes themselves with the client's wisdom they benefit more from therapy. The inclusion of two studies that focus on interpreter-mediated therapeutic relationships may have increased the prevalence of this theme and supported therapists to help the client access this wisdom even when there were language and cultural barriers.

The importance of support with adjustment to the host country was mentioned in all but two studies. This supports Karageorge et al's (2017) findings that refugees often present with a

more complex set of needs and require assistance with practical issues, and Duden et al's (2020) findings that "psychosocial work and advocacy" were crucial helpful aspects in the therapeutic process. These needs were often mentioned in relation to other people. In the 'value of multiple perspectives' analytic theme mutual support was mentioned within four studies, often related to providing practical support. Service users frequently mentioned enjoying being able to support other group members rather than just gaining support. This shows that although practical needs are important they can often link in with other needs rather than being mutually exclusive and linear, as described in Blackstock's (2011) work (see figure 4). The value of multiple perspectives has not arisen as an analytic theme in previous reviews. Groups were briefly mentioned as a descriptive theme within the analytical theme of 'adaptive approach and psychoeducation' in Duden et al's (2020) review and as a clinical implication in Demazur et al's (2021) review, due to the importance of social support to service users. Looking at this through a Western lens we may have understood this theme as relating to 'love and belonging' needs, however this could be better understood through the Blackfoot people's idea of 'community actualisation'. This suggests that meeting basic needs is a community responsibility, rather than falling on the individual. Even within the 'support with adjustment to host country' theme, descriptive themes often centred on connecting to the community and learning about the culture, suggesting these are a crucial part of the process.

Figure 4

Worldview principles orientated in the holistic model (Cross, 2007, as cited in Blackstock, 2011)



Staff and service users mentioned the lack of control over wider systemic factors and structures as making the therapeutic process difficult. This may suggest that 'community actualisation' needs are not being met, with responsibility being placed on to individuals for their wellbeing, rather than the community helping to provide these. It is important to acknowledge that the degree to which mental health structures and resources were missing varied across studies and settings. Studies conducted in European countries and America were more focused on the time-limited nature of support, whilst the two studies conducted in Brazil (Duden & Martins-Borges, 2020; Duden & Martins-Borges, 2021) highlighted higher-level structural difficulties in caring for refugees and asylum seekers.

Duden et al's (2020) review supported this, finding that 'external instability' acted as a hindering factor in the therapeutic process. Although the context of mistrust was mentioned in both Karageorge et al (2017) and Duden et al's (2020) reviews, the theme of power struggles was a lot more prevalent in the current review, being found in eight studies. This

may be linked to what is perceived as an adult's 'role' of 'providing', particularly if they have children. This may be more difficult to do in the host country. This supports Bogic et al's (2015) and Hynie et al's (2018) findings that factors individuals have little control over, such as poor socio-economic status and discrimination, are likely to increase the prevalence of mental health difficulties in this population. This explains why these may occur as topics during therapy. Moreover, adults are likely to have experienced more power and control in their home country, which has now been taken away. Alternatively, children and adolescents may be used to having less power due to their status, and will have access to tools to increase their power in the host country e.g., through education (Sleijpen et al., 2016). Interestingly, although both staff and service users were aware of the powerlessness of clients and staff in the wider context, only staff drew attention to power differences between the therapist and client. Viewing the relationship through a community actualisation lens (Blackstock, 2011), where everyone is responsible for helping to meet basic needs, could help explain this. Service users may see this support as part of a wider community of support, rather than the therapist providing a service to them.

Language and cultural barriers were seen as impacting on the therapeutic process in nine studies. Participants mentioned fears of being rejected by their own communities if disclosing mental health difficulties, and the fear of being misunderstood by their therapist due to language barriers or cultural differences. Both Karageorge et al (2017) and Duden et al (2020) supported this. Duden et al (2020) found that "cultural and language differences" was a key hindering factor, whilst Karageorge et al (2017) found that cultural avoidance led to refugees feeling unable to disclose details about their culture, for fear of being rejected. This can also act as a barrier to services initially (Satinsky et al., 2019). Participants mentioned spiritual understandings of mental health, which may be different to how therapists understood the difficulties, which can sometimes act as a barrier. In First Nation perspectives,

cultural perpetuity, i.e. the passing of knowledge to future generations and being informed by past generations, is very important (Blackstock, 2011). This may help to explain why therapist dismissal of cultural values and understandings could harm the relationship.

Several themes, both facilitating, hindering and neutral, linked to client's appraisals of the therapeutic process. Negative appraisals of mental health struggles and therapy was evident in nine studies. Negative appraisals of mental health was sometimes linked to shame and stigma stemming from their cultural understanding of mental health. Participants mentioned their diverse motivations for starting or continuing therapy and the psychological impact that talking therapy had. A similar theme of "talking therapy" was mentioned in Duden et al's (2020) review, which highlighted the cathartic impact talking therapy can have, and the reasons clients may or may not choose to talk.

Participants in three studies mentioned therapy being unhelpful or harmful, a theme that also occurred in Duden et al's (2020) review. This theme was only mentioned by service users suggesting it could be a blind spot for therapists, who may view therapy as always helpful. This suggests that it may be useful to name that therapy can be a difficult process and acknowledge that sometimes clients may need a different type of support than therapy, or that a biospsychosocial approach may be beneficial. For example, Moreira & Jakobi (2021) found that art-based interventions for social inclusion gave refugees and asylum seekers a space to express themselves and develop a sense of agency. They were also useful for developing a dialogue between the refugee or asylum seeker and the community they were now living in, which could support with community actualisation. This suggests that social interventions may sometimes be more effective than clinical interventions and can support with the feelings of powerlessness and cultural barriers that emerged in this review. It is important to acknowledge that interventions linked to the person's culture, such as seeing a traditional healer, may also be seen as more useful than therapy developed within a Western framework

(Satinsky et al., 2019). Similarly, the importance of the medical model was mentioned only by service users, suggesting this may be another blind spot for staff. However, staff did mention the importance of multi-disciplinary team (MDT) working, suggesting there is some consideration of the importance of other professionals in this work.

The role of the therapist and the importance of them receiving adequate support was highlighted in this review. The theme of 'therapist influences the work and work influences the therapist' suggests that therapists are both influenced by, and influence, the therapy in significant ways. This is similar to Duden et al's (2020) review which highlighted the impact of work on psycho-social professionals, including experiences of feeling overwhelmed and vicarious traumatisation, alongside more positive experiences of mutual learning and renewed awareness. In this review staff support was seen as a positive factor in allowing professionals to stay connected with the client. Having supervision, support from the team, and developing coping skills placed both supporting the client and meeting staff member's needs as more of a community responsibility, rather than falling specifically on the staff member. Mental health professionals having support structures was seen as a facilitator in Duden et al's (2020) review, and in both reviews this was understandably only mentioned by professionals themselves, rather than service users.

Assessment of strength of the evidence and the review

Overall, studies were of a high or medium quality. Those rated as medium quality were generally limited by a lack of information. Five studies failed to mention the research being assessed by an ethics committee, and the role of the researcher was not clearly described in eight studies. The inclusion of studies that looked at specific interventions or aspects of mental health support may have also biased the codes that were created. Despite this the

overall good quality of studies suggests that interpretations can be made with some confidence.

The variety of countries included may limit generalisability of studies, as some themes were more relevant to specific countries. For example, the lack of mental health structures in Brazil was seen as a significant barrier and this theme was less prevalent in studies conducted in European countries or the US. Moreover, the inclusion of both refugees and asylum seekers may have created more diverse codes, as their status in the host country may have impacted the difficulties they had at the time (e.g. asylum seekers may be more likely to find uncertainty about the future a barrier). A lack of heterogeneity has been viewed as a limitation of previous reviews and unfortunately the limited research in this area means there is a lack of heterogeneity in this review in terms of countries that refugees and asylum seekers are from or have resettled in.

Although the variety of aims of included studies may have resulted in specific codes being generated that related to these aims (e.g. Bartholomew's study was related to cultural understandings so generated more codes related to culture), all themes had a variety of studies included, suggesting this did not bias the results.

Clinical Implications and Future Research

Understanding these themes through Maslow's Hierarchy of Needs (Maslow, 1943) compared to Blackfoot/ First Nations ideas (Blackstock, 2011; Heavy Head, 2018) could create very different clinical implications. Although there is not one 'truth' that was created through this review, the themes suggest that some of the following implications may be useful.

It may be important to attend to service users' basic needs and adjustment to the host country. Although Maslow would suggest this should be done in a linear way, focusing on these needs

first, Blackfoot ideas suggest that therapists can support with these needs alongside other work (Blackstock, 2011). This can include therapists engaging in advocacy work and referring to other services, which supports in responsibility being placed on the community rather than just the client or therapist. Groups may be another useful way of meeting these needs, with service users valuing the opportunity to support one another both practically and emotionally. Future research could further explore the effectiveness of groups, as only a limited number of studies explored group therapy within this review.

The key theme of 'powerlessness' highlighted in this review suggests this may be important to attend to when working with an adult population who may have dependents to look after and are perhaps used to having power over their situation in their home country. Therapists could highlight this during formulation and intervention stages, e.g. through using power mapping (Hagan & Smail, 1997) or using the power threat meaning framework (Johnstone et al., 2018). This could help staff and service users develop a shared understanding, which was also highlighted as important in this review. The development of shared language, including through the use of interpreters, is essential for this and suggests that services should ensure they have the appropriate resources to allow attuned communication (e.g., hiring interpreters who have psychological understanding). Use of the power-threat meaning framework could help identify how multiple levels of power are operating in the client's life. This may include the impact of legal processes, economic processes and the impact of discrimination and racism. This was mentioned as a hindering factor for therapy, within the theme of 'unpredictable circumstances'. It would be interesting to understand whether service users feel like this impacts the therapeutic process itself, as it was only mentioned in relation to racism experienced in wider society.

Multiple themes highlighted how the therapist can impact on the work and the work can impact on the therapist. Staff support was seen as particularly important and highlights the

importance of services ensuring there are appropriate support structures in place. The importance of therapists being culturally sensitive, highlighted in this and previous reviews, suggests that these spaces should allow staff to reflect on their own cultural understandings of mental health and the social graces (Burnham, 2018). This may allow reflection on any biases or blind spots. Ideas from Blackfoot communities, that self-actualisation is innate, would support the idea of wisdom being drawn out through reflective groups, rather than staff being put into training that imposes certain beliefs and understandings on them. Therapists may consider using therapies that naturally decentre the therapist, such as narrative therapy. This refers to the therapist being "de-centred but influential" (White, 1997) and allows the therapist to consider their role and the importance of reflecting on this, whilst also drawing on the wisdom of the client.

Due to limited literature, both refugees and asylum seekers were included and there were no limits on how long participants had been in the UK. In the future, research could explore what is helpful and hindering during therapy at different time points. This could allow understanding of whether service users require different things depending on how long they have been resettled, in line with Bartholomew's (2021) findings that refugee and asylum seekers understanding and attitude towards mental health changed the longer they had been in the host country.

Both staff and service users were included in this review, due to a limited number of papers from the perspectives of service users. Although there were some overlaps in themes that staff and service users viewed as important, some themes did arise that were unique to one group. This suggests the results may have differed somewhat if only service users were included, and more research is needed in this area that speaks directly to service users. This is particularly important as powerlessness was a key theme in this review, so drawing on their wisdom to inform practice may help with feelings of empowerment.

Conclusion

Overall, this review highlights the importance of attending to community needs alongside individual needs when working with refugees and asylum seekers. The development of a trusting therapeutic relationship and shared understanding is crucial for drawing out the wisdom that service users have. This is facilitated by attending to cultural and language needs of the client. Allowing space for staff to access support and reflect on their own cultural understandings and biases is also crucial. Understanding that therapy occurs in a wider context and attending to this alongside mental health needs allows staff to work with other services. This allows both clients and staff members to view the client's needs as a community responsibility, rather than falling on one or both of them.

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Part Two: Empirical Paper

This paper is written in the format specified in the journal

Psychosis

Please see Appendix N for submission guidelines

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Experiences of staff working with refugees experiencing distressing suspicious thoughts

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Abstract

Background: Staff play an important role in supporting refugees experiencing distressing suspicious thoughts to access and remain in services that are crucial for their wellbeing and survival. However, there is currently no literature exploring the experiences of staff working with refugees experiencing these thoughts.

Methods: Seven staff members working with refugees experiencing distressing suspicious thoughts were recruited from NHS and community services and via social media. They were interviewed and data analysed using interpretative phenomenological analysis.

Results: Three superordinate themes were developed from the interviews: *working in broken systems; the social self* and *self-identity and its transformation.* These each contained subthemes.

Discussion: This research highlighted that staff play a critical role in the systems of refugees experiencing distressing suspicious thoughts. This relationship occurs within wider systems and is influenced by cultural and societal attitudes.

Key words

Psychosis; Paranoia; Suspiciousness; Refugees; Interpretative Phenomenological Analysis; Staff

Introduction

The United Nations High Commissioner for refugees defines a refugee as "an individual who has fled from their country of origin due to a well-founded fear of being persecuted on the grounds of race, religion, nationality, membership of a particular social group or political opinions" (United Nations High Commissioner for Refugees, 2020, p3).

In the UK, refugees work with general services (e.g. the NHS) and services that support them with specific matters associated with receiving status (Refugee Council, 2022). Staff have a key role in supporting refugees to access and remain in these services. Previous research exploring experiences of staff working with refugees highlighted the importance of building up trusting relationships, the impact of systemic factors like racism and lack of resources on the work, and personal experiences of staff such as finding the work emotional but rewarding and noticing personal growth. (Century et al., 2007; Guhan & Liebling-Kalifani, 2011; Robinson, 2014).

However, staff perceived refugee and asylum seekers frequent mistrust of them and their services as hindering to the work (Duden et al., 2020; Karageorge et al., 2017; Ní Raghallaigh, 2014). This mistrust can be seen as existing on a continuum or hierarchy of suspiciousness ranging from experiences that are infrequent or viewed as helpful to those that cause extreme distress (Cooke, 2017; Freeman et al., 2005).

In this way severe 'paranoia' can be viewed as building upon common emotional concerns that most people experience (Freeman et al., 2005). However, in the UK this is often constructed as a 'mental health difficulty', coming under the umbrella term of 'psychosis'(Cooke, 2017). A key criterion for suspiciousness being constructed in this way is

that it causes social or occupational dysfunction and is associated with distress (American Psychiatric Association, 2013).

The majority of research has looked at the experience of refugees in terms of the label of 'psychosis', which also includes other experiences such as hearing voices (American Psychiatric Association, 2013). These experiences have been found to be more common in refugees than in comparative populations (Dapunt et al., 2017; Parrett & Mason, 2010), and when compared to non-refugee migrants (Anderson et al., 2015; Hollander et al., 2016).

Some studies have explored the specific complaints that occur within these diagnoses, finding that refugees with "psychotic symptoms" experienced suspiciousness of others and lost everyday trust (Nygaard et al., 2017; Rhodes et al., 2016). This suspiciousness was sometimes directed towards individuals or organisations in their present life and sometimes related to their country of origin (Nygaard et al., 2017).

Two key pathways to unusual experiences help to explain this increased prevalence amongst refugees: trauma and "social defeat".

Unusual experiences have been found to be more common in individuals who have experienced trauma. In the unusual experiences literature, trauma is used in its widest sense and includes experiences such as sexual abuse, childhood abuse, neglect, political trauma, insecure attachment style, neighbourhood neglect and living in an urban area, which have all been linked to experiences of 'psychosis' (Gumley et al., 2014; Heinz et al., 2013; Kirkbride et al., 2014; Matheson et al., 2013; Morrison et al., 2003; Varese et al., 2012). In relation to refugees specifically, trauma in their home country was a potential causal factor for unusual experiences in general, but also suspiciousness specifically (Parrett & Mason, 2010). Negative experiences in the host country may moderate recovery from pre-migration trauma (Hynie, 2018).

The traumagenic neurodevelopmental model (Read et al., 2001) has been used to explain this increased risk in those who have experienced trauma. It suggests that if adverse life events, significant losses or deprivations are severe or early enough, they can mould the brain in a way that makes it more sensitive to stressors in adulthood. This increases the likelihood of individuals responding with 'positive symptoms of psychosis' such as delusions and hallucinations, that can often involve 'paranoid thoughts' (Read et al., 2001; Walker & Diforio, 1997).

The second pathway to unusual experiences is social defeat, which is described as having a subordinate or outsider status (Selten & Cantor-Graae, 2005). This is linked to sensitisation of the mesolimbic system, which can result in the development of unusual experiences, sometimes described as "psychotic" (Selten & Cantor-Graae, 2007). This theory is used to explain why individuals who are discriminated against are more likely to have unusual experiences. It is supported by higher levels of unusual experiences in groups from ethnic minority backgrounds (Kirkbride et al., 2017) and migrants that came from developing countries (Termorshuizen et al., 2020).

Gaps in the literature and rationale

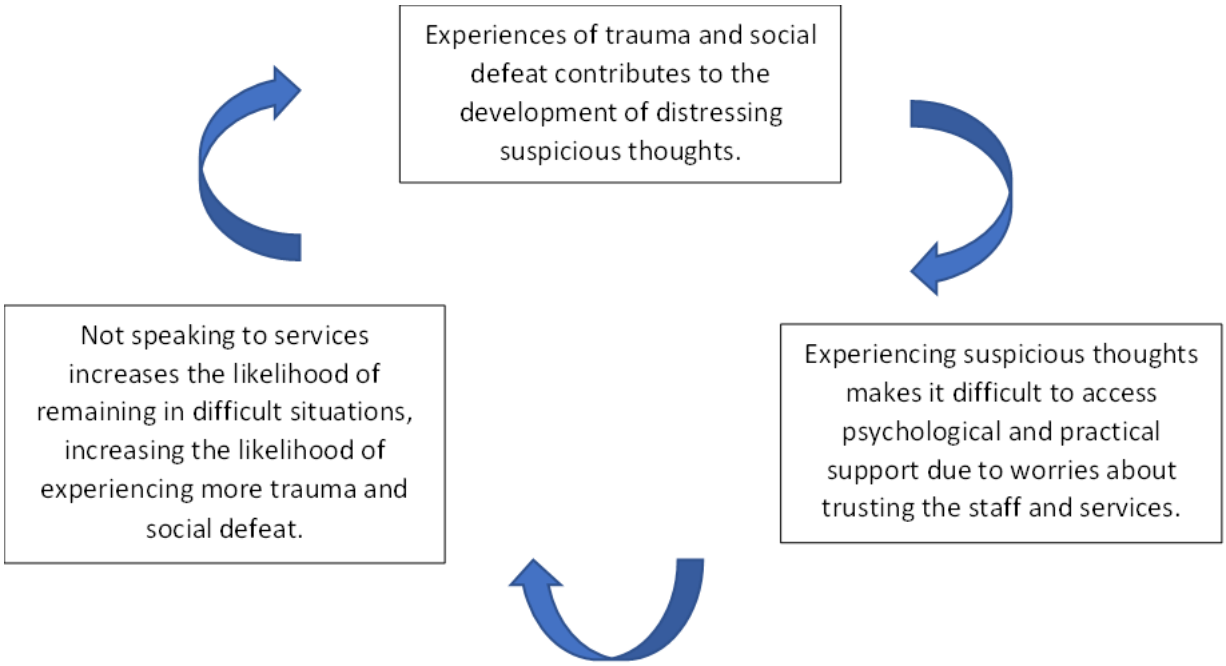
As described above, suspiciousness, both at the extreme end of the spectrum, where it was constructed as 'psychosis,' and general mistrust has been identified in refugees. This was identified within staff-refugee relationships, however no known research has directly explored the experiences of staff working with refugees experiencing distressing suspicious thoughts (hereafter referred to as DSTs).

This is important as experiencing DSTs may make it difficult for refugees to access and remain in services that are crucial for their survival and physical and mental wellbeing. This may form an almost cyclical process, whereby this lack of support makes refugees more

vulnerable to further trauma and social defeat (see figure 1). Understanding staff's experience in this work may help identify support needs, which will allow them to better support refugees.

Figure 1

Proposed cyclical process of trauma, social defeat, and suspicious thoughts in refugees



The research question is: *what are the experiences of staff members working with refugees who experience distressing suspicious thoughts?*

Methods

Design

A qualitative design using individual semi-structured interviews was used. Interpretative phenomenological analysis (IPA) was used to analyse the results (Smith et al., 2009).

Recruitment and participants

Ethical approval was obtained from the University of Hull, Faculty of Health Sciences Research Ethics Committee and the Health Research Authority (see appendix G). Posters (see appendix L) were displayed at bases of third sector and NHS services that work with refugees, and the researcher also attended staff meetings to speak about the research and answer any questions. An amendment was later submitted to open recruitment on social media due to low levels of recruitment. Posters were displayed in social media groups related to refugees or mental health.

Recruitment took place between May and August 2022. Participants self-identified using the criteria displayed on posters and contacted the researcher via email. Eleven participants initially contacted the researcher to express interest in the study. Three participants did not reply to follow up emails and one withdrew following initial contact due to personal reasons. This resulted in seven participants partaking in interviews, which was felt to be appropriate due to the informational power provided (Malterud et al., 2016) (see results section for further information on this).

When participants emailed the researcher, a participant information sheet was provided (see appendix H), and the participant was invited to ask any questions either over email or phone. They were asked to confirm they met inclusion criteria, which is as follows:

<u>Inclusion</u>

1. Have worked with at least one refugee experiencing suspicious thoughts. (See appendix H and L for how this was described on recruitment material).
2. Have worked with refugees for at least a year, in the past five years.
3. Speak English.
4. Are living and working in the UK.
5. Are 18+ years old.

Exclusion

1. Not having capacity to consent to an interview.
2. Not giving consent to have the interview recorded.

Seven participants were included. Please see table 1 for a summary of their demographic information. Please note Eman's missing demographic data is due to her interview taking place before the amendment to collect it was approved, and not being able to obtain it afterwards.

Table 7

Participant Demographics

Pseudonym	Gender	Years working with refugees experiencing suspicious thoughts	Number of refugees experiencing suspicious thoughts worked with	Ethnicity	Organisation type and job role
Zuri	Male	10	25	Black-British	Charity- CEO
Eman	Female	6	40-60	Not provided	Not provided
Janet	Female	5	8	White	NHS- mental health worker
Kayla	Female	6	50+	White	Charity- charity worker

Freya	Female	4.5	1	White	Charity- support worker
Jett	Female	20	100+ (up to 1000s)	White	Charity- charitable organisation officer
Grace	Female	3.5	10	White	Local authority- family practitioner

Procedure

Interviews were arranged via email and took place at the staff member's base. Video conference was used for participants recruited via social media or who preferred an online interview. A consent form (see appendix I) was signed in person or virtually. The researcher verbally checked consent and provided opportunity for questions at the start of the interview.

Interviews had an average length of 56 minutes and were verbally recorded on an encrypted laptop. Images were captured for interviews that took place on via video conference, but participants could turn their camera off if preferred. Interviews were transcribed immediately after participation. Participants received a source of support sheet (see appendix K) following participation and the researcher checked for signs of distress during interviews. Participants were asked to choose their preferred pseudonym, but four participants asked the researcher to select one for them.

Analysis

Analysis was conducted in line with IPA protocols (Smith et al., 2009). Transcripts were read line by line and the researcher conducted initial noting, which included descriptive, linguistic and conceptual comments. Emergent themes were generated from these notes. This was repeated for each transcript, and preliminary themes were compared between transcripts to

promote further development of subordinate and superordinate themes. Three analysed transcripts were shared with research supervisors. They conducted independent IPA analysis on the transcripts which was compared to the researcher's analysis and discussed in supervision to ensure rigour.

Researcher influence

Due to the interpretative nature of IPA it is important to acknowledge the researcher's own background and experiences, as these will have undoubtedly influenced the development and implementation of the research. The researcher has an active role in co-constructing the research with the participant (Finlay, 2002) so their own influence cannot be ignored.

The researcher is a white-British, female trainee psychologist who has lived in England since birth. Growing up within these Western structures has undoubtedly influenced the way she sees the world and required consideration during the research process. In England, individualism is largely valued, meaning she may have paid less attention to ideas around community and connection. Moreover, she will undoubtedly have been influenced by Western media throughout her life, which may have created specific preconceptions around refugees or suspiciousness.

Her role as a trainee psychologist focuses on understanding the psychological and social influences on people and her understanding of suspiciousness is guided by this. Participants knew that the researcher was a trainee psychologist, which may have influenced the ideas they shared with her. Previous research has highlighted how viewing the researcher as a professional can impact on what they share (Ballinger & Payne, 2000).

The researcher has values around equality and fairness, which will have influenced the construction of her research question (Finlay, 2000) and may have influenced avenues she

explored during interviews. Being aware of these and the influence of her demographics and reflecting on them in her research diary, during a reflexive interview with her supervisor, and during research supervision helped her to acknowledge the impact these may have had.

Please see appendices A and B for the researcher's extended reflective statement and epistemological statement which provides further context and information on how these influences were managed.

Results

Overall, seven participants were interviewed and their data was analysed. Seven participants was felt to be an appropriate number based on the criteria from Malterud et al (2016)'s model of informational power. The narrow aim of the research, sparseness of sample, lack of theory in the area, strength of dialogue during interviews and the cross-case analysis strategy were all considered and discussed in supervision. Data saturation was also considered (Morse, 1995) and following analysis of the seven interviews it was felt that no new information was being added.

Three superordinate themes were generated from the interviews, made up of three-four sub-ordinate themes. These are summarised in table 2 below.

Table 8

Subordinate and superordinate themes

Superordinate Theme	Subordinate Themes	Number of participants contributing
	The harm of system failures	7

Working within broken systems	Systemic injustice and dehumanisation	6
	Systemic 'stuckness' and change	6
The social self	Isolation and belonging	7
	Being part of a professional community	4
	Building safety within the therapeutic relationship	7
	Coping with emotions of self and other	6
Self-identity and its transformation	Transformation of staff identity	7
	Development of the 'suspicious self'	6
	Changing relationships with the 'suspicious self'	7
	Individuality of the refugee	7

Working within broken systems

Participants contextualised their experiences of working with refugees with DSTs in terms of the systems they worked in. Participants identified the challenges of working in systems that felt unjust, dehumanising and harmful.

<u>The harm of system failures</u>

All participants spoke about the impact of systemic failure on refugees, either in the development of their suspicious thoughts or in perpetuating them.

Eman recognised that systemic failure, such as *"government, police, army"* was something that led to refugee mistrust initially. However, participants identified continued failures in UK systems, through lack of timely support for DSTs and systems being organised around crisis support rather than preventative action.

For Janet, this lack of support seemed difficult to comprehend and perhaps different from the supportive systems she may have envisioned when starting in her role:

"I don't know. I can't find the words really… it's it's like… not wow as in wow, like wow as in, I can't believe this person has has had to end up like this before this intervention has occurred." (Janet)

Participants expressed frustration at not being listened to and felt personally let down by processes. Kayla appeared conflicted between anger at how systems let refugees down and recognising *"compassion fatigue"* in workers. However, she still found it challenging when other professionals *"feel attacked and take it really personally"* when she asks questions to try and support refugees.

<u>Systemic Injustice and Dehumanisation</u>

Six participants spoke about how injustice and dehumanisation of refugees within UK systems contributed to the development of suspicious thoughts or impacted on the help refugees received. This was often linked to stigma and racism related to both an individual and institutional level.

Participants mentioned racism on an individual level and being perpetuated through the media. These racist messages, stigma and misinformation around refugees can be infuriating for staff members. Janet viewed it as her responsibility to support with this:

"It isn't just the mental health aspect, it's the racial aspect as well that we're trying to change and this whole myth that you come across and you get loads of benefits and and things like that. It's just I sit there and my skin, I want to claw my skin off because I just think you haven't got a clue. You haven't got a single clue." (Janet)

Alongside these racist messages within society, participants noticed racism and dehumanisation of refugees on an institutional level. Kayla appeared upset and frustrated at how this institutional racism impacted on the support refugees received:

"We constantly praise ourselves for being ACE aware and an ACE aware nation and all these lovely positive things. And the reality is, that's only if you're white and born here." (Kayla)

Systemic 'stuckness' and change

Six participants spoke about the role of systems in creating 'stuckness' for refugees and in their work. They contrasted this with the ways they work to make change within these stuck systems.

Janet expressed sadness at the 'stuckness' that refugees seem to constantly face:

"I think the group feels like there's there's always a barrier to get to where they want to be." (Janet)

This mirrored the powerlessness that all six participants felt of being one person stuck within wider systems. Kayla highlighted how difficult this felt:

"And you can only help so many people. That needs to be through systematic system change and there needs to be… just more understanding and better provisions because I don't know what's going to happen if there's not. It just seems really dark for me…" (Kayla)

However, participants did try and hold hope for change, even when this felt difficult. For Janet, being involved in advocacy for refugees was a way of continuing to hold this hope, and helped her feel like she was making change on a wider level:

"I actually get out there, I get out into the community, I speak to people. I see people, you know." (Janet)

The Social Self

Participants highlighted the importance of social networks, relationships and a sense of belonging in their work with refugees experiencing DSTs. This was important for both themselves and the refugees, and contrasted with the isolation that was sometimes experienced.

<u>Isolation and belonging</u>

Staff spoke about the role of isolation and belonging in helping refugees feel able to trust and open up about their suspicious thoughts. Eman found it easier to support refugees with their thoughts when they had a support network around them:

"With people who've got a support network in general it's easier to go to go through their suspicious thoughts and maybe debunk myths" (Eman)

Belonging could occur in different ways, for example through being *"a regular member of the Church" (Grace), "art community" (Eman) or "cooking classes" (Grace)* and shows how individual this experience is.

Participants felt it was important to foster this sense of belonging within the services they worked in. Zuri highlighted the care and warmth he feels towards clients, by explaining how he attempted to make his service feel like a family home:

"I make sure they feel as being coming into the building as a family home or a family place." (Zuri)

Professional Community

Four participants spoke about the importance of belonging within a professional community in helping them support refugees with suspicious thoughts.

Grace appeared to worry about getting things 'right' for the client, highlighting her care for them. Speaking to other experienced professionals within her team was therefore reassuring:

"And if there were particular incidents, I would always I would I would always do a kind of, make an effort to speak to somebody." (Grace)

Jett agreed that inter-professional support was helpful and took it upon herself as a senior member of staff to break the stigma around not being able to share with colleagues when things were difficult. The importance of this was reinforced by her previous experiences of speaking to colleagues when working with a particularly challenging client. This sharing helped her to feel more contained, where previously she had been too concerned about the client to sleep:

"When those people started ringing me back, probation workers, social workers, and we could talk about her, as I talked, she went out of my head." (Jett)

Janet also highlighted that being part of a professional community aided with the provision of holistic support.

"And I mean, I'm low-level mental health as well, and that's why I bring in kind of other services, in with you know again that holistic look." (Janet)

Building safety within the therapeutic relationship

All participants spoke about the role of the therapeutic relationship between them and the client, in building trust and feelings of safety in refugees. For Eman, building this relationship was a priority:

"Instead of worrying about how I want to help them, how to do that, it's more about okay let's focus on building this relationship." (Eman)

Participants had different ways of building this relationship, however it predominantly focused on empowering the client and providing care and compassion. Zuri explained that asking the client's permission to ask questions was crucial and his use of dialogue suggests a centring of the client within the work:

"You need to ask the person 'can I ask a question?' because you need to get this client ready to answer you, so I always say 'can I ask you a question, do you mind, oh you did say something when you were talking, do you mind to talk a bit more about it?' That is the only way they begin to tell you." (Zuri)

Once they had this trusting relationship, participants described being in a position of responsibility to help build the trust with other people, and generalise it to organisations and systems. As Eman explained, this could often be a difficult position to be in:

"I found it really difficult to try to convince them is yes I did help them with everything, but it's not just me, it's the whole system, and that is usually the next step." (Eman)

Coping with emotions of self and other

Six participants spoke about the emotional side of working with refugees experiencing DSTs, for both them and the client, however they appeared at different stages of acknowledging this.

For Kayla, it has been very difficult to acknowledge the emotional impact the work has on her, but she has felt more able to do this recently:

"And but no, I find it very challenging. And I think it's only been in the last twelve months that I began began to really look at how I sort of protect myself and maintain boundaries better and cope with that level of challenge." (Kayla)

However, Jett has already seen the impact that not acknowledging the emotional toll of the work can have on staff:

"And and that is why there is such high burnout when it comes to the emotional stuff. Either people get really hard and unfeeling because they're cut off from their emotions, or they get over emotional and burnt out." (Jett)

Five participants spoke about using empathy and holding the pain between them and the client, however Zuri explained that having these high levels of empathy can sometimes mean you carry the client with you. His use of wording suggests an attempt to normalise this and produce compassion for these experiences:

"you you are human, you feel their pain their pain as well and it's really difficult to go away without thinking about them all the time." (Zuri)

However, at other times ignoring or suppressing emotions was seen as more useful:

"I try as much as possible not to show any sign of surprise or shock."(Zuri)

Despite the challenge of working with difficult emotions, participants mentioned the joy and privilege of being able to share the positive emotions clients experienced during their work. Grace highlighted her joy at sharing the moment when a client was reunited with her son:

"That was an incred-incredible moment that the joy that that I saw in her face when she introduced me to him." (Grace)

Transformation of self-identity

Participants highlighted the self-identities that both they and their clients had and how these changed over time and through their work together. They highlighted how both they and the client were made up of different parts, which developed through experiences.

Individuality of the refugee

All participants alluded to humanising refugees and recognising their individuality, however some participants mentioned this more explicitly. For example, Jett explained:

"You've also got your emotional side of things that's seeing the person as an individual, a person, and recognising their feelings." (Jett)

All participants referred to the positive qualities of clients they worked with, rather than just mentioning the suspicious thoughts they were experiencing. This suggested it felt important that their individuality was recognised outside of 'someone who experiences suspiciousness'.

For Grace, working with client's values and *"getting back to doing the things they love doing"* was crucial and highlighted the importance of recognising individuality.

Development of the suspicious self

Although acknowledging the refugee outside of their suspicious thoughts was important for participants, understanding how the refugee's 'suspicious self' emerged and became a part of their identity was also crucial.

For six staff members, understanding their backgrounds both in their home country and in the UK supported understanding of why this 'suspicious self' emerged. Zuri understood that refugees often had horrific experiences and mistrust became generalised from this:

"er looking at their background and where they come from, er especially those who have been trafficked and stuff, they don't trust people so therefore they become suspicious of everybody." (Zuri)

Four participants attempted to make meaning of the development of the 'suspicious self' through a psychological or trauma lens. For example, Kayla thought that attachment was particularly important to understand:

"And and and I think a lot of the link is with trauma. For me, the link is always about attachment and about early attachment in their childhood. (Kayla)

Five participants understood the development of the suspicious self in relation to the refugee's cultural background. Zuri explained that belief in *"witchcraft"* is common in refugees, particularly those from Africa, so when something is happening *"they believe oh okay that person is a witch or a wizard".* He mentioned that there are also *"a lot of birds or animals or plants that in some jurisdictions are attached to as evil animals or birds or plants."* This means that refugees he works with sometimes experience suspicious thoughts related to people being witches or wizards or ideas of 'evil'.

<u>Changing relationships with the 'suspicious self'</u>

Participants spoke about how their, and their clients' relationships with the 'suspicious self' changed with time and learning. They highlighted that this journey was ongoing and brought up confusion at times.

All participants highlighted learning and teaching as a way of changing both their, and their clients' understanding of the 'suspicious self.' For some participants, this learning took more official routes such as attending courses around trauma informed care or doing degrees or further education in this area. For Freya, reading papers helped develop her understanding of why not all refugees may be presenting as *"paranoid"* despite a lot of them having been through very difficult experiences. However, this seemed to be a continued process of meaning making:

"So I'm just thinking that maybe a lot more are having suspicious thoughts, but they're just not sharing them because there's quite an interesting paper…" (Freya)

Some participants began to see DSTs in terms of something they could understand in line with their own reality, existing on a continuum. For Freya, understanding the thoughts in this way was associated with a shift in her worldview:

"I'm kind of like revising my worldview and thinking, well, actually it's a like a continuum and people who are not um you know don't have severe mental illnesses can have these thoughts" (Freya)

However, for other participants, externalising the suspicious thoughts felt more helpful and changed this relationship with the 'suspicious self' in a different way:

"And I just said that's you know, that's not possible. You know it's it's it's just your mind doing, it's not actually happening. And I, you know, I it did seem to help." (Grace)

Transformation of staff identity

Participants highlighted the changes they noticed in themselves, both personally and professionally, as they worked with refugees experiencing DSTs.

Participants recognised parts of themselves that they brought to the work, such as being from a similar background to the client or personality traits that led them to this type of work, such as being a *"fixer"* (Kayla). Participants noticed how these then changed over time, with parts of their personal and professional identity merging together, or having to take on a new professional identity to accommodate the client. For example, Eman noticed shifts in her professional identity as she moved from a nurturing role to a *"tough parent"* role, as she prepared the client to leave the service and connect with other services for themselves. This change in identity was difficult for her, but she recognised its importance.

Participants spoke about sometimes feeling worried or experiencing imposter syndrome when they started working with refugees with DSTs but noticed changes in their confidence over time. For example, Jett noticed changes in her professional abilities, but recognised that this was a continuous process and there was still further to go:

"Um I think I'm getting better at recognising hang on, this is a definitely a mental health issue rather than a behavioural issue. But it's still, it's still a difficult one, it's still a difficult one." (Jett)

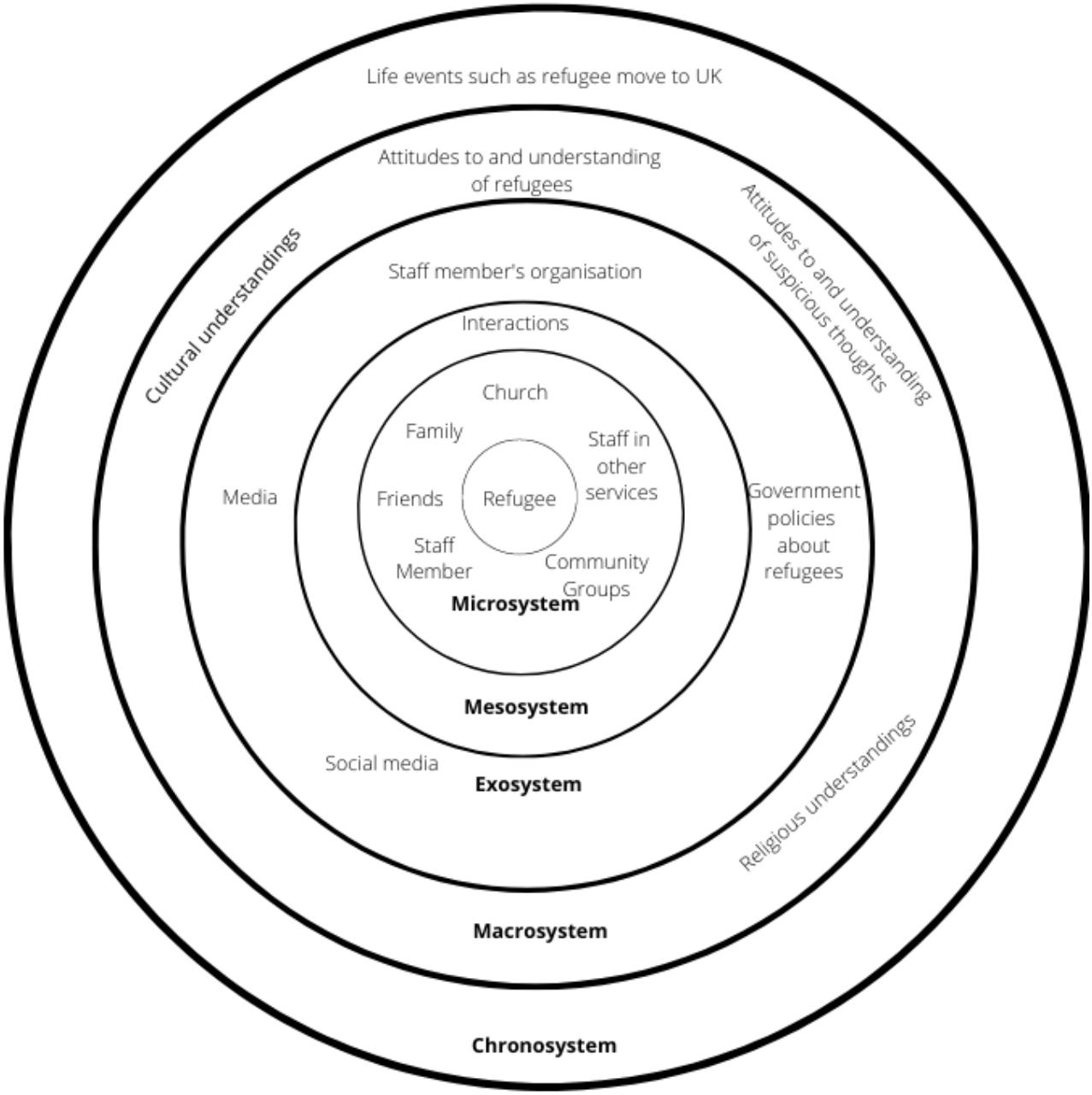
Discussion

This study highlighted that the relationship between refugees experiencing DSTs and staff that work with them exists within, and is influenced by, wider systems, communities and

relationships. Over time, this creates shifts in self-identity for both staff and refugees. This can be broadly understood in line with Bronfenbrenner's ecological systems model (Bronfenbrenner, 1977) as will be explored below (see figure 2). This provides novel understanding that professionals become a central part of refugees' systems, rather than simply someone they interact with.

Figure 2

Systems impacting on refugees experiencing distressing suspicious thoughts, based on Bronfenbrenner (1977)



Microsystem and Mesosystem

Participants described often being central to refugee's microsystems, particularly when they were very isolated. The therapeutic relationship was therefore key for establishing safety,

helping to challenge suspicious thoughts and beginning to build trust between the client and other people or organisations. A relationship of safety and trust was created through providing a 'secure base' (Ainsworth et al., 2015) from which refugees could safely explore relationships with other people and systems. Facilitating a sense of family and belonging within this relationship supported clients to find belonging within the wider community. However, when participants had difficult relationships with other services, this created ruptures in the mesosystem and impacted on refugees.

Participants highlighted that isolation, conceptualised in this model through having a limited microsystem, could contribute to the development of DSTs. This supports social defeat theory, which suggests that suspicious thoughts are more likely to develop when individuals feel they have 'outsider' status (Selten & Cantor-Graae, 2005). Participants highlighted the importance of belonging for refugees experiencing DSTs. This supports research that found social identification was associated with lower levels of 'paranoia' through increasing self-esteem (McIntyre et al., 2018).

Participant's central role in refugee's microsystems produced responsibility for containing clients' emotions, whilst managing difficult emotions that came up for them. Previous research has highlighted the emotional impact of working with refugees (Guhan & Liebling-Kalifani, 2011). However, being mistrusted by the client brought up additional sadness, confusion and frustration, even when they understood why the client was thinking in this way. Some participants mentioned that belonging within a professional community and accessing formal support helped their wellbeing. This supports previous research looking at the experiences of staff working with refugees in general (Robinson, 2013) and highlights the importance of positive relationships within refugee's mesosystems.

Exosystem

Participants described their work with refugees as existing within harmful, failing systems that do not provide refugees with timely support for their suspicious thoughts. Staff described not feeling physically or psychologically safe within their work, poor collaboration between services and limited acknowledgement of cultural factors within systems. These directly oppose some of the key features of trauma-informed care (Sweeney et al., 2016). This is despite refugees being a group likely to have experiences of trauma (Knipscheer et al., 2015) and trauma being a pathway to the development of suspicious thoughts (Read et al., 2001). Staff mentioned feeling powerless and helpless, a key indicator of working within 'trauma-organised systems' (Bloom, 2010).

Macrosystem

Systems were viewed as dehumanising refugees through being institutionally racist, highlighting the attitudes that impact on refugees on a macrosystem level and therefore influence work with staff. Racist and stigmatised viewpoints were perpetuated through the media and filtered into communities, meaning refugees experienced individual instances of racism too. The impact of racism on refugees has been highlighted in previous research with staff (Guhan & Liebling-Kalifani, 2011; Robinson, 2013), however in this research staff perceived direct influences of this racism on creating and maintaining refugees' suspicious thoughts. This fits with the social defeat literature, which explains that individuals who have 'subordinate' or 'outsider' status are more likely to have unusual experiences, including suspicious thoughts (Selten & Cantor-Graae, 2005).

Staff acknowledged the role of cultural and religious beliefs in the development of suspicious thoughts. For example, belief in witchcraft and supernatural powers is common in people from Africa (Asamoah-Gyadu, 2015) and sometimes featured in DSTs. Acknowledging these cultural and religious influences fits with principles of trauma-informed care (Sweeney et al.,

2016). It also provides further understanding of refugees' macrosystems and how these can impact the development and maintenance of DSTs.

Chronosystem

Participants noticed shifts in their professional identity and personal meaning making over time, which continue to develop. For example, one client spoke about shifting from a nurturing to a tougher 'parent' role and continuing to notice changes with this. This fits with narrative ideas that self-identity is a process formed through making sense of experiences (Kirkman, 2002) rather than being fixed. This shift in self-identity supports previous research that has found staff experience shifts in identity when working with refugees (Guhan & Liebling-Kalifani, 2011) however there may be specific shifts that are more relevant to staff working with refugees experiencing DSTs specifically.

Participants understood refugees' identities through similar ideas of self-identity being a continuous process. They acknowledged how trauma, attachment, and cultural expectations and narratives of their home country may have contributed to the development of the 'suspicious self'. This fits with the traumagenic neurodevelopmental model, which suggests that traumatic experiences can mould the brain in a way that makes it more sensitive to stressors in adulthood, increasing the likelihood of unusual experiences such as suspicious thoughts (Read et al., 2001). However, they also acknowledged the person outside of the 'problem' (White, 2007), humanising their clients, drawing attention to their values and goals. For example, one participant spoke about their client's dream of being a nurse and the values linked to this.

Limitations

Participants volunteered to participate, and many were recruited through social media pages dedicated to supporting refugees. Staff represented may have been particularly invested in

understanding the experiences of refugees experiencing DSTs and recruitment via a different method may have produced different outcomes.

Moreover, participants were from a variety of professional settings, which may have reduced the heterogeneity required for IPA (Smith et al., 2009). However, staff had all worked with refugees for at least a year in the past five years, making the sample homogenous in this respect.

Clinical implications and future research

These findings suggest the need for systemic changes to support both refugees experiencing DSTs and staff working with them. Staff suggested more joined-up working, with positive, collaborative relationships between systems, an approach that has been implemented effectively in other areas (Holbrook, 2020).

Alongside collaborative working, this research suggests the importance of systems being trauma-informed (Sweeney et al., 2016) and actively anti-racist (Hassen et al., 2021). Implementation of these principles in all systems that work with refugees, starting with first point of contact systems such as the Home Office, could help reduce development and maintenance of suspicious thoughts and allow refugees to access appropriate care.

The key role that professionals play in refugees' microsystems, the emotional impact of the work, and the shifts professionals experience in their self-identity highlight the importance of staff having regular supervision and support. The importance of supervision for staff working with refugees generally has been highlighted previously (Robinson, 2013), however supervision for staff working with refugees experiencing DSTs will allow them to reflect on the unique challenges that come with this.

Staff spoke extensively about the meaning they made of client's experiences and what they thought was helpful and unhelpful for refugees experiencing suspicious thoughts. However as

this is their interpretation it feels inappropriate to draw implications for clients from this. Future research could speak directly to refugees about their experiences of having DSTs. Staff could be involved in recruitment or interview processes due to findings from this study that trust is often uniquely built within their relationship and then extended to other people and organisations.

Conclusion

This study highlights the central role staff play in systems of refugees experiencing DSTs and the impact this has on them, prompting shifts in their self-identity and having substantial emotional impact. These findings allow for consideration of staff support within this role and shaping of the systems that refugees experiencing DSTs and staff working with them exist within.

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Part 3: Appendices

Appendix A: Reflective Statement

The beginning

The feeling of not knowing where to start with this reflective statement is all too familiar. Thinking back to the research fair in fourth year, I remember feeling simultaneously excited and overwhelmed by the range of options and opportunities and wondering how I could possibly decide. I knew that it was important to pick something I cared about, particularly as it would be a project that was with me for three years.

As I spoke to different supervisors, I found myself drawn towards a study looking at 'psychosis'. I had become interested in this area during undergraduate, completing my final year literature review around schizophrenia. I felt that it was an area that continued to be misunderstood and stigmatised within the media, and I was hopeful to do a research project that brought more understanding to it.

Whilst exploring options and conceptualising my research my supervisors sent me the *BPS Understanding Psychosis and Schizophrenia* (Cooke, 2017) paper. I found myself drawn towards parts of the article focused on refugees. It shocked me how little research there was

that spoke directly to refugees who had unusual experiences and I noticed there was no research that spoke to refugees about their experiences of suspiciousness, an 'individual complaint' (Bentall, 2006) within this broader label.

Ethical approval

Going through NHS ethics was more of a challenge than I envisioned. From submitting my ethics form to receiving my final approval took over a year and at times this produced feelings of 'stuckness' that felt overwhelming. However, it was important to me that refugees I spoke to were recruited through organisations where they had someone to go to if the interviews brought up difficult things. This was due to reading previous research that found recruiting through organisations refugees are familiar with helps participants feel more able to ask questions about how the research process may impact on aspects of their asylum claim (Vara & Patel, 2012). Within the context of covid-19 many community services were shut. Although I did receive interest from one community service, who have continued to help me massively during the recruitment process, opening up to NHS services alongside this felt like the best option to ensure participants had this support.

During the university ethics stage, I was asked to include a 'back up' study as it was felt that my plan to recruit refugees currently or previously experiencing suspicious thoughts may prove difficult. At first, I was reluctant to do this. I was eager to recruit refugees and thought that hearing their voices was important, due to the gap with this in the literature and my own values. However, after discussion with my supervisor we agreed that it made sense to have this option, particularly when trying to recruit refugees who may feel suspicious of me and the research. Looking at the literature, I noticed that there was no research exploring staff's experiences of working with refugees experiencing suspicious thoughts and I reflected on the usefulness of hearing their stories of working with this group of people, due to the important

role they play in helping them access and remain in services. We agreed that I would try to recruit refugees experiencing suspicious thoughts first, but if I was not able to recruit, I would interview staff working with refugees experiencing suspicious thoughts.

When this got to the final stage of NHS ethics, I was asked to give a time frame for how long I would keep recruitment open for refugees before opening to staff. During a tough conversation with my research supervisors, we decided that we would keep recruitment open for refugees for four weeks before closing this and opening to staff. This was in the context that we were already in April, with the original deadline at the end of May and conversations with services I was recruiting through pool of potential participants who fitted the inclusion criteria at that time was very small. My field supervisor worked in one of these services and explained that there a lot fewer refugees coming through services during the covid pandemic.

Recruitment and data collection

Unfortunately, within four weeks I did not have any participants for the first part of my study. I felt a lot of guilt and sadness as it had been so important to me that I recruited participants who had not had their voices heard in research before. I spent a lot of time questioning what I could have done differently and whether I was wrong to close recruitment after just four weeks. My supervisors were a great source of reassurance during this time and the conversations we had helped me to see that speaking to staff would still be an important and valuable piece of research.

Even when I opened up to staff I continued to struggle with recruitment and therefore submitted an amendment to open up recruitment online. This led to another period of waiting, which I found very difficult with the May deadline just weeks away.

We also considered whether I should just open up to staff in NHS services or just community services, or open recruitment for all services. We reflected on the heterogeneity of the

sample, which is a key factor in IPA (Smith et al., 2009) and I worried that if I opened up to all types of service that worked with refugees this could make the sample too homogenous. However, through further discussions in supervision we decided that requiring participants to have worked with refugees for at least a year in the past five years produced heterogeneity in its own way and ensured that participants had a wealth of experience with this group of people. Once I started interviews participants often spoke about having held lots of different roles working with refugees, which reassured me that this was the right decision and that the length of time participants had worked with refugees was more important for heterogeneity.

The feelings of sadness I initially felt about moving into interviewing staff members soon dissipated when I started interviews. I was incredibly moved by the stories participants shared, both saddened by the difficulties they faced in their role but also uplifted by the compassion and care they brought to their roles. I was aware of emotional reactions in myself as participants spoke about barriers they faced or the refugees they worked with faced. Having a reflexive interview with one of my research supervisors before I started interviews was very helpful for reflecting on my own values and expectations about the research and allowed to reflect in action (Schön, 1991) during the interviews, to ensure I stayed close to the participants experience, rather than being too caught up with my own experiences and understandings. My research diary was also invaluable for reflecting on the interviews afterwards and this reflection on my own relationship with the research topic is something I will carry forward to research I do in the future.

Analysis and write up

I found the analysis and write up enjoyable but challenging. Prior to starting the doctorate, I had purely done quantitative research and therefore developing themes felt outside of my comfort zone. I had chosen IPA because I felt it was important to acknowledge my own

involvement in the research, however when it came to putting my own interpretations into the research, I felt like I was being 'unscientific'. I also worried about not capturing things that felt important to the participants. However, upon the recommendation of my supervisors I took a step back and listened to participants interviews, with just a notepad to write down my thoughts. This really helped me to hear what the participants were saying and form my own interpretations, and themes began to develop more naturally from there. I noticed that my drive system was quite activated when analysing data and it felt like taking this approach allowed me to connect with the participants more and activate my soothe system (Gilbert, 2009). This is something that I will carry forward to future research, considering whether being in my drive system is impacting on my ability to really connect with the research.

During write up I again worried about not doing justice to participants accounts. It was important that their experiences were captured, and voices heard. I also continually came back to my research question during interviews, analysis and write up. I noticed that at times I was tempted to write about the experiences of refugees experiencing suspicious thoughts, as this had been my original research question. However, reminding myself that I was now focusing on staff experiences allowed me to stay grounded in what they were saying and their experiences.

The SLR

Although the waiting involved with ethics was challenging, I was grateful for the time that it gave me to focus on my SLR. The idea for what this could focus on emerged during a supervision session where my field supervisor wondered about how refugees and asylum seekers experience therapy. I was particularly excited about this as I was about to go on to placement in the same service as my field supervisor and knew that there was an increased

likelihood that I would be working with refugees and asylum seekers. I therefore felt that understanding how they experienced therapy would help me clinically too.

However, once I started looking into the area of the experiences of refugees and asylum seekers who access psychological therapy I was hit with another barrier- a review already existed! Looking at this review I noticed that the researchers had included papers with adults, children and adolescents. Reflecting on my experiences working in services that were often uniquely for adults or children, I felt that it would be important to focus on one group. With my field supervisor (and soon me) being in a service that uniquely worked with adults, I decided to conduct my review focused on people over the age of 18. This did lead me on to reflections around how we construct an 'adult' and how this may look different in different countries, and I was aware that I based my construction of an 'adult' in line with my own lens and the age we use in UK services.

When it came to analysis, I ended up with an astounding number of themes. I reflected afterwards that this was linked to my values around wanting people's voices to be heard and worries that if I merged themes then voice would be lost. However, I did realise that some themes were just emerging in one or two papers and therefore maybe should not be conceptualised as a 'theme'. Although my final draft still has a large number of themes, these all felt individually important to capture and reflected ideas that seemed unique from one another.

Initially I structured my discussion using Maslow's Hierarchy of Needs (Maslow, 1943) however one of my supervisors questioned if I knew that the hierarchy was based on the Siksika (Blackfoot) way of life. I found myself spending a huge amount of time reading about this and watching talks based around this development of the hierarchy. I was fascinated but simultaneously shocked that I had not heard about it before. I also reflected that I had jumped

to using Western models to understand the experiences of a largely non-Western group. It made me think about how often this may happen even when researchers have the best of intentions. I vowed that going forwards I would make more of an effort to seek out non-Western literature alongside Western literature. I found information on Blackfoot ideas significantly more difficult to access than information on Maslow's Hierarchy and will remember in the future that I may need to do more searching or spend more time to access these different understandings. This made me think of a comment my field supervisor made on my empirical paper, questioning the way services may position refugees as a 'hard to reach' group and the role we play in reaching them. For me the difficulty of accessing the papers around non-Western understandings were harder to reach but that does not mean it is any less important to make that effort to reach them.

Overall

This research has taught me so much. The importance of adapting and how often research does not go as planned. The value of qualitative research, when previously all I had known was quantitative. The emotional impact that research can have and the importance of acknowledging what you are bringing, in terms of values, expectations and experiences.

I am still interested in completing a research project around exploring the experiences of refugees experiencing suspicious thoughts and I hope I can bring this learning to that project in the future.

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Appendix B: Epistemological Statement

It is important for the researcher to be aware of how their experiences and assumptions impact and shape the research. Two things that largely impact on this are the researcher's epistemological and ontological position.

Ontological position refers to "the nature of reality and what there is to know about the world" (Ritchie et al., 2013). The two prevailing ontological positions are realist and relativist (Willig, 2008). People holding realist ontological positions believe that there is a "truth" to learn and that there is a reality that exists independently from the views and beliefs people hold about it (Ritchie et al., 2013). Alternatively, a relativist ontological position posits that realities exist through mental construction and their form and content is unique to the person who created it (Guba & Lincoln, 1994)

Epistemology is concerned with how we know and learn about the world (Ritchie et al., 2013). This can include understandings of how knowledge is acquired and the relationship

that the researcher has with the researched. This includes whether or not the research is seen as being impacted by the researcher (Ritchie et al., 2013).

When beginning the research process, I considered both which ontological and epistemological positions would fit with my own views and values and would be helpful in answering the research questions. I had observed in the media that varying narratives existed about both refugees and individuals experiencing things that could be described under the label of "psychosis". I read about the overlap in diagnoses of 'psychosis' and different responses to treatment (Bentall, 2006). All of these things suggested that there was not a "truth" to be discovered, but rather our way of understanding these experiences seemed to be historically and culturally specific (Burr, 2015). I therefore adopted a relativist ontological position and a social constructionist epistemological position. A social constructionist position challenges us to be suspicious of our assumptions of how the world is, and acknowledges that the way we divide the world up does not refer to "real" divisions (Burr, 2015).

These positions influenced the qualitative methodology that was selected. Interpretative Phenomenological Analysis (IPA) was felt to fit with the social constructionist epistemological position as it focuses on how participants make sense of their experiences, whilst also acknowledging the role of the researcher in this process (Smith et al., 2009) It encourages researchers to attend to the context-dependent nature of experiences, with a focus on social, historical and cultural factors (Fatough & Smith, 2006 as cited inWillig, 2008). This creates a double hermeneutic, where the researcher is making sense of the participant making sense of a phenomenon (Smith et al., 2009). Within this research there was a triple hermeneutic created at times, as the researcher tried to make sense of the participant making sense of the refugee's experiences.

A social constructionist perspective and relativist ontological position were also adopted in the systematic literature review. Thematic synthesis was used as it aims to stay close to the original data and context it was taken from, whilst holding an understanding that qualitative research may not be generalisable (Thomas & Harden, 2008). This fits with the social constructionist understanding of "multiple truths" that are specific to a certain time and place (Burr, 2015).

References

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Appendix C: Blank Data Extraction Form

Title of study	
Year of publication	
Authors	
Study aims	
Participant demographics (age, gender, country of origin, country of resettlement) and sample size	
Inclusion/ exclusion criteria	
Recruitment setting	
Study design	
Qualitative method of analysis	
Key findings	

Strengths and Limitations	
Conclusions	
Quality rating score	

Appendix D: NICE qualitative quality checklist

Study identification: Include author, title, reference, year of publication	
Guidance topic:	**Key research question/aim:**
Checklist completed by:	
Theoretical approach	

1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature?	Clear Unclear Mixed	Comments:

• Are underpinning values/assumptions/theory discussed?		
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		

4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:

6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		

8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated?	Rich Poor Not sure/not reported	Comments:

• Are responses compared and contrasted across groups/sites?		
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent?	Convincing Not convincing Not sure	Comments:

• Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?		
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic?	Adequate Inadequate Not sure	Comments:

• Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**		
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Overall assessment		

As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix E: Quality assessment scores breakdown

Study	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Score
Al-Roubaiy et al (2017)	Appropriate	Clear	Defensible	Not sure/ inadequately reported	Unclear	Not sure	Not sure	Rigorous	Poor	Not sure/ not reported	Not convincing	Relevant	Inadequate	Not sure/ not reported	+
Bartholomew et al (2021)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure/ not reported	++
Century et al (2007)	Appropriate	Clear	Indefensible	Inappropriately	Unclear	Unclear	Not sure	Not rigorous	Rich	Not sure/ not reported	Convincing	Relevant	Adequate	Appropriate	+
Duden & Martins-Borges (2020)	Appropriate	Clear	Not sure	Not sure/ inadequately reported	Not described	Not sure	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Duden & Martins-Borges (2021)	Appropriate	Clear	Indefensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Hanft-Robert et al (2021)	Not sure	Clear	Indefensible	Appropriately	Clearly described	Clear	Reliable	Rigorous	Poor	Reliable	Not convincing	Relevant	Adequate	Appropriate	++
Mirdal et al (2012)	Appropriate	Unclear	Indefensible	Inappropriately	Not described	Not sure	Reliable	Rigorous	Rich	Unreliable	Convincing	Partially relevant	Inadequate	Not sure/ not reported	+

Mitschke et al (2017)	Appropriate	Unclear	Indefensible	Inappropriately	Unclear	Unclear	Reliable	Rigorous	Poor	Not sure/ not reported	Convincing	Relevant	Inadequate	Not sure/ not reported	+
Vincent et al (2013)	Appropriate	Unclear	Indefensible	Not sure/ inadequately reported	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Partially relevant	Not sure	Inappropriate	+
Zehetmair et al (2019)	Appropriate	Clear	Indefensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Appendix F: Contact with researchers

Good afternoon,

I hope you're well!

I'm a final year trainee psychologist at the University of Hull and am currently completing a systematic literature review on the experiences of adult refugees who have accessed mental health interventions from both staff and service user perspectives. When collecting my pool of papers a paper that you worked on *'Integrating Cultural Beliefs About Illness in Counseling With Refugees: A Phenomenological Study'* was one of the key papers that came up and I was hoping to use. I could not see any explicit mention that all participants worked with adult refugees in this paper and was wondering if you could remember whether the participants all worked with adult refugees so I know whether this is suitable to include? The paper itself was really useful and informative, so I want to make sure I include it if I can.

Thank you very much for your time.

Best wishes,

Jessie Whichelow

Hi Jessie

Sorry to not reply to your prior email - it's been a busy start to my semester. Yes - all participants worked with adults who had refugee status. I don't have any other papers in shareable form that would fit for your review but it sounds like very interesting work!

Ted

Hi Gesa,

I hope you're well!

I'm a final year trainee psychologist at the University of Hull and am currently completing a systematic literature review on the experiences of adult refugees who have accessed mental health interventions from both staff and service user perspectives. When collecting my pool of papers a paper that you worked on 'psychotherapy with refugees- supporting and hindering elements' was one of the key papers that came up and I was hoping to use, however I could not see any explicit mention that all participants worked with adult refugees. I was wondering if you could remember whether the participants all worked with adult refugees so I know whether this is suitable to include? The paper itself was really useful and informative, so I want to make sure I include it if I can.

Thank you very much, I really appreciate you taking the time to read this.

Dear Jessie,

thank you for your question! Yes, the participants in our study all worked with adult refugees.

If you have any further questions, please do not hesitate to ask!
Take good care,

Gesa

Dear Gesa,

Thank you so much for your quick reply, that's much appreciated! I'm glad to hear that all participants worked with adult refugees.

I noticed on your profile your other paper 'Psychologists' perspectives on providing psychological care for refugees in Brazil'. It seems that this used the same participants from what I can see but could I just double check this to ensure it also used participants who worked with adult refugees?

Thank you so much for your help. It's been a pleasure reading your research, it's such an interesting topic and so useful researching in a country where there isn't much research in this area.

Take care,

Jessie

Dear Jessie,

I do understand the confusion here. The first article you mentioned "Psychotherapy with Refugees - Supportive and Hindering Elements ", works with 18 clinical psychologists/psychotherapists in Brazil.

The second one "Psychologists' perspectives on providing psychological care for refugees in Brazil" has a completely different sample - it looks at 14 psychologists who are not psychotherapists, but do "acolhimento", which could be translated as "counselling" or "psychological care". This work is often not as long, and maybe not as deep, as psychotherapy, but more acute.

The participants in the second article also work with adult refugees.

I hope that helps? If you have any further queries, please do not hesitate to ask!

All the best,

Gesa

Appendix G: Ethical approval and approval for amendments

Pages removed for digital archiving

Appendix H: Information Sheet

Date: 27/05/2022

Version Number: v1.6

IRAS ID: 296817

Participant information sheet

This research is being completed as part of the requirements of the Doctorate in Clinical Psychology course at the University of Hull. The researcher, Jessie Whichelow, is a Trainee Clinical Psychologist and this study is part of her thesis project.

Title of study

Experiences of staff members working with refugees who have distressing suspicious thoughts.

We would like to invite you to participate in this research on the experiences of staff working with individuals who currently or have previously had refugee status in the UK, and are currently experiencing distressing suspicious thoughts, or have experienced these since arriving in the UK.

Before you decide whether you want to take part, it is important for you to understand why the research is being done and what will happen if you take part. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear, you have any worries about taking part, or if you would like more information. You can do this using the contact details below.

What are suspicious thoughts?

Suspicious thoughts can include a number of things, not limited to:

- Difficulty trusting other people.
- Feeling like other people are watching or following you.
- Feeling like other people are out to get you or are planning to harm you.

You may have heard this referred to as ‘delusions’ or ‘paranoia’.

Everyone experiences suspicious thoughts from time to time but we are looking at suspicious thoughts that are distressing, for example they make the person you have worked with feel scared, worried, anxious or sad.

What is the purpose of the study?

The purpose of this study is to get a better understanding of the experiences of staff members working with this particular group of refugees who are experiencing suspicious thoughts. There is very little research exploring the experiences of refugees with suspicious thoughts and this group is particularly difficult to recruit due to worries these individuals may have about engaging with professionals. The researchers therefore hope that by speaking to staff members we will gain a better understanding of how refugees may begin to speak to professionals about their suspicious thoughts and what a relationship that fosters this sharing may look like. We also hope to gain a deeper understanding of one particular individual you have worked with and what you understand about their experience of having suspicious thoughts.

Why have I been invited to take part?

You have been invited to take part as you have self-identified as meeting the criteria for this study. In order to participate you must:

- Be 18+ years old
- Have worked with at least one refugee experiencing suspicious thoughts. This can include difficulties trusting others or feeling like other people are watching, following or planning to harm you.
- Have worked with refugees for at least a year.
- Be currently working with refugees or have worked with a refugee in the past five years.
- Speak English
- Be living and working in the UK

What will I be asked to do?

If you agree to take part, I will contact you via telephone, email or letter depending on your preference to agree a convenient date and time to have a conversation and to allow for questions to be asked. During this telephone call/ email/ letter exchange we will arrange to have a conversation at a convenient time and place, which will last for approximately one hour. During this time we will ask you to speak about your experiences of working with a refugee who has suspicious thoughts. This will include questions about your experience of working with them and your understanding of their experience of having suspicious thoughts. You will also be asked some short questions about your age, gender, ethnicity, the type of organisation you work for, your job role, and the length of time you have worked with refugees with suspicious thoughts and the number of refugees with suspicious thoughts you have worked with. This conversation will be audio recorded and will take place via MS teams depending.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part I will ask you to sign a consent form and you will be given a copy of this consent form to keep. If this is

something that you are not comfortable with, you will be able to provide verbal consent, which will be recorded as part of the conversation.

What are the potential risks of taking part?

This study will take approximately an hour of your time, which may be inconvenient for you. I will be asking about your experiences of working with someone who has suspicious thoughts, which could cause some distress. I will provide you with a list of organisations that you can contact following the study if you do experience distress. You can also stop or pause the conversation at any time if you need to. I would like to assure you that I will listen and will not judge anything that you say and if there is anything I can do to make you feel more comfortable I will try to support this.

If you say anything during our conversation that makes me worry that you or someone else is at risk of immediate harm then I may call the crisis team or 999. I will speak to you before doing this so that you are aware of what is happening.

Any information shared will be anonymised to protect your confidentiality. In other words, your data will be given a different name to yours to make sure that no-one can work out that it is you. However, if you share any information that suggests you or someone else is at immediate risk of harm, this may need to be passed on. This is to keep you and other people safe. If you have any worries about what kind of thing would be passed on please ask me and I am happy to talk through this further.

What are the possible benefits of taking part?

We cannot promise that there will be any direct benefits to you, however some people find it useful to share and speak about their experiences and tell their story. These findings will also be anonymised and shared with services involved in the research, as well as being published in an academic journal and shared at research conferences, which may be useful to other professionals working with refugees experiencing suspicious thoughts.

What will happen to the results of the study?

The findings from this study will be written up into a thesis, as a part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk. The research may also be published in academic journals or presented at conferences.

How will we use information about you?

This study is sponsored by the University of Hull. Any mention of 'we' in this document refers to the sponsor.

We will need to use information from you for this research project. This information will include your:

- Name
- Contact details

- Gender
- Ethnicity
- Type of organisation you work for (e.g. charity, mental health service) and job role
- Length of time you have worked with refugees experiencing suspicious thoughts

People will use this information to do the research or to check your records to make sure the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code name and number instead. We will keep all information about you safe and secure. Your data will be stored securely so that no one else can access it. Once we have finished the study, we will keep some of the data so we can check the results. We will write our report in a way that no one can tell it was you who took part.

Your consent form and demographic questionnaire may be kept in the chief investigator's home for up to 72 hours. During this time it will be kept in an NHS lockable bag to keep it safe. This will only be in exceptional circumstances.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have. We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Withdrawing from the study will not affect you in any way. Participant's data cannot be withdrawn from the study once the data has been anonymised and analysed. If you choose to withdraw from the study before this point the data collected will be destroyed. You have up to one week after having the conversation with us to withdraw your data from the research.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by sending an email to J.whichelow-2019@hull.ac.uk
- by sending an email to researchgovernance@hull.ac. to speak to the sponsor's data protection officer

If you have any questions or require more information about this study, please contact me using the following contact details:

Jessie Whichelow
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road

Hull
HU6 7RX

E-mail: J.whichelow-2019@hull.ac.uk

What if something goes wrong?

If you wish to make a complaint about the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Anjula Gupta
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: +44 (0) 1482 463254
Email address:

Thank you for reading this information sheet and for considering taking part in this research.

Appendix I: Consent Form

IRAS ID: 296817

Date: 02/06/2022

Version Number: V1.3

CONSENT FORM

Title of study: **Experiences of staff working with refugees who have distressing suspicious thoughts**

One signed copy of this consent form is to be given to the participant and one copy is to be given to the research team, for their records.

Name of Researcher: Jessie Whichelow

Please initial box

1. I confirm that I have read the information sheet dated 27/05/2022, V1.6 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time ☐

without giving any reason, without my legal rights being affected. I understand that the data I have provided up to the point of withdrawal will be retained.

3.I understand that the research conversation will be audio recorded and that my direct, anonymised quotes may be used in research reports and conference presentations. I understand that if my interview takes place on MS teams this will be video recorded, but I have the option to turn my camera off if preferred. ☐

4. I understand that the research data, which will be anonymised (not linked to me), will be retained by the researchers and may be shared with others and publicly shared to support other research in the future. ☐

5. I understand that my personal data will be kept securely in accordance with data protection guidelines, and will only be available to the immediate research team. ☐

6. I give permission for the collection and use of my data to answer the research question in this study. ☐

7. I understand that relevant sections of my data collected during the study may be looked at by
individuals from the University of Hull, from regulatory authorities or from the NHS Trust which ☐

is relevant to my taking part in this research. I give permission for these individuals to have access
to my records.

8. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Person taking consent	Date	Signature

Appendix J: Staff Demographic questionnaire

Date: 17/07/2022

Version Number: v1.3

IRAS ID: 296817

Demographic Questionnaire

What is your gender? (Please tick)

□ Male

□ Female

□ Non-binary

□ Other

□ Prefer not to say

What is your ethnicity? (Please tick)

□ White

□ Asian/ Asian-British

□ Mixed

□ Black/ Black-British

□ Other

Please give a basic description of the type of organisation you work for and your job role (e.g. charity and support worker)

……

……

……

……..

For how many years have you worked with refugees?

……

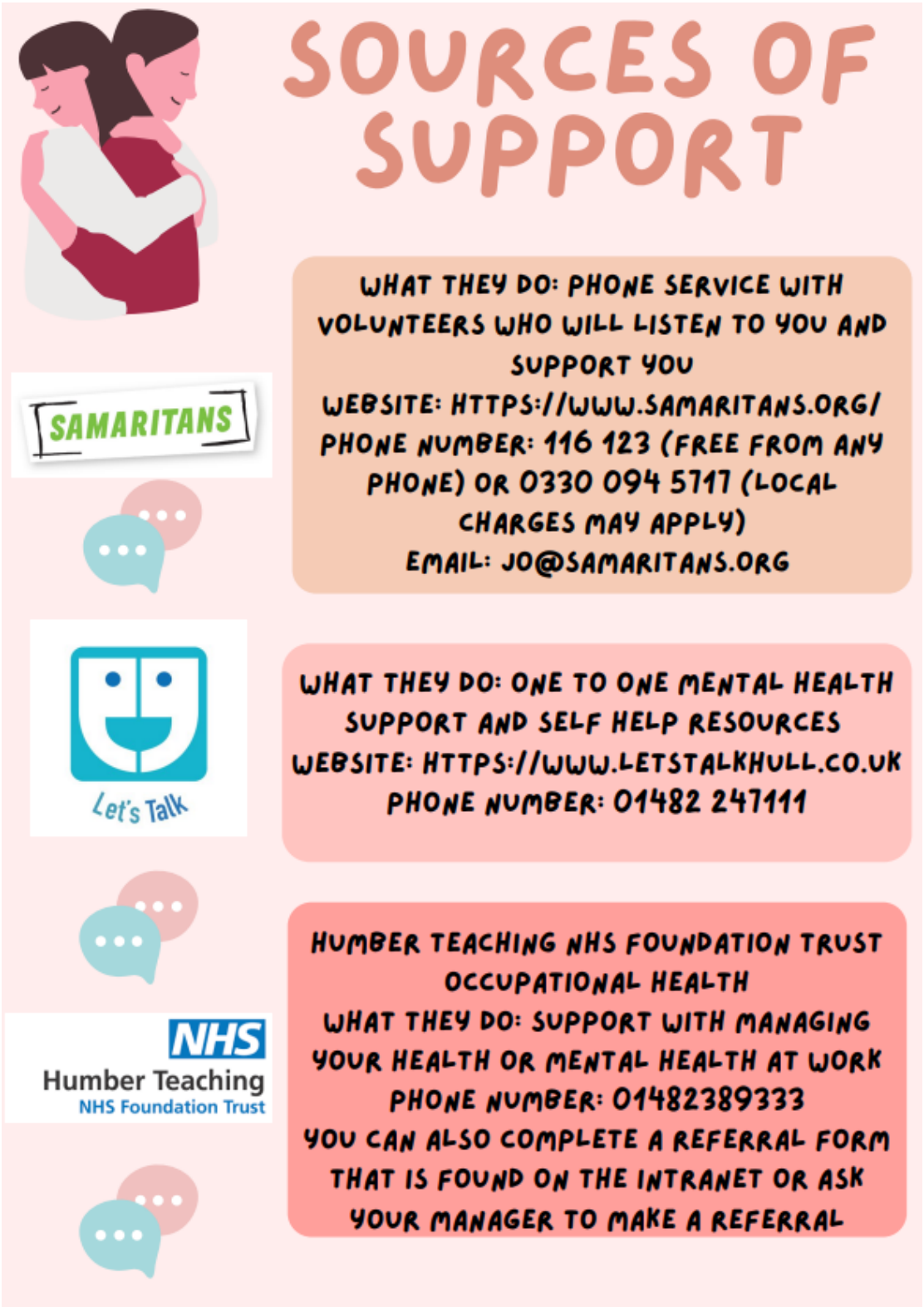
……..

Approximately how many refugees with suspicious thoughts have you worked with?

……

……

Appendix K: Sources of support sheets for Hull community services, Hull NHS services and UK wide



SOURCES OF SUPPORT

SAMARITANS

WHAT THEY DO: PHONE SERVICE WITH VOLUNTEERS WHO WILL LISTEN TO YOU AND SUPPORT YOU
WEBSITE: HTTPS://WWW.SAMARITANS.ORG/
PHONE NUMBER: 116 123 (FREE FROM ANY PHONE) OR 0330 094 5717 (LOCAL CHARGES MAY APPLY)
EMAIL: JO@SAMARITANS.ORG

Let's Talk

WHAT THEY DO: ONE TO ONE MENTAL HEALTH SUPPORT AND SELF HELP RESOURCES
WEBSITE: HTTPS://WWW.LETSTALKHULL.CO.UK
PHONE NUMBER: 01482 247111

mind Hull and East Yorkshire

HULL AND EAST YORKSHIRE MIND
WHAT THEY DO: CAN OFFER COUNSELLING, SUPPORT AT WORK OR GUIDED SELF HELP
WEBSITE: HTTPS://WWW.HEYMIND.ORG.UK/
PHONE NUMBER: AS THERE ARE PHONE NUMBERS FOR EACH SERVICE PLEASE REFER TO THE WEBSITE

SOURCES OF SUPPORT

SAMARITANS

WHAT THEY DO: PHONE SERVICE WITH VOLUNTEERS WHO WILL LISTEN TO YOU AND SUPPORT YOU
WEBSITE: HTTPS://WWW.SAMARITANS.ORG/
PHONE NUMBER: 116 123 (FREE FROM ANY PHONE) OR 0330 094 5717 (LOCAL CHARGES MAY APPLY)
EMAIL: JO@SAMARITANS.ORG

mind

WHAT THEY DO: OFFER A VARIETY OF MENTAL HEALTH SUPPORT AND SELF HELP RESOURCES. PLEASE SEE THE WEBSITE FOR THOSE RELEVANT TO YOUR AREA
WEBSITE: HTTPS://WWW.MIND.ORG.UK/

SANE

WHAT THEY DO: OFFERS "NON-JUDGEMENTAL AND COMPASSIONATE SUPPORT" VIA PHONE, EMAIL AND TEXT
WEBSITE: HTTPS://WWW.SANE.ORG.UK/
PHONE NUMBER: 07984 967 708 (OPEN 16.20-22.30)

Appendix L: Recruitment poster

Looking for staff who have worked with refugees who experience suspicious thoughts.

FOR MORE INFORMATION, OR IF YOU WOULD LIKE TO PARTICIPATE, PLEASE CONTACT **J.whichelow-2019@hull.ac.uk**

What is this study and what will I be asked to do?

- **What?** Chat with us about your experiences of working with refugees with suspicious thoughts.
- This will be audio recorded.
- **Where?** [base] or MS teams
- **Details we'll ask for?** Gender, ethnicity, type of organisation you work for/ job role, how long you have worked with refugees.

You can participate if you:

- Are 18+ years old
- Have worked with at least one refugee experiencing suspicious thoughts. If you're unsure what this covers please ask us!
- Have worked with refugees for at least one year in the past five years.
- Speak English.
- Live and work in the UK

Why should I consider participating?

- Opportunity to tell your story of working with refugees experiencing suspicious thoughts.
- Hopefully help other professionals working with refugees experiencing suspicious thoughts to create a trusting and collaborative relationship.

Appendix M: Journal submission guidelines for 'clinical psychology review'

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

• E-mail address

• Full postal address

All necessary files have been uploaded:

Manuscript:

• Include keywords

• All figures (include relevant captions)

• All tables (including titles, description, footnotes)

• Ensure all figure and table citations in the text match the files provided

• Indicate clearly if color should be used for any figures in print

Graphical Abstracts / Highlights files (where applicable)

Supplemental files (where applicable)

Critical Issues

- Ensure manuscript is a comprehensive review article (empirical papers fall outside the scope of the journal)

- Ensure that literature searches and reviews are as up to date as possible and at least to 3 months within date of submission
- Manuscript has been 'spell checked' and 'grammar checked'
- All references mentioned in the Reference List are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- A competing interests statement is provided, even if the authors have no competing interests to declare

  • Journal policies detailed in this guide have been reviewed
- Referee suggestions and contact details provided, based on journal requirements
- Ensure manuscripts do not exceed 50 pages, including references and tabular material, unless you have obtained prior approval of the Editor in Chief for an exception
- Ensure Highlights do not exceed 3 to 5 bullet points with a maximum of 85 characters, including spaces, per bullet point

Failure to follow these guidelines may result in your manuscript being returned for reformatting prior to further consideration by the journal.

For further information, visit our Support Center.

Before You Begin

Ethics in publishing

Please see our information on Ethics in publishing.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double anonymized) or the manuscript file (if single anonymized). If there are no interests to declare then please state this: 'Declarations of interest: none'. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify compliance, your article may be checked by Crossref Similarity Check and other originality or duplicate checking software.

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Appendix N: Journal submission guidelines for 'Psychosis'

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Appendix O: Sample of analysis

Emergent Themes	Text	Exploratory Themes
Failed by systems/ services Difficult relationship with services	Participant: It's complicated, they keep dumping him to be perfectly frank with you. And then we keep fighting to get mental health services brought back on board again. And and then the last for a wee while and then they disappear. Um but he's recently engaged with clinical psychologist, so *laughs* I'm very much hoping that that continues. Um he has huge amount of complex trauma, he's gone through…. he's a victim of torture. He's gone through a huge amount in his life. But the one thing that an awful lot of professionals working with don't seem to get is how hard he finds it to engage with professionals, particularly doctors,	Dump- very emotive- unwanted in the system? They keep having to try and get mental health services back onboard. Constant battle? Fighting- shows how hard it is to get them back on board; idea of her and the client vs mental health services; difficult relationship with services Making sense of experiences, including trauma Laugh communicates lack of hope/ trust that support from mental health services will continue? Staff mistrust of systems

Making meaning of suspicious thoughts through experiences of trauma Power and powerlessness within systems Desperation Feeling let down by systems	CPNS, nurses, all these different people because he simply doesn't trust them and and that means they continually continually say, well, he's not engaging with services, so there's nothing that we can do. And he's very unwell and he has paranoia. You know, he's been diagnosed with complex PTSD and dissociation and things like that. But his inability to engage with his medical professionals stops them from receiving the treatment that he absolutely desperately needs, and there seems to be really little awareness or I don't know what it is, you know, I'm not a medical professional, that's not my background in dealing with, you know, in working with refugees and asylum seekers. Um so I understand that it must be difficult when you're working with adults who need to consent to treatment and all that kind of stuff, I get that, I get the complexities of that, but he desperately needs better mental health support and it's just not forthcoming.	Mental health services 'disappear'- unplanned and unwanted discharge? The client has been through a lot in his life and has a lot of trauma. Making meaning of his suspicious thoughts through experiences of trauma? 'Awful' lot- he has been through so much that perhaps it would be difficult to comprehend. Professionals don't seem to understand how hard he finds it to engage with them. She holds this knowledge and understanding that is not shared by other professionals. Power and powerlessness of being in this position? Repetition of continually- highlights constant battle?

		Professionals will say that he's not engaging with services and he is then unable to access the treatment he needs. Absolutely, desperately- highlights how much he needs the support. There is something missing in these systems and she finds it hard to know what this is, but perhaps lack of awareness? I don't know what it is; it's not my background- confusion/ frustration that other professionals don't get it. I get that- understanding of the complexities but continued feeling of it not being good enough/ other professionals not doing enough. Feeling of responsibility for the client?

Challenge of building a therapeutic relationship Role as secure base for client Humanising refugees- more than just someone with suspicious thoughts	Interviewer: Mm, yeah. And I'm just thinking about kind of your experience of building your relationship up with him then, what was that like? Interviewee: That's been an absolute challenge um it's... I would say… I think his clinical psychologist said I was the only person he's ever had an attached sort of relationship with, um he translated the… I originally worked with him in the camps in [country] and he's got fantastic language sort of capabilities and he can translate all sorts of things and all sorts of different languages, he's incredibly clever. And he, he volunteered with us to do some um translation for some children and families that were working with and if I look back six years ago, nearly six years ago, just under six years he was an entirely different person and I don't know whether that's because his mental health problems have become more	Absolute challenge- highlights just how difficult it was to form this relationship. She is the only person he has ever had an attached relationship with- role as caregiver and secure base? The client is very intelligent and volunteered to do translation work for them. Highlighting strengths of client- more than just 'a suspicious refugee'- she sees the multi-faceted aspects of his personality. Repetition of six years- important role of time? Client did some translation work for the service- community support? Humanising him?

Challenge of trying to make meaning of suspicious thoughts The hidden true self vs the public self	acute, or whether it's because he has sort of let down his sort of façade and I can see the true him. I'm I'm not sure and I don't know whether I'll ever work out which, which why, you know, where that change came from and where that sort of based in.	Six years ago the client was an entirely different person. Not sure and don't know if I'll ever work out- hard to understand why his suspicious thoughts have increased- attempting to make meaning of this but confronted with confusion I can see the true him- does this mean there is a hidden/ secret him? Or a false him?