

THE UNIVERSITY OF HULL

**Trauma, Culture and Compassion: Interpreter, Asylum Seeker
and Refugee Perspectives of Mental Health Interventions**

being a Thesis submitted in partial fulfilment
of the requirements for the degree of Doctor of Clinical Psychology
in the University of Hull

by

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Overview

This portfolio thesis has three parts. Part one is a systematic literature review in which an analysis is conducted on existing research exploring asylum seekers' and refugees' beliefs and experiences of interventions for trauma-related distress. A systematic database search identified 18 studies to be reviewed. Narrative Synthesis is used to analyse the findings, and methodological quality is evaluated. The clinical implications for service design and directions for future research are also discussed.

Part two is an empirical paper which uses Interpretative Phenomenological Analysis to explore interpreters' experiences of working in mental health settings and how compassion may be experienced in their role. The findings are discussed in relation to psychological frameworks of compassion, and implications for practice and training, as well as recommendations for future research, are considered.

Part three comprises the appendices supporting the systematic literature review and the empirical paper. A reflective statement considering the process of the research, as well as an epistemological statement, are also included.

Overall word count for portfolio (excluding title pages, abstracts, figures/tables, references and appendices): 20,575

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Part One: Systematic Literature Review

This paper is written in the format ready for submission to Psychological Bulletin.

Please see Appendix C. for author guidelines.

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*for information only, there is no reported word limit within Psychological Bulletin author guidelines.

**The Beliefs and Experiences of Asylum seekers and Refugees
using Interventions for Trauma-Related Distress: A Systematic
Literature Review**

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Abstract

Background: Asylum seekers and refugees have been found to present to mental health services in their host nation as experiencing distress resulting from traumatic events. There have been reviews exploring efficacy of interventions in this population, yet the specific context influencing beliefs and experiences of trauma and intervention has not been considered.

Objective(s): To explore the beliefs and experiences regarding trauma and related interventions in a clinical asylum-seeking and refugee population.

Method: A systematic review was conducted. CINAHL, Academic Search Premier, MEDLINE, PsycINFO, PsycARTICLES and Web of Science were searched up to and including January 2017. Of 1027 potentially eligible articles, 81 full texts were screened, resulting in 18 eligible for review. Methodological quality was assessed using an adapted quality assessment tool, and the findings of the literature were synthesised using Narrative Synthesis.

Results: Asylum seekers' and refugees' beliefs around trauma considered the acceptability of help-seeking and how permanent and/or treatable trauma-related distress was deemed to be. Their experiences of trauma interventions were influenced by therapeutic preferences, therapeutic outcomes, professional and contextual factors.

Conclusions: Traumatized asylum seekers and refugees have pre-existing beliefs which can shift following positive experience of an intervention. Cultural awareness and compassion from providers was valued. Service-user input may provide insightful recommendations for future service design and delivery.

Key words: asylum seeker, refugee, trauma, intervention

Introduction

Applications for asylum in the UK have recently risen by 14% as of September 2016, with the highest number of applications since 2004 (Home Office, 2016). With a large number of applicants coming from countries such as Iran, Iraq, Pakistan, Afghanistan and Syria (Home Office, 2016), thousands of individuals have come from backgrounds of political unrest, war, torture and poverty.

For refugees and asylum seekers, both are likely to have experienced pre-migration stressors and trauma; post-migratory difficulties may be more specific to those in the asylum-seeking process given their unresolved residential status (Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1998). 'Trauma' may be understood as the experience of an event perceived as catastrophic by the individual, which though may not necessarily occur rarely, does overwhelm the ability to adapt due to the close encounter with death or violence, invoking an extreme sense of helplessness and terror (Herman, 1997).

Rates of Post-Traumatic Stress Disorder (PTSD) vary widely in this population, however reported variance is 4% - 86% (Hollifield et al., 2002). Fazel, Wheeler and Danesh (2005) report asylum seekers to be at risk of developing PTSD ten-fold compared to an age-matched general population.

Asylum Seekers and refugees are recognised to be an 'at risk' population in National Institute for Health and Care Excellence (NICE) guidelines for the management of PTSD (National Institute for Health and Care Excellence, 2016). The guidelines recommend a screening process as part of the initial healthcare assessment they receive upon entry into the UK.

For professionals working in mental health services, there is a challenge of understanding the different ways in which cultures communicate and

understand psychological distress (Sen, 2016). 'Culture' may be understood as the learned psychological attributes of a particular people or society, including the beliefs and values that influence their language, emotions, behaviours, and perception of reality.

Beliefs around mental health problems, such as PTSD, can vary widely based on an individual's community-based or cultural beliefs (Gilbert et al., 2007). McColl, McKenzie and Bhui (2008) discuss how care must be taken when assigning labels of mental health disorders and caution against adopting a Westernised approach to psychological distress.

There is evidence to suggest that those experiencing clinical levels of trauma-related distress are more likely to seek help than those with lower PTSD symptomology that have also experienced traumatic events (Slewa-Younan et al., 2015). A diagnostic model may lead to those who present at a non-clinical level of traumatisation (American Psychiatric Association, 2013) to fall through the cracks in service access.

McColl et al. (2008) suggest many refugees and asylum seekers utilise their own coping resources to manage traumatic or stressful events, pre and post-migration. It is therefore important to consider the unique current and previous circumstances from which these individuals originate.

The beliefs an individual holds regarding their trauma-related distress may be key in determining whether help is sought and services accessed (Savic, Chur-Hansen, Mahmood, & Moore, 2016). Barriers may exist in factors external to beliefs, e.g. language, inadequate recognition of PTSD and provider availability (Bischoff et al., 2003; Vermette, Shetgiri, Al Zuheiri, & Flores, 2015). The social difficulties this population experience are potentially not relevant to psychiatry or

talking therapies (Summerfield, 1998); interventions outside of the mental health field, providing social, legal or financial support, may be more effective.

In terms of efficacy, Crumlish and O'Rourke's (2010) review of trauma interventions for refugees and asylum seekers determined that despite no treatment being firmly supported, Narrative Exposure and Cognitive Behavioural Therapy (CBT) were deemed to be effective. They concluded that future trials should aim to investigate interventions developed within the service-user's culture based on local beliefs of trauma. Nicholl and Thompson's (2004) review also yielded similar results, with CBT implicated as a promising avenue of therapeutic intervention with this population. Understanding specific elements of intervention that promote efficacy, as well as increasing therapist awareness of the clinical implications of cultural diversity, is necessary (Nicholl & Thompson, 2004).

Despite this, no review has yet summarised the literature regarding how refugees and asylum seekers experience mental health interventions for trauma.

With increasing attention being paid towards services for refugees and asylum seekers, as well as a drive to have service-user experience taken into account when designing or delivering services (Sheldon & Harding, 2010), a review of studies is needed to explore asylum seekers' and refugees' experiences and beliefs around interventions for trauma.

The consideration of beliefs, as well as experiences, is appropriate due to the possibility that as with any population accessing services, pre-existing beliefs around help-seeking, services, and mental health generally, may either change or remain the same during service utilisation. This may highlight particular aspects of support that encourage or deter service access in this population.

A review could also identify the importance of service-user input in this area, where mental health professionals may face particular challenges (Sen, 2016), potentially contributing to the development, design and implementation of suitable interventions for trauma. This may have clinical implications for improved access to services, more positive help-seeking attitudes and potentially increased efficacy of interventions.

The aims underpinning this review were:

- To explore the beliefs regarding interventions for trauma in an asylum-seeking and refugee population.
- To explore the experiences reported by asylum seekers or refugee who have been involved with an intervention for trauma.
- To explore whether beliefs and experiences influence one another regarding perceptions of interventions for trauma in an asylum seeker and refugee population.

Method

Search Protocol

The following six databases were accessed via the EBSCOhost service, with the search being run up to and including January 2017: CINAHL, Academic Search Premier, MEDLINE, PsycINFO, PsycARTICLES and Web of Science. The respective thesaurus tools were used for each database, as well as identifying terms from a general scope of the literature. A broad search was conducted in order to determine the specificity of the research question and to ensure a thorough selection process. The 'All Text' field was selected for the majority of

search terms to ensure the inclusion of all relative papers. The only exception to this was for search terms relating to 'asylum seekers' or 'refugees', which was limited to 'Title Only'. As the search was so broad, it was deemed suitable to limit this term to title only to ensure relevance to the research question. The reference lists of key papers were manually searched to identify any additional relevant references.

Search terms used for the online database search were as follows:

belief* OR experience* OR view* OR perspective* OR view* OR perception* OR
attitud* OR attribut* OR opinion* OR stigma* OR idea* OR ideol* OR prejud* OR
impact* OR satisfact*

AND

refugee* OR asylum seeker* OR asylum seeker* OR asylee* OR immigra* OR
migra* OR displaced OR indigent OR transient OR resettle*

AND

trauma* OR PTSD OR "post-traumatic stress disorder" OR "post traumatic stress
disorder"

AND

intervention* OR treatment* OR therap* OR psychotherap* OR rehab* OR
program* OR programme* OR counseling OR counselling OR help seek* OR
help-seek* OR seeking help OR help* OR self-refer* OR "self N2 refer*" OR "care
N2 utilis*" OR "care N2 utiliz*" OR "assistance N2 seek" OR "service* N2
access*"

Inclusion and exclusion criteria

Inclusion:

- Participants are asylum seekers / refugees / immigrants
- A proportion of participants are indicated to have experienced distress in response to a traumatic event(s).
- Methodology is qualitative, quantitative or mixed
- The study explores the experiences of participants and / or their beliefs regarding interventions for psychological trauma. Any study exploring beliefs around intervention, regardless of whether actually experienced or not, are included.
- Articles are from peer reviewed journals

Exclusion:

- Not reported in the English language
- Participants are not asylum seekers / refugees / immigrants
- If one or less participants are indicated to have experienced trauma-related distress.
- The study only investigates efficacy of an intervention for trauma
- The participants are only health professionals, interpreters or families of service-users.
- Review or discussion papers
- Not from a peer reviewed journal

All journal articles retrieved from the search were initially screened by title and abstract. Articles were dismissed if they did not meet all inclusion criteria or met one or more exclusion criteria. After this initial filtering, articles were retrieved in full to remove those from the initial search that were unclear of eligibility. Once

the relevant articles were retrieved, articles were read thoroughly in full and inclusion and exclusion criteria were applied. A final sample of 18 articles remained – Figure 1 summarises the article selection process.

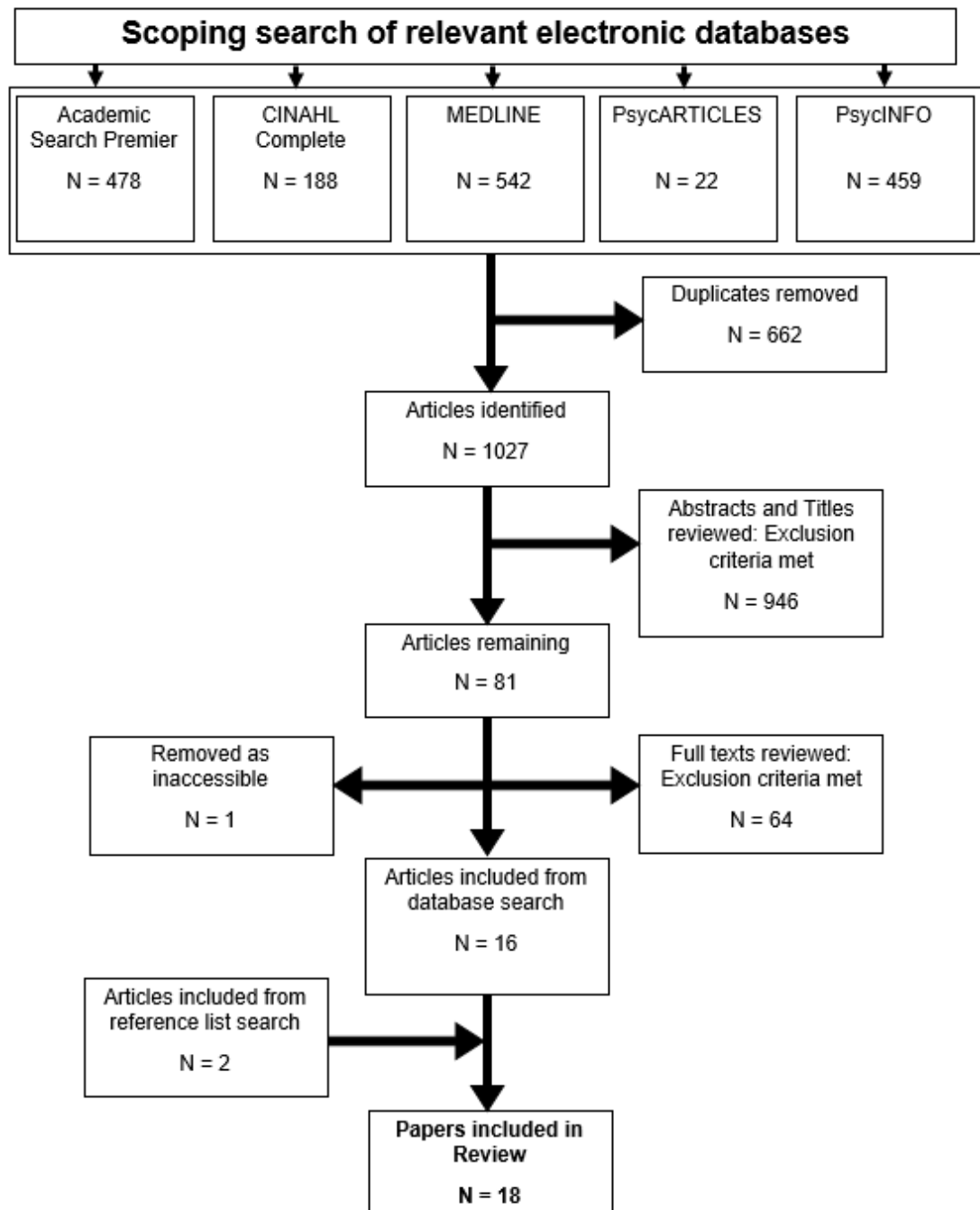


Figure 1. Summary of article selection process

Data Extraction

A data extraction form (see Appendix G) was designed specifically to glean and summarise key information for each article.

Quality Assessment

In order to make inferences regarding the quality of each study, a bespoke checklist was devised by the author, given the heterogeneity of designs included. This utilised items from the Downs and Black checklist (Downs & Black, 1998), the Joanna Briggs Institute Critical Appraisal tool (qualitative research checklist) (Joanna Briggs Institute, 2016), the NICE quality appraisal tools (National Institute for Health and Care Excellence, 2012), and the Mixed Methods Assessment Tool (MMAT) (Pluye, Gagnon, Griffiths, & Johnson-Lafleur, 2009).

The amalgamation of items from various prescribed quality assessment tools allowed adequate assessment of all aspects of quality for each study. Percentage scores were calculated with 0% being of lowest quality and 100% the highest. A subset of studies with a range of quality scores were assessed by another researcher (not involved with this piece of research) to determine inter-rater reliability. Discrepancies were discussed until consensus was reached, with some minor changes being made to scores as a result.

Data Analysis

A Narrative Synthesis was conducted to analyse the results of the studies. This method was chosen due to the heterogeneity in designs, outcome data and the wide range of interventions. The method of narrative synthesis aims to develop a

preliminary synthesis of the findings and explore the relationships within and between included studies.

Four major steps were followed in order to complete the narrative synthesis:

1. **Developing a theory of how the intervention works, why and for whom**

Considering the rationale for interventions and various levels of outcomes.

2. **Developing a preliminary synthesis of the findings of included studies**

Describing the studies, grouping them, tabulating results in order to search for patterns, transforming the data into a descriptive format, and translating the data using thematic or content analysis.

3. **Exploring relationships in the data and between studies**

Exploring reasons for differences in various aspects of studies, and examining the effects of heterogeneity.

4. **Assessing the robustness of the synthesis**

Looking at the amount and quality of evidence, and methods used to synthesise the evidence.

(Ryan & Cochrane Consumers and Communication Review Group, 2013).

Results

Overview of included studies

The initial search yielded a total of 1027 articles. After the exclusion of articles based on the above criteria, 18 were identified that met selection criteria (see Figure 1). The main characteristics of these 18 papers are summarised in Table

1. The studies were conducted across five countries (UK, USA, Denmark, Switzerland, Australia, and The Netherlands).

Sample sizes ranged from three (Madsen, Carlsson, Nordbrandt, & Jensen, 2016) to 225 (Slewa-Younan et al., 2014). Participants across the studies were mainly refugees and asylum seekers, though some were classed as immigrants (Jensen, Johansen, Kastrup, Krasnik, & Norredam, 2014; Kaltman, de Mendoza, Gonzales, & Serrano, 2014; Kaltman, Hurtado, Serrano, & Gonzales, 2016). There was a diverse range of culture of origin across the samples, with most participants originating from areas of Africa, Asia, the Middle East, Central and South America. A total of 716 individuals participated across the studies. There was a relatively even split of gender in the collated sample population, with a slight majority (54.3%) of females taking part. Several studies used female participants only (Halcón, Robertson, & Monsen, 2010; Kaltman et al., 2014; Kaltman et al., 2016; Praetorius, Mitschke, Avila, Kelly, & Henderson, 2016; Singer & Adams, 2011), whilst this was not the case for males.

All studies included participants who were reported to present as having PTSD (as a singular diagnosis or a comorbid), or a clinical level trauma-related distress, however all but one study (Madsen et al., 2016) did also include participants who had non-PTSD mental health problems, sub-clinical levels of trauma-related distress or instances where it was unclear whether the presentation was of clinical concern.

For those studies that were exploring experiences of individuals who had actually experienced an intervention (Bernardes, Wright, Edwards, Tomkins, & Difo, 2010; Halcón et al., 2010; Jensen et al., 2014; Kaltman et al., 2016; Madsen et al., 2016; Maier & Straub, 2011; Majumder, O'Reilly, Karim, &

Vostanis, 2015; Mirdal, Ryding, & Essendrop Sondej, 2012; Praetorius et al., 2016; Silove, Chang, & Manicavasagar, 1995; Silove et al., 1997; Singer & Adams, 2011; Stade, Skammeritz, Hjortkjær, & Carlsson, 2015; Strijk, van Meijel, & Gamel, 2011; Vincent, Jenkins, Larkin, & Clohessy, 2013), there were a vast range of interventions described, and sometimes described in a more general sense of service-utilisation. The purpose of this review was not to compare experiences of various interventions, which was not possible due to the level of heterogeneity. The variety of interventions used are presented in the aims section of Table 1.

Eight studies were qualitative (Jensen et al., 2014; Madsen et al., 2016; Maier & Straub, 2011; Majumder et al., 2015; Mirdal et al., 2012; Praetorius et al., 2016; Singer & Adams, 2011; Vincent et al., 2013), six were mixed methods (Bernardes et al., 2010; Halcón et al., 2010; Kaltman et al., 2014; Kaltman et al., 2016; Stade et al., 2015; Strijk et al., 2011), and four were quantitative (Silove et al., 1995; Silove et al., 1997; Slewa-Younan et al., 2014; Yaser et al., 2016). A variety of qualitative and quantitative techniques were used to analyse data.

Methodological Quality

Quality assessment scores are reported in Table 1. For a more detailed breakdown of scores, see Appendix I. The key methodological limitation identified related to the representativeness of the samples as a whole, though arguably the refugee / asylum-seeking population is naturally a heterogeneous group due to variety of culture. Participants were frequently recruited from a singular service in a single location. There was a wide range of how defensible and rigorous the methodology and design was perceived to be; the two quantitative studies that

were explicitly exploring participants' therapeutic experiences and satisfaction levels had low quality ratings of 50% and 59%, suggesting that a qualitative or mixed approach may better evaluate experience.

Another limitation across the literature was limited reflexivity; in the majority of cases, the role and impact of the researcher on the interpretation of results was often unconsidered.

Table 1.
Summary of included articles

Article Authors, Year, Country	Aims	Sample Size (n)	Participant Characteristics Sex, Age, Culture of Origin, Immigration Status, Trauma Diagnosis	Methods Measures used	Design & Analysis Method	Key Relevant Findings	Quality Score
Bernardes et al. (2010) UK	To investigate asylum seekers' symptoms of psychological distress, subjective experiences of the asylum process and potential impacts on mental health, and their suggestions for tackling mental health needs.	29 (completed questionnaires) 8 out of 29 completed interviews.	<ul style="list-style-type: none"> • Male (26) • Female (3) • Mean age: 29.5yrs • Iran (9), Zimbabwe (3), Afghanistan (3), Iraq (2), Sri Lanka (2), Eritrea (2), Ethiopia (2), Guinea (1), Morocco (1), Cabinda (1), Sudan (1), Kuwait (1), Turkey (1) • Asylum Seekers • 16 (76%) met diagnostic criteria for PTSD based on PSS-I score. 	<p><i>Qualitative:</i> In-depth interviews 1 month following mental health screening.</p> <p><i>Quantitative:</i> Shortened PMLD, GAD- 7, CORE-34, PSS-I</p>	<p>Mixed <i>Qualitative:</i> Free association narrative interview method. Pro-formas and pen portraits.</p> <p><i>Quantitative:</i> Descriptive statistics. Statistically analysed demographics.</p>	Psychological distress is common among asylum seekers, but so are post- migratory living difficulties. Mixed experiences of health and social care services.	87%
Halcón et al. (2010) USA	Test feasibility, accessibility and acceptability of a strengths-	19	<ul style="list-style-type: none"> • Female • Aged 23-72yrs • Somalia (9) & Ethiopia (10) • Refugees 	<p><i>Qualitative:</i> Post-intervention (1 mth) evaluation sessions</p> <p><i>Quantitative:</i></p>	<p>Mixed <i>Qualitative:</i> Data from each training session and post-intervention</p>	Feasibility established through recruitment, retention, participation and participant response. Accessibility established	52%

	based community-delivered intervention with Somali and Ethiopian (Oromo) women refugees.		<ul style="list-style-type: none"> Reported trauma histories – had taken part in previous study 	Sessional evaluation (questionnaires), Refugee Appraisal & Coping Experience Scale (RACES – developed for the study)	evaluation transcribed verbatim. Qualitatively analysed. <i>Quantitative:</i> Descriptive statistics for sessional questionnaires, reliability analysis for RACES	through providing meals, transportation and child-care assistance. Acceptability established through evaluating translated materials, cultural congruence and perceived relevance.	
Jensen et al. (2014) Denmark	To investigate continuity of care in the psychiatric healthcare system from the perspective of patients, including vulnerable groups such as immigrants and refugees.	15	<ul style="list-style-type: none"> Male (9) Female (6) Aged 25-58yrs Denmark (6), Morocco (1), Nigeria (1), Iran (1), Bosnia (1), Iraq (1 Kurdish, 1 Iranian), Pakistan (1), Turkey (1 Kurdish, 1 Turkish) Immigrant (4), Refugee (5) or Ethnic Danes (5), Descendent (1) Self-reported PTSD (3) 	2 semi-structured pilot interviews initially conducted to assess applicability of using illness narratives. Some patients interviewed twice (19 interviews in total).	Qualitative Content analysis (described by Graneheim and Lundman, 2004)	For immigrants and refugees, issues of accessibility: lack of mental illness knowledge and obligations towards children. Individualised care, trauma, additional vulnerability and taboo around mental illness of specific concern. Social services included assistance with immigration papers. No differences identified in relationship base domain.	92%
Kaltman et al. (2016) USA	To develop and preliminarily evaluate a mental health intervention for trauma-exposed Latina	28	<ul style="list-style-type: none"> Female Mean age: 48.2yrs Central America (17), South America. El Salvador (13), 	<i>Quantitative:</i> SLESQ, PCL, PHQ-9, MOS-SSS. <i>Qualitative:</i>	Mixed <i>Quantitative:</i> Descriptive statistics (demographics, symptomology, perceived social support) and within-	Overall positive perceptions, specific components highlighted. Overall deemed to be feasible, acceptable and safe.	77%

	immigrants with depression and/or PTSD		<ul style="list-style-type: none"> Bolivia (4), Peru (3), Argentina (3). Immigrants 57% PTSD & Depression, 36% PTSD only 	Semi-structured interviews (what liked most/least about individual and group sessions)	<p>samples t-tests (baseline to post-intervention)</p> <p><i>Qualitative:</i> Directed content analysis approach</p>	PTSD/Depression symptomology significantly changed, levels of social support non-significant but suggested there was improvement in qualitative data.	
Kaltman et al. (2014) USA	To identify preferences for treatment modality, type of psychotherapy, type of provider, and setting, as well as influence of logistical factors and potential barriers on the help-seeking behaviours of trauma-exposed Latina immigrants.	27	<ul style="list-style-type: none"> Female Mean age: 45.6yrs South America, Central America, Mexico (most frequent: El Salvador, Bolivia, Mexico, Peru) Immigrants 7 PTSD only, 12 PTSD and depression 	<p><i>Quantitative:</i> Stressful Life Events Questionnaire, PHQ-9 and PCL as part of screening for recruitment.</p> <p>Card-sorting task: saliency of type of treatment modality, psychotherapy. Also identified logistical factors and potential barriers.</p> <p><i>Qualitative:</i> Interview to explain rankings.</p>	<p>Mixed</p> <p><i>Quantitative:</i> Card-sort task generated saliency scores.</p> <p><i>Qualitative:</i> Discussion of main themes and directed content analysis.</p>	<p>Most preferred options: Treatment modality: individual Type of Psychotherapy: Supportive Psychotherapy & CBT Provider: Mental health care specialist Setting: Primary Care Clinic Logistical Factor: Cost Potential Barriers: Uncertainty</p>	85%
Madsen et al. (2016) Denmark	To investigate refugee experiences of individual Body Basic Awareness Therapy (BBAT) and level of transference into daily life.	3	<ul style="list-style-type: none"> Male (1) Female (2) Aged 26-50yrs N/A Culture of Origin Refugees PTSD 	Semi-structured interviews	<p>Qualitative</p> <p>Systematic Text Condensation – Giorgi’s 4 step analysis</p>	Traumatized refugees experienced BBAT movements as small and simple with big effects. Experienced relief of pain, tension, peace of mind/body, slept more easily. Transference of BBAT to daily life experienced.	89%

Maier & Straub (2011) Switzerland	To explore the concepts of illness and treatment expectations in traumatised migrants.	13	<ul style="list-style-type: none"> • Male (8) • Female (5) • Mean age: 37yrs • Bosnia (2), Kosovo (2), Turkey (Turkish 1, Kurdish 1), Iran (Kurdish 2), Afghanistan (2), Cameroon (1), Sudan (1), Chechnya (1) • Refugees (5), Asylum Seekers (8) • PTSD (11) 	Semi-structured interviews	Qualitative Content analysis – stepwise procedure	Participants believe that symptoms not physically caused but suffering could be alleviated medically, doctors and therapists biomedical experts, influential social agents and powerful. Majority considered early traumatic events to be main cause. Majority used different support systems. Folk medicine marginally reported. No prior knowledge of psychotherapy but willing to enter therapeutic process.	79%
Majumder et al. (2015) UK	Appreciate the views and perceptions that unaccompanied minors hold about mental health and services.	15	<ul style="list-style-type: none"> • Male (14) • Female (1) • Aged 15-18yrs • Afghanistan (11), Iran (2), Eritrea (1), Somalia (1) • Refugees (7), Asylum Seekers (8) • PTSD (8) 	Semi-structured interviews	Qualitative Thematic Analysis	Negative views of mental health, lack of trust in services, engaging with talking therapy difficult. Implications for ethics and services.	66%
Mirdal et al. (2012) Denmark	To study how traumatised refugees, their therapists, and their interpreters perceive both curative and	16	<ul style="list-style-type: none"> • Male (9) • Female (7) • Mean 'most successful' age: 40yrs, Mean 'least successful' age: 38yrs (31-55yrs) 	Semi-structured interviews	Qualitative Giorgi's (1985) approach modified by Malterud (1993) qualitative phenomenological analysis	Good working alliance and trust in the triadic relationship important, most curative factor. Psychoeducative methods, cognitive interventions and	71%

	hindering factors in psychological therapy.		<ul style="list-style-type: none"> • Iraq (6), Bosnia (5), Lebanon (1), Afghanistan (1), Palestine (1) • Refugees • PTSD (12) 			practical help/advice curative and facilitating.	
Praetorius, et al. (2016) USA	To qualitatively assess the acceptability, satisfaction and impact of a group-based financial education course and social enterprise on the self-reported mental health of resettled Bhutanese refugee women.	12	<ul style="list-style-type: none"> • Female • >18yrs • Bhutan • Refugees • Recruited from larger quantitative study sample, 48% qualified for further assessment for PTSD. Sample taken from this group, unclear of PTSD symptomology/potential. 	Interviews – Guiding questions with added prompts.	Qualitative Grounded Theory	Women in financial+ (social enterprise group) had an additional cultural transition to make that other group did not – moving culture of work from Bhutan to US. Knitting component (skill) positive but produced anxiety that dampened impact of intervention on mental health. Mental health still improved significantly.	79%
Silove et al. (1995) Australia	To explore whether Southeast Asian participants find disclosure of their trauma stories to be helpful in allaying their psychological symptoms during	20	<ul style="list-style-type: none"> • Male (8) • Female (12) • Aged 30-50yrs • Cambodia • Refugees • Half exceeded HTQ cut-off score for PTSD 	Cambodian versions of HTQ & HSCL-25 (demographics) Semi-structured interviews	Quantitative Number of responses yes/no to questions – quantitative or not? Statements about responses to interview questions? Quantitatively framed?	Majority of participants found the therapist understood problems, the therapist cared about problems, and they were willing to discuss trauma experiences but did not find this helpful in relieving symptoms. Assistance with practical problems was deemed unhelpful, and medication deemed helpful. Refutes the commonly held belief	50%

	individual therapy.					that Asians are not psychologically minded and avoid disclosing emotionally sensitive information, however self-disclosing alone did not appear to benefit patients, only 4 found this helpful and 3 of these 4 found the relief to be transitory.	
Silove et al. (1997) Australia	To examine levels of satisfaction with mainstream mental health services and specialised mental health services for refugees among Vietnamese psychiatric patients and their relatives. Demographic, diagnostic, symptomatic and service-related issues that might influence satisfaction were investigated.	86 (+56 relatives)	<ul style="list-style-type: none"> • Male (52) • Female (34) • Mean age: 39.1yrs • Vietnam • Refugees • 15% had PTSD diagnosis 	<p>Measure of Satisfaction with Services. 4 point scale 0 (very dissatisfied) to 3 (very satisfied). Close relative or partner completed modified version of questionnaire.</p> <p>Abbreviated interviews conducted for further demographics, family and social characteristics of their relative.</p> <p>Case note reviews.</p> <p>Semi-structured interview – specific aspects of care received from designated mental health service.</p>	<p>Quantitative Multiple Regression Analyses on demographic factors, diagnosis, symptom scores (HTQ and HSCL), site of treatment and treatment issues. Analyses of each group of predictor variables used total satisfaction score as outcome variable.</p> <p>Semi-structured interviews statistically analysed.</p>	<p>Satisfaction of patients/relatives = moderately satisfied. Closely related. Demographics: Only English fluency statistically related to levels of satisfaction.</p> <p>Site of treatment – patients attending specialised refugee service more satisfied than mainstream services.</p> <p>Interview: (following Bonferroni correction) Significantly more from specialised service reported that clinician's explanations about treatment programs easy to understand Significantly more from specialised service reported that their</p>	59%

Singer & Adams (2011) Australia	To examine refugee women's experiences of complementary therapies and counsellors reasons for referral to complementary therapies (CTs).	12	<ul style="list-style-type: none"> Females Age: N/A Iran, Afghanistan, Serbia, Burma, Iraq, Yemen, Somalia Refugees Clients at centre for survivors of torture and trauma 	In-depth interviews guided by a theme list (background details, current life experiences in Australia, participant's 'home story', experiences of CTs)	Qualitative Grounded theory (Strauss & Corbin 1996)	<p>psychiatric diagnosis had been communicated directly to them.</p> <p>Notion of relationship central to efficacy of CTs (clients and counsellors)</p> <p>Counsellors – belonging: cultural familiarity, important for clients too.</p> <p>Counsellors – somatic presentations</p> <p>Both – CT as working directly with the body.</p>	61%
Slewa-Younan et al. (2014) Australia	To use a Mental Health Literacy (MHL) survey to determine knowledge of, and beliefs about, helpfulness of treatment interventions and providers for PTSD among resettled Iraqi refugees.	225	<ul style="list-style-type: none"> Male (98) Female (127) Mean age: 37.9yrs Iraq Refugees 31.1% probable PTSD based on IES-R scores. 	Presented culturally appropriate vignette depicting individual suffering from PTSD. Completed MHL survey assessing what participants considered individual's main problem to be, and beliefs about most helpful/harmful intervention for individual.	Quantitative Statistical analysis – Mann-Whitney U tests, Kruskal-Wallis tests, Spearman's rank correlations or Chi square as appropriate.	14.2% identified PTSD in vignette, modal response (41.8%) 'a problem with fear'. Reading Koran or Bible helpful (79.2%), most helpful (19.0%), psychiatrist helpful 84.5%, most helpful 35.4%. Variation in problem recognition and helpfulness of treatment influenced by length of resettlement in Australia. This cohort has low levels of problem recognition with regards to PTSD and complex belief systems regarding treatment.	74%
Stade et al. (2015) Denmark	To explore compliance, acceptability and treatment	9	<ul style="list-style-type: none"> Male (4) Female (5) Mean age: 47.3yrs 	<i>Qualitative:</i> Semi-structured interviews	Mixed <i>Qualitative:</i> Thematic Analysis	Participants had high compliance, acceptability and treatment satisfaction with BBAT. Majority	85%

	satisfaction using group Basic Body Awareness Therapy (BBAT) in traumatised refugees. Study changes in psychiatric and somatic symptoms as well as quality of life, level of functioning and quality of movement during treatment with BBAT.		<ul style="list-style-type: none"> Arabic speaking: culture/countries not specified Refugees 'Traumatised' – trauma types listed in study. 	<p><i>Quantitative:</i> Treatment Satisfaction Questionnaires</p> <p>Self-report scales: HTQ, WHO-5 HSCL-25 Somatisation items from SCL-90, SDS, VAS</p> <p>Observer version of BARS (BARS-MH)</p>	<p><i>Quantitative:</i> Demographic statistics (Treatment Satisfaction Questionnaires)</p> <p>All other scales: Sample Sized Paired T-Tests</p>	showed improvements from baseline to post-intervention (self-report questionnaires and BARS-MH)	
Strijk et al. (2010) Netherlands	To describe the care needs of adult traumatised refugees and asylum seekers.	30 (of which 8 were interviewed)	<ul style="list-style-type: none"> Male (20) Female (10) Adults (age not specified) Afghanistan, Angola, Armenia, Azerbaijan, Bosnia & Herzegovina, Burundi, Congo, Guinea-Bissau, Iraq, Iran, Jordan, Kosovo, Moldova, Niger, Serbia & Montenegro, Sierra Leone, 	<p><i>Quantitative:</i> CAN</p> <p><i>Qualitative:</i> In-depth interviews to supplement (CAN not specific to target groups) interviewed about nature of specific care needs and degree to which needs were met in their opinions.</p>	<p>Mixed</p> <p><i>Quantitative:</i> Descriptive statistics</p> <p><i>Qualitative:</i> Analysed at textual level with MaxQDA qualitative text-analysis program.</p>	<p>Key themes:</p> <ol style="list-style-type: none"> 1) Psychological Distress 2) Being a Refugee 3) Loneliness 4) Discrimination 5) Accommodation 6) Benefits and Money 7) Daytime Activities 8) Symptoms 9) Shared Experience 10) Transport <p>Key themes among refugees are loneliness and grief. Refugees are in severe psychological distress. Also encounter</p>	65%

			<ul style="list-style-type: none"> Somalia, Sudan, Tajikistan, Chechnya Asylum Seekers & Refugees Traumatized (patients in psychiatric hospital specialising in trauma treatment) 14 Hospitalised, 6 Day-care 			all kinds of practical problems influencing quality of life. Many of them suffer from serious psychiatric and trauma-related problems.	
Vincent et al. (2012) <i>UK</i>	Considers the acceptability of Trauma Focussed CBT (TF-CBT) for asylum seekers with PTSD by exploring their experiences of this treatment	7	<ul style="list-style-type: none"> Male (4) Female (3) Aged 19-42yrs Sudan, Burundi, Iraq, Zimbabwe, Afghanistan Asylum Seekers PTSD 	Semi-structured interviews	Qualitative Interpretative Phenomenological Analysis (IPA)	Ambivalence regarding engaging in therapy described. Treatment challenging but found to be helpful. Fear of repatriation can impede engagement in TFCBT, still beneficial. Therapeutic relationship important.	89%

Yaser et al. (2016) Australia	Examine the mental health literacy (MHL) of resettled Afghan refugees in Adelaide, Australia.	150	<ul style="list-style-type: none"> • Male (74) • Female (76) • Mean age: 32.8yrs • Afghanistan • Refugees (64), Asylum Seekers (52), Immigrants (34) • 69 (46%) probable PTSD based on IES-R scores 	Presented culturally appropriate vignette depicting individual suffering from PTSD. Completed MHL survey assessing what participants considered individual's main problem to be, beliefs about most helpful/harmful intervention for individual. AWES, IES-R, HSCL-25.	Quantitative Statistical analysis – Mann-Whitney U tests, Kruskal-Wallis tests, Spearman's rank correlations or Chi square as appropriate.	31% of participants identified PTSD in vignette, 26% thought 'fear'. 18% thought finding new hobbies most helpful form of treatment, 16% thought improving diet/more exercise. Of medications, 33.3% for each vitamins/minerals and herbal medicines most helpful, and for people Psychiatrist most helpful at 43.3%. Aspects of MHL specific to this cohort. Variation in MHL may be function of both cultural origin of refugee population and resettlement country	88%
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Notes: The following abbreviations were used for details regarding 'Measures used':

Post-migration Living Difficulties (PMLD) (Schweitzer, Melville, Steel, & Lacherez, 2006); Generalized Anxiety Disorder-7 (GAD-7) (Spitzer, Kroenke, Williams, & Löwe, 2006); Clinical Outcomes Routine Evaluation - Outcome Measure (CORE-OM) (Evans et al., 2002); PTSD Symptom Scale-Interview (PSS-I) (Foa, Riggs, Dancu, & Rothbaum, 1993); Stressful Life Events Screening Questionnaire (SLESQ) (Green, Chung, Daroowalla, Kaltman, & Debendictis, 2006); PTSD Checklist (PCL) (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996); Patient Health Questionnaire-9 (PHQ-9) (Kroenke & Spitzer, 2002); Medical Outcomes Study Social Support Survey (MOS-SSS) (Sherbourne & Stewart, 1991); Harvard Trauma Questionnaire (HTQ) (Mollica & Caspi-Yavin, 1991); Hopkins Symptom Checklist (HSCL-25) (Mollica, Wyshak, de Marneffe, & et al., 1987); Mental Health Literacy (MHL) Survey (Jorm, 2012); World Health Organisation-5 (WHO-5) (WHO, 1998); Symptom Checklist (SCL-90) (Derogatis, Rickels, & Rock, 1976); Sheehan Disability Scale (SDS) (Arbuckle et al., 2009); Visual Analogue Scale (VAS) (Boonstra, Schiphorst Preuper, Reneman, Posthumus, & Stewart, 2008); Body Awareness Rating Scale (BARS) (Friis, Skatteboe, Hope, & Vaglum, 1989); Camberwell Assessment of Need (CAN) (McCrone et al., 2000); Afghan War Experience Scale (AWES) (Miller et al., 2006); Impact of Events Scale – Revised (IES-R) (Weiss & Marmar, 1997).

Narrative Synthesis

Due to the heterogeneity of outcome measures and methods used by the 18 studies in this review, the beliefs around trauma were interpreted as falling within the following two domains: the acceptability of help-seeking and how permanent and / or treatable trauma-related distress was deemed to be. Experiences of trauma interventions were organised into the following domains: therapeutic preferences, therapeutic outcomes, factors regarding the professional, and contextual factors.

Beliefs

Pre-existing to entry to the host nation and potential access to services, refugees and asylum seekers hold expectations and ideas of the acceptability of mental health interventions. This may be influenced by how treatable they determine their distress, as well as pre-existing ways of coping, culture-specific values, and the perception of Westernised mental healthcare.

Acceptability

There were contrasting views of how acceptable or unacceptable seeking formal intervention would be, influencing engagement with services.

Several studies demonstrated help-seeking as acceptable. Participants across the samples identified seeking psychological support as an acceptable coping strategy, amongst others such as medication, spiritual, and social support (Bernardes et al., 2010). Some participants may enter the intervention with a hope for their mental health to be improved, providing insight into their intentions

behind help-seeking (Stade et al., 2015). There may be inner-conflict between intending to engage in therapy, wanting to improve wellbeing, and ambivalence regarding what the intervention may involve (Vincent et al., 2013).

Further literature suggests a process of weighing up whether to engage in therapeutic intervention or not. The asylum-seeking or refugee individual may identify their psychological distress as an unmet need, however cultural taboos of mental health and intervention cause uncertainty about engagement (Strijk et al., 2011). Individuals may be better informed and more accepting of the use of medication in mental health settings compared to talking-based therapies (Maier & Straub, 2011).

The conflict is not only the modality of support, but also the provider was evident; mental health specialists and psychiatrists were perceived as most helpful for trauma-related distress (Kaltman et al., 2014; Slewa-Younan et al., 2014; Yaser et al., 2016). In Kaltman et al. (2014), the preference for mental health specialists was concordant with the preference for supportive psychotherapy and CBT; however participants were only able to select from types of psychotherapy rather than more general ways of coping as options, perhaps biasing results. In Slewa-Younan et al. (2014) and Yaser et al. (2016) however, in larger samples having wider choice, reading religious texts (Slewa-Younan et al., 2014) or finding a new hobby (Yaser et al., 2016) were considered the most helpful, despite the discordant preference for psychiatrists as a provider. Interestingly, of these three studies, it is unclear whether or not the participants have actually had any experience of any of the suggested options for interventions, or providers of support. The views presented in this selection of research may stem from pre-existing beliefs, potentially influenced by cultural values, rather than opinions based on experience. More general coping

strategies may be a more familiar experience. Uncertainty of more Westernised, mental health focused supports may deter individuals. The more acculturated an individual becomes with Western society, the more familiar and more accepting they may become with mental health supports, e.g. psychiatric hospital admission (Slewa-Younan et al., 2014).

Overall, the literature considering acceptability links understanding the nature of the intervention to be a key factor, and a lack of knowledge as a significant barrier (Kaltman et al., 2014). Compared to mainstream services, specialist services aimed towards an asylum-seeking or refugee clinical population receive higher satisfaction and acceptability levels (Silove et al., 1997). This tailored approach potentially reduces ambivalence and promotes engagement by removing the fear of the unknown.

Permanence/Treatability of Trauma-related Distress

Throughout the literature, participants express their concepts of trauma-related distress and how 'treatable' it may be, influencing perceived efficacy of interventions. Previous coping strategies for distress also make an impact. How culture influences beliefs and the fit of the Western medical model is considered.

Beliefs of trauma and the expectations for treatment

In several studies, trauma-related distress often manifested in physical symptoms, therefore physical remedies were sought out e.g. medication (Maier & Straub, 2011) and movement-based interventions (Madsen et al., 2016; Stade et al., 2015). This reinforces acceptability of medication and unacceptability of

talking therapies. Physical and psychological difficulties are not necessarily dichotomous; initial physical coping strategies such as exercise and healthy eating may be followed by getting information about the problem and engaging in a talking-therapy focusing on the past (Yaser et al., 2016). Over time, this may promote an increased recognition of the links between the physical and the psychological body and mind.

Not recognising trauma as a psychiatric diagnosis i.e. PTSD, as it is in Western society, may lead to belief of mental health interventions being irrelevant (Slewa-Younan et al., 2014). In Slewa-Younan et al.'s (2014) study, symptoms of PTSD were recognised as a problem with fear, and therefore reading religious texts was a preferred intervention; seeking comfort from a higher power may reduce the fear. For those who believe distress has a physical cause, a physical solution is favoured.

Those with a higher education may have a more integrated concept of how trauma may be both physical and psychological, and more able to label distress as PTSD (Yaser et al., 2016). The recognition of social factors and post-migratory stressors may lead to beliefs of distress being transient for those longer resettled in the host nation (Slewa-Younan et al., 2014).

Conversely, In Silove et al.'s (1995) study, psychological causes were identified, however talking was deemed unhelpful, and medication helpful. This study did however have a 50% quality rating, and had reported potentially rich data from semi-structured interviews into dichotomist yes / no responses. It cannot be determined what mediating factors contributed to these beliefs.

Overall, the literature demonstrates the potential for asylum seekers and refugees to identify biological, psychological and social factors in trauma-related

distress. Though considered initially to be separate entities, the more experience, acculturation or education an individual has may enable them to integrate these ideas, paralleling the biopsychosocial model that dominates Western mental healthcare.

Pre-existing alternative ways of coping

Across several studies, individuals described using spiritual, social and physical coping strategies (Bernardes et al., 2010; Slewa-Younan et al., 2014; Yaser et al., 2016). The preference for these over more strictly 'psychological' choices may reflect the arsenal of familiar tools which have been shaped by individual and cultural contexts. A dependency on these strategies may cause reluctance to engage in Western interventions.

Cultural influences: Western versus Non-Western Approaches

Attitudes stemming from cultural beliefs influenced perceived benefits of Western mental health interventions.

Individualised care may be perceived to have an excessive focus on medication (Jensen et al., 2014), taking more of a strictly biological approach. Individuals in Jensen et al.'s (2014) sample placed more significance on the narrative of their traumatic events, which felt pushed aside and distorted when clinicians adhered to a strictly medical model. The cultural attitudes of the individual may consider psychiatric diagnoses as taboo and shameful (Strijk et al., 2011).

Other negative beliefs of the Westernised mental healthcare system relate to the traumatic context of the individual, making it difficult for the service-user to form trusting relationships with services (Majumder et al., 2015). Individuals are likely to have experienced exploitation or mistrust in their trauma; the strict asylum-seeking system also having an isolating and potentially re-traumatising effect (Majumder et al., 2015).

Despite this, some positive attitudes have been reported, but confidence was based on medication (Maier & Straub, 2011). A possible bias in Maier and Straub's (2011) study was that all but one participant were already taking medication, not receiving psychotherapeutic input until they were referred to the outpatient clinic. It was reported that due to a lack of knowledge, talking therapy as a possible intervention has a pre-existing stigma attached to it (Maier & Straub, 2011).

Having culturally relevant session content and intervention modalities is an important factor (Halcón et al., 2010; Singer & Adams, 2011). Taking into account cultural values when designing an intervention e.g. separating gender, can be crucial to satisfaction and engagement (Stade et al., 2015).

It cannot be assumed that Western approaches will always be perceived as helpful as alternative spiritual or physical strategies (Kaltman et al., 2016; Yaser et al., 2016). Culturally relevant and familiar techniques may supersede Western methods, though the benefits of Western approaches are still acknowledged and come as a close second in order of preference (Kaltman et al., 2016; Yaser et al., 2016). Over time, Western approaches may be seen as more beneficial than culturally-based coping strategies such as seeking spiritual guidance (Kaltman et al., 2014).

Intervention Experiences

When the asylum-seeking or refugee service-user goes through the actual experience of a mental health intervention for trauma, pre-existing beliefs might be altered or reinforced. This is dependent on the congruency between the belief and the experience, and if therapeutic change is perceived as a product of engagement.

Therapeutic preferences

Participants discussed particular aspects of varying interventions and their helpfulness; congruence with pre-existing beliefs is considered.

Medication

Several studies demonstrated positive views regarding medication. Generally, having experience and familiarity with medication contributed to the acknowledgement of the benefits and acceptance of its use (Maier & Straub, 2011). Some conveyed the perception that medication is more effective and viewed more positively than talking therapies (Silove et al., 1995). Individuals may be more likely to request and take medication, even when not knowing why it is prescribed (Majumder et al., 2015). Despite this, not all individuals are acquiescent, and a clear explanation of the reasons for prescription are valued (Silove et al., 1997). A preference for medication may bias a preference for providers who have the power to prescribe, e.g. psychiatrists (Slewa-Younan et al., 2014; Yaser et al., 2016). There may however, be discordance in who the most appropriate person to support the individual may be, as less medically-

informed strategies, such as taking vitamins or herbal medicines, was deemed to be preferable than psychiatric medication (Yaser et al., 2016).

Negative attitudes around medication focused on side-effects which may contribute to non-adherence (Bernardes et al., 2010) or difficulty engaging in talking therapy (Mirdal et al., 2012). In addition to acquiescence to taking medication (Maier & Straub, 2011), clinicians using the medical model may have a reductionist approach to the service-user's distress, with service-user narratives perceived as being disregarded (Jensen et al., 2014). Overall, it is dependent on the individual, demographic and cultural contexts as to whether individuals believe that medication, talking therapy, or a balance of the two, is optimal for their care.

Content of sessions

Participants scrutinised specific components of interventions as well as general components demonstrated across various therapeutic models.

Psychoeducation

Psychoeducation around topics such as the somatisation of distress (Bernardes et al., 2010), PTSD diagnosis (Silove et al., 1997), post-traumatic reactions, the culture of the host nation, and social and coping skills were deemed to be helpful and essential to therapeutic progress (Mirdal et al., 2012).

A specialised refugee service providing a more tailored approach to the unique context of the service-user in terms of delivering psychoeducation is perceived as more satisfactory (Yaser et al., 2016).

Psychoeducation is not always universally perceived to be useful, and for some, receiving information about the diagnosis and treatment was not identified as a highly unmet need (Strijk et al., 2011). Furthermore, for service-users with self-blaming beliefs around their distress, an overload of new information regarding the nature of problems may be problematic when having to consider the new, non-blaming explanations provided by clinicians (Vincent et al., 2013).

Talking

Some individuals communicated a positive attitude of the 'talking' part of therapies: participants valued that talking about past experiences had an unburdening and cathartic effect. This felt important and validating, promoting continued engagement (Kaltman et al., 2014; Kaltman et al., 2016; Majumder et al., 2015; Mirdal et al., 2012; Vincent et al., 2013).

Talking can be perceived as conditionally helpful, depending on who the listener is e.g. not wanting to talk to individuals from their own ethnic group in case of re-traumatisation (Bernardes et al., 2010). Some individuals communicated a willingness to talk, considering it important, but not necessarily instilling long-term change (Bernardes et al., 2010; Silove et al., 1995). Some may all together not believe in a talking cure, only seeing benefit in medication or practical support, hindering therapeutic engagement (Mirdal et al., 2012).

Some individuals in the literature held negative views of talking, fearing re-traumatisation when recounting traumatic events (Majumder et al., 2015). Majumder et al. (2015) consider how the unique social position of asylum seekers and refugees should be considered, contributing to a difficulty to be trusting and open in therapy sessions. For some individuals, when stability and trust have

formed, talking and engaging may become more acceptable, acknowledging that medication alone may not address the complexity of the problem (Maier & Straub, 2011). An important factor of helpfulness of talking was to have a specific focus, such as the past, relationships with others, or changing thoughts and behaviours (Slewa-Younan et al., 2014; Yaser et al., 2016).

Role of emotions: psychology vs. physiology

Physical manifestations of distress, and psychological benefit from physically or medically based interventions were reported (Madsen et al., 2016; Singer & Adams, 2011; Stade et al., 2015). Despite a physical focus in some samples, psychological distress has been determined as an unmet need (Strijk et al., 2011). Integration of the physiology and psychology was viewed positively, and deemed beneficial for mental wellbeing (Madsen et al., 2016; Singer & Adams, 2011; Stade et al., 2015). Those who attributed distress to psychological causes did not necessarily find psychological intervention to be helpful, but did so for medication (Silove et al., 1995). Regardless of the beliefs around the cause of distress, an integration of physical and psychological techniques may be of more benefit than considering them to be mutually exclusive.

Therapy-specific components

Participants noted the significance of intervention-specific components. Behavioural activation (Kaltman et al., 2016), developing cultural literacy (Praetorius et al., 2016), using complementary therapies (Singer & Adams, 2011), and focusing on body-awareness (Madsen et al., 2016; Stade et al., 2015)

were all valued as specific aspects of interventions. This suggests an appreciation of Western techniques which also incorporate the service-user's cultural context.

In Praetorius et al.'s (2016) study, the downsides of specific components are also considered, for example the 'social enterprise' part of the intervention, due to cultural differences, was perceived to be anxiety provoking, cancelling out any intended benefits.

Having a specific focus was considered to be a valuable aspect of talking therapies rather than just 'talking about the problem' (Kaltman et al., 2014; Slewa-Younan et al., 2014; Yaser et al., 2016). Culture may influence which aspects are considered helpful; in an Iraqi sample, focusing on relationships with others was most favoured, and changing thoughts the least (Slewa-Younan et al., 2014). In an Afghan sample however, a focus on the past was most favoured and changing thoughts the least (Yaser et al., 2016). In a Central and South American sample, a focus on thoughts was key (Kaltman et al., 2014). It should be noted that in these three studies, participants had not necessarily experienced these interventions, so their views may have been based purely on pre-existing beliefs, potentially influenced by culture.

Therapeutic Outcomes

A key factor in how beneficial interventions were perceived to be was the overall change and outcome attributed to engagement in therapy.

New ways of coping

Several studies found that interventions promoted new ways of self-supporting, e.g. identifying inner coping resources (Bernardes et al., 2010; Kaltman et al., 2016), new thinking strategies (Vincent et al., 2013) and the use of breathing techniques (Madsen et al., 2016; Stade et al., 2015). Finding alternative ways to manage distress was depicted to be a key benefit of therapeutic engagement. Identifying inner coping resources through psychological support, as well as developing relaxation, self-soothing skills and more positive thought patterns (Bernardes et al., 2010; Kaltman et al., 2016; Vincent et al., 2013) suggest value is placed on developing transferrable distress-management skills that can be used in everyday settings (Vincent et al., 2013). Physical strategies such as exercises and breathing techniques have also been reported to be useful in self-regulating (Madsen et al., 2016; Stade et al., 2015). This further supports the value of integrating physical and psychological concepts in interventions for this population.

Interventions were not always helpful in developing coping strategies, for example sharing the traumatic story may be deemed as unhelpful, yet medication was helpful (Silove et al., 1995). Though medication could be argued to coping strategy, it may also imply a dependence and inability to use internal resources to alleviate distress. Silove et al.'s (1995) study did however have a low quality rating of 50% due to the lack of richness in the data, potentially missing deeper information.

Changes in self

Noticing a change in their sense of self and personal development as a result of therapy was positively viewed.

Feeling reassured about life in a new country provided an increased sense of safeness, as well as developing literacy skills, providing the stability to learn and therefore improving wellbeing (Praetorius et al., 2016). Regaining a sense of identity and forming new non-blaming explanations for difficulties was also regarded as a positive change (Vincent et al., 2013). Also conveyed was an increased connection to self and others, this being an important shift in perspective as a result of therapy (Madsen et al., 2016; Stade et al., 2015).

Feeling more secure, stable and connected after a prolonged, distressing time period is valued in this population.

Symptom reduction / Psychological vs. Physical outcomes

Efficacy of intervention, gauged by reduction in symptomology, was important in the experiences of the service-user. A methodological shortcoming of the literature base was that most either reported objective changes in symptomology via questionnaire data, and may or may not have been noticed by the participants themselves. Alternatively, participants would self-report a subjective change in their trauma-related distress. It was a notable strength in the quality of studies which used both quantitative and qualitative reports of symptom reduction and improvement of wellbeing (Halcón et al., 2010; Kaltman et al., 2016; Stade et al., 2015), demonstrating a reliability between measures of symptoms and participant self-report.

Symptoms tended to be categorised as physical or psychological; integration of these concepts may remove emphasis from symptom reduction, and more on expressing the complexity of distress (Singer & Adams, 2011). Participants using physical intervention for physical manifestations of trauma symptoms experienced both physical and psychological improvement (Madsen et al., 2016; Stade et al., 2015). A shared learning intervention, with no explicit focus on psychological or physical issues, also contributed to self-reports of improved physical and psychological wellbeing (Praetorius et al., 2016). Interventions, regardless of specific focus, have the potential to improve overall, general wellbeing.

Some individuals demonstrated and reported significant psychological changes in their ability to cope with distress (Halcón et al., 2010). Others have demonstrated significantly decreased PTSD and depression symptomologies, reporting benefits of relaxation, self-care and other therapeutic strategies (Kaltman et al., 2016). This suggests some interventions are successful in achieving the therapeutic goals intended, service-users themselves experiencing this.

The Professional

Another important aspect of the individual's experience were perceptions of the professional responsible for their care. Various aspects of the dynamics between the professional and the individual are explored, as well as particularly favoured professional traits and skills.

Therapeutic relationship

Participants acknowledged how fundamental the therapeutic relationship was to their experience of interventions, it being a catalyst for therapeutic engagement.

A strong therapeutic alliance, feeling understood and acknowledged by the professional, was considered fundamental for engagement and progression in therapy (Jensen et al., 2014; Mirdal et al., 2012; Singer & Adams, 2011; Vincent et al., 2013). Despite this, some consider that though a positive relationship is important, alone it is not sufficient to instil therapeutic change, specific intervention strategies being the main driver (Bernardes et al., 2010).

Practical as well as interpersonal considerations can contribute to the relationship, such as availability of staff and time dedicated to service-users. Some individuals may refer to professionals as family due to perceived closeness (Jensen et al., 2014). A downside to a very strong therapeutic bond however, is that after feeling isolated for so long prior to therapeutic input, the prospect of ending therapy can impose the threat of re-isolation (Vincent et al., 2013). The relationship with the service as a whole is considered important, familiarity being key in a positive portrayal (Kaltman et al., 2014).

The unique social position of this population can make trusting services difficult, consequently feeling to not be understood or helped by professionals (Majumder et al., 2015). Poor therapeutic rapport is likely to impede the individual's ability to engage in therapy.

The addition of an interpreter is reported to impact the dynamics, success requiring a positive triadic relationship between all three parties (Mirdal et al., 2012). The addition of an interpreter can disrupt and weaken therapeutic

relationship, and it is preferred that where possible, bilingual professionals are used (Kaltman et al., 2014).

Trust

Specific aspects of the therapeutic relationship were valued by participants. Trust had high importance in fostering a positive rapport.

Trust alleviated anxieties about confidentiality; keeping sensitive information 'in the room' being important to this population (Kaltman et al., 2014; Kaltman et al., 2016). Experience of past trauma where an individual may have been exploited can make trust in an unfamiliar professional difficult to establish (Majumder et al., 2015; Vincent et al., 2013). Some individuals have reported this difficulty to dissipate over time, with increasing levels of trust and improved engagement as therapy progresses, also helping them to place trust in other individuals (Singer & Adams, 2011).

Caring

Perceiving the professional as a caring individual was reported to foster a positive therapeutic relationship. Participants described favourable traits in professionals that depicted a caring personality type e.g. wanting to listen, being supportive, non-judgemental, kind, empathic, genuinely concerned, and going over and above the job requirements. Also valued were the demonstration of solicitude, compassion, solidarity, strong liking and tenderness towards the individual (Kaltman et al., 2016; Madsen et al., 2016; Mirdal et al., 2012; Vincent et al., 2013).

Feeling cared for was valued by service-users (Bernardes et al., 2010; Silove et al., 1995; Singer & Adams, 2011; Stade et al., 2015), with some describing a preference for providers based on beliefs of how caring they may be; religious leaders were perceived by some to be insensitive, and avoided them on this basis (Kaltman et al., 2014). Care fostered feelings of trust, safety, and for some, love; essential to the experience of particular interventions, e.g. complementary therapies (Singer & Adams, 2011). Despite this, being over involved in the individual's care, i.e. perceived to be overly loving/caring, is considered an impeding factor to therapeutic progress (Mirdal et al., 2012).

Professional's ability

Participants also placed value on the professional's skill and expertise in conducting the intervention, valuing incorporation of their own understanding of their difficulties.

Many participants across the sample valued the professional's specialist expertise. Mental health knowledge influenced a preference towards a mental health provider for support, rather than a religious leader (Kaltman et al., 2014). Taking the time to explain PTSD as a diagnosis was valued, and perceived to be more client-centred, with a tailored approach to the needs and ability of the service-user (Silove et al., 1997). Delivering information in an accessible manner is a valued professional skill.

Expert knowledge and incorporation of the individual's specific distress has been alluded to as key to therapeutic engagement, as well as direction from the professional to facilitate therapeutic progression (Madsen et al., 2016; Mirdal et al., 2012; Singer & Adams, 2011). The professional taking an active role in

intervening is key; simply feeling understood alone being insufficient for alleviation of distress (Silove et al., 1995).

Being excessively 'expert' in the medical model however can be unhelpful if individual's own perspectives of their distress are disregarded or distorted by professionals, creating feelings of detachment from treatment (Jensen et al., 2014) Feeling questioned too much by professionals can make the session feel intense and unhelpful (Majumder et al., 2015), suggesting a professional flaw if having excessive focus on gleaning knowledge rather than forming therapeutic rapport.

Contextual Factors

The last key factor involved contextual factors related to the intervention itself and external to therapy. The service's and / or professional's consideration of these additional factors, and recognition of the unique social, political and psychological circumstances faced by refugees and asylum seekers, was valued.

Accessibility

The practical aspects associated with service access formed an important part of individuals' experiences.

An uncertainty about mental health services and referral processes were considered barriers to accessing care (Bernardes et al., 2010; Kaltman et al., 2014). In a specialist refugee service, obtaining help and changing treatment program was easier compared to a mainstream service (Silove et al., 1997). Practical barriers identified were language difficulties, long waiting times,

transportation, child care, financial cost and high pain levels (Bernardes et al., 2010; Halcón et al., 2010; Kaltman et al., 2014; Kaltman et al., 2016; Stade et al., 2015; Strijk et al., 2011). This emphasises the importance of recognising the unique context of the asylum-seeking / refugee service-user, and making an effort to break down barriers to accessing services.

On a more socio-political level, some individuals reported feeling rejected and discriminated against by the system, not being considered 'ill enough' to receive care (Bernardes et al., 2010; Jensen et al., 2014). A lack of knowledge of mental health issues further contributed to an inability to articulate the severity of distress and need for support (Bernardes et al., 2010; Jensen et al., 2014). Additional factors for low accessibility were having the course of treatment interrupted due to funding issues, and lack of communication between different services (Jensen et al., 2014).

Extra-therapeutic context considered

Individuals from this population have various life factors relevant to their asylum-seeking or refugee status which impact on their experiences of, or beliefs around engaging with mental health services. Participants valued services which acknowledged and accounted for their unique contexts.

Awareness and consideration of the specific distress regarding individual, social and political contexts can have a curative effect in therapy (Singer & Adams, 2011). Examples of additional stressors include feeling lonely and discriminated against as well as having a lack of routine or daytime activity (Strijk et al., 2011). Experiencing traumatic events and the complicated asylum-seeking journey can contribute to mistrust of services and potential re-traumatisation upon

entry to the host nation (Majumder et al., 2015). Uncertainty regarding the status of their family's welfare, their own status in the host nation and lack of stable social living were also described as complicating factors impacting wellbeing (Bernardes et al., 2010; Jensen et al., 2014; Majumder et al., 2015). Engagement in therapy can be impacted by the individual perceiving the therapist to be powerless in having any control over their asylum status (Vincent et al., 2013), suggesting being granted leave to remain is central to wellbeing.

Factors related to cultural attitudes were also of high salience across the samples. The gender of the provider or members in group therapy, mental health stigma, confidentiality concerns, age, religion and educational level were all contributed to willingness to engage (Kaltman et al., 2014; Maier & Straub, 2011; Slewa-Younan et al., 2014; Stade et al., 2015; Yaser et al., 2016). Despite this, for some, the severity of trauma could dominate and bias treatment expectations and illness concepts (Maier & Straub, 2011). A lack of attention to cultural contexts can change the experience of an intervention to something quite different than was intended by the provider (Praetorius et al., 2016). This highlights the importance of exploring service-users' experiences when designing and delivering interventions.

Language is fundamental: congruency of translation as well as ease of communication were valued, concepts needing to be understood as intended (Halcón et al., 2010; Praetorius et al., 2016). A specialised refugee service, versus a mainstream one, was considered to be significantly more satisfactory for those with Low English Fluency (Silove et al., 1997). This suggests that when there is a language barrier, providers who ensure information is understood are more highly valued by service-users. Acquiring cultural literacy has been

demonstrated to be a key benefit of an educational intervention described in Praetorius et al.'s (2016) study.

Additional support and continuity of care

As well as mental health interventions, this population typically access a variety of other services. It is important to consider the experiences of these services, which may influence perceptions of host-nation services generally, including those for mental health.

When individuals access multiple services, they may prioritise which needs are most important when considering which providers to access. For example in Jensen et al.'s (2014) sample, general health and GP contact was the most important, followed by asylum proceedings, joblessness, financial problems, and lastly, educational issues. This depicts the variety of issues faced, and the importance of mental health; if symptoms are somatised, they may be regarded as issues of general health (Madsen et al., 2016; Singer & Adams, 2011; Stade et al., 2015). Continuity of care between services was also valued, whether this is between different mental health services (Jensen et al., 2014) or using a transdisciplinary, coordinated intervention (Mirdal et al., 2012). Service responsibility, flexibility, good transfer of information and synchronisation of contributed professional effort contributed to positive perceptions of services (Jensen et al., 2014; Mirdal et al., 2012).

Additional services may be experienced negatively when perceived as insensitive to the individual's multiple needs, e.g. asylum, immigration and housing systems (Bernardes et al., 2010). Support from these services is fundamental in resolving the instability experienced in this population; inadequate

support further contributing to distress arising from post-migratory living difficulties (Bernardes et al., 2010).

Acculturation

Adjusting to life in the host nation also influenced individuals' experiences. Acculturation was considered difficult upon entry to the host country; the negative impact of not acculturating contributing to feelings of isolation and being a victim of discrimination (Bernardes et al., 2010; Strijk et al., 2011). Individuals may be more prone to mistrust services (Majumder et al., 2015) hindering the process of acculturation.

An intervention that actively attempts to dispel the anxiety-provoking myths held about the host-country can be helpful in developing the confidence to integrate into a new society (Praetorius et al., 2016). Considering the unique social position and specific post-migratory stressors in an intervention has potential as part of a tailored approach to intervention.

Length of the resettlement period may also influence or change beliefs, for example PTSD symptoms may be seen as transient, and attributable to homesickness when the person has been resettled for longer (Slewa-Younan et al., 2014). Accepting formal mental health support, such as inpatient admission to a psychiatric hospital, may seem increasingly acceptable rather than trying to manage alone (Slewa-Younan et al., 2014).

Social support

A final influence on experience was the level and significance of social support received. This may be being part of a group intervention, providing individuals with the opportunity to be with similar others.

Social support may buffer against mental health problems, considered valuable regardless of the nationality of others (Bernardes et al., 2010). Similarity in ethnicity can for some be anxiety provoking, with concern that too much similarity in cultural and traumatic contexts could lead to re-traumatisation (Bernardes et al., 2010). Individual sessions may feel more secure and confidential if uneasiness is experienced when sharing information in the group setting (Kaltman et al., 2014). Ambivalence about being part of group sessions may be linked to cultural values, for example female participants in Stade et al.'s (2015) study reported gender segregation, and having a female-only group, being key to reducing anxiety and promoting engagement.

Despite an initial uncertainty, sharing experiences can be largely positive for individuals. Recognising that others have been through similar situations, feeling part of a group, as well as meeting and learning from new people, provided the potential for relationships to be established that could continue beyond the intervention (Kaltman et al., 2014; Kaltman et al., 2016; Praetorius et al., 2016; Stade et al., 2015; Strijk et al., 2011). The aforementioned aspects depict how group dynamics may empower individuals to engage and progress towards improved psychological wellbeing.

Discussion

Asylum seekers and refugees originating from cultures considered minorities in the UK, or other Western host-nations may hold contrasting beliefs of trauma as an 'illness' concept, and how it should be managed (Gilbert et al., 2007; McColl et al., 2008; Sen, 2016). This is supported by the literature from this review, which used a systematic approach to explore beliefs and experiences of trauma interventions in this population. These widely varied across the literature, and beliefs were demonstrated to be shaped by not only cultural attitudes, but also actual experience of an intervention.

Despite research investigating efficacy of interventions (Crumlish & O'Rourke, 2010; Nicholl & Thompson, 2004), there has not yet been a review to understand and explore the beliefs and experiences of service-users. This may allude to underlying mechanisms of interventions contributing to the success, or failure, in improving psychological wellbeing.

Overall, individuals experiencing trauma-related distress from the asylum-seeking and refugee population enter the host-nation with preconceived ideas regarding mental health and help-seeking. There is conflict between recognising a need for support and a lack of knowledge and uncertainty acting as a barrier to seeking help. This has relevance to Slewa-Younan et al.'s (2015) findings that those presenting with 'clinical levels' of PTSD symptomology are more likely to seek help than those who may present as less severe, or below the clinical threshold. It is important to consider that PTSD is not the only manifestation of trauma-related distress, and not necessarily everyone who experiences a traumatic event develops PTSD as defined by the DSM-V (American Psychiatric Association, 2013; Bender, 2013). It was not clear in every study whether responses came from individuals with a formal PTSD diagnosis, however

individuals were reported to experience trauma-related difficulties requiring support.

The mental health beliefs around trauma are suggested to influence help-seeking attitudes and service access, with services needing to be sensitive to the diversity of needs in this population (Savic et al., 2016). This is highlighted across in the review, with various manifestations of distress being demonstrated across samples. Individuals considered interventions as more acceptable if they were congruent with the perceived cause of the problem. If symptoms were physical, seeking help using a physical, or medical intervention, was accepted. Likewise, if distress was attributed to psychological, or social causes, interventions couched in these terms were accepted.

Individuals were generally more accepting of medication than talking therapies. Part of this linked to the passive nature of taking medication, versus having to actively participate in talking therapy and experience psychological discomfort. Individuals were also more familiar with medication, and familiarity of an intervention heavily determined expectations and engagement. A preference for psychiatrists, potentially viewed as highly qualified, expert professionals, may bias preference for medication rather than psychotherapy.

When interventions and providers demonstrated that biological, psychological and social factors are interlinked, service-users were more accepting of how the previously 'unacceptable' domains could be impacting on their wellbeing. This emphasises the importance of encouraging engagement from the outset, tailoring the professional's approach and intervention offered to be congruent with service-user beliefs. This in turn, opens the service-user up to alternative, more holistic conceptualisations and ways of coping.

With culture influencing belief, a move to a Western host nation places the individual in a system promoting contrasting attitudes, putting the individual in a position of inner-conflict. They may accept or reject the Western mental health model, acculturation having potential impact on levels of acceptance. To facilitate the processes initiated by acculturation, it is important that positive rapport is built between the individual and all professionals involved, including the clinician, service-providers, multi-disciplinary team professionals, and interpreters.

Individuals from an asylum-seeking or refugee background may, understandably, have difficulty building trust with unfamiliar professionals who hold a position of power. This may link to negative experiences of powerful people in their country of origin, potential exploitation related to a traumatic event, or negative treatment from powerful services in the host nation, e.g. immigration systems.

Many of the traits considered important for positive rapport parallel those identified in Rogerian theory (Rogers, 1951). Rogers posits the idea that the service-user enters therapy in a state of 'incongruence'; a discrepancy between their actual self and ideal self. This is supported by the findings from this review, that individuals generally only accept interventions that are congruent with their beliefs, removing shame from seeking help. To be person-centred, and to reduce incongruence, the professional must possess the following traits, or 'core conditions' (Rogers, 1951):

Firstly, the professional must be self-aware, genuine, and congruent; conveying themselves 'authentic', i.e. as an imperfect, human being, who is not overly expert in their role. This is valued by individuals in this review, appreciating

professionals who, though knowledgeable, understand the service-user's own beliefs and use this therapeutically, rather than being a reductionist, invalidating and incomprehensible approach.

Secondly, the professional should hold the service-user in unconditional positive regard. That is to see the individual, and their distress, with no judgement. Again, fear of judgement for their distress, and the shame experienced around mental health and help-seeking is evident in this review. This may stem from cultural taboos and subsequent external shame (Gilbert, 1998). Unconditional positive regard can provide a safe environment to build trust, and encourage openness in the therapeutic setting. Confidentiality is also an issue, with some fearing being 'found out' and being shamed by others. With a professional providing non-judgmental psychoeducation, combined with a collaborative atmosphere in a group setting, individuals can develop less self-blaming narratives, improving wellbeing.

Lastly, the professional should demonstrate empathic understanding of the service-user's experience, to an appropriate degree. This reflects the preference for a 'goldilocks zone' indicated in this review, i.e. the professional showing care and a genuine desire to understand and alleviate suffering, however not becoming overly involved and becoming enmeshed. The purpose of intervention is to support and equip the service-user with the skills to manage distress outside of the therapy room, which may be hindered if there is over-dependency on the professional.

Individuals appreciated compassion in professionals, which could be understood by Gilbert's framework of the key attributes of compassion (Gilbert, 2010), i.e. empathy, sympathy, distress tolerance, non-judgement, care for

wellbeing, and sensitivity. Up until therapeutic input, compassion may have rarely been experienced by individuals who have been through prolonged periods of trauma and distress, in their home and host countries.

Clinical Implications

This review emphasises the importance of obtaining service-users' perspectives of interventions. This supports the initiative instigated by the British Psychological Society (BPS) for providers to have service-user, or 'expert-by-experience' input into the design and delivery of mental health services (Sheldon & Harding, 2010). Rogers (1951) provides a theoretical framework for person-centred therapy, which the review implicates to be worth considering when working with this specific population.

Though services may be well intended, as with any demographic group there is no 'one-size-fits-all' approach. Though it may be an impossible task to design bespoke interventions for each individual, considering the unique asylum seeker / refugee context is key in progressing towards more person-centred and satisfactory therapies.

Access to specialist mental health services, or a specialist pathway, specifically aimed at the asylum-seeking / refugee population, may improve experiences and reduce stigmatised, self-blaming beliefs around distress. Though specialist services are referred to in this review, results suggest a need for further development. Change needs to occur at a service-access level, taking a preventative, health-promotion stance upon entry to the host nation. If educated about how trauma-related distress may be experienced, and how relevant

support may be accessed, acceptability and potentially psychological wellbeing may vastly improve.

This population face extra-therapeutic barriers to accessing interventions for trauma (Bischoff et al., 2003; Vermette et al., 2015), experiencing social difficulties generally not addressed in psychological interventions (Summerfield, 1998).

Therefore in light of the contextual factors conveyed in this review, inter-agency working for integrating biological, psychological and social support could have a preventative effect before individuals reach crisis level. This approach may help the individual to integrate into the society of the host nation. Continuity of care is essential, with it being key that when leaving specialist care and entering mainstream services, professionals still remain diligent and proactive in their training and development of skills to work specifically with asylum seekers and refugees.

At a wider systems level, if every professional in any involved service was vigilant in understanding the unique biopsychosocial context, and collaborated with the service-user, wellbeing may be drastically improved. This could be hugely empowering and promoting of health to these highly vulnerable, at-risk individuals.

Herman's (1997) three phases of trauma recovery may parallel the needs of this population from services. They first require to feel stable and safe, which may link to the input of immigration and housing services, and support in feeling protected from harm. Input from charities such as the British Red Cross in reuniting families could also be fundamental at this stage. The second stage involves processing the trauma (Herman, 1997), when mental health

interventions specifically provide a safe environment for individuals to grieve and explore their trauma. The third phase of reconnection and reintegration (Herman, 1997) describes the point where intervention has helped individuals reach congruence between their ideal and actual self (Rogers, 1951), providing a strong foundation for successful integration into the host society.

The supportive systems placed around the asylum seeking or refugee individual may operate through learning processes such as the Zone of Proximal Development (Vygotsky, 1978), in which the professional(s) or peer group surrounding and supporting the individual can help them move from what is known (e.g. how a system operates in their country of origin and/or trauma and fear based reactions, behaviours etc.) to what is unknown (e.g. learning how systems work and using them to their benefit in the host nation, and/or using more effective coping strategies to regulate overwhelming emotions). In this process, the learning occurs when knowledgeable supporters guide and encourage the individual to master skills that would initially be too difficult to do so on their own, and with guidance move towards a position of successfully and later, independently, supporting themselves (Vygotsky, 1978).

The frameworks suggested here provide a basis on how integrated, inter-agency working with this population could be organised.

Future Directions

There are various therapeutic and contextual factors indicated across the studies that could be scrutinised on a deeper level in future research. A cross-cultural comparison may be warranted, though it is appreciated that within cultures is

great heterogeneity. It may be fruitful to examine how services could be tailored to generalised cultural beliefs.

A review focusing on the experiences of mental health issues generally in the UK's NHS system may shed some light on future direction for services. As attributes of compassionate care, a presence and a lack of, are alluded to in several studies (Bernardes et al., 2010; Kaltman et al., 2016; Madsen et al., 2016; Mirdal et al., 2012; Vincent et al., 2013). Consideration of how professionals can instil compassion in the socio-political contexts of wider systems, focusing on the discourse around asylum seekers and refugees, may instigate change.

Longitudinal studies may also be of benefit, to determine how the beliefs and experiences of interventions for trauma, or mental health generally, may change and develop over the time the individual has been resettled and more acculturated with the host nation.

Comment on the Studies

The identified studies were heterogeneous in their aims, samples, methods and measures. The majority of studies had a specific focus regarding experience, e.g. acceptability or level of satisfaction with the intervention (Halcón et al., 2010; Kaltman et al., 2016; Madsen et al., 2016; Mirdal et al., 2012; Praetorius et al., 2016; Silove et al., 1995; Silove et al., 1997; Singer & Adams, 2011; Stade et al., 2015; Yaser et al., 2016). It was unclear in these studies how closely linked the researcher was to the particular service or intervention being scrutinised, which potentially may bias their interpretation of results.

Whilst most studies had good quality ratings, this review did highlight methodological limitations. Several used convenience sampling, researchers approaching participants deemed suitable for the study, for example due to participation in an intervention, a specific time-point or language spoken. Some studies recruited participants from a pool used in a larger-scale study, meaning the sample was only representative of the group from which they had been drawn. None used a truly random sample. This may have led to sample biases, as asylum seekers or refugees who held more trust in systems and services may have been more likely to consent to participate, contributing to a positive bias regarding service experience.

Though participants' perceived decrease in symptomology has been a part of their experience, the literature does not consider the concordance or discordance between outcome measure results and experiential, qualitative data. Similarly, some studies in this review used outcome measures pre and post-intervention, however did not consider exploring experiences in this way, missing an opportunity to explore how attitudes may shift pre and post-intervention. An attitudinal shift is implicated in this review, however this is across several studies and between heterogeneous samples. Future research may warrant exploration of this within one sample group.

It is also important to consider that there was a Western bias for the research studies that came up in the systemised search, and therefore 'trauma' was normally understood as the Western, medical concept of 'PTSD'. Though this represents one approach to thinking about trauma, it does not consider that it may be problematic to pathologise individuals who come from contexts that are

normally dangerous and volatile, i.e. those exposed to continuous traumatic stress (DeAngelis, 2013). Individuals experiencing continuous traumatic stress, rather than PTSD, may lack safe places to heal and recover and may be more concerned of the present and future rather than the past (DeAngelis, 2013). This may be particularly relevant to an asylum seeking and refugee population, and was why ‘trauma*’ was used as a search term in order to try and include those who may not have a diagnosis of PTSD, but have been exposed to traumatic events pre and post-migration, and may require support. Continuous traumatic stress, rather than PTSD, opens up a conceptual rather than diagnostic perspective, and invites more systemic approaches and interventions at different levels; not only the psychological impact is considered, but also sociocultural and political understandings of trauma (DeAngelis, 2013). This conceptualisation parallels the findings of this review, and the potential for a broader, multi-faceted approach to most benefit this population.

Strengths and Limitations

This is the first review synthesising a diverse range of research looking specifically at the experiences and beliefs of asylum seekers and refugees regarding interventions for trauma. The findings could provide supplementary information for efficacy reviews in determining which interventions are most suitable, and specific mechanisms contributing towards efficacy.

A limitation is that despite the review exploring both beliefs and experiences of interventions for trauma, only 18 studies met inclusion criteria. This highlights a lack of trauma-specific research. More may be gleaned from exploring beliefs and experiences of intervention for psychological distress

generally, rather than specifically trauma. Studies were possibly missed that included the perspectives of traumatised individuals, but the focus of the study was on mental health issues generally. The findings in this review are confined to trauma specifically, and constrained by a small body of literature utilising diverse designs, measures, samples and interventions. A broadening of the review to general mental health, or narrowed and focused on a particular cultural group or intervention type, may allow more firm conclusions to be drawn.

Conclusions

Traumatised asylum seekers and refugees have pre-existing beliefs of their difficulties before entry to the host country, which may shift following positive experiences of interventions. Individuals valued professionals demonstrating cultural awareness and compassion towards the unique asylum-seeking / refugee context. A trusting, therapeutic rapport can provide individuals the assurance and confidence to consider more helpful, alternative explanations of their difficulties, whilst also incorporating existing beliefs. This may reduce the shame attached to being a victim of traumatic events, and seeking support for the ensuing difficulties. Exploring perceived benefits and components of therapeutic interventions deemed helpful or unhelpful by these 'experts-by-experience' provides scope for how approaches may be tailored in future service development for the asylum-seeking and refugee population.

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References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th Ed.). Washington, DC: APA.
- Arbuckle, R., Frye, M. A., Brecher, M., Paulsson, B., Rajagopalan, K., Palmer, S., & et al. (2009). The psychometric validation of the Sheehan disability scale (SDS) in patients with bipolar disorder. *Psychiatry Research*, *165*(1), 163-74.
- Bender, J. (2013). What are the differences between PTS and PTSD?
Retrieved from <http://www.brainlinemilitary.org/content/2013/12/what-are-the-difference-between-pts-and-ptsd.html>
- Bernardes, D., Wright, J., Edwards, C., Tomkins, H., & Dfhoz, D. (2010). Asylum seekers' perspectives on their mental health and views on health and social services: Contributions for service provision using a mixed-methods approach. *International Journal of Migration, Health & Social Care*, *6*(4), 3-19.
- Bischoff, A., Bovier, P. A., Isah, R., Francoise, G., Ariel, E., & Louis, L. (2003). Language barriers between nurses and asylum seekers: Their impact on symptom reporting and referral. *Social Science & Medicine*, *57*(3), 503.
doi:10.1016/S0277-9536(02)00376-3
- Blanchard, E. B., Jones-Alexander, J., Buckley, T. C., & Forneris, C. A. (1996). Psychometric properties of the PTSD checklist (PCL). *Behaviour Research and Therapy*, *34*(669-73)

- Boonstra, A. M., Schiphorst Preuper, H. R., Reneman, M. F., Posthumus, J. B., & Stewart, R. E. (2008). Reliability and validity of the visual analogue scale for disability in patients with chronic musculoskeletal pain. *Journal of Rehabilitation Research, 31*(2), 165-9.
- Crumlish, N., & O'Rourke, K. (2010). A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. *Journal of Nervous and Mental Disease, 198*(4), 237-51.
- DeAngelis, T. (2013). Traumatic stress in a violent world: Psychologists and others explore how best to treat victims of continuous traumatic stress. *Monitor on Psychology, 44*(8), 38.
- Derogatis, L. R., Rickels, K., & Rock, A. F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. *British Journal of Psychiatry, 128*(3), 280-9.
- Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology & Community Health, 52*(6), 377-84. doi:10.1136/jech.52.6.377
- Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry, 180*(1), 51-60.

- Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *The Lancet*, 365(9647), 1309-14.
- Foa, E. B., Riggs, D. S., Dancu, C. V., & Rothbaum, B. O. (1993). Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. *Journal of Traumatic Stress*, 6(459-73)
- Friis, S., Skatteboe, U. B., Hope, M. K., & Vaglum, P. (1989). Body awareness group therapy for patients with personality disorders. 2. Evaluation of the body awareness rating scale. *Psychotherapy and Psychosomatics*, 51(1), 18-24.
- Gilbert, P. (1998). What is shame? Some core issues and controversies . In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behaviour, psychopathology and culture* (pp. 3-38). New York: Oxford University Press.
- Gilbert, P. (2010a). *The compassionate mind: A new approach to life's challenges*. London: Constable & Robinson Ltd.
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women. *Mental Health, Religion & Culture*, 10(127-141)
- Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), *Phenomenology and psychological research* ()

- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, *24*, 105-12.
- Green, B. L., Chung, J. Y., Daroowalla, A., Kaltman, S., & Debendictis, C. (2006). Evaluating the cultural validity of the stressful life events screening questionnaire. *Violence Against Women*, *12*, 1191-1213.
- Halcón, L. L., Robertson, C. L., & Monsen, K. A. (2010). Evaluating health realization for coping among refugee women. *Journal of Loss and Trauma*, *15*(5), 408-425. doi:10.1080/15325024.2010.507645
- Herman, J. L. (1997). *Trauma and recovery*. New York: BasicBooks.
- Hollifield, M., Warner, T. D., Lian, N., Krakow, B., Jenkins, J. H., Kesler, J., . . . Westermeyer, J. (2002). Measuring trauma and health status in refugees: A critical review. *Journal of the American Medical Association*, *288*(5), 611-21.
- Home Office. (2016). National statistics: Asylum. Retrieved from <https://www.gov.uk/government/publications/immigration-statistics-july-to-september-2016/asylum#key-facts>
- Jensen, N. K., Johansen, K. S., Kastrup, M., Krasnik, A., & Norredam, M. (2014). Patient experienced continuity of care in the psychiatric healthcare system-a study including immigrants, refugees and ethnic Danes. *International Journal of Environmental Research and Public Health*, *11*(9), 9739-9759. doi:10.3390/ijerph110909739

- Joanna Briggs Institute. (2016). Critical appraisal tool: Checklist for qualitative research. Retrieved from <http://joannabriggs.org/research/critical-appraisal-tools.html>
- Jorm, A. F. (2012). Mental health literacy; empowering the community to take action for better mental health. *American Psychologist*, *67*(Suppl 3), 231-43.
- Kaltman, S., de Mendoza, A. H., Gonzales, F. A., & Serrano, A. (2014). Preferences for trauma-related mental health services among Latina immigrants from Central America, South America, and Mexico. *Psychological Trauma: Theory, Research, Practice & Policy*, *6*(1), 83-91. doi:10.1037/a0031539
- Kaltman, S., Hurtado, d. M., Serrano, A., & Gonzales, F. A. (2016). A mental health intervention strategy for low-income, trauma-exposed Latina immigrants in primary care: A preliminary study. *American Journal of Orthopsychiatry*, *86*(3), 345-354. doi:10.1037/ort0000157
- Korte, K. J., Allan, N. P., Gros, D. F., & Acierno, R. (2016). Differential treatment response trajectories in individuals with subclinical and clinical PTSD. *Journal of Anxiety Disorders*, *38*, 95-101. doi:10.1016/j.janxdis.2016.01.006
- Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatr Ann*, *32*(9), 1-7.
- Madsen, T. S., Carlsson, J., Nordbrandt, M., & Jensen, J. A. (2016). Refugee experiences of individual basic body awareness therapy and the level of

- transference into daily life. An interview study. *Journal of Bodywork and Movement Therapies*, 20(2), 243-251. doi:10.1016/j.jbmt.2015.10.007
- Maier, T., & Straub, M. (2011). "My head is like a bag full of rubbish": Concepts of illness and treatment expectations in traumatized migrants. *Qualitative Health Research*, 21(2), 233-248. doi:10.1177/1049732310383867
- Majumder, P., O'Reilly, M., Karim, K., & Vostanis, P. (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents. *International Journal of Social Psychiatry*, 61(2), 129-136. doi:10.1177/0020764014537236
- Malterud, K. (1993). Shared understanding of the qualitative research process: Guidelines for the medical researcher. *Family Practice*, 10, 201-6.
- McColl, H., McKenzie, K., & Bhui, K. (2008). Mental healthcare of asylum-seekers and refugees. *Advances in Psychiatric Treatment*, 14, 452-59.
- McCrone, P., Leese, M., Thornicroft, G., Schene, A. H., Knudsen, H. C., Vasquez-Barquer, J. L., & et al. (2000). Reliability of the Camberwell assessment of need - European version. Epsilon study 6. European psychiatric services: Inputs linked to outcome domains and needs. *British Journal of Psychiatry: Supplement*, 39, 34-40.
- Miller, K., Omidian, P., Samad, A., Quraishy, N., Nader, M., Nasiry, S., & et al. (2006). The afghan symptom checklist: A culturally grounded approach to mental health assessment in a conflict zone. *American Journal of Orthopsychiatry*, 76(423-33)

- Mirdal, G. M., Ryding, E., & Essendrop Sondej, M. (2012). Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment. *Psychology and Psychotherapy, 85*(4), 436-455. doi:10.1111/j.2044-8341.2011.02036.x
- Mollica, R., & Caspi-Yavin, Y. (1991). Measuring torture and torture-related symptoms: Psychological assessment. *Journal of Consulting and Clinical Psychology, 3*, 581-87.
- Mollica, R., Wyshak, G., de Marneffe, D., & et al. (1987). Indochinese versions of the Hopkins symptom checklist-25: A screening instrument for the psychiatric care of refugees. *American Journal of Psychiatry, 144*, 497-99.
- National Institute for Health and Care Excellence. (2012). *Methods for the development of NICE public health guidance* (3rd Ed.). London: NICE.
- National Institute for Health and Care Excellence. (2016). National institute for health and care excellence pathways: Post-traumatic stress disorder overview. Retrieved from <http://pathways.nice.org.uk/pathways/post-traumatic-stress-disorder>
- Nicholl, C., & Thompson, A. (2004). The psychological treatment of post traumatic stress disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. *Journal of Mental Health, 13*(4), 351-362. doi:10.1080/09638230410001729807
- Pluye, P., Gagnon, M. P., Griffiths, F., & Johnson-Lafleur, J. (2009). A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in

mixed studies reviews. *International Journal of Nursing Studies*, 46(4)
doi:10.1016/j.ijnurstu.2009.01.00(merged)

Praetorius, R. T., Mitschke, D. B., Avila, C. D., Kelly, D. R., & Henderson, J. (2016). Cultural integration through shared learning among resettled Bhutanese women. *Journal of Human Behavior in the Social Environment*, 26(6), 549-560. doi:10.1080/10911359.2016.1172997

Rogers, C. (1951). *Client-centred therapy: Its current practice, implications and theory*. London: Constable.

Ryan, R., & Cochrane Consumers and Communication Review Group. (2013). Cochrane consumers and communication review group: Data synthesis and analysis. Retrieved from <http://cccr.org.cochrane.org/sites/cccr.org.cochrane.org/files/public/uploads/AnalysisRestyled.pdf>

Savic, M., Chur-Hansen, A., Mahmood, M. A., & Moore, V. M. (2016). 'We don't have to go and see a special person to solve this problem': Trauma, mental health beliefs and processes for addressing 'mental health issues' among Sudanese refugees in Australia. *The International Journal of Social Psychiatry*, 62(1), 76-83. doi:10.1177/0020764015595664

Schweitzer, R., Melville, F., Steel, Z., & Lacherez, P. (2006). Trauma, post-migration living difficulties, and social support as predictors of psychological adjustment in resettled Sudanese refugees. *Australian & New Zealand Journal of Psychiatry*, 40(2), 179-187. doi:10.1111/j.1440-1614.2006.01766.x

- Sen, P. (2016). The mental health needs of asylum seekers and refugees - challenges and solutions. *BJPsych International*, 13(2), 30-2.
- Sheldon, K., & Harding, E. (2010). *Good practice guidelines to support the involvement of service users and carers in clinical psychology services*. Leicester: British Psychological Society - Division of Clinical Psychology.
- Sherbourne, C. D., & Stewart, A. L. (1991). The MOS (medical outcomes study) social support survey. *Social Science & Medicine*, 32, 705-14.
- Silove, D., Sinnerbrink, I., Field, A., Manicavasagar, V., & Steel, Z. (1998). Trauma exposure, postmigration stressors, and symptoms of anxiety, depression and post-traumatic stress in Tamil asylum seekers: Comparison with refugees and immigrants. *Acta Psychiatrica Scandinavica*, 97, 175-81.
- Silove, D., Chang, R., & Manicavasagar, V. (1995). Impact of recounting trauma stories on the emotional state of Cambodian refugees. *Psychiatric Services (Washington, D.C.)*, 46(12), 1287-1288.
- Silove, D., Manicavasagar, V., Beltran, R., Le, G., Nguyen, H., Phan, T., & Blaszczyński, A. (1997). Satisfaction of Vietnamese patients and their families with refugee and mainstream mental health services. *Psychiatric Services (Washington, D.C.)*, 48(8), 1064-1069.
- Singer, J., & Adams, J. (2011). The place of complementary therapies in an integrated model of refugee health care: Counsellors' and refugee clients' perspectives. *Journal of Refugee Studies*, 24(2), 351-375.
doi:10.1093/jrs/fer001

- Slewa-Younan, S., Mond, J. M., Bussion, E., Melkonian, M., Mohammad, Y., Dover, H., . . . Jorm, A. F. (2015). Psychological trauma and help seeking behaviour amongst resettled Iraqi refugees in attending English tuition classes in Australia. *International Journal of Mental Health Systems*, 9, 5-5. doi:10.1186/1752-4458-9-5
- Slewa-Younan, S., Mond, J., Bussion, E., Mohammad, Y., Uribe Guajardo, M. G., Smith, M., . . . Francis Jorm, A. (2014). Mental health literacy of resettled Iraqi refugees in Australia: Knowledge about posttraumatic stress disorder and beliefs about helpfulness of interventions. *BMC Psychiatry*, 14(1), 1-8. doi:10.1186/s12888-014-0320-x
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Löwe, B. (2006). A brief measure for assessing generalised anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.
- Stade, K., Skammeritz, S., Hjortkjær, C., & Carlsson, J. (2015). "After all the traumas my body has been through, I feel good that it is still working."-- basic body awareness therapy for traumatised refugees. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, 25(1), 33-50.
- Strauss, A., & Corbin, J. (1996). *Basics of qualitative research; techniques and procedures for developing grounded theory*. London: Sage.
- Strijk, P. J. M., van Meijel, B., & Gamel, C. J. (2011). Health and social needs of traumatized refugees and asylum seekers: An exploratory study. *Perspectives in Psychiatric Care*, 47(1), 48-55. doi:10.1111/j.1744-6163.2010.00270.x

- Summerfield, D. (1998). Sociocultural dimensions of war, conflict and displacement. In A. Ager (Ed.), *Forced migration* (pp. 111-35). London: Pinter.
- Vermette, D., Shetgiri, R., Al Zuheiri, H., & Flores, G. (2015). Healthcare access for Iraqi refugee children in Texas: Persistent barriers, potential solutions, and policy implications. *Journal of Immigrant & Minority Health, 17*(5), 1526-1536. doi:10.1007/s10903-014-0110-z
- Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy, 41*(5), 579-593. doi:10.1017/S1352465812000550
- Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes*. Cambridge, MA: Harvard University Press.
- Weiss, D., & Marmar, C. (1997). The impact of event scale-revised. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD: A handbook for practitioners* (pp. 399-411). New York: Guilford Press.
- WHO. (1998). *Info package; mastering depression in primary care*. Frederiksborg, Denmark: World Health Organisation, Regional Office for Europe, Psychiatric Research Unit.
- Yaser, A., Slewa-Younan, S., Smith, C. A., Olson, R. E., Guajardo, M. G. U., & Mond, J. (2016). Beliefs and knowledge about post-traumatic stress disorder amongst resettled afghan refugees in Australia. *International Journal of Mental Health Systems, 10*, 1-9. doi:10.1186/s13033-016-0065-7

Part Two: Empirical Paper

This paper is written in the format ready for submission to the Journal of Clinical Psychology.

Please see Appendix D. for author guidelines.

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The Experiences of Interpreters Working in Mental Health Settings: An Exploration of Compassion

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Abbreviated Title: Experiences and Compassion in Interpreting
Key Words: interpreters, mental health, experiences, compassion

Abstract

Objective(s): To explore the experiences of interpreters working in mental health settings, with a focus on the emotional demands of the work and how compassion may fit into their role.

Methods: Semi-structured interviews were carried out with eight interpreters. Interpretative Phenomenological Analysis was used to explore subjective experiences, contextualised by data from the Attitudes towards Mental Health Problems Scale.

Results: The analysis generated three major themes: 'System dynamics', and 'The interpreter as a professional translation tool' versus 'the interpreter as an emotional helper'. Central to findings was an inner-conflict between the expectation of emotional detachment and being 'invisible' within the therapeutic process, and experiencing emotional responses, also being pulled into various roles of involvement by both service-user and professional. Psychological frameworks of compassion are used to discuss the findings.

Conclusion: The potential for models of compassion in interpreter training and support is discussed.

Introduction

In 2016, the United Kingdom received 30,603 applications for asylum (Refugee Council, 2017). Many sub-populations within this group are from cultures that have experienced profound loss, repression and violence (Patel, 2003) thereby needing mental health and interpretation services. Healthcare service providers, e.g. the National Health Service, understand that the presence of asylum seekers and refugees has highlighted gaps in existing healthcare provision, rather than 'creating new problems' (Johnson, 2003).

These cultures may hold differing opinions on mental health issues to typical views and approaches held in Western society; a high proportion not sharing the same explanatory beliefs and processes behind mental health, i.e. the biopsychosocial model (Tribe, 1999).

Due to the presence of language barriers in host countries, interpreters are often needed when working with the asylum-seeking population. There is debate in the literature as to what the specific role of the interpreter is in mental health settings. Bontempo and Malcolm (2012) discuss a 'machine metaphor' for the interpreter's role, where he/she may be expected to remain completely neutral and inherently 'dehumanised', their reactive role in the interaction being dismissed. In formal guidance for interpreters, it is encouraged to be able to emotionally separate from the content of the session and the service-user (Bontempo & Malcolm, 2012). This is based upon the finding that interpreters' emotional reactions can influence the other participant in an interpreted interaction (Gold Brunson & Lawrence, 2002). Bontempo and Malcolm (2012) argue for dispelling the myth of neutrality, a belief similarly held by interpreters themselves when considering their multiple roles in this setting (Resera, Tribe & Lane, 2014).

As literal translation is often not possible within psychological therapy, active translation is required and the interpreter may have to act as a cultural informant, reframing Western concepts of mental health into a more comprehensible format relevant to the context of the service-user's own culture. This knowledge needs to be conveyed both ways – to the service-user, and the clinician, allowing both to grasp an understanding of what should be the same issue (Raval, 2003).

The wellbeing of interpreters

Research suggests that interpreters engage with the content of what they are interpreting and subsequently experience emotional difficulties. Dean and Pollard (2001) discuss 'Demand Control Theory' to explain processes of interpreter reactions in mental health settings. This describes the difficulties interpreters face by having low control over which role they are expected to fulfil, as well as having to manage high emotional demands due to distressing sessional content (Bontempo & Malcolm, 2012). Interpreters are more likely to experience vicarious trauma in these settings (Mehus & Becher, 2015).

In a qualitative study with interpreters, Splevins, Cohen, Joseph, Murray and Bowley (2010) identified the parallels between posttraumatic-growth in the service-user with a vicarious process in interpreters. Interpreters experienced feeling what the service-user felt, and a disbelief of the atrocities faced and resilience demonstrated by service-users. They described having to find a way to self-manage this distress, and experiencing an overall change in self and life philosophy as a result of this process.

Doherty, MacIntyre and Wyne (2010) identified in a sample of interpreters that mental health work was reported to have an emotional impact. Challenges in

maintaining professional boundaries were reported, with a service-user's expectations sometimes going beyond the typical role of the interpreter.

To summarise, the literature implies that interpreters struggle to remain emotionally neutral with respect to their experience with the service-user and the emotional content of therapeutic sessions. The 'good practice' promoted during interpreter training of remaining detached from the subject matter and individuals concerned may therefore not be realistic and detrimental to interpreter wellbeing.

Why is compassion relevant?

Compassion Focussed Therapy (CFT) is a model of therapy that has been developed to alleviate psychological distress (Gilbert, 2010b) and has been used in both trauma victims (Lee & James, 2012) and in promoting the wellbeing of NHS staff (Welford & Langmead, 2015). An important element is that compassion flows between and within people in relationships. In the flow of compassion, self-to-self (self-compassion) and other-to-self compassion (compassion *from* others) has an impact on the wellbeing of the individual; in the self-to-other flow of compassion (compassion *towards* others), the therapeutic relationship is most influenced (Gilbert, 2010a).

In 2015, NHS England posited a plan to target staff health and burnout (National Health Service, 2015). As interpreters are often employed by agencies but carry out work in NHS settings, they receive similar levels of stressors to NHS staff however do not have the employee occupational health benefits. As interpreters in mental health settings are regularly exposed to the suffering of others, and may have experienced similar levels of suffering themselves, the concept of compassion may have relevance in maintaining their wellbeing.

Developing self-to-other compassion in professionals working with interpreters, as well as self-to-self compassion (Gilbert, 2010a) in the interpreter themselves, may have potential in working with interpreters' occupational distress.

Rationale

Research has implicated a need for interpreters to be supported, as due to the emotive nature of their job, they are at an increased risk for vicarious trauma to occur (Mehus & Becher, 2015). Improving the flow of compassion could intervene with these issues (Gilbert, 2010a); it is important to understand what compassion means to an interpreter in their perceived role, working in mental health settings.

Aims

This study aimed to explore the experiences of interpreters working in mental health settings. This includes exploring the emotional impact of the work, in order to determine if there is a need for further support in interpretation services. This study also aimed to contribute to an understanding or identification of how compassion may be used to support interpreters in their mental health role. This could have potential service-wide benefits, such as optimal working and improving service-user wellbeing, preventing burnout and therefore making financial savings.

The nature of this research was inductive and exploratory, using a qualitative approach to explore the following questions:

- What are the experiences of working as an interpreter in a mental health setting?

- What are the emotional demands of this work?
- What are interpreters' perceptions and understanding of compassion in relation to their role?

Method

Design

The study used semi-structured interviews to generate qualitative data and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) to draw out interpreters' experiences and how they relate to the ideas around compassion. Cultural and community beliefs were assessed using the Attitudes towards Mental Health Problems Scale (see Appendix O) (Gilbert et al., 2007).

Sample

A voluntary sampling method was used to recruit interpreters from local services in the area of Hull and the East Riding of Yorkshire. Individuals were only included if they were a spoken-language interpreter who had worked with at least one service-user (child or adult) in a mental health setting, and also from a 'non-Western' culture, i.e. Africa, Asia, Middle-East. The above criteria were applied to retain homogeneity in the sample, necessary to conduct an in-depth analysis.

Eight interpreters were recruited; all those who took part had access to an information sheet (see Appendix K).

Participant demographics are reported in Table 1. Six out of eight participants were female, two were male. Ages ranged from 20-59 years (mean = 42.63). Three participants were British Asians (two from Pakistan, one from

Bangladesh). One was from Singapore, one from Iraq (Kurdish), one from Ethiopia and one from the Republic Democratic of Congo. Religions included Islam (n = 4), Christianity (n=2), Hinduism (n=1) and no religion (n=1). A range of two to eight different languages were spoken (including English). Years of working as an interpreter ranged from three months to 29 years (mean = 8.69 years), with a range of settings and cases worked with.

Ethics

The study was reviewed and granted approval by the Research Ethics Committee within the Faculty of Health and Social Care at the University of Hull (see Appendices E and F). A proposal for the study had also been reviewed and amended according to feedback by a small group of interpreters who did not take part. Every participant was offered £20 cash to take part in the research, given the nature of their employment and financial income depending upon available hours in the day.

Table 1. Participant Demographics

Participant ID	1	2	3	4	5	6	7	8
Gender	M	F	F	F	F	F	F	M
Culture of Origin	Moroccan	Singaporean	British (Parents from Pakistan)	Kurdish (Iraq)	British Asian (Pakistan)	British Asian (Bangladesh)	Ethiopian, born in Kenya	Congolese
Yeas living in the UK	13	9	50	30	37	40	2	2.5
Religion	None	Hinduism	Islam	Islam	Islam	Islam	Christianity	Christianity
Languages spoken	3	2	5+ (8)	4	4	2	3	5+
Years/months interpreting	8 yrs	1 yr	4 yrs	29 yrs	>12yrs	15yrs	3 mths	3mths
Level of training	Formally trained	None	None	Formally trained	Formally trained	None	Short course	Short course
Settings worked in	Mental Health, Social Refugee Medical Legal Charities	Mental Health, Armed Forces	Mental Health, Medical, Charities	Mental Health, Social, Refugee, Medical, Legal, Police	Mental Health, Social, Refugee, Medical, Legal, Charities	Mental Health, Social, Medical	Mental Health, Refugee, Medical	Refugee, Medical
No. of service providers worked with in mental health	2	1	1	4 or 5	"A few"	1	1	3
No. of service-users worked with in mental health	50	10	3	3000	5 or 6	3-5	"A few people"	1

Data collection

A semi-structured interview schedule (see Appendix N) was utilised to guide the interview and glean information regarding each individual's experiences. The participants were informed of the researcher's interest in their experiences generally, and more specifically in mental health settings. Compassion was not mentioned until the end of the interview, in order not to bias their accounts of their general experiences. Prompts were used appropriately to obtain further information on what seemed to be raised as particularly key or emotive points.

Interviews were conducted in a choice of two locations central to the local area, at the convenience of the participant. All interviews were audio-recorded and transcribed verbatim, with interview duration ranging from approximately 25-60 minutes each.

Measures

Demographic information: Ethnicity, religion, age, sex, refugee status/history, how long living in Britain, how many other settings working/worked in as an interpreter, how long working in mental health interpreting, and any history of mental health problems (see Table 1).

Following each interview, each participant completed an Attitudes towards Mental Health Problems Scale (see Appendix O), where a higher score reflects higher levels of shame (Gilbert et al., 2007). This was used to contextualise the interview data by looking at culturally influenced shame-based attitudes towards mental health problems. The scale examines how views may vary according to attitudes in the following domains:

1. A person's perception of how their community sees mental health problems
2. A person's perception of how their family sees mental health problems
3. A person's perception of how their community would see them if they had a mental health problem
4. A person's perception of how their family would see them if they had a mental health problem
5. Internal shame (ashamed of self) and the negative self-evaluation of having a mental health problem
6. Reflected shame (bringing shame to others) and beliefs about how one's family would be seen if one had a mental health problem
7. Fears of reflected shame on self, associated with a close relative having a mental health problem.

Data Analysis

Data from the semi-structured interviews was analysed using IPA, with the procedure informed by Smith et al., (2009). IPA is an ideal method for gathering experiential data and exploring participants' personal and social worlds, whilst acknowledging the contextual and idiosyncratic factors behind the researcher's interpretation (Smith et al., 2009).

The author utilised reflection in supervision and a reflective journal, aided to maintain self-awareness and the influences of her own context throughout the research process (See Appendices A and B for a Reflective and Epistemological statement, respectively).

The four key steps of analysis included:

Step 1: The author becoming immersed in the data through listening to the recording whilst transcribing, and re-reading transcripts repetitively. Rough noting of the data detailing initial thoughts, reflections and reactions to the content aided progression to the next stage.

Step 2: Exploratory comments were noted line-by-line for each transcript. Descriptive, linguistic and conceptual content was scrutinised for the most in-depth level of analysis, forming the basis for an initial interpretation of the data.

Step 3: The exploratory comments were studied and developed into the next tier of analysis; emergent themes.

Step 4: Emergent themes were compared and contrasted firstly within each data-set, and then across all transcripts in order to make connections and create an overarching conceptual framework (See Table 3). An excerpt of the transcript analysis process is demonstrated in Appendix R.

Results

The contextualising data from the Attitudes towards Mental Health Problems Scale (Gilbert et al., 2007) are summarised in Table 2. Evidently, there is a wide spread of results across the sample, with the lowest level of shame-based attitudes towards mental health problems ranging from a total score of 22 (Participant 5) to 44 (Participant 1). In terms of the levels of specific types of shame, the highest level of shame on average was perceived to come from negative attitudes towards mental health and external shame from the community (total scores being 59 and 69 respectively). Reflected shame brought to the family if the participant had a mental health problem also scored highly with 59. The lowest level of shame was reflected shame from the family if the participant had a mental health problem (total score of 17) as well as the least negative attitudes towards mental health coming from the family (scoring 19). Though there are stark differences between scores of different types of shame within the sample, it is noteworthy that generally, more shaming and stigmatising attitudes stem from community beliefs rather than family beliefs. This may suggest that within the context of the family home, individuals living in cultures where mental health is stigmatised share more open-minded and accepting beliefs that may have to be concealed from the more judging and punitive society around them. This provides an understanding of the high contrast in settings faced by service-users and interpreters alike upon entry to the UK, where mental health problems are more accepted and less stigmatised than in their home culture.

Table 2.
Results of the Attitudes towards Mental Health Problems Scale (Gilbert et al., 2007)

Participant ID	1	2	3	4	5	6	7	8	Total Sample Score for each domain
Community Mental Health Attitudes	10	9	8	12	2	11	4	3	59
Family Mental Health Attitudes	0	8	2	0	3	2	4	0	19
Community – External Shame and Stigma Awareness	15	10	3	15	3	8	7	8	69
Family – External Shame and Stigma Awareness	0	5	0	0	4	0	0	8	17
Internal Shame	15	3	8	0	0	0	9	4	39
Reflected Shame - Family	4	8	12	0	10	4	11	10	59
Fear of Reflected Shame on Self – Close Relative	0	0	0	0	0	5	8	8	21
Total Score for each Participant across the domains	44	43	33	27	22	30	43	41	

In the interview data using IPA, Fourteen themes emerged with three higher order themes: ‘professional dynamics’, ‘the interpreter as a professional translating tool’ and ‘the interpreter as an emotional helper’. The superordinate and subordinate themes derived from participants accounts are presented in Table 3.

Table 3.
Superordinate and Subordinate Themes

Superordinate Themes	Subthemes
System Dynamics	<ul style="list-style-type: none"> • Cultural values around the Western model • Powerful expert professionals • Strong interpreter/service-user bond • Wider system's impact
Interpreter as a Professional Translating Tool	<ul style="list-style-type: none"> • The value of experience • Accuracy of language is paramount • Implementing boundaries • Constraints of the interpreting role
Interpreter as an Emotional Helper	<ul style="list-style-type: none"> • Feeling motivated and responsible for therapeutic progress • Interpreters are human beings too • Feeling what the service-user feels • Service-users as an emotional burden • Lack of desired support – having to manage alone

System Dynamics

This theme is comprised of four subthemes which represent various factors within the triadic relationship as well as the influence of services and agencies that utilise or employ interpreters. Professionals and services / agencies were perceived as expert and powerful. Separation between Western providers and the interpreters and service-users was conveyed and linked to cultural beliefs around mental health, therefore reinforcing an interpreter/service-user alliance.

Cultural values around the Western model

Professionals were reported to frame mental health problems within a Westernised medical model. There was acknowledgement of diagnostic labels not exactly translating across languages. Participant 6 described how lack of words for diagnostic labels reflects a stigmatisation of mental health problems, and a clash between the service-user's and professional's understanding of the problem:

*"I don't think there is a word for depression in Bengali... there is something that's like, mental...we say [pagol]... So we have to explain to the patient... I mean our people don't believe in depression...We have to explain and calm the patient down...just say that you know, doctor **thinking**"*

Participant 6

Despite this, several interpreters acknowledged their more accepting views of the model and how it may benefit service-users, perhaps demonstrating acculturation and acceptance of the Western mental health system:

"I liked psychology a lot... mental health was a good setting for me because I could see how the specialist tried to help...There is no antidote, it needs proper healing"

Participant 1

This also emphasised how the Western approach to working with Mental Health requires 'proper healing', reflecting the perceived utility of hour long therapy sessions to understand the service-user's problems in more depth and working with them.

Participant 2 considered how an hour or two a week may still not be enough to address the issues, and the Western model does not suffice for how much input is needed:

“But do they [the service-user] want to the listen? Would they put it in practice? How, ‘cause they are here like once a week or twice a week to see them and, it’s just an hour...after that what happens to them?”

Participant 2

Powerful expert professionals

Professionals were perceived as highly knowledgeable and holding power, either upheld or passed on to the service-user. Expertise was valued as being helpful, though a dominance of power was considered a hindrance, highlighting the importance of balance:

Participant 3 described the professional being at the top of the hierarchy due to their qualifications, making it clear that her own role of interpretation sits beneath this:

“Obviously they’re the boss (laughter) they’re the qualified person”

Participant 3

The responsibility of helping the service-user was deemed as the professional’s duty, with professional titles and qualifications meaning it is they who have the ability to ‘fix’ the service-user:

“I’ve got this problem, I’ve got this problem I’ve got this problem, but someone who’s going to give you the answer of all these problems... is the doctor”

Participant 8

A dominance of power was unfavourable, appreciating that the session needed to be focused, but not necessitating disempowerment of the service-user by limiting their voice. Participant 4 demonstrates how this had stirred up strong personal reactions towards the professional, there being occasions when she feels the need to stand up to this power and advocate for the service-user:

“And honest to God, she used to “I’m starting my session”, okay, this upsets me of course and I get angry...I tell her can you give her a chance to talk, “no, I’m here to talk about my subject, she’s not allowed talk about her subject”, and she [the service-user] goes, “is she mad at me is she mad at me?”... So the patient become more mentally stressed out than had been”

Participant 4

Strong interpreter/service-user bond

This theme refers to the participants’ perceptions of their bonds with the service-user being significantly strong due to cultural and/or linguistic similarities. Many participants found that the cultural bond was helpful in quickly building good rapport and a level of trust that would help the service-user to feel more comfortable. This bond may be strengthened by the aforementioned power imbalance between interpreter/service-user and clinician, experiencing a sense of common humanity.

Participant 3 emphasises how quickly the trust is built due to the linguistic bond, and feeling good that she can help to make the service-user feel able to tell their story:

“It’s nice that they open up, as soon as they realise they speak your language I think they open up more to me as the interpreter”

Participant 3

Some participants reflected on particularly close relationships with specific service-users, and issues of transference and counter-transference. Relationships may parallel those found in more personal or familial relationships, which can feel comfortable and familiar. Participant 4 highlights such an example:

“Some people become that much attached, for me it was good to talk to someone in my own language... And for her it was like a mother... Yeah, so it is nice job”

Participant 4

For some interpreters this strong bond can seem imposed by the service-user. Participant 8 considers the downsides, such as service-users misunderstanding the interpreter’s role in the therapeutic triad, excluding the professional:

“...If me who speaking in French, and me who is close to him, maybe I can help him, that happens sometimes... Sometimes they ask me.... What can I do and then the case-worker’s there, he should ask the case-worker... so it uncomfortable to me”

Participant 8

Across the sample, participants discussed how they felt to be facilitating the professional/service-user relationship, balancing and distributing the trust within the triad:

“I mean, you can’t afford to lose the professional’s trust, you can’t afford to lose the patient’s trust, so you have to sort of weight it out, it’s better”

Participant 5

Wider system's impact

This theme refers to perceived attitudes of the wider systems around the interpreter, outside of the therapeutic triad. Participants described mainly negative experiences of services and interpreter agencies who are perceived to have high expectations and devalue the services the interpreter provides. Several participants described how this could impact on the views they had of themselves as professionals in their own right. In some instances, interpreters refer to the individual professionals' roles in either confirming or disconfirming the attitudes of the providers.

Some participants discussed how some of the attitudes from services convey a sense of interpreters being unfamiliar, unimportant and perceived as a financial burden. Participant 4 emphasises how distressing this can be on a personal level:

“The reception [act] as if I am taking all the NHS money for myself...So we get abused the way they are talking to us “Why you are here? What are you doing?” so you get really upset”

Participant 4

Others reflected on how the agency they are employed by can feel like a powerful and punitive system, perhaps paralleling the triadic power imbalance. Agencies may expect interpreters to be flexible and self-sacrificial, and punish those who cannot fit their highly-set and rigid requirements:

“Sometimes when you have to cancel a job, they say you have to cancel, before four working days...That’s a bit hard... you don’t know what’s going to happen...And they fine you quite a bit...But they can book you there and then...I don’t think that’s fair”

Participant 5

Some participants reflected on the importance of positive attitudes to boost self-esteem, and that positive feedback of individual professionals can be protective against the negative views of the wider systems. Received professional compassion contributing to job satisfaction:

“Some people believe in me. I can’t believe in myself...But when someone tells me that you do very well at your job...So I feel very well, that’s why until now, I’m still doing this job, and I will not give up this job”

Participant 8

Interpreter as a Professional Translating Tool

This higher order theme is to be considered in contrast with the following higher order theme of ‘Interpreters as an Emotional Helper’. There was an overarching sense of inner conflict within the interpreters, where two ideals of being a ‘good’ interpreter existed, but not comfortably. The first of these ideals is for the interpreter to be seen as a professional, knowledgeable and boundaried translator who acts within the constraints of their role, as defined by agency and professional policy and guidance; the second is to be discussed later.

The value of experience

Experience was perceived as a crucial tool, enabling an interpreter to reach high professional standards; training is not necessarily offered or required in order to be employed. Participant 6 reflected on how her years of being an interpreter has made the role feel easier and less effortful, highlighting the difficulties a new interpreter may face:

“First job I did it was really [hard] because I didn’t have any experience... But then I got used to it, I’ve been doing it for all these years”

Participant 6

Participant 7, a new interpreter with lack of experience, discusses how she predicts experience to have positive influence in her future career:

“Confusing... but in end it get better, I think more years and months, you get used to it... it’s a matter of time and everything comes proper good”

Participant 7

Some participants considered how interpreting experience compares to formal mental health professional training, arguing that only experience can provide the level of depth needed to truly understand the service-user:

“Maybe if you students study, I’ve got life experience of the counselling so I’ve been to different places...I know each of them, how they work... I know my clients very well”

Participant 4

Experience was deemed to build resilience to emotional content of sessions. Participant 3 considered how personal experiences supersede any formal training in handling distressing content:

“There’s nothing quite as good as experience...you can get as much training in the world as you need, until you’re thrown into it, I think that’s better than anything else”

Participant 3

Accuracy of language is paramount

Interpreters felt high expectations and levels of responsibility were placed on them regarding accuracy of translation. Participant 1 describes the ‘life and death’ seriousness of mental health, and the interpreter’s obligation to ensure the professional has an accurate picture of any identifiable risk factors the service-user may allude to:

“It’s very important to be good at interpreting in that setting, that can help people, sometimes they might want to harm themselves or do something bad about themselves. So as long as you interpret that accurately to the specialist they can do something about it, sometimes you can save, you know lives, because you know mental health is a bit tricky”

Participant 1

Participants described how accuracy of information is key to the service-user receiving the correct support. Participant 7 considers the consequences of getting the information wrong, suggesting a fear of making mistakes:

“You just have to say what exactly that person is saying...If I guess, and I give the wrong information they would get the wrong medication...Which I always fear”

Participant 7

Participant 5 emphasises the importance of accurately relaying information, it being crucial to service-users knowing what support is available to them so they can make an informed decisions about their care:

“[Our role is to] translate and to give the patient exactly what the professional is saying or what sort of help they can give... or what they entitled to”

Participant 5

The challenges of accurate translation are also described, with a dilemma of feeling pressured to translate accurately, however there not always being an exact translation for certain concepts e.g. diagnostic labels:

*“Our interpreting is very hard ‘cause you can’t say anything extra you can’t say anything less you have **exactly**... like the words to words, sometimes we do explain the word... sometimes patient can’t understand”*

Participant 6

Implementing boundaries

Participants felt required to enforce boundaries within the working relationship in order to remain professional. This innately conflicts with the strong bond between service-user and interpreter, but may be protective against work encroaching on their personal lives. Participant 7 describes how she keeps a strict boundary

between work and her personal life, protecting her own time. This may implicate a coping mechanism in order to tolerate work-related distress:

“I mean if it’s work it’s work...but if it’s outside that’s another story... I do my stuff, I say it, I close the chapter with that”

Participant 7

Participants also reflected on how boundaries must be maintained within the therapeutic triad. Participant 4 describes the dilemma between having the positive and strong cultural bond with the service-user, but this not deemed as ‘professional’ in terms of guidance and policy. Interpreters must attempt to stifle compassion, however natural human instinct may override this:

“There become that much bond between interpreter and the patient, just we don’t want this happen...You can’t help it...Whatever is written in the rule and regulation, you have to do this and that, but you can’t help it you are human being”

Participant 4

Participant 1 considers the appropriateness of the bond with the professional, emphasising confidentiality and the room as a container of sensitive information. He considers having a balance of having social rapport with the professional, but nothing deeper than this in terms of discussing emotional content and the impact of the session:

“Everything stays in the room, once you get out, so you can talk about something else, our social life, or what we’re doing for the weekend... Have you seen this or that, but nothing about anyone or any clients”

Participant 1

The importance of confidentiality is consistently emphasised; Participant 2 explains how her work must be kept privately, away from her home life. This could be a personal protection, as well as a professional requirement. Those in her personal life are expected to understand that the interpreter is expected to be boundaried and a container of sensitive information. This may have implications for feeling unable to approach family or loved ones for support when feeling an emotional strain from the work:

“I tell my husband I’m going for an interpreting job, he wouldn’t ask what happened at it, I wouldn’t discuss anything like that, they don’t have to know, they don’t know”

Participant 2

Constraints of the interpreting role

Participants felt limited in what they could do to directly benefit the service-user. A conflict is depicted by wanting to help more but being restricted by the professional expectations imposed by their employing agency. Participant 6 shares her own personal dilemma and how she is moved and motivated by the service-user’s distress, but perceives her role as confined to only interpreting the exact content of the session. This is communicated as being difficult to tolerate:

“...And it’s very upsetting but you want to help them but you don’t know how to help them...All you can do is interpret...”

Participant 6

Participant 8 describes feeling absolved of responsibility but does acknowledge the emotional reaction of wanting to 'rescue'. He justifies that it is not his role, therefore distancing and avoiding psychological investment in the service-user:

"I know at that time when you're working you must get sad, according to how the client is feeling...But you can't do nothing extra...You just... finish, all the sadness, and go home, relax, because you can't do anything...You can't help your client...Because the client has got a case-worker...Who is in charge of him"

Participant 8

Participants considered how unacceptable and unhelpful showing emotion may be, and if the role of the interpreter is to communicate the service-user's needs effectively, then showing emotion may make the service-user hesitate to continue discussing their difficulties:

"...If I'm doing like "aw, aw"...that person will feel like, I can't say anything anymore, that means this is bigger than I ever thought...So I want them to keep going, saying all of it, so that it gets help"

Participant 7

Participant 2 considers the unacceptability of professionals showing emotion, considering resilience as key to being a professional interpreter. She communicates a sense of duty and responsibility that professionals and interpreters should be willing to commit to:

"I've seen the counsellor cry once but sometimes you have to put a wall...Toughen yourself up... when it comes to clients you have to toughen up...do your job...don't do a job if you can't handle it"

(Versus) Interpreter as an Emotional Helper

This higher order theme can be considered in contrast to the previous higher order theme of 'Interpreters as a Professional Translating Tool'. A dilemma was conveyed of being expected to be a neutral, emotionally detached professional abiding by professional duties and obligations, and this conflicting with natural human reactions. In some respects, this was also seen as an ideal in a different manner, participants acknowledging the importance of emotion and its necessity in the therapeutic setting. This is in stark contrast to the professional ideal of being a neutral translating tool, where detachment is perceived as favourable for not influencing the service-user's content as well as a protective strategy against emotional discomfort. Interpreters are placed in a tug-of-war between two mutually exclusive, idealised roles. Participants also acknowledged the difficulties that they face as a cost of containing their own, as well as the service-user's, complex emotions in the room.

Feeling motivated and responsible for therapeutic progress

This theme refers to a contrasting view to the helplessness depicted in the subtheme 'constraints of the interpreting role', instead feeling integral to the process. There was a sense of pride in feeling like a contributor in the therapeutic setting, potentially suggesting the impact of other-to-self compassion in job satisfaction.

Participant 1 reflects on how feeling important and responsible spurs him on, and feeling needed is a positive part of his role:

“I really enjoy it to be honest. Maybe some other people don’t, but I really enjoy it because I feel that I am really in need, because without me I feel, I’m very important”

Participant 1

Another important aspect was feeling key to breaking down the language barrier, acting as a ‘golden ticket’ for the service-user to access support:

“...And [if] they don’t speak the language of the counsellor, how are they gonna get themselves across, how are they gonna get help? So yeah the interpreter’s very important”

Participant 3

Participant 7 reflects on how the positive experience of helping can act as a buffer against the negative emotions stirred by the service-user’s traumatic stories. She communicates a genuine pleasure in being part of alleviating service-user distress in her role:

“It’s nice, but it’s very upsetting when you see these patients, very upsetting, but it’s nice that I’m helping them you know...Through my English”

Participant 7

Interpreters are human beings too

Agencies, services, and the participants themselves reported to place high expectations on the interpreter, who are trained to be well-oiled, detached

translating machines. Participants acknowledged that emotions are inherent to their role, despite being encouraged to suppress them as professionals. Here, a more forgiving stance is conveyed regarding acceptability of not being the 'perfect professional'. Succumbing to compassionate urges, expressing emotions and crossing strict boundaries are framed as being blameless actions with good intentions.

Participant 1 considered how interpreters can set unachievable standards for themselves. He depicts an inner-critic, and considers how understanding this can make it feel normal and acceptable to 'be human':

"Sometimes you can't have everything in life, we have to acknowledge our own limits...And it's not a bad thing, we're human beings, so we can excel in things...But in others we can't. But that self-voice always wants to harm us... By telling us you have to be, this way. That's what helped me... reading"

Participant 1

Being human and conveying oneself emotionally was considered key to positive therapeutic and professional rapport. Participant 5 reflected on how expressing emotion can be positive within the triadic relationship, and suppressing this expression can have negative connotations, such as appearing unapproachable or uncaring:

"But if you're just sort of, just there with no emotions, no feelings, you're nothing, I don't think either of them would be happy to talk to you"

Participant 5

Similarly to the difficulties faced with managing boundaries, Participant 8 depicts the inner conflict between having a human urge to help those in distress, and a

fear of the powerful systems that dictate what a 'good' interpreter should be, i.e. detached and uninvolved. A strong sense of personal duty to help is challenging to suppress in the emotive therapeutic setting:

"A human being, I know that I must help...But in the job... because they told us in induction, you can't add, all you can use is what the client said...so as human being you can feel a need to help"

Participant 8

Feeling what the service-user feels

Empathy was acknowledged as a powerful experience, with interpreters feeling moved by the service-users' distress. Participants drew similarities from their own experiences, or imagined themselves in the same situation, thus experiencing a strong, emotionally-fuelled understanding and appreciation of the service-user's problems.

Participant 2 described how her own experience aids her understanding of the experiences of the service-user. It is implied that this brings back uncomfortable feelings, and presents an emotional challenge:

"So it's nice, interesting, meeting people...trying to understand people, what they're going through, sometimes they would have gone through what I've gone through so, so yeah, it's quite challenging job"

Participant 2

Participant 3 reflected on the concept of compassion, describing a wisdom that comes with experience and maturity. She argued that with maturity comes

improved empathy, having experienced more in life and therefore more able to relate to how the service-user feels:

“I’m not saying you’re not compassionate when you’re younger...But I guess you can’t reflect on it as something that could happen to you, or may have happened to you, whereas when you’re older you may have gone through more experiences, come across more people who’ve been through it, so I genuinely think you become more compassionate anyway don’t you?”

Participant 3

Participant 4 revisits her own distress experienced upon entry to the UK, emphasising the lack of support. This again may parallel the power imbalances faced within the therapeutic triad, with Western individuals holding power, and the foreign or asylum-seeking individual being vulnerable. She describes the isolation she felt, later reflecting on how this is also experienced by service-users, motivating her to alleviate their distress and provide the support she did not receive herself:

“So I been through lots of things... feeling lonely, feeling left out, being pregnant, not having anyone to support me, not having [support] from family side, not NHS side, there wasn’t any organisation to support me, I just needed someone to help me, to talk to me”

Participant 4

Service-users as an emotional burden

Strong emotional reactions and empathy were frequently reported to fatigue the interpreter, draining personal and professional resources. This was considered a challenge to the role.

Participant 4 acknowledged how containing the service-user's emotional distress can be problematic. She considered training as ineffective in managing this, and that natural human responses will always override. It is implied that with extensive training and experience in this area, similarly to what psychologists and psychiatrists receive, one could perhaps become 'less human' i.e. emotionally detached. This suggests a perception of mental health professionals having the ability to successfully detach and not be impacted by the service-user's story:

“We listen to things and we hear people's problem and this sometimes causes lots of problem for ourselves... I've done courses, I training things about many things like that but still you are human being you are not like a psychiatrist or like a psychologist...”

Participant 4

Despite the positive experiences described in the theme of 'feeling motivated and responsible for therapeutic progress', there is a sense of hopelessness when interpreters cannot intervene and must simply bear the emotional weight. Participant 2 considers how strong sympathy can be burdening, being unable to help people out of their distressing situations. She described coping by attempting to detach from emotions and suppress a sympathetic reaction to deal with the emotional load:

“Oh yeah you feel sorry for them, what they’re going through, but I have to detach myself...I can’t get involved, I, I can’t have the turmoil, you know carrying her grief”

Participant 2

Participant 8 communicates his frustration of the boundaries and emotional load of the role, feeling like there is no choice but to sit and ‘deal with’ uncomfortable feelings:

“We’re not allowed to use, the telephone number for service-user, even the service-user cannot have my telephone number...It’s not allowed, so...It’s me to deal with my heart (laughs)...”

Participant 8

Lack of support

Closely linked with the aforementioned three themes, there is a perception of the rarely available existing support being inadequate. There is a sense of desperation for support to manage the emotional content, with participants reporting they currently manage by creating their own coping strategies.

Participant 6 stresses that despite experiencing distress requiring support, this is not provided or considered by the agency as necessary. A lack of support and boundaries of confidentiality can result in having nobody to turn to. There is a strong view that interpreters are deserving of this support:

“We do get upset seeing them the way they are, we don’t get any support...it’s not just go there and just interpret and just come back, sometimes it stays there at the back of our mind, you know upsetting really upsetting, and we can’t come

home and talk about it because we're not allowed...this is upsetting, we need something, at least some support from our services, I think, all the services should have something"

Participant 6

Participant 2 communicated an unacceptability of support-seeking, and interpreters should manage this themselves, despite acknowledging the emotional demand. Requiring formal professional support is portrayed as being for those who are vulnerable, not for the ideal interpreter who should be strong and resilient:

"No I don't need [support]... Because I'm fine... the clients I've met, there's nothing tragic ...so I've not come to that stage where I need counselling...I can detach myself from situation... if I feel very sad about situation I'll go for a jog"

Participant 2

Participant 4 tells the story of exceptional individual professionals providing support in allotted debriefing time. This was generally considered a rarity, and precious if offered. This contributed to interpreters feeling unworthy of support. Financial and time pressures can act as a barrier:

"If I need it I stay with her [professional], sometimes I say I don't need it but suddenly something comes up and I talk about this so it's always usual I say I've got another appointment I have to go but no there is lots of thing that comes out from my experience, it helps...It's like releasing"

Participant 4

Overall, there is a need for support to be provided as a standard, not as an exception. Though interpreters may gain some relief from their own coping

strategies, the level of self-compassion and received compassion appears to be low. Interpreters seem to be surviving, rather than thriving, in their roles.

Discussion

This study aimed to describe interpreter experiences of working in mental health settings, with an additional focus of how compassion may be relevant to their role. Central to the themes identified was an internal conflict. One side of this was an obligation of adhering to the guidance of the powerful services and professionals, upholding a boundaried and detached approach. The other side was driven by human instinct, to want to help and empower the vulnerable service-users, potentially overstepping the boundaries dictated by professional guidance.

This is the first study to consider how psychological frameworks of compassion may provide an understanding of interpreters' experiences in therapeutic settings. The results, in combination with wider literature, will be discussed using Gilbert's compassionate mind theory (Gilbert, 2010a) and Neff's conceptualisation of self-compassion (Neff, 2012) as models.

Frameworks of Compassion

Gilbert postulates a theory of compassion using neuropsychological, evolutionary and Eastern Philosophical (Buddhist) underpinnings. The Dalai Lama's (1995) definition of compassion is central to the compassionate mind framework: "A *sensitivity* to the suffering of self and others with a *deep commitment* to try to relieve it" (p.16). An important element of this theory is that compassion flows

between and within people in relationships (Gilbert, 2010a). Gilbert (2010a) posits that the six key attributes of compassion are: sensitivity to suffering, sympathy, empathy, distress tolerance, non-judgement and compassionate motivation.

Neff (2012) defines self-compassion as being composed of three key components; self-kindness, a sense of common humanity, and mindfulness. Self-kindness refers to being warm, understanding, and non-judgmental of our suffering, acknowledging that we may not always have the life that we want. The use of positive emotions, kindness, and care, can help us to cope with the acceptance of this reality (Neff, 2012). Common humanity refers to the acknowledgement that we are not alone in our suffering, and distress is an experience of being human (Neff, 2012). Lastly, mindfulness refers to connecting with the present and simply noticing our thoughts and feelings, without judgement or jumping into problem-solving or rumination, observing them as they are (Neff, 2012).

Gilbert (2010a) couches psychological wellbeing as being balanced in the three emotional regulation systems (see Figure 1), which work in harmony to maintain wellbeing and manage distress. The three systems are comprised of the drive system (wanting, pursuing, achieving, progressing, focus), the soothing/affiliative system (contented, safe, protected, cared-for, trust) and the threat system (anxiety, anger, disgust) (Gilbert, 2010a).

Our ability to regulate these systems can be influenced by 'social mentalities' which describe the organisation of an individual's abilities and competencies depending on specific motives (Gilbert, 2010a). The motivational

system in place influences how the emotional regulation systems are used; for example our compassionate motive for another's wellbeing may trigger the drive system to save them from significant harm. In this situation our threat system is triggered and in turn triggers the drive system. The soothing system is active as we have in mind to maintain the relationship with the other person.

Interpreters and the Conflict of Compassion

There was an overall sense of Western providers being powerful and dominating, interpreters feeling more equal with the service-users. They may bond in a sense of common humanity, trying to find a way to support, or be supported, in a culture that holds conflicting views around mental health. The importance of remaining neutral was emphasised, it being unacceptable to allow personal values to influence the session. This supports the views of interpreters in Green, Sperlinger and Carsewell's (2012) study who report how 'negotiating multiple identities' can be difficult regarding help-seeking attitudes, being part of both a Western professional system and a member of their own cultural community.

The interpreters in this study described the naturally forming bond with the service-user. Similarity in culture, ethnicity or religion made the service-user more relatable to them, and vice-versa, allowing trust and rapport to quickly form. Trust was considered essential to the service-user feeling comfortable enough to open up and share difficult experiences. The wider literature supports this, with other samples of interpreters describing a conscious effort to build trust, allowing the clinician to be provided with the information to determine the most effective support (Miller, Martel, Pazdirek, Caruth & Lopez, 2005; Resera et al., 2014).

A conflict was apparent regarding the expectation to be an invisible translation machine, but also as a cultural informant or co-therapist. The ambiguity of role is a source of discomfort for interpreters in this sample, as well as across interpreter and mental health professional samples in other research (Becher & Wieling, 2015; Gartley & Due, 2017; Raval & Smith, 2003; Resera et al., 2014)

Interpreters in the sample were demonstrative of possessing a care-giving social mentality, motivated to alleviate the distress of their service-users, being sensitive and sympathetic to their needs. This was complicated by the desire to be viewed as professional. Professionalism in interpreter training promotes emotional detachment and neutrality, in order to ensure accuracy and non-biasing of information (Bontempo & Malcolm, 2012; Resera et al., 2014). Arguably, the interpreters may demonstrate compassion by their drive to be boundaried and professional, as this is portrayed by agencies to be beneficial to the service-user, ensuring they receive the correct support. As is evident in the sample, as well as other research, though it is recommended for the interpreter to switch off their compassionate urges, emotions are still internally experienced even when not expressed (Engstrom, Roth & Hollis, 2010; Resera et al., 2014). This could create discomfort due to the dissonance between values and behaviour (Festinger, 1962).

If there is no support provided for this discomfort, severe distress and burnout may occur. Interpreters in the sample discussed the difficulty of 'taking work home', moved by the distress of the service-user but feeling frustrated by not being able to act upon a motivation to help them.

For some, the care-giving mentality can stir feelings of protectiveness for the service-user when working with professionals deemed as unsympathetic. This may shift the interpreter into taking a more active role in their input with the service-user, activating a competitive mentality within the professional who may feel excluded from the triad (Becher & Wieling, 2015; Raval & Smith, 2003).

Despite sometimes competitive attitudes, research with professionals suggests they highly value interpreter input in therapy (Miller et al., 2005); this discrepancy in professionals' and interpreters' views of how valued interpreters are in the mental health setting may be due to issues of communication and outward demonstration of compassionate behaviour.

The overall sense drawn from the present study and the wider literature was that the role of the interpreter is not made to be explicit, however the 'middle ground' of involvement, i.e. being a cultural broker, is perceived as an optimal role within the therapeutic triad.

The relationship between the interpreter and professional is considered in this study and wider research. In Green et al.'s (2012) study, interpreters reported a sense of having lower professional status than clinicians. This is supported in the present study, participants reporting to be unappreciated or undervalued by the providers. This suggests a lack of self-to-other compassion from provider to interpreter. A lack of understanding from providers was conveyed regarding the impact of the interpreting role, and the lack of support provided. Interpreters were sensitive to their own emotional needs and motivated to try and alleviate their distress with their own coping strategies, however professional support was suggested to be inconsistent and inadequate.

The implication derived from this research, as well the wider literature, is that interpreters consider there to be an emotional impact from their work, and therefore an increased risk of vicarious trauma (Mehus & Becher, 2015).

Interpreters in the present study acknowledged the emotional impact of the work having an effect on their personal and professional life. Some considered how experience can build up resilience and distress tolerance; similar views were held by interpreters in Miller et al.'s (2005) study. Interestingly, professionals in Miller et al.'s (2005) study considered emotional reactions in interpreters as uncommon. This may reflect the ability of the 'professional' interpreter to mask their emotional reactions. The views of these professionals were that emotional reactions, if not too extreme, were acceptable and should be addressed (Miller et al., 2005). Interpreter participants in Miller et al.'s (2005) study and this study communicate how rarely they are offered supportive supervision or debriefing, this being highly valued when provided.

Emotional involvement is also viewed as a positive aspect in this study, with participants linking it to the positive interpreter/service-user bond and the joy of being part of the service-user's therapeutic progression. This supports the idea of a vicarious post-traumatic growth process postulated in Splevins et al.'s (2010) study, as well as in Miller et al.'s (2005) study where interpreters felt the process had enriched their lives and contributed to personal development.

Interpreters across the present study and wider literature, though perhaps not explicitly naming it, have inherently acknowledged the general premise of self-compassion. It is implied as an important part of self-support, requiring further input to nurture and develop. The interpreter strives to achieve a fine balance of

appearing approachable without being too emotionally involved, which can frequently contribute to frustration and distress in their role.

Clinical Implications

Compassion, as conceptualised by Gilbert (2010a) and Neff (2012), could be used as a framework for developing interpreter and mental health professional training. Cultivating compassion in health professionals is suggested to promote wellbeing and improve therapeutic relationships – both from the perspective of the health-care worker and person receiving care (Department of Health & National Health Service, 2012).

Providers are currently obligated by policies and guidance to have a duty of care towards their interpreters (Tribe & Thompson, 2008); the recommendations for delivery of support however, are vague. Though interpreters may not necessarily be explicitly aware of compassion in their role, they are inadvertently able to recognise the various attributes of compassion (Gilbert, 2010a) that may become fatigued. This has the potential to lead to burnout and imbalance in the emotional regulation systems if unsupported, and having to manage a challenging role with an emotional load i.e. a dominating threat system and diminished soothing system (Gilbert, 2010a).

The key notion of this research is that the interpreter may feel obligated to be neutral, boundaried, and detached from the service-user due to high expectations from powerful providers. The reality that is demonstrated however, is that the interpreter is an empathic human being; something that has previously been considered mostly in the professional's context (Department of Health & National Health Service, 2012). The interpreter may comparably be more

emotionally receptive to the service-user's distress, due to the strong and quick-to-form rapport facilitated by cultural and experiential similarities. The interpreter is left without consistent support, and generally expected to manage alone.

Gilbert (2014) highlights the role of compassion in social mentalities, and how it is easier for us to be compassionate towards those we know, like, love or are similar to, compared to those we see as different and / or do not like or hate. This has relevance for the professional and interpreter and levels of compassion towards each-other and the service-user, depending on how they relate to them.

Empathy can play a role in how social mentalities manifest, being more difficult when feeling threatened in different social roles (Liotti & Gilbert, 2010). This has relevance to the potentially complicated dynamics within the therapeutic triad, if the interpreter feels threatened by a lack of control over role boundaries (Bontempo & Malcolm, 2012), or if the clinician feels threatened by the interpreter's involvement in the therapeutic process (Becher & Wieling, 2015; Raval & Smith, 2003). Clinician training is suggested by Miller et al. (2005), focusing on the different and fluid roles of the interpreter and how the therapeutic alliance may not form instantly, but grow gradually, reducing levels of jealousy regarding the more evident interpreter/service-user bond. This may potentially resolve issues concerning the perceived lack of other-to-self compassion received from health professionals in the interpreter population, strengthening co-operative and care-giving social mentalities rather than competitive. This will inherently have benefits for the service-user who is more likely to be satisfied when the interpreter and clinician have a 'shared enterprise', collaborating together for the service-user's wellbeing (Costa & Briggs 2014)

Suggestions for interpreter training are made by Miller et al. (2005). This includes the provision of training around self-care and triadic relationship issues, as well psychoeducation on the nature of trauma and relevant interventions (Miller et al., 2005). Supplementing this with a compassionate mind training approach, developing compassionate skills and attributes (Gilbert, 2010a), may help interpreters to cultivate compassion effectively, and use this within the triadic relationship.

For a larger focus on self-compassion and mindfulness, Neff (2012) has developed a Mindful Self-Compassion Course that has been used with a clinical sample, and successfully increased self-compassion, mindfulness, compassion for others and life satisfaction, whilst decreasing depression, anxiety, stress, and the impact of trauma. There is potential for this intervention to be adapted as a support to be used for interpreters, identified as high-risk for vicarious trauma (Mehus & Becher, 2015).

Overall, it is implicated by the data in this study and other research that there is a need to develop compassionate skills in order to balance the emotional regulation systems of all three parties within the triad. Care-giving mentalities from the interpreter and clinician may be well developed, with self-to-other compassion flowing into the service-user, who may have a care-seeking mentality. Despite this, the dynamics and emotional regulation of both interpreter and clinician may determine if this social mentality is cooperative or competitive in nature. A competitive social mentality may negate the previously shared goal of providing care. Compassionate mind training with particular focus on self-compassion for interpreters and self-to-other compassion for clinicians working with interpreters, may promote more cooperative social mentalities.

Clinicians may have more access to support that allows them to develop self-compassion, through the occupational health benefits and supervision time that they are entitled to. Interpreters are often not offered such support, which is where the author proposes a change to be made. Interpreters in the sample communicated appreciation for debriefing sessions provided by professionals following sessions. Though this is currently recommended by guidance (Tribe & Thompson, 2008), it is apparent that this is not yet, but should become, common practice. There is potential for compassionate mind training to be incorporated into this debriefing time.

If both the interpreter and clinician can engage their drive and soothing / affiliative systems to achieve the shared motive of alleviating the service-user's distress, this may buffer against the threat systems' responses in all three parties. The diagram in Figure 1 combines Gilbert's (2010a) and Neff's (2012) conceptualisations of compassion to formulate how emotions may be regulated and more positive mentalities fostered in the therapeutic context.

Bringing compassion into awareness and practicing skills to cultivate it could have a potential long-lasting benefit, helping interpreters to feel safe, supported and confident in continuing to perform optimally in their tricky roles, with their tricky brains (Gilbert, 2010b).

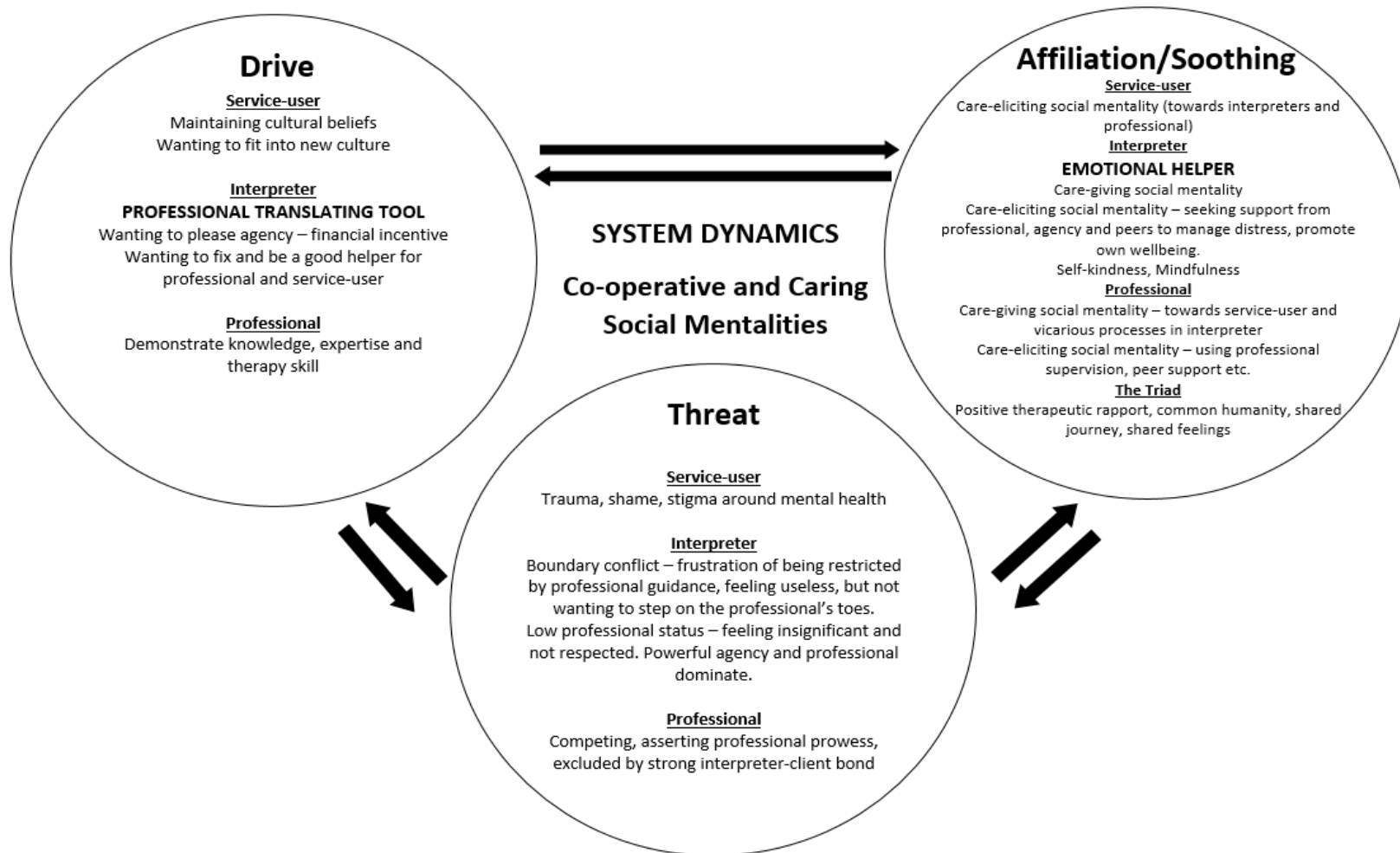


Figure 1. A formulation of the therapeutic triad's emotional regulation systems for maintaining care and cooperation using Gilbert's (2010a) model and Neff's (2012) conceptualisation of self-compassion

Limitations of the Study

The study design was exploratory and qualitative, therefore confirming or disconfirming hypotheses, or finding causal or correlational relationships, was not the aim. The author had to consider her own beliefs that may have influenced her interview style and interpretation of results due to a professional interest in psychological frameworks of compassion, not necessarily shared by the research participants. A reflective journal and supervision was used to maintain awareness of these processes and to determine whether findings from analysis truly reflected the experiences of the participants, or were biased by the author's own beliefs and frameworks of thinking. Though there may have been cross-over between the author's theoretical interests and the findings of the research, the process was conducted in a way which was as unbiased as possible, whilst accepting the reality that the findings are inevitably the author's interpretation of the participants' interpretations of their experiences, and therefore inevitably perceived through a particular lens, and cannot be considered as an 'objective truth'. The findings of the study should not be generalised due to the small and unrepresentative sample size, and the idiographic nature of the analysis. Please refer to Appendices A and B for more detailed Reflective and Epistemological Statements concerning these processes.

Though recruitment was done mainly via leaving advertisements in local services and through social media, approximately half of the participants were recruited via word-of-mouth in a 'snowball-like' sampling method. This highlights a potential response bias; participants may only represent the population of interpreters that are willing and open to talk about their emotional experiences, potentially being more aware of compassionate processes. The focus of the study was not how experiences and compassion concepts vary across different

cultures. Non-Western cultures were grouped as one cultural perspective, and does not accurately depict the nuances of attitudinal differences between these cultures which could be significant in how effective a compassion-based intervention may be.

Lastly, on reflection, some of the questions comprising the interview schedule were quite specific in nature, which therefore contributed to there being a similarity in the themes of the questions asked, and the themes derived from the interview data. This is not to say that these themes are therefore not weighted as important, but it would be worth exploring if similar themes are derived from more open questions in future research. Additionally, the important link between the three higher order themes, i.e. how system dynamics contribute to the internal conflict of the interpreter wanting to be a professional translating tool, but also an emotional helper, and how these latter two categories were perceived as mutually exclusive, was considered to be a concept purely derived from the interview data itself, independent of how specific the interview questions were.

Future Directions for Research

As a follow-on from this research, an intervention study assessing the efficacy of a compassion-focused support group in an interpreter population, with a focus on specific cultural differences, may be warranted. Additionally, the views of service-users have not been considered in depth here, and future research may consider how compassion relates to experiences of mental health settings using interpreters. The British Psychological Society (BPS) guidelines on working with interpreters are currently being updated from the 2008 version (Tribe &

Thompson, 2008). These are due to be published in 2017 (Tribe & Thompson, 2017); it would be of particular relevance to the wider implications of this study to determine whether updated guidelines incorporate more specific advice on how interpreters can be supported in mental health settings. Collaborating with authors of BPS guidelines and implementing suggestions gleaned from research studies such as this may have potential for further incorporating the voices of interpreters into the guidance for their much needed support.

Conclusion

The purpose of this study was to explore the subjective experiences of interpreters working in mental health settings, and how compassion may be relevant to their perceived role. The experiences of the interpreters suggest that they regularly struggle with feeling obligated to abide by the expectations of the powerful provider, acting as a neutral, detached and bounded professional. The discomfort arises from the conflicting compassionate, human urges often elicited during therapy sessions. The interpreter may feel the desire to be more involved with the service-user's care, an 'emotional helper', as opposed to being a 'professional translation tool'. This is complicated by an uncontrollable emotional connection, intensified by a likening of oneself to the service-user in terms of culture and experiences. Participants acknowledged the complicated triadic dynamics in the setting, as well as complex emotions arising from the sessions. An absence of support to resolve these issues was evident. Findings were couched in psychological frameworks of compassion (Gilbert, 2010a; Neff, 2012); interpreters' experiences were conveyed as interactions between the emotional regulation systems, social mentalities, and attributes key to a successful flow of compassion. This brings to light the lack of, and need for, the emotional support that they are entitled to. The importance of standard provision of debriefing and the potential for a compassionate mind / mindful self-compassion training package (Gilbert, 2010a; Neff, 2012) is suggested. This ideally would have a focus on developing self-compassion in interpreters, as well as self-to-other compassion from professionals towards interpreters

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Conflicts of interest: None

References

- Becher, E. H., & Wieling, E. (2015). The intersections of culture and power in clinician and interpreter relationships: A qualitative study. *Cultural Diversity and Ethnic Minority Psychology, 21*(3), 450-7.
- Bontempo, K., & Malcolm, K. (2012). An ounce of prevention is worth an ounce of cure: Educating interpreters about the risk of vicarious trauma in healthcare settings. *Examining the education of healthcare interpreters* (pp. 105-130). Washington DC: Gallaudet University Press.
- Costa, B., & Briggs, S. (2014). Service-users' experiences of interpreters in psychological therapy: A pilot study. *International Journal of Migration, Health and Social Care, 10*(4), 231-244.
- Dalai Lama. (1995). *The power of compassion*. New Delhi: Harper Collins.
- Dean, R. K., & Pollard, R. Q., Jr. (2001). Application of demand-control theory to sign language interpreting: Implications for stress and interpreter training. *Journal of Deaf Studies and Deaf Education, 6*, 1-14.
- Department of Health, & National Health Service. (2012). Compassion in practice: Nursing, midwifery and care staff. Our vision and strategy. Retrieved from <https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>
- Doherty, S., MacIntyre, A., & Wyne, T. (2010). How does it feel for you? The emotional impact and specific challenges of mental health interpreting. *Mental Health Review Journal, 15*, 31-44.

- Engstrom, D. W., Roth, T., & Hollis, J. (2010). The use of interpreters by torture treatment providers. *Journal of Ethnic and Cultural Diversity in Social Work, 19*(1), 54-72.
- Festinger, L. (1962). Cognitive dissonance. *Scientific American, 207*(4), 93-107.
- Gartley, T., & Due, C. (2017). The interpreter is not an invisible being: A thematic analysis of the impact of interpreters in mental health service provision with refugee clients. *Australian Psychologist, 52*, 31-40.
- Gilbert, P. (2010a). *The compassionate mind: A new approach to life's challenges*. London: Constable & Robinson Ltd.
- Gilbert, P. (2010b). An introduction to the theory and practice of compassion focused therapy and compassionate mind training for shame based difficulties. Retrieved from http://www.compassionatemind.co.uk/downloads/training_materials/1.%20Workbook_2010.pdf
- Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British Journal of Clinical Psychology, 53*(6-41)
- Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women. *Mental Health, Religion & Culture, 10*(127-141)
- Gold Brunson, J., & Lawrence, P. S. (2002). Impact of sign language interpreter and therapist moods on deaf recipient mood. *Professional Psychology: Research & Practice, 33*(6), 576-80.

- Green, H., Sperlinger, D., & Carswell, K. (2012). Too close to home? Experiences of Kurdish refugee interpreters working in UK mental health services. *Journal of Mental Health, 21*(3), 227-35.
- Johnson, M. (2003). Asylum seekers in dispersal: Healthcare issues. Retrieved from <http://webarchive.nationalarchives.gov.uk/20130128103514/http://rds.homeoffice.gov.uk/rds/pdfs2/rdsolr1303.pdf>
- Lee, D., & James, S. (2012). *The compassionate mind approach to recovering from trauma using compassion focused therapy*. London: Constable & Robinson.
- Liotti, G., & Gilbert, P. (2010). Mentalising, motivations and social mentalities: Theoretical considerations and implications for psychotherapy. *Psychology and Psychotherapy, 84*, 9-25.
- Mehus, C. J., & Becher, E. H. (2015). Secondary traumatic stress, burnout, and compassion satisfaction in a sample of spoken-language interpreters. *Traumatology, Advance online publication* doi:10.1037/trm0000023
- Miller, K. E., Martell, Z. L., Pazdirek, L., Caruth, M., & Lopez, D. (2005). The role of interpreters in psychotherapy with refugees: An exploratory study. *American Journal of Orthopsychiatry, 75*(1), 27-39.
- National Health Service. (2015). NHS England news: Simon Stevens announces major drive to improve health in NHS workplace. Retrieved from <https://www.england.nhs.uk/2015/09/nhs-workplace/>

- Neff, K. D. (2012). The science of self-compassion. In C. Germer, & R. Siegel (Eds.), *Compassion and wisdom in psychotherapy* (pp. 79-92). New York: Guilford Press.
- Patel, N. (2003). Speaking with the silent: Addressing issues of dis-empowerment when working with refugee people. In R. Tribe, & H. Raval (Eds.), *Working with interpreters in mental health* (). London & New York: Routledge.
- Raval, H. (2003). Applying theoretical frameworks to the work with interpreters. In R. Tribe, & H. Raval (Eds.), *Working with interpreters in mental health* (pp. 122-134). London & New York: Brunner-Routledge.
- Raval, H., & Smith, J. A. (2003). Therapists' experiences of working with language interpreters. *International Journal of Mental Health*, 32(2), 6-31.
- Refugee Council. (2017). Refugee council information: Quarterly asylum statistics - Retrieved February 2017 from https://www.refugeecouncil.org.uk/assets/0003/9782/Asylum_Statistics_Feb_2017.pdf
- Resera, E., Tribe, R., & Lane, P. (2014). Interpreting in mental health, roles and dynamic in practice. *International Journal of Culture and Mental Health*, doi:10.1080/17542863.2014.921207
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Publications Ltd.

Splevins, K. A., Cohen, K., Joseph, S., Murray, C., & Bowley, J. (2010).

Vicarious posttraumatic growth among interpreters. *Qualitative Health Research, 20*(12), 1705-1716.

Tribe, R. (1999). Bridging the gap or damming the flow? Some observations on using interpreters/bicultural workers when using refugee clients, many of whom have been tortured. *British Journal of Medical Psychology, 72*, 567-576.

Tribe, R., & Thompson, K. (2008). *Working with interpreters in health settings: Guidelines for psychologists*. Leicester: British Psychological Society.

Tribe, R., & Thompson, K. (2017). British psychological society guidelines on working with interpreters. Retrieved July 2017 from <https://www.researchgate.net/project/British-Psychological-Society-Guidelines-on-Working-with-Interpreters>

Welford, M., & Langmead, K. (2015). Compassion-based initiatives in educational settings. *Educational & Child Psychology, 32*(1)

Part Three: Appendices

Appendix A: Reflective Statement

Reflection has been an ongoing process from day one, up until the point I am writing this, approximately two weeks before submission deadline. The use of this statement allows me to structure my reflections in a way that will hopefully provide the reader contextual information concerning the research, and the researcher herself.

Having grown up in York, a small city primarily populated by the white, British, middle-class, I was excited to be moving to the 2017 City of Culture and to become integrated into a diverse, multi-ethnic community.

I distinctly remember a moment on my six week community psychology placement when the buds of my research ideas began to bloom. I was working with Humber All Nations Alliance (HANA) and Open Doors – two local community services providing support to ethnic minorities, particularly refugees and asylum seekers. Having very little experience with this diverse population, I particularly enjoyed assisting in ESOL (English for Speakers of Other Languages) classes. It became very apparent the strength and resilience demonstrated by people who had been through unspeakable traumas, and truly inspired me. It dawned upon me the barriers that must be faced if these individuals needed support for their trauma-related distress, but could not speak any English. I wondered how the issues would translate across different cultures, how the dynamics would be different having an interpreter in the room, and many other factors that would change on the basis that the service-user and professional do not share cultural or linguistic similarities. These curiosities propelled my decision to research the experiences of asylum seekers and refugees using services for trauma in my review, and interpreters for my empirical research.

On a visit to The Haven Project, a service providing psychological support to refugee and asylum-seeking families in the local area, I met with Project Manager Jackie Wright (field supervisor for my empirical research). It was here that my interest in the experiences of interpreters was piqued, by her observation that interpreters are exposed to the same distressing content of therapy sessions that the professionals are exposed to, but in fact may be at more risk of experiencing distress in their role. Firstly, this was due to the lack of support offered, and secondly the fact that the interpreters themselves may have come from asylum-seeking or refugee backgrounds, and experienced their own traumas. Jackie mentioned how the Haven had their own interpreter support group in the pipeline, which later I was lucky enough to attend for a couple of months. After scoping the literature, this was something that appeared to be under-researched and an area severely neglected within the NHS context. I needed to know more about interpreters' experiences in the mental-health setting and how this impacted them on an emotional level, particularly with a lack of professional support.

I already had a keen interest in Compassion Focused Therapy as a model, and was thankful to have Dr Philip Molyneux, not only my research supervisor but also my clinical tutor, on board to offer his ideas of how compassion may fit into this. Prior to my training, I had a keen interest in trauma and later went on to have an elective placement in Humber Traumatic Stress Service. Dr Jennie Ormerod, the consultant psychologist for this service at the time, sparked my interest in focusing on the impact of trauma and vicarious processes. Lastly, Dr Tim Alexander, my research guru throughout this process, helped me to finalise these concepts and interests into specific research questions, considering which methodologies to use in order to truly capture the experiences I wanted to investigate.

After the long and tricky process of finalising my research proposal and receiving ethical approval, this made it all seem very real, and very exciting. The stage had been set; recruitment was slow at first, and I rejoiced when I started to get more phone calls from interpreters, keen to participate in my research.

I then had to think about my own beliefs that may bias my interview style and interpretation of my results. Yes, I was interested in compassion, yes, I was interested in trauma. Despite this, I had to keep in check that my understandings of compassion, trauma and mental health were based on psychological frameworks, and not necessarily shared by those I was researching. There were moments during analysis when I really had to consider: “is this what the participant is saying, or what I am saying?”. With Tim and Philip to keep me on the straight and narrow and be as unbiased as I could try to be, I felt I was able to temporarily put my own beliefs aside for the sake of unbiased research. Admittedly, I was pleased when the results from both components of the portfolio had ties to the psychological frameworks of compassion that I had strong personal and professional interest in.

The research also unveiled information which was new to me, which would not have been apparent if I had gone through this process wedded to specific theories. Key were the stark differences amongst individuals in their experiences, originating from cultures that I had perhaps stereotyped to typically not hold particular views. This opened my eyes to how we can become shut off and unaware of not just the differences, but the similarities we hold with individuals from other cultures. I had previously considered myself as somebody who was non-assuming of how others conceptualised mental health. Unconscious biases and judgements I held around cultural beliefs were brought into consciousness during the process; this may be a very human, naturally occurring phenomenon,

but something I will now be aware and mindful of moving forward in my career. Culture is important, but the individual experience will always supersede this.

Despite the clear individual differences, there was a sense that change is required within the wider systems. For asylum seekers and refugees, my review highlighted the importance of accounting for service-users' experiences and unique contexts in the design and delivery of mental health services. In my empirical report, it was evident that interpreters are currently expected to manage very difficult roles in complex and demanding settings, without support. For many of these individuals, for myself, and I am sure for many other professionals, this is unacceptable. In an NHS, amongst other services where compassionate care is at the forefront of professional values, this cannot be possible unless **everyone** involved in these settings is provided with the support and resources to be self-compassionate. The flow of compassion needs exist within and between self and others, so it can be exuded to our service-users.

Appendix B: Epistemological Statement

***“The map is not the territory” – Alfred Korzybski
(Korzybski, 1933)***

This statement aims to convey and explore the ontological and epistemological stances held by the researcher, which underpin the Systematic Literature Review and Empirical paper which comprise this portfolio.

Ontology refers to what there is to know about the world, and in the context of social research concerns whether or not reality can exist outside of human interpretation (Snape & Spencer, 2003). Epistemology concerns the ways in which the social world can be understood, and how we may come to understand reality (Snape & Spencer, 2003). In research, the epistemological stance of the researcher is what influences the choice of research method and will have a practical impact on the way the research is carried out (Smith, Flowers, & Larkin, 2009).

Categories of epistemology and ontology for researchers with a purist philosophy are dichotomous; that is, quantitative and qualitative methods are mutually exclusive and not to be combined (Onwuegbuzie & Leech, 2005).

For those selecting purely quantitative approaches, a positivist epistemology may be assumed. This stems from the ontological stance of realism, where it is understood that an external reality exists independently from human understanding, distinguishing beliefs about the world from the way the world is (Snape & Spencer, 2003). Positivism suggests that research can be conducted and not effected by the researcher’s values, observations being objective (Snape & Spencer, 2003).

For those selecting purely qualitative approaches, an interpretivist epistemology may be assumed. This stems from the ontological stance of idealism, where it is understood that conversely to realism, no external reality exists and is only understood through our social constructions of the world (Snape & Spencer, 2003). Interpretivism emphasises the influence of the researcher, stating that our perspectives inherently impact our observations, therefore 'facts' and values cannot be distinguished from one-another (Snape & Spencer, 2003).

Despite this dichotomous perspective of methodological, ontological and epistemological stances, Onwuegbuzie and Leech (2005) argue that this need not be the case. The authors argue the stance of pragmatism as an alternative to purism. The pragmatic approach emphasises the similarities between quantitative and qualitative approaches, and the benefits of combining them (Onwuegbuzie & Leech, 2005). Observations in both quantitative and qualitative approaches are subjective; this refutes the positivist stance popular in quantitative methodologies. It is implicated that though scores on instrumental outcome measures can be analysed objectively, the development of the instrument itself inevitably involved subjective processes (Onwuegbuzie & Leech, 2005).

“SUBJECTIVITY + OBJECTIVITY = SUBJECTIVITY”

(Onwuegbuzie & Leech, 2005, p. 377)

The systematic literature review in this portfolio included a combination of qualitative, quantitative and mixed methods papers, and therefore was underpinned by pragmatist principles. The choice of breadth in methodology was based on the above idea that valuable information, from an interpretivist stance, could be gleaned from any study aiming to explore asylum seekers' and refugees'

experiences of trauma interventions, regardless of this being done in a quantitative or qualitative manner.

For the empirical paper, the methodology was considered to be qualitative, as the quantitative measure utilised was for the purpose of contextualising the interview data, rather than discussed in depth as findings in their own right. This approach allowed the researcher to capture the subjective experiences of interpreters working in mental health settings. A purely quantitative approach was not selected as the topic of compassion and general subjective experiences warranted a methodology that was phenomenological in nature.

Phenomenology, hermeneutics and idiography are theoretical perspectives central to Interpretative Phenomenological Analysis (IPA), used in the empirical report (Smith et al., 2009). Phenomenology is the philosophy of studying experience (Smith et al., 2009); the phenomenological method can be described in the following three steps, and was adhered to as best as possible by the researcher during the analytical process:

- **Step 1: The Rule of Epoché:** This urges the researcher to temporarily set aside initial biases and prejudices in order to focus on the data depicting experience.
- **Step 2: The Rule of Description:** This emphasises the importance of describing, rather than explaining, the data. This allows immediate and concrete impressions of the data to be made, rather than speculating or fitting it into a theoretical frame which may occur in discussion of the findings.
- **Step 3: The Rule of Horizontalisation (Equalisation Rule):** This advises the researcher to avoid placing hierarchies or varying levels of significance

on the different items that have arisen from descriptions, initially treating every item as having equal significance (Spinelli, 2005).

The researcher has experience of working from a compassion-focused therapeutic model in a trauma service setting where refugees and asylum seekers, needing interpreter input, would frequently present. A preference for this therapeutic model and frame would have, despite following the above three-step phenomenological method, had an influence on the content of the interview. This was attempted to be rectified by developing a balanced interview schedule which did not directly use the word 'compassion' until the end, in order to allow the interviewee to provide their true perceptions of their experiences. The researcher may have been influenced by theoretical preferences during the analysis sections for both components of this portfolio, which was addressed by keeping in mind the rule of description (Spinelli, 2005) throughout the process, reflecting on this in supervision and in a reflective journal (see Appendix X for further detail).

Despite attempting to remain as unbiased as possible during the research design and analysis of both the author's research, and the reviewed research of others, the inevitable subjectivity postulated by Onwuegbuzie and Leech (2005) implies a pragmatic philosophy, with an inherently interpretivist epistemological stance (Snape & Spencer, 2003).

As quoted by Alfred Korzybski (Korzybski, 1933) at the head of this statement "the map is not the territory" – the abstraction that the researcher has derived from the data within both components of this portfolio, is not necessarily the reality of the experiences held by the participants themselves.

References

Korzybski, A. (1933). *Science and sanity. An introduction to non-Aristotelian systems and general semantics*. Oxford, England: International Non-Aristotelian Library Pub. Co.

Onwuegbuzie, A. J., & Leech, N. L. (2005). On becoming a pragmatic researcher: The importance of combining quantitative and qualitative research methodologies. *International Journal of Social Research and Methodology*, 8(5), 375-87.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE Publications Ltd.

Snape, D., & Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie, & J. Lewis (Eds.), *Qualitative research practice: A guide for social science students and researchers* (pp. 1-23). London: SAGE Publications Ltd.

Spinelli, E. (2005). The phenomenological method. In E. Spinelli (Ed.), *The interpreted world: An introduction to phenomenological psychology* (2nd ed., pp. 19-34). London: SAGE Publications Ltd.

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Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

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[Submit manuscripts electronically](#) through the Manuscript Submission Portal.

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The identities of authors will be withheld from reviewers and will be revealed after determining the final disposition of the manuscript only upon request and with the permission of the authors.

Authors are responsible for the preparation of manuscripts to permit masked review. Manuscripts submitted electronically should include all author names and affiliations, as well as the corresponding author's and co-authors' contact information, in the box labeled "cover letter," not in the manuscript file.

Every effort should be made to ensure that the manuscript itself contains no clues to the authors' identities, including deletion of easily identified self-references from the reference list.

If an author feels that revealing his or her identity is critical to receiving a fair review, such a request along with its justification should be made in the cover letter accompanying the manuscript.

Please ensure that the final version for production includes a byline and full author note for typesetting.

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Prepare manuscripts according to the *Publication Manual of the American Psychological Association* (6th edition). Manuscripts may be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*).

Review APA's [Checklist for Manuscript Submission](#) before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the [APA Style website](#).

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

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Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we

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If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

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All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statements

Authors submitting manuscripts to the *Psychological Bulletin* are required to provide two to three brief sentences regarding the relevance or public health significance of the study or meta-analysis described in their manuscript.

This description should be included within the manuscript on the abstract/keywords page.

It should be written in language that is easily understood by both professionals and members of the lay public.

Examples:

"This meta-analysis strongly suggests that (description of a given psychosocial treatment) is an effective treatment for anxiety, but only if it is of mild to moderate severity. For persons with severe anxiety, additional treatments may be necessary."

"This systematic review indicates that personality changes following psychotherapy and pharmacotherapy. The changes are small and persist for (description of time in months or years)"

"This meta-analysis reveals a small to moderate effect of incidentally presenting words (e.g., as part of a game) on the actual actions of the recipients following priming. These effects are stronger when recipients of the primes are likely to value the behavior."

To be maximally useful, these statements of public significance should not simply be sentences lifted directly from the manuscript.

This statement supports efforts to increase dissemination and usage of research findings by larger and more diverse audiences. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Authors may refer to the [Guidance for Translational Abstracts, Public Significance Statements, and Social Media Messages](#) page for help writing their statement.

Prior to final acceptance and publication, all public significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

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Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151. <http://dx.doi.org/10.1037/a0028566>

Authored Book:

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.

Chapter in an Edited Book:

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, [please see the general guidelines](#).

When possible, please place symbol legends below the figure instead of to the side.

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The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

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Appendix D: Author guidelines for submission to the Journal of Clinical Psychology

Author Guidelines

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1. Go to your Internet browser (e.g., Netscape, Internet Explorer).
2. Go to the URL <http://mc.manuscriptcentral.com/jclp>
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure.
6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).
7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

Timothy R. Elliott, Editor-in-Chief
The Journal of Clinical Psychology
4225 TAMU
Texas A&M University
College Station, TX 77843-4225
Email: timothyrelliott@tamu.edu

All *Journal of Clinical Psychology: In Session* articles are published by invitation only. Individuals interested in nominating, organizing, or guest editing an issue are encouraged to contact the editor-in-chief:

Barry A. Farber, Ph.D.
Department of Counseling & Clinical Psychology
Teachers College
Columbia University
New York, NY 10027
E-mail: farber@exchange.tc.columbia.edu

Manuscript Preparation

Format . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure

Legends 9) Permissions. Start each element on a new page. Because the ***Journal of Clinical Psychology*** utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote . EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal*: If you already use EndNote, you can [download the reference style](#) for this journal. *How to Order*: To learn more about EndNote, or to purchase your own copy, [click here](#) . *Technical Support*: If you need assistance using EndNote, contact endnote@isiresearchsoft.com , or visit www.endnote.com/support .

Title Page . The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:

Objective(s): Succinctly state the reason, aims or hypotheses of the study.

Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.

Results: Succinctly report the results that pertain to the expressed objective(s).

Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

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Article Types

- **Research Articles** . Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).
- **Review Articles** . Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.
- **Commentaries** . Occasionally, the editor will invite one or more individuals to write a commentary on a research report.
- **Editorials** . Unsolicited editorials are also considered for publication.

- **Notes From the Field** . Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.
- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

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Production Questions:

Jackie Beggins

E-mail: jbeggins@wiley.com

Appendix E: Confirmation of Ethical Approval

REMOVED FOR HARDBINDING

Appendix F: Confirmation for Ethical Approval – Procedural Amendment

REMOVED FOR HARDBINDING

Appendix G: Data Extraction Form

Study Title:

General

Author(s)
Year of Publication
Peer Reviewed
Research Aims
Research Design
Country of Study

Participants

Gender
Age
Immigration Status
Trauma Status
Countries of Origin
Sample Size

Intervention

Name/title
Duration
Actually experienced
Mode of Delivery (who/how)
Description of Content

Outcomes

Measurement of 'experience'
Qualitative/Quantitative Technique
Other outcomes measured
When measured
Key findings

Conclusions (of Authors):

Notes from Review:

Quality Score:

Appendix H: Quality Assessment Checklist

Study Identification: (APA 6 th Reference)	
CRITERIA (Scoring System: 2 = Yes, 1= Partially, 0 = Not/Not Reported, N/A if not applicable to study)	SCORE
Section 1: Theoretical Approach	
1.1. Is the study clear in what it seeks to do? → Is the purpose of the study discussed – aims/objectives/ research question/s? → Is there adequate/appropriate reference to the literature? → Are underpinning values/assumptions/theory discussed?	
1.2. Are the main outcomes to be measured clearly described in the Introduction or Methods section?	
Section 2: Study Design	
2.1. Is a qualitative approach appropriate? (Qualitative studies only) → 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?	
2.2. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)? (Mixed Methods studies only)	
2.3. How defensible/rigorous is the research design/methodology? → Is the design appropriate to the research question? Is a rationale given for using a qualitative/quantitative/mixed 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?	
Section 3: Data Collection	
3.1. How well was the data collection carried out? → 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?	
3.2. Is the context clearly described? → Are the characteristics of the participants and settings clearly defined? → Were observations made in a sufficient variety of circumstances? → Was context bias considered?	
3.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)? (Quantitative/Mixed Methods studies only)	
3.4. Is there an acceptable response rate (60% or above)? (Quantitative/Mixed Methods studies only)	
Section 4: Validity/Reliability	
4.1. Were the methods reliable? (Qualitative/Mixed Methods studies only) → 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?	

<p>4.2. Is the analysis reliable? (Qualitative/Mixed Methods studies only)</p> <ul style="list-style-type: none"> → Did more than one researcher theme and code transcripts/data? If so, how were differences resolved? → Did participants feedback on the transcripts/data if possible and relevant? 	
<p>4.3. Were the subjects asked to participate in the study representative of the entire population from which they were recruited?</p> <ul style="list-style-type: none"> → The study must identify the source population for patients and describe how the patients were selected. → Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. → Random sampling is only feasible where a list of all members of the relevant population exists. → Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine. 	
<p>4.4. Were those subjects who were prepared to participate representative of the entire population from which they were recruited?</p> <ul style="list-style-type: none"> → The proportion of those asked who agreed should be stated. → Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population. 	
<p>4.5. Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive?</p> <ul style="list-style-type: none"> → For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. → The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend. Internal validity - bias 	
<p>Section 5: Analysis</p>	
<p>5.1. Is the data analysis sufficiently rigorous? (Qualitative or Mixed Methods studies only)</p> <ul style="list-style-type: none"> → 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? 	
<p>5.2. Is the data 'rich'? (Qualitative or Mixed Methods studies only)</p> <ul style="list-style-type: none"> → 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? → Are responses compared and contrasted across groups/ sites? 	
<p>5.3. Are the findings convincing? (Qualitative or Mixed Methods studies only)</p> <ul style="list-style-type: none"> → Are the findings clearly presented? → Are the findings internally coherent? → Are extracts from the original data included? → Are the data appropriately referenced? → Is the reporting clear and coherent? 	
<p>5.4. Are the findings relevant to the aims of the study?</p>	
<p>5.5. Conclusions</p> <ul style="list-style-type: none"> → How clear are the links between data, interpretation and conclusions? → Are the conclusions plausible and coherent? → Have alternative explanations been explored and discounted? 	

<ul style="list-style-type: none"> → Does this enhance understanding of the research topic? → Are the implications of the research clearly defined? → Is there adequate discussion of any limitations encountered? 	
<p>5.6. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)? (Mixed Methods studies only)</p>	
<p>5.7. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative? (Mixed Methods studies only)</p>	
<p>5.8. Are the main findings of the study clearly described? (Quantitative or Mixed Methods studies only)</p> <ul style="list-style-type: none"> → Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below) 	
<p>5.9. Were the statistical tests used to assess the main outcomes appropriate? (Quantitative or Mixed Methods studies using statistics only)</p> <ul style="list-style-type: none"> → Non-parametric methods should be used for small sample sizes. → Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. → If the distribution of the data (normal or not) is not described it must be assumed that the estimates used were appropriate and the question should be answered yes. 	
<p>5.10. Have actual probability values been reported? (Quantitative or Mixed Methods studies using statistics only)</p>	
Section 6: Ethics	
<p>6.1. Is the role of the researcher clearly described?</p> <ul style="list-style-type: none"> → Has the relationship between the researcher and the participants been adequately considered? → Is the influence of the researcher on the research, and vice-versa, addressed? → Does the paper describe how the research was explained and presented to the participants? 	
<p>6.2. Is there a statement locating the researcher culturally or theoretically?</p>	
<p>6.3. How clear and coherent is the reporting of ethics?</p> <ul style="list-style-type: none"> → 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? 	

Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of epidemiology and community health*, 52(6), 377-384. doi: 10.1136/jech.52.6.377

Joanna Briggs Institute. (2016). Critical appraisal tool: Checklist for qualitative research. Retrieved from <http://joannabriggs.org/research/critical-appraisal-tools.html>

National Institute for Health and Care Excellence (2012). *Methods for the development of NICE public health guidance (3rd Ed.)*. London: Author. Retrieved from: <https://www.nice.org.uk/article/pmg4/resources/non-guidance-methods-for-the-development-of-nice-public-health-guidance-third-edition-pdf>

Pluye, P., Gagnon, M. P., Griffiths, F., & Johnson-Lafleur, J. (2009). A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in Mixed Studies Reviews. *International Journal of Nursing Studies*, 46(4), 529-546. doi:10.1016/j.ijnurstu.2009.01.00(merged)

Appendix I: Quality Assessment: Breakdown of individual scores for each checklist item* and total scores and percentages

Study	Checklist Item Number																							Total Score	Max Score	Percentage %					
	1.1	1.2	2.1	2.2	2.3	3.1	3.2	3.3	3.4	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4	5.5	5.6	5.7	5.8	5.9				5.10	6.1	6.2	6.3	
Bernardes et al. (2010)	2	2	NA	2	2	2	2	2	2	2	2	1	1	2	2	1	2	2	2	2	0	2	2	2	2	2	2	2	45	52	87%
Halcón et al. (2010)	2	2	NA	2	1	2	1	1	2	1	0	1	1	0	0	0	1	1	1	1	0	1	NA	NA	1	0	2	25	48	52%	
Jensen et al. (2014)	2	2	2	NA	2	2	1	NA	NA	2	2	1	1	2	2	2	2	2	2	NA	NA	NA	NA	NA	2	2	2	35	38	92%	
Kaltman et al. (2016)	2	2	NA	2	1	2	2	2	2	2	2	1	1	2	1	1	1	2	1	2	1	2	2	2	1	0	1	40	52	77%	
Kaltman et al. (2014)	2	2	NA	2	2	2	2	2	2	2	2	1	1	2	2	2	2	2	2	2	1	2	0	2	1	1	1	44	52	85%	
Madsen et al. (2016)	2	2	2	NA	2	2	2	NA	NA	1	2	1	1	1	2	2	2	2	2	NA	NA	NA	NA	NA	2	2	2	34	38	89%	
Maier & Straub (2011)	2	2	2	NA	2	2	2	NA	NA	1	0	1	2	0	2	2	2	2	2	NA	NA	NA	NA	NA	1	1	2	30	38	79%	
Majumder et al. (2015)	2	1	2	NA	1	2	2	NA	NA	1	1	1	1	1	2	1	2	2	2	2	NA	NA	NA	NA	NA	0	0	1	25	38	66%
Mirdal et al. (2012)	2	2	2	NA	1	2	2	NA	NA	2	2	1	0	1	2	1	1	2	2	NA	NA	NA	NA	NA	1	0	1	27	38	71%	
Praetorius, et al. (2016)	2	2	2	NA	2	2	2	NA	NA	2	2	2	1	1	2	1	2	2	2	2	NA	NA	NA	NA	NA	0	0	1	30	38	79%
Silove et al. (1995)	1	2	NA	NA	0	1	1	2	2	NA	NA	1	1	1	0	0	1	2	2	NA	NA	2	NA	NA	0	0	0	19	38	50%	
Silove et al. (1997)	2	2	NA	NA	1	1	1	2	2	NA	0	1	1	2	0	0	0	1	2	NA	NA	2	2	2	1	0	1	26	42	62%	
Singer & Adams (2011)	2	2	2	NA	1	2	1	NA	NA	1	1	1	1	0	1	2	2	1	1	NA	NA	NA	NA	NA	1	0	1	23	38	61%	
Slewa-Younan et al. (2014)	2	2	NA	NA	1	1	2	2	2	NA	NA	1	1	NA	NA	NA	NA	2	2	NA	NA	2	2	2	0	0	1	25	34	74%	
Stade et al. (2015)	2	2	NA	2	2	2	2	2	2	2	2	1	0	1	2	2	2	2	2	2		2	2	2	2	1	1	44	52	85%	
Strijk et al. (2010)	2	2	NA	2	1	1	2	2	1	1	0	1	1	0	1	2	2	2	2	2	1	2	NA	NA	1	0	0	31	48	65%	
Vincent et al. (2012)	2	2	2	NA	2	2	2	NA	NA	2	2	1	1	2	2	2	2	2	2	NA	NA	NA	NA	NA	2	1	1	34	38	89%	
Yaser et al. (2016)	2	2	NA	NA	1	2	2	2	2	NA	NA	1	1	NA	NA	NA	NA	2	2	NA	NA	2	2	2	1	2	2	30	34	88%	

*NA = Item not applicable to study methodology

Appendix J: Example Recruitment Poster

RECEIVE £20 FOR TAKING PART IN A RESEARCH STUDY

Project Title: Experiences of Interpreters working in Mental Health

Settings

Are you from a 'non-Western' (e.g. Middle Eastern, African or Asian) country/culture?

•

Do you live in Hull or the East Riding of Yorkshire?

Are you a spoken-language interpreter working in a mental health setting?

•

Do you have experience working with service-users and mental health professionals?



If the answer is **yes** to all of these questions you might be eligible to take part in a study exploring the experiences of interpreters working in mental health settings.

This is a research project which aims to help identify any needs interpreters may have when working in a mental health setting, to potentially benefit the future running of interpreting services and improve provided support.



You will be offered £20 for completing an interview as part of this study

(lasts approximately 1.5hrs)

For more information or if you are interested in taking part please contact

Claudia Myler:

Phone: REMOVED FOR BINDING

or e-mail

c.myler@2014.hull.ac.uk

Department of Psychological Health and Wellbeing
Faculty of Health and Social Care

Appendix K: Participant Information Sheet



Title of Project: Experiences of Interpreters working in Mental Health Settings

*We would like to invite you to take part in a research study. Before you decide on whether you would like to participate, we would like you to understand why the research is being carried out and what it would involve for you. **Please read the information below. If you have any questions please ring the number at the end of this form.***

Background

There are an increasing number of asylum seekers and refugees coming into the UK, and Hull, experiencing psychological distress from the backgrounds they have come from. Many of these individuals require support from mental-health services to help with their distress; however the clinical workforce is not always skilled in meeting these individuals' language needs. There is an increasing need for interpreters to attend mental health appointments with the service-user, in order for it to be beneficial and useful for the individual.

Though there has been research on how working in a mental health setting may affect the health professional, there has been little research done into how experiences of mental health work affects the *interpreter*.

What is the purpose of the study?

This study aims to explore the experiences of interpreters working in mental health settings. We hope this will help us to better understand how this work affects the interpreter, how the interpreters already manage any emotional impact, and whether there is any need for change in the current running of interpretation services or improvement in the level of support provided.

Why have I been invited?

You have been invited to take part because you contacted us after seeing our advertisements for the study. You are an interpreter who works, or has

previously worked in, a mental health setting in the UK. You live in Hull or the East Riding, and have some experience of working in a mental health setting with a service-user and a clinician.

Do I have to take part?

No, it is up to you to decide whether or not you want to take part. This information will tell you what is involved in the study and then whether or not you take part is up to you.

What will happen if I decide to take part?

After deciding to take part, it is asked if you could please get in touch with the research team via phone or e-mail to arrange an interview appointment. The time and location of the interview will be arranged to conveniently fit with your schedule as best as possible.

After arranging the appointment, you will be asked to complete some forms relevant to the study. If you do not have time to do this, or forget to do so before your appointment, there will be another opportunity for you to fill these out.

The consent form will ask you to sign to confirm you understand the purpose of the study and are willing to take part. We will also ask you to confirm if we can record the interview, so the researcher can analyse what everyone has said in depth to ensure the report is accurately representing your views. Once recorded, your data will be kept securely and anonymously, and only used by the research team in order to analyse and write up the data. You unfortunately cannot be interviewed if you do not consent to being recorded.

At the appointment, after being given the opportunity to ask any further questions about the study and filling out the above paperwork, you will first be given a form asking you to fill out some basic information about yourself, for example your age, gender, years of working as an interpreter, years living in the UK etc.

After this, you will be interviewed by one of the research team, who will ask questions about your experiences of mental health interpreting. There are no right or wrong answers – the purpose of this study is to understand the reality of what you experience in your work, and its effect on you. The interview is likely to last 60 – 90 minutes.

After the interview, there will be one more questionnaire to help the researcher understand more about how you, your culture and your community perceive / think about mental health problems.

Following this, there will be time for you to ask any further questions and/or discuss how the interview was for you. This is similar to the 'debriefing' time you may have with a clinician after a session.

We have a limited amount of participants that we can interview due to time constraints, so we ask that any individual interested in taking part has confirmed by **Tuesday 28th February, 2017**. If the maximum number of participants has been reached before then, the cut-off date will be sooner.

What are the possible disadvantages and risks of taking part?

Taking part in the study has minimal risk associated with it and we anticipate that it will be like you are having 'debriefing' with a clinician you work with. We understand that the amount of time you are talking about your experiences is much longer than you may be used to, and some of the experiences you discuss may bring up difficult emotions. If at any point during the study you feel unable to continue, you are free to stop or take a break, and we can discuss how we can find further support to help you feel more able to manage.

We also ask that, as you would in your profession anyway, to keep patient confidentiality and to not use any names of service-users when explaining any work done with them. Though it will be agreed that whatever you say in the interview is confidential between you and the research team, this is only if there is no concern that you or someone else is not at risk of harm. You will be informed that if anything you say brings up any concern about your wellbeing, practice or the practice of any staff involved with service-users, the researcher will have to follow safeguarding policy and procedure which may involve breaking the confidentiality of the interview content. If such an issue arises, this will first be discussed with you and the next steps will be explained.

Unfortunately we will be unable to reimburse travel expenses if you have not travelled specifically for the interview appointment.

What are the possible benefits of taking part?

We hope that you will find the study a good opportunity to talk more in depth about your experiences of interpreting in a mental health setting and

how it impacts on you. By taking part and helping us understand your experiences, this could potentially highlight any areas for improvement in the running of interpretation services, for example in training, supervision, or general support provided. Additionally, there is a multitude of research suggesting that when staff involved with service-users feel more supported and satisfied in their job-role, this can have benefits for the wellbeing of the service-users, as well as colleagues.

What will happen if I decide I no longer wish to take part?

If after reading this information sheet you decide not to take part, you do not need to do anything. We will contact you to check whether or not you want to take part but if you do not want to, just tell us and we won't contact you again.

If you attend the interview appointment, and after asking further questions and filling out the paperwork you then decide not to be interviewed, you simply need to tell us and you can leave, however you will only be reimbursed for travel if you have travelled specifically for the appointment, and not given the £20 we offer for taking part in the interview. Any paperwork you have filled out will be destroyed.

If you decide to be interviewed, but any point during the interview you wish not to continue anymore, you are free to stop by telling the interviewer, and you will still receive the £20. If you want us to, we will destroy your data including any recording. You can still opt to finish the interview, and have your data kept in the study and analysed – we understand that for some people, difficult emotions might be stirred by talking about your experiences, and it is perfectly reasonable to finish on your terms.

After completing the interview, and you later decide you no longer wish your data to be included in the study, we will destroy your data. This will only be possible up to the point when we start analysing the findings of the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the researcher's supervisors (contact details are noted at the end of this form).

Will my taking part in this study be kept confidential?

All data will be handled according to ethical and legal practice. All information which is collected about you during the course of the research will be made anonymous. We will give you a code number at the start of the study and all your questionnaires will have this code number on them rather than your name. We will keep the list of code numbers separate from the questionnaires to ensure the anonymity of your results.

If you take part in an interview we will record the interview but we will destroy the recording as soon as we have typed up the interview. We will make sure that the typed up interviews are anonymous.

All the coded data we collect during the study will be stored securely on University Departmental premises for ten years after completion of the study.

What will happen to the results of the study?

The results will be written up and submitted as part of a doctoral thesis written by the researcher Claudia Myler, who is completing training as a Clinical Psychologist.

The results will also be submitted for publication in a scientific journal. Direct quotes from your interview may be used in the publication of the results of the study but we will make sure that any quotes we use would not identify you so no-one would know they came from you. We can also send you the overall results of the study if you would like.

Who is organising the research?

This research is being undertaken at the University of Hull as part of a doctoral thesis written by Claudia Myler, who is completing training as a Clinical Psychologist.

Who has reviewed the study?

All research is looked at by independent group of people, called an ethics committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed by the Faculty of Health and Social Care's ethics committee and been given approval to proceed.

Further information and contact details

If you have any further questions or queries, please contact Claudia Myler. Her number is: REMOVED FOR BINDING or you can email her on c.myler@2014.hull.ac.uk

The supervisors of this project are:

Dr Tim Alexander, Research Co-Ordinator, Dept. of Psychological Health & Wellbeing, University of Hull

Email address: t.alexander@hull.ac.uk

Contact telephone number: REMOVED FOR BINDING

Dr Philip Molyneux, Clinical Practice Co-Ordinator, Dept. of Psychological Health & Wellbeing, University of Hull

Email address: p.molyneux@hull.ac.uk

Contact telephone number: REMOVED FOR BINDING

Appendix L: Participant Consent Form



Title of Project: Experience of interpreters working in mental health settings

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 10/03/2016 for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason up to the point of data analysis.

3. I agree to take part in the interview part of the study and understand that my interview will be audio recorded.

4. I confirm that direct quotes from the interview may be used in future publications and understand that they will be anonymised.

Name of participant

Date

Signature

Name of researcher

Date

Signature

INFORMATION ABOUT YOU

Please answer the following questions:

Participant number:..... (FOR RESEARCHER USE)

1. What is your age in years?.....

2. What is your gender? Male Female please tick

3. Country and/or Culture of Origin (please state, and if applicable, include details of any other Countries/Cultures that you have been part of prior to coming to the UK):

4. Approximately how long have you lived in the UK? (please state)

5. Religion: No religion Buddhism
 Christianity Hinduism
 Judaism Islam
 Sikhism
 Other (please state):

6. Number of languages spoken (including English):

- 2
- 3
- 4
- 5+

Please list the names of the languages:

7. Approximately how long have you worked as an interpreter (please state, and if applicable specify if as a paid professional or as a volunteer):

8. Please tick the option that best describes your training to be an interpreter:

- Formally trained
- Short course
- None

Please provide further details of your training if applicable:

9. Which work settings have you worked in / do you currently work in? (Please note next to the box whether you work in this setting currently or previously, and approximately for how long)

- Mental health services _____
- Social services _____
- Refugee services _____
- Medical Services _____
- Legal Services _____
- Charities _____
- Other (please state) _____

10. Approximately how many service providers have you worked with in a mental health setting? (Please state)

11. Approximately how many service-users have you worked with in a mental health setting? (Please state)

Thank you for completing this form.

Appendix N: Interview Schedule

1. How would you define an interpreter and the role they play in a mental health setting?
2. Can you tell why you chose this job? Were there particular reasons or motivations?
3. Tell me about your experiences of being an interpreter in mental health settings, a good and a bad example?
4. Describe to me the joys and challenges of your work as a mental health interpreter.
5. How do your experiences of working in mental health settings compare to other settings you have worked in?
6. Tell me about a situation where you have been affected by a service-user's story. Please remember to keep their identity anonymous to maintain confidentiality;
Prompts: How did you feel/think about them and their emotions? How/what did you feel/think about the therapist? How/what did you think about yourself and your emotions?
7. What are your different experiences working with different types of clients?
Prompt: For example, working with an adult compared with working with a child?
8. Do you use 1st or 3rd person when you interpret in a Mental Health setting?
Prompt: How do you think yours and the service-users experiences of therapy may differ between the two approaches?
9. Has there been an emotional demand in your work? If so...
 - How has your training impacted on your ability to manage the emotional content of mental health interpreting?
10. How have you managed confidentiality in this role?
Prompt: For example, adhering to guidelines, knowing the service-user outside of the therapeutic setting etc.
11. What are your experiences of the power dynamics in the working triad during therapeutic sessions?
Prompt: What are your thoughts on how you are valued as a professional in your own right in this setting?
12. What support do you receive?
 - If support is received, how much does it help you manage any distress you have felt during/after a session?
13. What does the word 'compassion' mean to you? –
Prompt (if the interpreter reports they do not know what compassion is):
Gilbert's Definition: Compassion involves being open to the suffering of self and others, in a non-defensive and non-judgemental way. Compassion also involves a desire to relieve suffering, [thoughts] related to understanding the causes of suffering, and behaviours – acting with compassion.
 - Does it have any relevance to your role?

Appendix O: Attitudes towards Mental Health Problems Scale and Scoring Instructions (Gilbert, 2007)

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Appendix P: Sources of Support Sheet



If during/after completion of the study you experience any emotional distress, please contact:

Dr Jennie Ormerod (Consultant Clinical Psychologist) if you provide interpretation services for Humber Traumatic Stress Service

OR

Ms Jackie Wright (Manager of Haven Project) if you provide interpretation services for The Haven Project

Please liaise with Jennie or Jackie to arrange an appointment to give you the time to discuss any difficulties that have become apparent to you following participation in this study. They can either provide, or signpost you towards support to relieve any distress you are experiencing.

You can also contact your GP for advice.

If you have any specific issues that taking part in the study has raised you can contact the research team:

Claudia Myler

c.myler@2014.hull.ac.uk

Phone: REMOVED FOR HARDBINDING

If you wish to complain formally, you can do this through the Associate Dean for Research in the Faculty of Health and Social Care, University of Hull:

Professor Mark Hayter

m.hayter@hull.ac.uk

Phone: REMOVED FOR HARDBINDING



Receipt of Payment for Participation

I, _____
confirm that I have received £20.00 cash from
Student Investigator, Claudia Myler, as payment
for taking part in her research study
investigating: **“Experiences of Compassion for
Interpreters working in Mental Health Settings”**

Participant Signature:

Date:

CLAUDIA MYLER

Trainee Clinical Psychologist

Appendix R: Excerpt of Transcript and Example Analysis

Bold text: Interviewer speech

Normal text: Participant 4 speech

Emergent Theme	Transcript	Exploratory Comments
<p>Being the service-user's voice Not adding extra Inner conflict Interpreters are human too</p>	<p>So how would you define an interpreter and the role that they play in a mental health setting?</p> <p>We try to be as a voice, that's supposed to be as a voice, not to involve with anything, but still we are human being</p> <p>Mhmm</p>	<p>Being the service-user, not adding anything but conflict of own emotions making things difficult.</p>
<p>Emotional burden from client</p>	<p>We listen to things and we hear people's problem and this sometimes causes lots of problem for ourself</p> <p>Yeah</p>	<p>Distress of others upsetting, emotional burden of the work, concern for own wellbeing.</p>
<p>Professional qualification = resilience Interpreters not offered same privileges as professionals Experience = resilience Exposure builds up tolerance</p>	<p>And we supposed to leave our... most of you here train not to take problem with you, to home. At the beginning for me it's very very difficult but I started to get used to it when I be at that many problems from other peoples, but sometimes you can't help it</p> <p>Yeah</p>	<p>'Supposed to' – how can anyone expect us to do this? Lack of training, why are we not supported when handling exactly the same content, if not more when being the actual voice. Gets easier over time, with experience. Experience makes up for lack of training. Can't help being human.</p>
<p>Vulnerable service-users</p>	<p>You can't help it, because they are... at the beginning I start working with the err ORGANIZATION you know with the asylum seekers</p>	<p>The types of service-user bring big emotional burden cannot help being affected, impossible not to be.</p>

<p>Untrustworthy service-users Scepticism of those applying for asylum Influence of other settings</p> <p>Credibility of service-user's stories</p> <p>Legalities of the UK asylum system Desperation of asylum seekers Traumatic journey to the UK</p> <p>Being service-user's voice Losing own identity Avoiding connection with service-user</p>	<p>Mhmm</p> <p>I had that many people apply for asylum some of them are just genuine some of them are not genuine, because I used to work with legal side as well</p> <p>Okay</p> <p>So I knew whenever I hear during the mental health issues things like some of them exaggerating and some of them not exaggerating</p> <p>Yeah</p> <p>That's what I used to get much affected by, but by working for long time, and knowing people from inside, even the one that has come to this country they are not genuine asylum seeker, you find out that many things happen to them while they're travelling from their own country to here, so they been attacked, and they've been through lots of things during their journey</p> <p>Yeah</p> <p>So we try to be as a voice, but being a voice it's just not practical, we try not to eye contact, from my side, I'm talking about myself I try not to eye contact with the client</p>	<p>Scepticism, influence of other settings on mental health settings and beliefs. Division, 'them' – separation. Conflicting roles between settings?</p> <p>Scepticism of stories, influence of legal system, conflict in beliefs, own beliefs about client influencing role?</p> <p>Sense of justice impacting beliefs? What constitutes 'genuine' – story of the traumatic journey emotionally moving.</p> <p>Being a voice goes against natural human nature. Eye contact – coping? Avoiding makes it easier to detach?</p>
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