SOFIA WEIDENBACH GERBASE

EXPERIENCES OF SERVICES AND FAMILY THERAPY WITH REFUGEES AND ASYLUM-SEEKERS

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Mãe e pai, obrigada. Vocês são o meu exemplo. I would not be here without you and the opportunities you gave us.

Summary of the MRP portfolio

Section A

A review of the literature on refugees' and asylum seekers' experiences of Western mental health services and psychological therapies. Findings outlined barriers and facilitators to engagement, hopes and anticipations, and the limits of services. Conclusions suggest that psychosocial interventions which adopt pluralistic understandings of distress beyond Western diagnostic frameworks and engage the wider community and socio-political contexts should be prioritised. Psychological interventions which emphasise talking through traumatic events may be experienced as less helpful. Future research should explore current systemic family therapy practice with people from refugee and asylum-seeking backgrounds.

Section B

A qualitative study exploring how conversations about trauma emerge in systemic family therapy with families from refugee and asylum-seeking backgrounds. Ten clinicians using systemic family therapy were interviewed. Data were analysed using grounded theory methodology. Findings suggested that therapists aimed to develop an open space where new conversations could emerge, outlining attending to several factors which might enable families to feel 'readier' to speak. Incorporating narrative and liberation approaches, therapeutic work centred on the re-establishment of meaning. This study adds to the paucity of research investigating systemic approaches with families from refugee and asylum-seeking backgrounds, and has implications for future research and clinical practice.

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Section A

Refugees' and asylum-seekers' experiences of Western mental health services and psychological therapies

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Abstract

To date, the mental health of refugees and asylum-seekers has primarily been captured through the diagnosis of post-traumatic stress disorder (PTSD). There is increasing recognition that the medicalisation of distress in this way can be unhelpful for this client group, whose difficulties are so closely associated to social and political factors. Psychosocial approaches have therefore been advocated as more helpful. However, service users' views have seldom been considered in this debate. This review aimed to explore refugees' and asylum seekers' experiences of Western mental health services and psychological therapies. A systematic search of five electronic databases and relevant reference lists identified 18 papers which qualitatively explored service users' views. Services and interventions which imposed Western diagnostic conceptions of distress and prioritised talking through difficulties without addressing wider social factors were experienced as unhelpful. It may be important for future research to explore alternative intervention models that are better suited to addressing the wider context and that avoid imposing Western frameworks by working with clients' meanings.

Key words: refugee; asylum seeker; mental health services; service user experience

Introduction

> "You've got a swarm of people coming across the Mediterranean, seeking a better life, wanting to come to Britain because Britain has got jobs, it's got a growing economy, it's an incredible place to live – but we need to protect our borders" David Cameron (2015)

History has shown that times of economic hardship can fuel social exclusion and persecution, and the current economic climate has seen an upsurge in xenophobic and anti-immigration sentiment throughout Europe, which has been argued to have had a bearing on Britain's decision to leave the European Union (Golec de Zavala, Guerra, & Simão, 2017; Nougayrède, 2016). Damaging political rhetoric and societal discourses have at times vilified asylum seekers, obscuring the fact that these are people fleeing war and persecution in search of safety (Bidisha, 2015; Georgiou & Zaborowski, 2017).

The United Nations High Commissioner for Refugees (UNHCR) estimates 28,300 people a day are forced from their homes due to conflict and persecution. The end of 2015 saw a record 65.6 million forcibly displaced people worldwide. Most came from South Sudan, Afghanistan, and Syria (UNHCR, 2015). The 1951 United Nations Convention on the Status of Refugees defines a refugee as a person who:

> "…owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country…"

Asylum seekers are defined as people who have claimed asylum under the 1951 United Nations Convention on the Status of Refugees. Refugees are defined as people whose application for asylum has been successful. The UNHCR estimates that in 2015, there were 123,067 refugees, 45,870 asylum seekers, and 41 stateless persons in the UK (UNHCR, 2015).

Service provision and meeting mental health needs

The rising number of displaced people worldwide in recent years has been increasingly recognised as a key global public health issue (Siriwardhana, Sheikh Ali, Roberts, & Stewart, 2014). Concurrently, the significant psychological distress that can be associated with the refugee and asylum seeker condition has posed a challenge for mental health services in host countries aiming to meet the needs of this population (Llosa et al., 2014; Vostanis, 2014). Pre-migration factors and challenging journeys, in combination with difficulties associated with resettlement (Pernice & Brook, 1996; Steel et al., 2009; Tribe, 2002) mean refugees and asylum seekers can experience increased rates of psychological distress compared to people from non-refugee backgrounds (Porter & Haslam, 2005; Silove, Ventevogel, & Rees, 2017; Steel et al., 2009).

However, research has shown a lack of uptake of services in this population, suggesting a mismatch between services offered and refugees' and asylum seekers' needs; barriers to service access may not yet be fully understood (Colucci, Minas, Szwarc, Guerra, & Paxton, 2015; Ellis, Miller, Baldwin, & Abdi, 2011). It is known that people from ethnic minorities underutilise mental health services (Ellis et al., 2010; Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006). Vostanis (2014) outlines

that services working with refugees and asylum-seekers have failed to address issues like stigma, language barriers, transport, and a lack of integration between agencies. Indeed, working with transitional populations can pose additional challenges to mental health services. Service users from refugee and asylum-seeking backgrounds may present with psychosomatic difficulties, which might differ from the usual referrals services are accustomed to addressing (Tribe, 2002; Vostanis, 2014), and the experience of talking to mental health professionals about feelings may feel alien or culturally incongruent (Tribe, 2002). The heterogeneity of refugee and asylum-seeking populations can also make meeting the needs of this population particularly challenging (Vostanis, 2014), and clients can present with additional complex social needs.

Critiques of current practice

To date, the 'medical model' has been the main theoretical approach to refugee mental healthcare and research, and psychological distress has mainly been captured through the diagnosis of post-traumatic stress disorder (PTSD) (Papadopoulos & Hildebrand, 1997). The National Institute for Health and Care Excellence (NICE, 2005) recommends screening all refugees and asylum seekers for PTSD. Individualised trauma-focused cognitive behavioural therapy (CBT) approaches and Eye Movement Desensitisation and Reprocessing (EMDR) are recommended for PTSD treatment in the general population, but treatment guidelines do not specifically address people from refugee and asylum-seeking backgrounds (NICE, 2005).

A principal critique of refugee mental healthcare has centred on the diagnostic-led approach adopted by Western mental health services, which locates

deficit within the individual (Bhugra, Craig, & Bhui, 2010; Watters, 2001). Opponents argue that medicalised service provision may not be appropriate for the unique refugee experience, as it can pathologise normal reactions to war, loss and displacement (De Haene, Rober, Adriaenssens & Verschueren, 2012). Summerfield (1999) has critiqued the application of PTSD to non-Western people who have experienced extreme events, arguing that this reflects a medicalisation of distress, which benefits Western agencies, perpetuating a colonial position. Indeed, there is "the possibility that the Western trauma discourse imported into communities socioculturally devitalised by war might impair their struggle to reconstitute a shared sense of reality, morality and dignity" (Summerfield, 1999: p. 1458).

Additionally, given that NICE guidelines underlying individualised psychological interventions for PTSD are based on research with Western populations, it is questionable whether these recommendations can be applied to refugee populations (NICE, 2005). Refugees and asylum seekers have different cultural backgrounds and may have experienced ongoing trauma of a different intensity and severity, perhaps beyond that which has been researched. Indeed, recent studies have highlighted the limited efficacy of EMDR and CBT for PTSD with refugee populations (Nosè et al., 2017; Tribe, Sendt, & Tracy, 2017). NICE (2013) concede further research is required to evidence the efficacy of trauma-focused psychological approaches with people from refugee backgrounds.

At a broader level, it has been argued that the application of psychological therapies outside their original white, middle class, and European setting is limited (Liu, Pickett, & Ivey, 2007; Littlewood, 1990). Evidence suggests that therapy is less beneficial to people from lower socio-economic backgrounds (Falconnier, 2009), and

service users from minority backgrounds are more likely to prematurely terminate therapy (Organista, Muñoz, & González, 1994). There is also a concern that the medicalisation of inherently social problems aids national and international communities to avoid the responsibility of addressing social causes to these problems (Ager, 1994).

Towards psychosocial understandings

The important association between the socio-political context of the refugee experience and mental health has been highlighted (Porter & Haslam, 2005) and strong associations exist between psychiatric diagnoses and social class, gender, marital status, and ethnicity (Thornicroft, 1991). Refugees and asylum seekers have often experienced persecution, conflict, displacement, and extreme life events, often living in uncertainty due to their transitory status (Fazel, Wheeler, & Danesh, 2005). Psychosocial theories of psychological wellbeing among refugees have been proposed as a more helpful alternative to medical understandings and diagnostic-led individualised psychological approaches. Based on Maslow's hierarchy of needs (1970), Ryan, Dooley, and Benson (2008) propose a resource-based model of migration, understanding wellbeing as dependant on personal, material, social and cultural resources. Research supports this model, demonstrating the central impact of ongoing social conditions and daily stressors on the wellbeing of refugees (Silove et al., 2017).

The central influence of the socio-political context on refugees' and asylum-seekers' wellbeing can challenge existing Western models of mental healthcare, including psychological models and interventions (Tribe, 1999), as these often

individualise problems, detaching people from their contexts. Though recent policies have promoted the integration of health and social care (Humphries, 2015), mental health services focusing on individual medicalised models of care may struggle to meet the wider social needs of this population. The lack of uptake of services in this population suggests there might be a mismatch between what is being offered and what might best meet service users' needs. At the heart of this lies a fundamental lack of knowledge about what service users from refugee and asylum-seeking backgrounds would find most helpful from mental health services.

Objectives

This review aims to systematically review the literature which qualitatively explores refugee and asylum seekers' beliefs and experiences of mental health services and psychological therapies to answer the following questions:

1. What does the literature tell us about refugees' and asylum seekers' beliefs and experiences of mental health services in general, and psychological therapies specifically?
2. What are the barriers and facilitators to access to services and engagement with therapies?

Method

Eligibility criteria

This review aimed to identify qualitative studies exploring the views of service users from refugee and asylum-seeking backgrounds on Western mental health

services. Mental health services were defined as services comprising practitioners whose roles include assessment, treatment, and support for people experiencing emotional distress (Valibhoy, Kaplan & Szwarc, 2017). Data reporting was guided by PRISMA statement recommendations (Moher, Liberati, Tetzlaff, Altman, & Group, 2009). The search was restricted to studies using qualitative methodology, as these are known to capture rich accounts, giving voice to those less heard by society, and might be less restricted by Western conceptions of distress (Taylor, DeVault, & Bogdan, 2015). Studies using mixed methods were included, but only qualitative results were analysed.

The following inclusion criteria were applied: (a) written in English; (b) including original qualitative data outlining participants' hopes or experiences of mental health services; (c) including participants who were currently using services or who had used services in the past. Exclusion criteria were: (a) review articles; (b) opinion pieces; (c) studies in which refugees or asylum seekers did not represent at least 50% of the sample; (d) studies where refugees' or asylum seekers' views were indistinguishable from views of other participants (e.g. economic migrants); (e) services where the service context was not one primarily focused on mental health (e.g. general practice) (f) studies investigating new interventions not routinely delivered by mental health services.

Search strategy

A systematic search of the literature was conducted in order to identify all relevant papers. Electronic searches were conducted using PsycInfo, Medline, Web of

Science, Applied Social Sciences Index and Abstracts (ASSIA), and Cumulative Index of Nursing and Allied Health Literature (CINAHL).

Table 1. Search strategy

Strategy	#1 AND #2 AND #3 AND #4
#1	[refugee* OR asylum]
#2	[attitude* OR opinion* OR belief* OR experienc* OR perception* OR expect* OR engage* OR disengage* OR barrier* OR preference* OR choice*OR choose OR perspective*]
#3	[mental* OR psych* OR treatment* OR therap* OR intervention*]
#4	[qualitative* OR interview* OR open question* OR focus group* OR participant observation* OR participatory research OR mixed method*]

Note. * represents a wildcard.

Searches were limited to studies written in English and published in peer-reviewed journals. Search terms were chosen following an exploration of search terms used in similar reviews with different populations. The term 'migrant' was included in initial searches but was subsequently excluded as it primarily yielded papers focusing on economic migrants and did not generate any additional papers not already targeted by the terms 'refugee' and 'asylum'. Reference sections of included studies were screened for additional relevant literature.

Figure 1 depicts a flowchart outlining the search process in detail. Eighteen papers were included as a result of this process. A total of 1,558 articles were identified in the initial search, of which 408 were duplicates and excluded. An additional 13 articles were identified through reference searching. Of the remaining 1,163 articles, 1,119 were excluded following title and abstract review. In total, 44 full text articles were screened for inclusion: 26 were excluded, yielding a total of 18 articles for inclusion in this review.

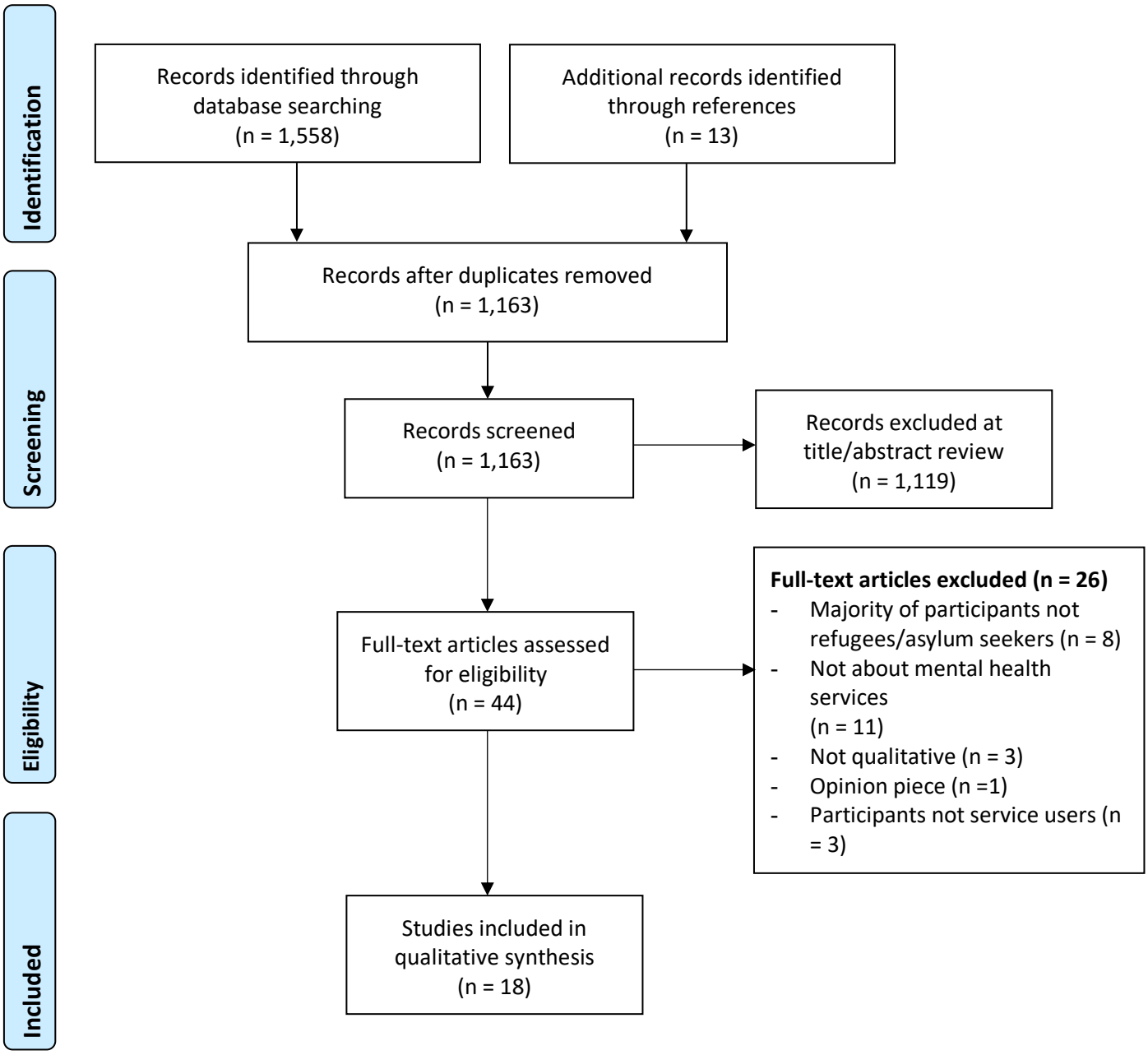

Figure 1. PRISMA flow chart of search process. (PRISMA Group, 2009).

Quality appraisal

Following guidance outlined by Thomas and Harden (2008), the quality of the 18 papers included was assessed to avoid unreliable conclusions. This was done using the 'Methods for the development of NICE public health guidance qualitative

checklist' (NICE, 2012). Study data supporting the scoring procedure were extracted and tabulated. Further details are presented in Appendix A. As this review focused on an understudied area and because its primary aim was to include as many service user views as possible, studies were not excluded based on quality. Indeed, little guidance exists to determine decisions for excluding studies based on quality (Thomas & Harden, 2008). However, study quality was considered when examining the contribution of studies to resulting themes, conclusions, and recommendations.

Synthesis of study findings

Synthesis of the literature was guided by the methods outlined by Thomas and Harden (2008). Thematic synthesis is a method used to integrate findings from multiple qualitative papers, based on thematic analysis (a method widely used to analyse data in primary qualitative research). Thematic synthesis allows for the synthesis of qualitative data from multiple sources to generate new interpretative constructs, explanations, and hypotheses (Thomas & Harden, 2008). Firstly, the 'results' sections of the studies and any additional relevant abstracts containing raw data were analysed line-by-line. This contributed to the synthesis of findings by enabling the translation of codes across studies. Secondly, through an iterative process and continuous checking against the data, patterns in the codes were explored and initial codes were grouped into new descriptive themes, which captured the meaning of initial codes. The final stage involved the iterative development of analytic themes which organised the previous descriptive themes by relating them to the aims of the present review.

Review

An initial overview of the studies' characteristics is presented, followed by an appraisal of the reviewed literature, and a description of the themes generated by the thematic synthesis. Themes are related to the broader literature in the discussion.

Literature characteristics

Details from the 18 studies included can be found in Table 2. The studies originated in five Western countries: eight in the UK, three in the USA, four in Australia, two in Denmark, and one in Switzerland. Participants were refugees or asylum seekers originating from Somalia, Cameroon, Democratic Republic of the Congo (DRC), Liberia, Burundi, Ethiopia, Tanzania, Côte d'Ivoire, Eritrea, Zimbabwe, Liberia, Sudan, Rwanda, Lebanon, Pakistan, Afghanistan, Iraq, Iran, Russia, Bosnia/Serbia, Kosovo, Chechnya, Albania, Cyprus, Turkey, Ukraine, Bhutan, and Colombia. Seventeen studies reported data on participants' countries of origin, and 14 interviewed participants from a variety of backgrounds. Four studies interviewed only participants from Somalia. The number of participants interviewed in each study ranged from 7-85. Three studies employed mixed methods, and the remainder used qualitative methodologies. Fifteen studies used semi-structured interviews, one study used focus groups, and two studies used both interviews and focus groups.

Participants were recruited from a variety of settings, including specialist refugee and asylum seeker mental health services, community organisations, and child and adolescent mental health services. All studies interviewed participants with direct experience of mental health services. Sixteen studies reported participant

genders. Taking studies as a whole, the proportion of males to females was about even. Fourteen studies reported participant ages, which ranged from 12-65. Participants reported on a range of hopes and experiences, including of adult mental health services, school-based child and adolescent mental health services, looked after children and child and adolescent mental health services, rehabilitation centres for traumatised refugees, a third sector service for survivors of torture, and an outpatient service providing specialist treatment for PTSD. One study focussed on participant experiences of school-based mental health services (Fazel, Garcia, & Stein, 2016), and was included because these services are increasingly common (Rones & Hoagwood, 2000) and potentially a key access point for younger refugees and asylum seekers. Another concentrated on participant experiences of CBT for PTSD (Vincent, Jenkins, Larkin, & Clohessy, 2013), and was included as this is a routinely offered intervention (Kar, 2011) which refugee and asylum seeking populations might be offered. These two studies were thus included as they were understood to reflect common interventions adopted by Western mental health services.

Literature appraisal

Studies were predominantly of high quality. Fourteen achieved a score of 'good' (+ +), four obtained a score of 'fair' (+), and none obtained a 'poor' score (−). It was not deemed likely that study quality impacted on findings, as no papers were rated 'poor'. However, though studies had clear aims and presented rich data, many lacked reflexivity, failing to consider the role of the researcher. Posselt, McDonald, Procter, de Crespigny, and Galletly (2017) and Palmer (2007) both considered the role of the researcher and stood out positively in this regard. It is of note that studies often

achieved a 'fair' score due to failing to provide sufficient methodological detail to ascertain reliability of the data and analysis. Indeed, many studies failed to report sufficient detail and rationale for qualitative analyses. Though findings were mainly clearly reported, ethical issues were typically not considered. A key critique of the literature reviewed centred on the fact that most studies interviewed participants from a variety of cultural backgrounds, but combined views into homogenous themes. Unfortunately, this limited the scope of this review's conclusions.

Thematic Summary

The analysis resulted in various concepts, organised broadly under three themes: barriers and facilitators to engagement, hopes and anticipations, and the limits of services. A table of themes and subthemes is presented in Appendix B. Appendix C presents supporting quotes.

Barriers and facilitators to engagement

All authors discussed barriers and facilitators to engagement. Study findings were organised under six subthemes: cultural factors, support networks, stigma, trust, structural factors, and not being understood in the context of the refugee experience. These subthemes are discussed below.

Cultural factors. Thirteen studies suggested that cultural factors could influence engagement with mental health services. Study participants were from a variety of backgrounds; cultural discourses and understandings of mental health would therefore have been varied. However, Western conceptions of distress such as 'mental health problems' and 'depression' appeared very foreign for many

participants. Authors understood this to inherently act as a barrier, as people are unlikely to seek help when they have different cultural understandings of their experiences.

> "People don't believe in mental health"
>
> Congolese woman (Piwowarczyk, Bishop, Yusuf, Mudymba & Raj, 2014: p. 211)

Service users also believed that services operating in a different cultural framework might not be able to understand them (De Anstiss & Ziaian, 2010). Additionally, studies outlined that participants preferred working with professionals from the same cultural background as them (De Anstiss & Ziaian, 2010; Misra, Connolly, & Majeed, 2006; Palmer & Ward, 2007; Valibhoy et al. 2017a). Verbalising internal experiences and emotions was an alien experience which could be an obstacle to engagement for refugee young people from a variety of backgrounds (Valibhoy, Szwarc, & Kaplan, 2017).

Vincent et al. (2013) reported that refugee and asylum-seeking communities from a variety of backgrounds living in the UK appeared to conflate engaging with services with weakness. Valibhoy et al. (2017)b suggested that struggling was not seen as an option for young refugee service users living in Australia, who often had family members back home or in refugee camps depending on them. Both these studies suggested accessing services challenged important beliefs about the self as autonomous, self-reliant, and independent.

Table 2. Reviewed literature.

Author/s, Year, Title	Country	Sample size (n) and characteristics	Aims	Methodology	Quality appraisal
Bernardes et al. (2010). *Asylum seekers' perspectives on their mental health and views on health and social services: Contributions for service provision using a mixed-methods approach.*	UK	n=8; asylum seekers; no further information	To contribute to a specific understanding of asylum seekers' mental health in a manner that can inform the services (if any) that should be offered while they wait for the outcome of their asylum application.	'Free association narrative interview method'	++
Bettmann et al. (2015). *Somali refugees' perceptions of mental illness.*	USA	n=20; Somali refugees; 10 male, 10 female	The study sought to answer the following questions: (1) How do Somali and Somali Bantu refugees perceive, describe, and explain mental illness and (2) What are the beliefs about treatment for mental illness among Somali and Somali Bantu refugees?	'Inductive analysis'	++
De Anstiss & Ziaian (2010). *Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation.*	Australia	n=85; 44 male; 41 female; refugee adolescents aged 13-17 from Afghanistan (8 male 15-16yrs, 8 female 14-17yrs), Bosnia/Serbia (5 male 15-17yrs, 5 female 14-17yrs), Persian (8 male 14-17yrs, 6 female 15-17yrs), Iraq (9 male 14-17yrs, 8 female 14-17yrs), Liberia (7 male 15-17yrs, 8 female 13-17yrs) and Sudan (7 male 16-17yrs, 6 female 15-16yrs)	To fill a number of gaps in knowledge left by previous help-seeking research, including rates and patterns of service utilisation across service sectors, use of informal supports, and actual and perceived barriers to services.	Thematic analysis	++
Ellis et al. (2010). *Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing.*	USA	n=14; Somali refugee adolescents; 7 male, 7 female	To examine the utility of the Gateway Provider Model in understanding service utilization and pathways to help for Somali refugee adolescents resettled in the North-eastern United States.	Not described	++

Fazel, Garcia & Stein (2016). *The right location? Experiences of refugee adolescents seen by school-based mental health services.*	UK	n=40; adolescents (13 unaccompanied minors); 29 male, 11 female; 27 living with a family member, 8 living alone, 4 living with foster families, 1 living with a family friend; 11 with permanent status to remain in the UK; median length of time in the UK=2.5yrs; 9 from Europe (5 Albania), 13 from Africa (4 Somalia; 3 Sudan), 9 from Iran/Iraq/Afghanistan, 7 from 'other' Asia, 2 from South America. Age range: 15-24yrs, median=17yrs. All participants were studying: 26 at school and 14 in higher education	To address the absence of data on the actual experience of adolescents directly seen by services by asking those seen by school-based mental health services about their experience of being seen within the school location, how they perceived the therapy, whether or not it helped them and finally about any worries and preoccupations that might be impacting their time at school.	Framework analysis with a thematic analysis of content	++
Maier & Straub (2011). *"My head is like a bag full of rubbish": Concepts of illness and treatment expectations in traumatized migrants.*	Switzerland	n=13; mean age 37yrs; range 22-53yrs. 8 male, 5 female. Bosnia (2), Kosovo (2), Turkey Turkish (1), Turkey Kurdish (1), Iran Kurdish (2), Afghanistan (2), Cameroon (1), Sudan (1), Chechnya (1). 8 asylum seeker, 5 refugee. Duration of stay: mean 5.1yrs, range 1.5-1.7yrs. 3 single, 10 married with children. Education: 1 no school, 4 basic school, 6 high school, 2 university	The study aimed to investigate the following questions: • What is the variety of concepts of illness found in traumatized migrants attending our institution? • What kind of help/treatment do affected subjects expect from the local health care system? • What kind of help/treatments (medical or non- medical) have the subjects already made use of during their stay in the host country? • Do traumatized migrants attending our institution have prior knowledge of psychotherapy and, if so, do they consider it an appropriate treatment for their current health problems?	Content analysis	++

			• How do the subjects evaluate their perceived present distress in relation to earlier trauma and current living conditions? Methods		
Majumder et al. (2015). *"This doctor, I not trust him, I'm not safe": The perceptions of mental health and services by unaccompanied refugee adolescents.*	UK	n=15; unaccompanied adolescents; 13 male, 2 female; ge range 15-18yrs. Afghanistan (11); Iran (2); Somalia (1); Eritrea (1). 7 refugees, 8 asylum seekers; Nature of mental health problems: Depression (6), self-harm (8); PTSD (8); anxiety (3); adjustment reaction (3); substance misuse (1); learning difficulties (1); dissociative disorder (1); psychosis (1); impaired sleep(1)	To appreciate the views and perceptions that unaccompanied minors hold about mental health and services.	Thematic analysis	+
Mirdal, Ryding & Sondej (2011). *Traumatized refugees, their therapists, and their interpreters: Three perspectives on psychological treatment.*	Denmark	n=16; 7 male, 9 female; age range 31-55yrs; Countries of origin: Iraq, Bosnia, Lebanon, Afghanistan; All but one had a Muslim background; 12 married, rest either single or divorced; 13 had children	To study how traumatized refugees, their therapists, and their interpreters perceive both curative and hindering factors in psychological therapy, thereby highlighting the mediators of change in a transcultural clinical setting.	'Phenomenological approach'	++
Misra, Connolly & Majeed (2006). *Addressing mental health needs of asylum seekers and refugees in a London Borough: Epidemiological and user perspectives.*	UK	n=10; Albanian, Kosovans, Turkish, Kurdish, Greek Cypriot, Somali, Iraqi, Afghan	To undertake a needs assessment of mental health services for asylum seekers and refugees in the London Borough of Haringey, to estimate accurate numbers of asylum seekers and refugees who need mental health services, and to understand their perspective on mental health needs and services.	Grounded theory	+

Persson & Gard (2013). *Tortured refugees' expectations of a multidisciplinary pain rehabilitation programme: An explorative qualitative study.*	Denmark	n=15; All male; mean age 47yrs; 13 from Iraq, 2 from Lebanon; 3 working, 12 not working; Professional backgrounds: accountant, teacher, university student, lawyer, engineer, taxi driver, truck driver, hairdresser, greengrocer, solider; 15 had sleep disorders. Years living in Denmark: mean=17, median=19, range=8-30	To explore tortured refugees' expectations of a multidisciplinary pain rehabilitation programme.	Content analysis	++
Piwowarczyk et al. (2014). *Congolese and Somali beliefs about mental health services.*	USA	n=31; all female; Somalia and DRC; Somali mean age 34.1yrs, range 18-59yrs; DRC mean=age 34.5 (range 18-50); 60% Congolese women attended university, 12.5% Somali women attended university; Somali women mostly identified as refugees or US citizens; Congolese women were generally asylum seekers/US citizens. 86.6% Congolese women employed, 61.9% Somali women employed; marital status comparable across both groups	To examine concepts of mental illness and attitudes and beliefs about treatment as well as potential barriers to accessing mental health services.	Grounded theory	++
Posselt et al. (2017). *Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: Addressing the barriers.*	Australia	n=15; 6 male, 9 female; mean age 17.7yrs, range 12-25yrs; Afghan (60%), African [Congolese, Liberian, Burundian] (27%), Bhutanese (13%); Living in Australia on average 4.9yrs	To determine the barriers and facilitators to effective, culturally responsive service provision for young people of refugee background living with comorbid mental health and alcohol and drug problems.	Thematic analysis	++

Valibhoy, Kaplan & Szwarc (2017) (a). *"It comes down to just how human someone can be": A qualitative study with young people from refugee backgrounds about their experiences of Australian mental health services.*	Australia	n=16; refugees; 7 male, 9 female; age range 18-25yrs; participants born in Iraq, Iran, Afghanistan, Sudan, DRC, Ethiopia, Tanzania, Côte d'Ivoire, Pakistan; Lived in Australia an average of 5.2 years; 6 Christian, 10 Muslim; 6 employed, 13 students, 2 neither working nor studying	To help fill that gap in the literature by asking young people with refugee experiences how they accessed mental health services, their feelings about disclosing personal problems, what promoted and what discouraged engagement with services and practitioners what assisted them, and what they recommended to improve services	Thematic analysis	++
Valibhoy, Szwarc & Kaplan (2017) (b). *Young service users from refugee backgrounds: Their perspectives on barriers to accessing Australian mental health services.*	Australia	n=16 refugees; 7 men, 9 female; Iraq (5), Afghanistan (3), Iran (2), Sudan (1), Pakistan (1), Tanzania (1), Ethiopia (1), Cote d'Ivoire (1), DRC (1); Years in Australia: <3yrs (6), 3-5.9yrs (3), 6-8.9yrs (6), 9-12yrs (1); Muslim (10), Christian (6); Studying (13), working (6), neither working nor studying (2); Current client (8), former client (8)	To describe the barriers to accessing mental health services faced by young people from refugee backgrounds, in order to inform appropriate service delivery.	Thematic analysis	++
Vincent et al. (2013). *Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study.*	UK	n=7; 6 asylum seekers, 1 refugee; 4 male, 3 female; Country of origin: Sudan (2), Iraq (1), Zimbabwe (1), Burundi (2), Afghanistan (1), Age range: 19-42years; Time in UK: 0.5-10yrs	To consider the acceptability of trauma-focussed CBT for asylum- seekers with PTSD by exploring their experiences of this treatment.	Interpretative phenomenological analysis	++
Palmer (2006). *Imperfect prescription: Mental health perceptions, experiences and challenges faced by the Somali community in the London*	UK	n=7; 3 male, 4 female; Somali; mean age 34yrs; All participants unemployed	To assess the Somali community's own perception of mental illness and some of the barriers to accessing and utilising services in the London Borough of Camden.	Thematic approach according to principles of the 'framework method'	+

Borough of Camden and service responses to them.					
Palmer & Ward (2007). *'Lost': Listening to the voices and mental health needs of forced migrants in London.*	UK	n=21; 6 asylum seekers, 12 refugees, 1 without status having been refused asylum, 1 with exceptional leave to remain, 1 with British citizenship; 11 male, 10 female; age range 21-65yrs; Time in UK: 18months-12years; Azeri (1), Bosnian (1), Colombian (1), Congolese (1), Ethiopian (3), Iranian (3), Iraqi (1), Kosovan (1), Iraqi Kurdish (1), Russian (1), Rwandan (1), Somali (5), Ukrainian (1); Sleeping problems (15), Anger (10), Panic (5), Tearful (5), Depressed (4), Nightmares (4), Stress (4), Sad (2), Nervousness (2), Distressed (2), Bad memories (2), breathing problems (2), easily upset (1), hates noise and crowds (1), feel worse (1), worry (1)	To attempt to redress the balance between service provider and user by prioritising the user perspective.	Thematic approach according to principles of the 'framework method'	+
Palmer (2007). *Caught between inequality and stigma: The impact of psychosocial factors and stigma on the mental health of Somali forced migrants in the London Borough of Camden.*	UK	n=9; Somali. 4 male, 5 female; mean age 32yrs, range 18-62yrs; 1 asylum seeker, 1 with refused asylum application, 1 with exceptional leave to remain, 1 with British Citizenship, 5 with refugee status; 4 had mental health diagnosis.	To assess the impact that psychosocial factors have on the mental health of Somali refugees and how Somali people's perception of mental illness impacts on both community engagement and on accessing and utilising services.	Thematic approach according to principles of the 'framework method'	++

Note. Palmer (2007), Palmer & Ward (2007), and Palmer (2007) used overlapping data. All three studies were included because each also included original data.

Whilst Valibhoy et al. (2017)b suggested that young people in Australia from a variety of backgrounds might avoid services because attending might be perceived as departing from religion, other studies suggested that participants favoured services over religion, dismissing religion as a solution only used by people less educated (Misra et al., 2006; Palmer, 2007; Piwowarczyk et al., 2014; Valibhoy et al., 2017a; Vincent et al., 2013).

> 'You are between the doctor and the community. You don't know what to do about it.''
>
> Congolese young woman (Piwowarczyk et al., 2014: p.212)

Support networks. Seventeen studies suggested a preference for informal help-seeking through family, friends, or religious and community leaders. However, four studies indicated that fear of exclusion was a barrier to seeking community help for participants from a range of backgrounds (Palmer, 2006; Palmer & Ward, 2007; Valibhoy et al., 2017a; Valibhoy et al. 2017b).

Indeed, studies outlined that friends played a major role in determining engagement with services for young people from a variety of backgrounds living in Australia, the USA, and the UK (De Anstiss & Ziaian, 2010; Ellis et al., 2010; Misra et al., 2006; Valibhoy et al., 2017a; Valibhoy et al., 2017b). Though young people often preferred relying on each other for support (De Anstiss & Ziaian, 2010; Elis et al., 2010; Misra et al., 2006), they also told each other about services available (De Anstiss & Ziaian, 2010). Depending on their experiences of

services, they might also encourage or discourage each other from engaging with services (Ellis et al., 2010; Valibhoy et al., 2017a).

Yet, studies suggested mixed views on peer support. Whilst some service users found it helpful to connect with people with similar lived experiences (Bernardes et al., 2011; Ellis et al., 2010), others found this unhelpful (Bernardes et al., 2011). It is of note that professionals such as schoolteachers and general practitioners played an important role in facilitating contact with services (Fazel et al., 2016; Maier & Straub, 2011).

Stigma. Sixteen studies outlined stigma as an important barrier to accessing mental health services. Participants from a variety of backgrounds viewed emotional distress as something shameful to be hidden from others (De Anstiss & Ziaian, 2010; Misra et al., 2006; Palmer & Ward, 2007; Piwowarczyk et al., 2014; Posselt et al., 2017). These ideas appeared to originate from home country cultures; studies suggested that representations of people with mental health difficulties in home country media influenced participants' preconceptions of service users and mental health services (Valibhoy et al., 2017a; Valibhoy et al., 2017b). Services in the UK and Australia were therefore often accessed as a 'last resort', when difficulties reached a critical stage (Misra et al., 2006; Palmer, 2006; Piwowarczyk et al., 2014; Valibhoy et al., 2017a; Valibhoy et al., 2017b).

Trust. Relatedly, 12 studies suggested that trust could affect engagement with mental health services. Distrust of Australian and UK mental health systems, including services and

professionals, influenced engagement with services (De Anstiss & Kaplan, 2010; Majumder et al., 2015; Palmer, 2006; Posselt et al., 2017; Valibhoy et al., 2017b). For participants from a variety of backgrounds, the absence of mental health services in home countries also promoted distrust, as services were perceived as unfamiliar (Fazel et al., 2016; Majumder et al. 2015; Valibhoy et al., 2017b). Understandably, given that refugees and asylum seekers often flee violent governments who abuse their power, participants from a variety of backgrounds expressed concerns about what professionals and services in a position of power might do with the information shared with them (e.g. sharing information with communities or with government officials) (Posselt et al., 2017; Valibhoy et al., 2017a). Fear of stigma, negative reactions, and exclusion from communities meant that participants in most studies stressed the importance of privacy and confidentiality.

Structural factors. Twelve studies suggested structural factors could impact on service access and engagement. Flexible and easily accessible services in convenient locations such as schools were perceived favourably (Bernardes et al., 2011; Fazel et al., 2016; Posselt et al., 2017; Valibhoy et al., 2017a). Given the lack of knowledge and mistrust identified, services in accessible locations may be seen as more familiar and therefore less intimidating. In the UK and Australia, long waiting times acted as barriers (Palmer & Ward, 2007; Valibhoy et al., 2017a; Valibhoy et al., 2017b; Misra et al., 2006). In Australia, fragmented services and complex referral processes were also identified as barriers (Posselt et al., 2017; Valibhoy et

al., 2017a; Valibhoy et al, 2017b). Language was also a barrier to engagement with services. Inadequate interpreting facilities in British, Australian, and American services often caused participants to feel misunderstood during appointments, or to miss appointments altogether (Bernardes et al., 2011; Bettmann et al., 2015; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Posselt et al., 2017; Valibhoy et al., 2017a).

Not being understood in the context of the refugee experience. Four studies (conducted in the UK and Australia) outlined clients felt misunderstood when practitioners were not mindful of their experiences as refugees and did not understand the impact of these experiences (Misra et al., 2006; Valibhoy et al., 2017a; Valibhoy et al., 2017b; Vincent et al., 2013). Studies suggested this could act as a barrier for people engaging with psychological therapy. Refugees from a variety of backgrounds outlined traumatic experiences but also family separation, distrust of authorities, fear of deportation, and uncertainty about the future (Valibhoy et al., 2017a; Vincent et al., 2013).

> "You can't take someone like refugee and someone Australian ... as counsellor, just say, 'this is gonna help you'— no. There's some Australian they just grow up here— they have everything, they doesn't see fighting, they doesn't sleep no eating ... [refugees] eat, like a brick, you know, you eat like something because you need like your stomach to come to feel like you have something

to eat. They're suffering ... fighting is still there ... yesterday there are people dying there."

Christina, refugee young person (Valibhoy et al., 2017a: p. 10).

Hopes and anticipations

Seventeen studies outlined service users' hopes and anticipations of services. The three sub-themes (lack of anticipations, desperate hope, and medicalised care) are discussed below.

Lack of anticipations. Fifteen studies discussed this theme. Studies interviewing people who had used services in the USA, UK, Australia, Switzerland, and Denmark highlighted that participants often had a lack of knowledge of services and treatments available prior to their initial appointment (Bettmann et al., 2015, Maier & Straub, 2011; Majumder et al., 2015; Palmer, 2006), of where to get help (Bettmann et al., 2015; De Anstiss & Ziaian, 2010; Valibhoy et al., 2017b), and of how mental health services might be able to help them (Maier & Straub, 2011; Persson & Gard, 2013).

Desperate hope. Three studies discussed this theme. Despite limited knowledge of how services might be able to help, refugees and asylum seekers from a variety of backgrounds in Switzerland and Denmark maintained hope and held varied views on expected outcomes (Maier & Straub, 2011; Persson & Gard, 2013). Whilst some outlined very general ideas around regaining health (Maier & Straub, 2011), others hoped to learn new

things about themselves, how to cope with difficulties, improve sleep, eliminate tiring thoughts, and become less isolated (Persson & Gard, 2013).

Medicalised care. Ten studies suggested participants from various backgrounds expected mental health services to follow a medical model of care, encompassing medication (Bettmann et al., 2015; Maier & Straub, 2011; Majumder et al., 2015; Persson & Gard, 2013; Piwowarczyk et al., 2014; Valibhoy et al., 2017b), hospitalisation (Bettmann et al., 2015; Fazel et al., 2016; Majumder et al., 2015; Piwowarczyk et al., 2014; Valibhoy et al., 2017b), receiving a diagnosis (Maier & Straub, 2011; Majumder et al., 2015; Persson & Gard, 2013; Vincent et al., 2013), and multidisciplinary team working (Mirdal, Ryding & Sondej, 2011; Misra et al., 2006; Persson & Gard, 2013). Service users were therefore familiar with a medical model of care, using a physical healthcare model as a reference point and viewing services as active agents 'doing to' passive recipients (Persson & Gard, 2013).

The limits of services

All studies discussed the limits of services. This theme was organised into three sub-themes: caring services' understanding of culture and context, medication can be helpful but is not a panacea, and ambivalence about talking.

Caring services' understanding of culture and context. Eleven studies discussed this theme. Services were experienced positively when service users felt listened to, cared for, supported, welcomed, and understood (Bernardes et al., 2011; Maier & Straub, 2011; Mirdal

et al., 2011; Valibhoy et al., 2017a). The importance of a collaborative approach in psychological therapies was emphasised by a Danish study interviewing male service users from refugee backgrounds who had experienced torture (Persson & Gard, 2013). The fundamental importance of trust was emphasised (De Anstiss & Ziaian, 2010; Valibhoy et al., 2017a; Vincent et al., 2013).

Feeling misunderstood because of cultural differences could hinder therapeutic relationships, negatively impacting service users' experiences of mental health services (De Anstiss & Ziaian, 2010; Misra et al., 2006; Valibhoy et al., 2017a; Valibhoy et al., 2017b). Young people from refugee backgrounds (from Afghanistan, DRC, Liberia, Burundi, and Bhutan) in Australia explained how important it was for mental health workers to understand issues from non-Western viewpoints, and proposed training in the form of an information exchange between mental health services and resettled refugee communities as a meaningful way forward (Posselt et al., 2017).

Medication can be helpful but is not a panacea. Eight studies discussed service users' experiences of medication, highlighting mixed views. Whilst some valued medication as it provided a relief from symptoms (Bettmann et al., 2015; Majumder et al., 2015; Mirdal et al., 2011; Palmer, 2007) others did not like depending on it (Bernardes et al., 2011), suggesting that whilst it could be helpful for symptom reduction, it could not cure the true causes of suffering (Maier & Straub, 2011).

"I have taken tablets, but I still wasn't feeling accepted or so…. The tablets, they don't really help with that."

34-year-old woman from Cameroon (Maier & Straub, 2011: p. 242)

Ambivalence about talking. All eighteen studies indicated that service users were largely ambivalent about the experience of psychological therapy due to emphasis on talking through traumatic events. A tension was experienced between wanting to forget past experiences and being required to 'unload' in order to forget and feel better (Fazel et al., 2016; Vincent et al., 2013). Participants' approaches to coping with trauma through forgetting appeared to conflict with psychological interventions offered, which emphasised talking through traumatic events. Despite this, participants found sharing problems in a therapeutic space helpful. Talking was seen as cathartic, and assigning words to thoughts and feelings helped to structure internal and social experiences (Mirdal et al., 2011).

"One should not wake up the demons (djinns). There are things one should not talk about. It makes you feel worse"

Refugee of unknown background (Mirdal et al., 2011: p. 454)

However, the degree of change experienced tended to determine whether therapy was experienced as helpful (Bernardes et al., 2011; Fazel et al., 2016; Maier & Straub, 2011; Mirdal et al., 2011; Vincent et al., 2013). A belief that talking about problems was not enough to bring about change also promoted negative experiences. For some young people, multiple

questioning at the assessment process was primarily the cause of discomfort (Majumder et al., 2015). Participants felt they told their story but received little help in return. Multiple assessments and prolonged questioning could cause discomfort, perhaps emphasising clients' powerlessness, especially given service users' experiences with immigration officers (Majumder et al., 2015).

Social factors take precedence. Importantly, 13 studies highlighted the central influence of factors outside the therapy room on wellbeing. This meant that, for many, practical solutions to real life problems were most helpful. Employment (Bernardes et al., 2010; Mirdal et al., 2011; Misra et al., 2006; Palmer & Ward, 2007; Valibhoy et al., 2017a; Valibhoy et al., 2017b), housing (Bernardes et al., 2010; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007), and racism, xenophobia, and marginalisation (Posselt et al., 2017; Valibhoy et al., 2017a; Valibhoy et al., 2017b) had a major impact on wellbeing, highlighting the crucial importance of wider socio-political factors. Indeed, participants in six studies identified socio-political solutions to their distress, explaining that simply talking could not remedy the very real everyday problems faced in terms of violence, discrimination, family separation and poverty (Bernardes et al., 2010; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Persson & Gard, 2013; Valibhoy et al., 2017b).

"…they [the general public] say, 'You're (from) Afghanistan. Terrorist!

> Terrorist!' and [they] keep blaming … harassing him so he will also get a mental illness."
>
> Afghan male refugee adolescent (De Anstiss & Ziaian, 2010: p. 33)

Talking might therefore not always be the first or most immediately needed solution to ongoing difficulties, highlighting the limitations of psychological therapy. Interestingly, asylum seekers from a variety of backgrounds interviewed by Vincent et al. (2013) explained that perceived therapist powerlessness in the face of these issues undermined engagement in therapy. Though specialist knowledge from professionals, psychoeducation, and coping strategies such as relaxation techniques were valued (Bernardes et al., 2011; Mirdal et al., 2011; Vincent et al., 2013; Fazel et al., 2016), some found practical strategies such as sleep hygiene information unhelpful and even invalidating, as these emphasised therapists' lack of understanding of real life problems (Valibhoy et al., 2017a).

As such, studies emphasised the importance of therapists being able to work beyond the normal bounds of therapy (Fazel et al., 2016; Mirdal et al., 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Valibhoy et al., 2017a; Valibhoy et al., 2017b; Vincent et al., 2013). Though this might be core work for some psychologists, studies suggested that every clinician working with this client group must embrace this. Service users outlined the value of a therapist who could address post-displacement stressors such as powerlessness, poverty, housing, unemployment, and family separation and also help with

asylum applications (Fazel et al., 2016; Valibhoy et al., 2017a). Service users valued holistic services which could meet non-clinical needs in addition to their mental health needs (Persson & Gard, 2013; Posselt et al., 2017).

Discussion

Summary

This review identified 18 studies in an attempt to further understand refugees' and asylum seekers' beliefs and experiences of Western mental health services and psychological therapies. Service users' experiences were broadly organised under three main themes: barriers and facilitators to engagement, hopes and anticipations, and the limits of services. Sub-themes discussed suggested that strengths-based psychosocial approaches which can conceptualise distress beyond diagnoses and engage with the wider social context might be most helpful in addressing service users' needs.

Developing pluralistic understandings of distress

The reviewed literature suggested that cultural differences in conceptions of distress could act as a barrier to accessing services, echoing existing literature in this area (Colucci et al., 2015). Indeed, Western diagnostic labels were alien for many participants, and a belief that services might not be able to understand non-Western conceptualisations of distress could prevent people from accessing services. Importantly, the literature suggested that professionals who were unable to understand difficulties from non-Western viewpoints were

not able to sustain a trusting therapeutic relationship, as participants felt misunderstood. Service users suggested that clinicians should receive specialist training in order to be able to work flexibly using different cultural frameworks.

However, to date, services have instead promoted 'mental health literacy' (Jorm, 2000), or education around Western concepts of distress. Blackwell (1993) and Summerfield (2008) have convincingly argued the dangers of imposing Western psychological discourses, which can negate non-Western knowledge systems, perpetuating colonialism and disempowerment. Originating from professionals in a position of power, Western explanatory models can become 'facts' which are impossible to challenge (Kleinman, 1980).

As an alternative, ethnographic accounts of healing in non-Western contexts have helped to emphasise the universality which can be found in context-dependant meaning (Littlewood, 1990); cross-cultural work may be possible when therapists work from clients' meanings. Some therapeutic approaches may be better suited to working with pluralistic understandings of distress. One study reviewed in this paper suggested systemic approaches as a helpful way forward (Valibhoy et al., 2017a). Family therapy has been cited as the only therapy which does not assume shared notions of what constitutes 'therapy' and a 'problem', allowing for context-dependant meaning making (Littlewood, 1990; Daelemans & Maranhão, 1984). Indeed, post-modern systemic approaches influenced by social constructionism

oppose the idea that a real world exists which can be known with objective certainty, and allow, instead, for multiple realities (Hoffman, 1992).

Destigmatising services are more accessible

Interestingly, accessing services sometimes challenged individuals' sense of self-efficacy, autonomy, independence and self-reliance, and stigma could also prevent people from accessing services. This is aligned with the wider literature on barriers to help-seeking (Gong-Guy, Cravens, & Patterson, 1991; Moller-Leimkuhler, 2002; Wilson & Deane, 2012). Diagnostic-based frameworks are understood by some as problem-focused approaches which emphasise vulnerabilities within the individual (Beresford, Nettle & Perring, 2010), and may therefore further challenge service users' identities. Strengths-based models and interventions may thus be experienced as more helpful and encourage access to services. Given that it has been proposed that diagnostic-based frameworks can increase stigma (Timimi, 2014), models which are less culture-centric and understand distress as part of the continuum of normal human experience may also be less stigmatising.

Services should empower and establish trust

Distrust of Australian and UK mental health systems in particular also influenced engagement with services. This is supported by the wider literature (Colucci et al., 2015; Ellis et al., 2011; Tribe, 2002), and is perhaps unsurprising given experiences with immigration officers and that refugees and asylum seekers often flee countries where organised violence

means that isolation and mistrust are key for survival (Nadeau & Measham, 2006). An important association showed that feeling unsafe and lacking knowledge fostered feelings of distrust towards services (Fazel et al., 2016; Majumder et al. 2015; Valibhoy et al., 2017b). This emphasises how important it might be for services to use collaborative and transparent approaches such as formulation in order to avoid further disempowerment and distrust.

The value of integrated holistic services

Studies also highlighted the influence of structural factors on access and engagement with mental health services. In line with existing literature on service use (Goddard & Smith, 2001; Katon et al., 1995; Memon et al., 2016), long waiting times and fragmented services were cited as barriers, whilst flexible services in convenient and easy to access locations facilitated engagement, perhaps because this made services more familiar and therefore more trustworthy. Service users valued flexible services which were able to meet multiple health and social care needs. More holistic services which combine social care and mental health have been advocated for in the literature (Watters, 2011). In the UK, meeting the needs of this client group might pose a particular challenge to services in which health and social care are not integrated. Unsurprisingly, inadequate interpreting facilities often caused participants to miss appointments or to feel misunderstood, echoing views presented in the wider literature (Kirmayer et al., 2011; Wong et al., 2006).

Prioritising social interventions

The current review identified the major influence of social issues such as unemployment and social exclusion on service users' wellbeing, who often identified socio-political solutions to distress. Eastmond, Ralphsson and Alinder (1994) found that Bosnian families resettled in different communities in Sweden fared better when offered employment but no psychological therapy than when offered psychological therapy but no employment opportunities. Services may therefore wish to prioritise social interventions, and will benefit from working closely with social care and employment agencies. Importantly, public health policies aimed at refugees and asylum seekers should not overlook unemployment. Despite debilitating difficulties and limited knowledge of how services might be able to help, refugees settled in Denmark and Switzerland were able to maintain the hope of receiving help (Maier & Straub, 2011; Persson & Gard, 2013). It could be hypothesised that the generous welfare systems in place in Denmark and Switzerland (ISSA, 2016) instil the understanding that host countries can and do meet the needs of refugees and asylum seekers. Clinical models of refugee mental healthcare prioritise establishing safety and trust as a first port of call (Herman, 1997). A strong social welfare system should undoubtedly be the foundation for instilling this sense of safety.

Building community links

An important finding of the current review centred on the impact of support

networks on service engagement. Participants from a variety of backgrounds often preferred to rely on informal support networks, and this has been identified previously in the literature (Donnelly et al., 2011; Watters, 2001). However, communities were sometimes described as unhelpful due to stigma and fear of exclusion. It is therefore important for services to consider service users' social resources, prioritising community capacity building by forging and maintaining links with local communities.

Psychological interventions need to engage the wider socio-political context

This review suggested that not being understood in the context of the refugee experience could act as a barrier to engaging with psychological therapies. This has been a longstanding critique of individualised interventions for this client group, in particular CBT for PTSD (Nickerson, Bryant, Silove, & Steel, 2011). Indeed, it has been argued that this approach can neglect the socio-political context as well as ongoing stressful social and material conditions (Miller & Rasmussen, 2010). Importantly, studies suggested that clients valued therapists who actively worked beyond the normal boundaries of therapy in order to meet practical needs and include the wider socio-political context. This was also suggested in a recent study by Schweitzer, van Wyk, and Murray (2015). The systemic model helpfully incorporates an understanding of socio-political issues into consideration and could be a more appropriate framework for working with this client group. Indeed, authors in one study reviewed proposed that participant perspectives on good mental health practice broadly

aligned with a systemic approach, which is contextualised and attuned to the individual's experience (Valibhoy et al., 2017a). However, though specific psychological models can help professionals attend to the wider socio-political context, given that participants in many studies felt professionals did not sufficiently consider their unique needs, this raises a broader issue around whether a largely white and middle-class profession (Littlewood, 1990) is sufficiently skilled in working with difference.

Talking can be difficult

Ambivalence about psychotherapy was a crucial theme in a majority of studies. As previously highlighted by Tribe (2002), service users felt ambivalent about verbalising internal experiences and speaking about the past. Though some suggested it could be helpful, it was seen as an alien concept for many, and could prevent engagement. The idea that merely talking could somehow alleviate the distress caused by extreme powerlessness, persecution, and oppression was often viewed with doubt. Western psychological approaches prioritise talking through difficult experiences, but some cultures emphasise forgetting and not talking about difficulties as a helpful coping strategy (Summerfield, 1999). Some have argued that pushing for disclosure of events which are culturally taboo can be harmful (Angel, Hjern, & Ingleby, 2001; Rousseau, Measham, & Nadeau, 2013), and interventions focusing on emotional debriefing immediately after traumatic events have been shown to be unhelpful (Sijbrandij, Olff, Reitsma, Carlier, & Gersons, 2006). Interestingly, it has been suggested that

Western talking therapies can overly emphasise talking about past trauma, when service users might find solving current difficulties more helpful (Palmer, 2006; Schuchman & McDonald, 2008; Watters, 2001). The literature therefore presents a rich account of service users' views of Western mental health services and raises important issues.

Methodological limitations

Methodological issues identified in the literature require commentary, as any conclusions drawn from this review will have been impacted by these.

Samples

A key limitation of the reviewed literature was the consistent neglect of the heterogeneity of refugee and asylum-seeking populations. Studies often interviewed participants from multiple backgrounds, but combined their views into homogenous themes. Though the challenges of doing research with a heterogeneous group like this have been highlighted (Vostanis, 2014), grouping together people of different cultural backgrounds means that people's context-dependant meanings and cultural frames of understanding are lost. Unfortunately, given the methodologies of the current literature in this field, conclusions drawn in this review therefore do not reflect the heterogeneity of refugee and asylum-seeking populations.

Reflexivity

It is also of note that many of the studies identified lacked reflexivity, failing to consider the relationships between researchers and participants. It is therefore difficult to ascertain whether the authors considered the impact of subjectivity on data analysis (Gough, 2003).

Implications

Clinical implications

The issues raised in this review suggest that current mental health service provision could do more to meet the mental health needs of refugees and asylum seekers, supporting ideas presented in the wider literature (Heidi, Miller, Baldwin, & Abdi, 2011). In view of the importance of informal support networks in these communities, it is suggested that services aim to forge strong links with local asylum-seeking and refugee communities through community outreach in order to foster trust. Working with communities and providing education about services whilst respecting different constructs of distress could help people to feel safer when accessing services. Locating services in approachable community settings was also indicated to be beneficial. Mental health services could work more closely with social care and voluntary agencies in order to provide holistic and flexible services that can address service users' multiple needs. Procter (2006) outlines practical steps that can be undertaken to foster trust and promote continuity and integration in the mental healthcare of refugees

and asylum seekers. Transparent approaches to mental health care that promote trust should be encouraged. Services should also prioritise the provision of adequate interpreting facilities, given how indispensable this was shown to be to engagement.

Services wishing to engage people from refugee and asylum-seeking backgrounds will need to work with pluralistic understandings of distress beyond the Western psychiatric viewpoint. Most importantly, the central significance of social factors should not be underestimated, and psychosocial approaches should be promoted. In support of Summerfield (2001), this suggests that psychological models which acknowledge diverse understandings of psychological distress and embrace the wider socio-political landscape may be better suited to working therapeutically with people from refugee and asylum-seeking backgrounds. Systemic therapy has been suggested as one helpful model of working given its social constructionist underpinnings and emphasis on wider contexts (Papadopoulos & Hildebrand, 1997).

Importantly, psychologists will need to recognise their strengths and limitations and work collaboratively with other professions and the wider community in order to work more appropriately with difference and better meet the needs of service users. This will also mean working beyond the traditional 'therapist' role, actively helping with social and legal issues. Clinicians could receive training to develop their ability to understand difficulties through alternative cultural frameworks and elicit service users' illness models (Tribe, 2002), but

diversity in the mental health professions may need to be further addressed, as well as professionals' ability to work with difference.

Research implications

The methodologies of most studies included in this review neglected to reflect the heterogeneity of refugee and asylum-seeking populations. Future research will make a valuable contribution to the knowledge base if it is able to capture the cultural heterogeneity of refugees' and asylum-seekers' views. Qualitative and ethnographic methodologies which focus on a single cultural group will be most appropriate for achieving this. Capturing specific cultural frameworks and meanings related to experiences which in the West might be understood as 'mental health' will provide an increased understanding of different non-Western cultures' realities, helping clinicians to work from different cultural frameworks. As previously outlined, this should be conducted with particular attention to reflexivity.

There is also a need for further research on how current service delivery and psychological therapy models are being adapted to meet refugees' and asylum seekers' unique needs. Indeed, though in reality services may be adapting models and practice to meet the needs of refugees and asylum seekers, limited research currently exists which captures and evidences this.

The systemic model has emerged as a particularly helpful psychological approach for working with refugees and asylum seekers. Though family therapy has been suggested as a

helpful intervention, literature investigating family interventions with refugees and asylum-seekers is limited (Slobodin & De Jong, 2015). Future research should therefore explore current practice in family therapy with people from refugee and asylum-seeking backgrounds and consider its efficacy. Given that service users were largely ambivalent about talking through traumatic events, studies should explore how clinicians navigate client ambivalence about talking.

Conclusion

To our knowledge, this review is the first of its kind, reviewing qualitative literature to investigate refugees' and asylum seekers' experiences of Western mental health services and psychological therapies. Findings outlined barriers and facilitators to engagement, hopes and anticipations, and the limits of services. Conclusions suggest that Western mental health services may need to develop more flexible and pluralistic understandings of distress beyond diagnostic Western frameworks in order to work effectively with this population, and that psychosocial interventions which engage the wider community and socio-political contexts should be prioritised. Psychological interventions which emphasise talking through traumatic events may be experienced as less helpful. Systemic family therapy interventions may be a helpful approach, as these emphasise wider contexts, work with clients' meanings, and do not centre on the disclosure of traumatic events. However, given the lack of research in this area, future research should further explore current systemic family therapy practice with

people from refugee and asylum-seeking backgrounds.

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Section B

How do clinicians using systemic family therapy navigate conversations about trauma with refugees and asylum-seekers?

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Abstract

The systemic model has been proposed as particularly relevant for addressing the mental health needs of refugees and asylum-seekers. Clinicians working with families from refugee and asylum-seeking backgrounds who have experienced trauma may wish to encourage family communication to promote resilience, but may find it difficult to know whether to address traumatic memories. This study aims to develop a theoretical understanding of how conversations about trauma emerge in systemic family therapy with families from refugee and asylum-seeking backgrounds. Ten systemic family therapists were interviewed, and data were analysed using grounded theory methodology. Resulting constructs highlight co-constructed conversations about trauma between families and therapists. Therapists attend to several factors in order to create a space where unspoken stories can be voiced, so that families can find new meanings and re-connect. Showcasing current practice in this field, the study emphasises the need for clinicians working with this population to actively engage with the wider context, and highlights the need for research investigating the effectiveness of systemic family therapy interventions for this client group.

Key words: refugee; asylum-seeker; systemic family therapy; trauma

Introduction

The 2015 'refugee crisis' saw a record 65.6 million forcibly displaced people worldwide (UNHCR, 2015), with Europe receiving a record 1.26 million first-time asylum applications, of which 281,305 were families with children aged below 18 (Eurostat, 2018). In a climate of global economic recession, Western societal and political discourses have become increasingly xenophobic (Amnesty International, 2010), perhaps culminating in the UK's decision to leave the European Union (O'Reilly et al., 2016). Damaging alarmist political rhetoric and societal discourses depicting migrants as a threat to Western culture and civilisation (Perraudin, 2015; The Daily Express, 2016) can obscure the duress and desperation which can lead people to flee war and persecution, leaving loved ones behind in search of safety and protection.

Asylum seekers are defined as people who have applied for protection under the European Convention on Human Rights "…owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion" (United Nations, 1951). Refugees are defined as people who have successfully completed this legal process and obtained permanent residency within a host country (Refugee Council, 2013).

The rising number of displaced people worldwide has been an increasingly recognised global public health issue (Siriwardhana, Sheikh Ali, Roberts, & Stewart, 2014), and it has

become increasingly necessary to consider the psychological needs of this population. Refugee and asylum-seeking children and families have often experienced war, persecution, and traumatic life events. People live in uncertainty due to the asylum process, experiencing many losses and encountering a range of difficulties associated with resettlement (Burnett & Yohannes, 2002). Unsurprisingly, pre-flight experiences, distressing journeys, and difficulties associated with resettlement can lead refugees and asylum-seekers to experience increased rates of distress, particularly given the demonstrated links between social factors, inequality, and mental health (Marmot, 2010; Fazel, Wheeler, & Danesh, 2005; Porter & Haslam, 2005; Thornicroft, 1991). When considering children from refugee backgrounds, perceived discrimination, exposure to post-migration violence, parental exposure to violence, and parental psychiatric problems have been identified as risk factors for adverse mental health (Fazel, Reed, Panter-Brick, & Stein, 2012).

Generally, clinical models in refugee mental healthcare follow a three-phased approach (Ehntholt & Yule, 2006), involving the establishment of safety and trust, trauma-focused therapy/treatment, and social reintegration (Herman, 1997). To date, the mental health of refugees has primarily been diagnostic-led, the most common approach being through the diagnosis of Post-Traumatic Stress Disorder (PTSD) (Papadopoulos & Hildebrand, 1997). NICE (2005) recommend screening all refugees and asylum seekers for PTSD and offering trauma-focused cognitive behavioural therapy (CBT) to children and adults diagnosed

with PTSD “in the first month after the traumatic event” (p.41), though it has been noted that this guidance is based on limited evidence (Murray, Davidson & Schweitzer, 2010). Given that evidence for trauma-focused CBT is based on research with Western populations, it is questionable whether this intervention can be applied to refugee populations (NICE, 2005).

Crucially, it is an oft forgotten fact that becoming a refugee is not intrinsically a psychological phenomenon, but a socio-political and legal one (Papadopoulos, 2007). Research demonstrates the association between the socio-political context of the refugee and asylum-seeking experience and psychological distress (Porter & Haslam, 2005). Biopsychomedical understandings therefore risk pathologising social phenomena, locating deficit within individuals and ignoring the wider context (Bhugra, Craig, & Bhui, 2010; Summerfield, 1999; 2008), whilst disempowering clients by imposing Western knowledge frameworks (Summerfield, 2008). Diagnostic-led approaches may also pathologise normal reactions to war, loss, and displacement (De Haene, Rober, Adriaenssens, & Verschueren, 2012). Furthermore, individualised approaches like trauma-focused CBT focus on single traumatic events, which may not match the multiple prolonged difficulties often experienced by refugee and asylum-seeking families. It may therefore be helpful to consider the contribution of other models when working with this population.

Papadopoulos (2007) outlines that being exposed to adverse situations in the context of the refugee experience can result in three types of negative effects: ordinary human

suffering, distressful psychological reaction, and psychiatric disorder. Papadopoulos (2007) suggests the literature tends to have a narrow view of refugee trauma as 'PTSD only', but emphasises that not all trauma is of the PTSD type. He highlights that difficult experiences need not result in negative effects, but can also result in neutral or positive effects. Others have also understood refugee trauma more broadly, as an existential loss of meaning (Alcock, 2003; Slobodin & de Jong, 2015). Qualitative studies interviewing refugees have demonstrated the importance of gaining meaning during life in exile (Kramer & Bala, 2004). Narrative perspectives suggest traumatic experiences can impact on meaning-making processes (Kiser, Baumgardner, & Dorado, 2010). Diagnostic-led PTSD treatments such as CBT for PTSD aim to mitigate symptoms, but may not address the deeper issue of meaning-making which can underlie traumatic reactions (Figley & Figley, 2009). This study assumes trauma to be a universal emotional experience which can occur in response to extreme events outside of normal human experience, encompassing but not limited to symptoms typically associated with the diagnosis of PTSD.

Current approaches in refugee mental healthcare may thus overlook the broad impact of adverse experiences, emphasising vulnerability and potentially pathologising distress. Western psychological approaches to trauma also centre on the premise that 'working through' experiences by talking and 'emotionally ventilating' can alleviate distress (Summerfield, 1999). Indeed, both trauma-focussed CBT and Eye Movement Desensitization

and Reprocessing (EMDR) emphasise talking to 're-process' traumatic memories (Ehlers & Clark, 2000; Shapiro & Laliotis, 2011). The potential associated pitfalls of this are perhaps best illustrated by the implementation of psychological debriefing, which was routinely recommended before it was shown to be unhelpful when offered too soon after a traumatic event (Bisson, Jenkins, Alexander, & Bannister, 1997; Kenardy et al., 1996). The potential deleterious impact of debriefing may not just be limited to the issue of timing. In some non-Western cultures, forgetting and not talking about difficulties is understood as a helpful long-term coping strategy (Summerfield, 1999). Imposing Western psychological models focusing on 'disclosure' may therefore be experienced as unhelpful by people from cultures where forgetting is prioritised, and in some cases, might be detrimental to wellbeing (Rousseau, Measham, & Nadeau, 2013; Angel, Hjern, & Ingleby, 2001).

Systemic family therapy may propose a fundamentally different understanding to assumptions generally held by individualised Western therapy approaches. Unlike other approaches, which hold assumptions about what constitutes the 'problem' and 'therapy', systemic theory may offer a radically different understanding (Littlewood, 1990; Rober & De Haene, 2014), viewing 'problems' and 'outcomes' as constructed, avoiding ontological traps by working from clients' understandings and meanings (Goolishan & Anderson, 1992; Daelemans & Maranhão, 1990). Rather than locating problems within individuals, systemic theory understands distress as a product of interactional dynamics, and post-modern

developments increasingly emphasise wider socio-political contexts (Dallos & Stedman, 2014; De Haene et al., 2012; Papadopoulos & Hildebrand, 1997). Systemic approaches may therefore offer a particularly important way of making sense of distress experienced by refugees and asylum-seekers in a way that serves to understand higher levels of context, moving away from a position of pathology by minimising the imposition of narrow Western conceptions of distress.

NICE (2005) recommends considering "the impact of the traumatic event on all family members". Indeed, families can be a valuable resource for refugee children (Voulgaridou, Papadopoulos, & Tomaras, 2006; Walsh, 1996). It has been proposed that "the single best way to promote the psychosocial well-being of [refugee] children is to support their families" (UNHCR, 1994, p. 43). However, the literature evidencing systemic family therapy with this population is limited (Slobodin & De Jong, 2015).

De Haene, Grietens and Verschueren (2010) suggest supporting family relationships through family therapy can act as a primary vehicle for restoring continuity in refugees' and asylum seekers' lives. Exposure to trauma can have adverse consequences for families (Dekel, Goldblatt, Keidar, Solomon, & Polliack, 2005; Henry et al., 2011; Kiser et al., 2010; Matsakis, 2004), and political violence can affect family communication, relationships, and connections with the wider community (Weine et al, 2004). Watzlavick, Beavin, and Jackson (1967) propose disturbances in communication within the family, such as silencing traumatic life

events, can result in inadequate family interaction. Ambiguity results when there is contradiction between the stories told and stories lived (Montgomery, 2004). This can be detrimental to refugee children's mental wellbeing (Braga, Mello, & Fiks, 2012; Dalgaard & Montgomery, 2015). In a systemic approach, individuals can be understood as 'symptom bearers' for families' distress (Byng-Hall, 1980). Systemic approaches emphasise meaning-making as a key ingredient in trauma treatment and for strengthening family resilience (Figley & Figley, 2009; Walsh, 2002). However, clinicians may find it difficult to know whether to address traumatic memories when considering how to develop refugee families' resources (Reichelt & Sveass, 1994).

In an important piece of research, Dalgaard and Montgomery (2015) systematically reviewed the literature considering therapeutic disclosure of traumatic experiences within refugee families from a range of cultures, drawing out significant conclusions. Findings suggested a 'modulated' approach to disclosure could promote psychological adjustment in children, where timing and manner of disclosure are emphasised, rather than disclosure itself. Parental sensitivity to children's emotional needs and developmental status, the family's reunion status, and the meaning of disclosure of traumatic events within the family and culture were described as key (Measham & Rousseau, 2010). This study highlights current understandings of the effects of disclosure within refugee families, but authors outline a lack of clarity regarding how 'modulated disclosure' can be facilitated, acknowledging this as an

important area for future research. The present study seeks to expand on this by considering family therapists' perspective on this topic.

The present study

This study aimed to develop understandings of current systemic practice with families from refugee and asylum-seeking backgrounds who have experienced trauma. In particular, the study aimed to develop a theoretical understanding of how conversations about trauma emerge in systemic family therapy. The following broad research questions were used as a guide.

1. What are systemic family therapists' understandings of trauma in families from refugee and asylum-seeking backgrounds?
2. What key processes and factors influence how conversations about trauma are navigated between systemic family therapists and families from refugee and asylum-seeking backgrounds in therapy?
3. What are the key mechanisms of change in systemic family therapy with families from refugee and asylum-seeking backgrounds according to systemic family therapists?

Method

Design

Using a qualitative non-experimental design, semi-structured interviews were employed and analysed using grounded theory methodology (GTM) (Glaser & Strauss, 1967; Urquhart, 2013). A qualitative methodology was chosen to capture the richness of the therapeutic process. GTM allows for the iterative and systematic development of new theoretical models, grounded in participants' social experiences (Glaser & Strauss, 1967; Urquhart, 2013). This was chosen over other qualitative methodologies due to its particular emphasis on theory generation, allowing for the development of a theoretical understanding of how conversations about trauma are navigated in systemic family therapy.

Epistemological position

GTM, as originally posited by Glaser and Strauss (1967), held a positivist epistemological position. Developments since this seminal text have meant that GTM's epistemological position has been understood more flexibly (Urquhart, 2002). Whilst Glaser (1978) held a positivist stance, understanding findings to be discovered within the data, Strauss and Corbin (1990) understood findings to result from the construction of intersubjective meanings. Whilst this study follows the Glaserian method of data analysis, the researcher held a 'critical realist' position (Collier, 1994), viewing the generation of data as a combination of objective reality and researcher subjective interpretation. In line with this,

this study assumed symptoms associated with PTSD to be a universal emotional human experience which can occur in response to extreme events outside of normal human experience, but a critical position was held towards Western conceptualisations of trauma as 'PTSD only' and the diagnosis of PTSD.

Participant recruitment

Participants were initially recruited from a north London mental health service which exclusively supports refugee and asylum-seeking children, young people and families. Recruitment was subsequently broadened and participants working in services across England were theoretically sampled to strengthen the emergent theory (Glaser & Strauss, 1967). These participants were recruited through the Association of Family Therapy and word of mouth. Potential participants were initially approached by email. Phone calls were organised with interested participants to answer questions and arrange interviews. Participants completed consent forms before commencing the interview (Appendix D).

Participants

Participants were included in the study if they were:

- Family and Systemic Psychotherapists who were UKCP-registered and had completed a qualifying level MSc programme approved by the Association for Family Therapy & Systemic Practice (AFT).

OR

- Clinical Psychologists, Counselling Psychologists, or Psychotherapists who had completed or were in the process of completing an Association for Family Therapy & Systemic Practice (AFT) accredited Foundation or Intermediate Systemic Training course.

Participants had all worked with refugee and/or asylum-seeking families using systemic family therapy. A broad definition of systemic family therapy was used, encompassing structural and strategic approaches focusing on behaviour patterns and regularities; approaches aligned with the Milan school; and social constructionist approaches.

Participants were required to have at least one year of post-qualification experience and to have worked systemically with at least one family from a refugee or asylum-seeking background who had experienced trauma where a child was involved. A family was defined as at least two relatives, one of whom is a child (4-18 years old). A broad definition of trauma was used, encompassing emotional distress resulting from political repression, detention, torture, other kinds of violence, disappearance of relatives, separation and loss, and hardships in exile (van der Veer, 1998).

Ten people participated in the study. Participants were aged 32-70 (mean 51.4) and were mostly white British and female, though some participants were from other cultural backgrounds. Further demographic details are presented in Table 3.

Ethical considerations

The study received ethical approval from the ethics panel at Canterbury Christ Church University (Appendix E) and from the Health Research Authority (Appendix F). The British Psychological Society's code of ethics and conduct was followed (BPS, 2009). Participants were given at least one week to consider participation in the study. Consent was checked before interviews commenced, and participants were reminded all data would be anonymised. Following the interview, participants were given the opportunity to engage in a debriefing conversation to share and discuss any concerns.

Table 3. Participant demographics.

Participant	Gender (age)	Cultural background	Relevant professional title(s) and qualification(s)	Years practicing systemically
1 (Bisi)	F (42)	British (Black African, Nigerian)	Clinical Psychologist; Systemic Psychotherapist; Level 1 Narrative Therapy training	10 years
2 (Adele)	F (41)	French (Black African, Congolese)	Functional Family Therapist; Systemic Psychotherapist in training	3 years
3 (Daniel)	M (57)	British (White, Ashkenazi Jewish)	Social Worker; Consultant Systemic Psychotherapist	24 years
4 (Patricia)	F (61)	White British (European)	Clinical Psychologist; PG Dip. Systemic Psychotherapist	30 years
5 (Alice)	F (36)	White British	Systemic Psychotherapist; PG Dip. Play Therapy	6 years
6 (Louisa)	F (63)	British/German (Jewish)	Psychiatrist; Systemic Psychotherapist	10 years
7 (Heather)	F (51)	English (White English)	Social Worker; Systemic Psychotherapist	20 years
8 (Joan)	F (70)	British (White British)	Social Worker; Systemic Family Therapist	26 years
9 (Ciara)	F (32)	British, Irish (White Irish; Roman Catholic)	Clinical Psychologist; Systemic Psychotherapist in training; Narrative Therapy Levels 1+2; MA Refugee Studies	1.5 years
10 (Arthur)	M (61)	British (White British)	Social Worker; Systemic Psychotherapist	23 years

Note. 'Years practicing' conveys years practicing family therapy with families from refugee or asylum-seeking backgrounds.

Interviews

A qualitative approach using individual interviews was chosen to allow for rich data collection whilst enabling participants to speak confidentially (Taylor, DeVault, & Bogdan, 2015). Interviews lasted from 48 minutes to 1h 28 minutes (mean 1h 3mins). Seven

interviews were conducted face-to-face and three through video-conferencing software. Interviews covered clinicians' positions on talking about trauma with families, the process of talking about trauma, and the perceived effects of talking about trauma. Prior to data collection, the interview schedule (Appendix G) was reviewed by an experienced systemic family therapist to ensure questions were appropriately aligned with systemic principles. For example, in line with second order systemic theory which understands the mutual influence between families and therapists (Gosnell, McKergow, Moore, Mudry, & Tomm, 2017), participants were asked not only about the families they worked with but also about how families' stories might interact with their own. Existing literature was broadly considered in designing the interview schedule, however, the researcher was careful not to unduly influence participants, allowing for exploration of emergent hypotheses (Glaser, 1978). Open questions were used

in order to foster rich and diverse responses (Charmaz, 2014).

The interview schedule was revised with agreement from the ethics panel after initial data collection (Appendix H) as an incongruity was observed between the assumptions behind the questions asked and the positioning of therapists interviewed. Interviews were audio-recorded and transcribed.

Data analysis

Data analysis followed procedures outlined by Glaser and Strauss (1967). In keeping

with GTM, data collection and analysis proceeded concurrently to allow initial codes to influence sampling. Data were analysed using NVivo 11. The first stage of data analysis involved coding transcripts following 'line by line', or 'open' coding, allowing the researcher to fully immerse themselves in the data. In the second stage of analysis, selective coding, data were coded into relevant core categories. Table 4 presents examples of open codes and selective codes. 'Constant comparison' of the data was undertaken, meaning new occurrences of data and codes were compared to previous data and codes, directing the analysis. In the third stage of coding, codes were 'scaled up' into conceptual constructs, and relationships between these constructs were considered. Constructs and relationships were developed with the aid of theoretical memos, which were kept throughout the coding process (Appendix I).

Theoretical sufficiency

Recruitment and data collection were guided by theoretical sufficiency, ceasing when this was considered to have been achieved. Constant comparison and discussions in supervision aided decision-making. Dey (1999) understands theoretical sufficiency as the stage at which enough data has been collected to offer sufficient depth of understanding to develop a theory. Theoretical saturation, the collection of data until new codes no longer emerge (Urquhart, 2013), was not used due to critiques in the literature (Nelson, 2017) and time limitations.

Quality assurance

The influence of researcher bias on data analysis was considered. A research diary was kept throughout the research process (Appendix J). Documenting preconceptions, motivations, and decision-making encouraged researcher self-awareness. Four peer meetings were held to ensure quality and rigour of coding procedures, and a peer researcher analysed an extract of the data to ensure reliability. Codes were cross-checked and compared, and disagreements were resolved through discussion. Respondent validation (Mays & Pope, 2000) was employed, whereby all participants were invited to give feedback on study results. Two participants responded, indicating that the model correctly represented their practice and fit well with systemic theory.

Table 4. Example of open coding.

Text from interview transcript	Initial open code	Selective code
Um... yea, or how, how you look after children might be slightly different.	Differences in parenting	Parenting
Um, and their child was very anxious as well.	Anxious child	Child's emotional wellbeing
Um… I mean particularly in England, I think we live in one of the most secular societies in the world	Living in most secular society in world	Therapist culture
We didn't stand in judgement on them at all.	Therapist is non-judgmental	Non-judgmental
Helping the family think about	Therapist as helper	Therapist facilitates

Results

Findings are presented in Figure 2 and Table 5. The resulting theory contributes to understandings of how systemic family therapists and families from refugee and asylum-seeking backgrounds negotiate conversations about trauma. The model depicts the circular and dialogic nature of relationships and systems within the areas identified, focusing on two key constructs: 'trauma as loss of meaning' (depicted in red) and 'meaning-making through the therapeutic encounter' (depicted in green). Constructs are colour-coded to ease comparison across the pictorial model (Figure 2) and text.

The therapeutic encounter is understood to emerge from a meeting of two systems, 'the family system' (blue) and 'the therapist system' (purple), which operate within different contexts and experience different pressures. Both the family and therapist have different experiences which have contributed to help-seeking and help-giving. Refugees and asylum seekers can experience specific traumatic events, but the emphasis is on the accumulation of prolonged difficult experiences, which promote a sense of disconnection within individuals and families and between individuals and their wider contexts. These experiences of disconnection can cause people to lose meaning in their lives, precipitating distress: 'trauma as loss of meaning' (red). Therapists can also experience a sense of disconnection between their own values and the values of the wider socio-political and legal system, precipitating a loss of meaning which can cause discomfort. The therapeutic encounter is therefore

understood as a process of meaning making, both for families and therapists ('meaning-making through the therapeutic encounter'; green). Therapists and families co-construct conversations about trauma. If families indicate wanting to talk about trauma, therapists take time to 'warm the context' before these conversations happen. Through a process of meaning-making, families can connect with new narratives and meanings. This can promote a new-found sense of connection and wellbeing. Therapists also engage in a separate process of meaning making, becoming 'active witnesses' to influence the wider context *(orange)*. The influence of the wider context (*black*) is ever present. A more detailed account of the model's principal constructs and processes is presented in Figure 2.

Table 5. Identified core components and subcomponents.

Core components and sub-components	Number of participants*
Wider context	10
Immigration policy	3
Oppressive wider systems	5
Social justice	3
Societal narrative	6
Safety and stability	10
Sociopolitical context	9
The family system	10
Experiences which lead to help-seeking	10
Assimilation	7
Social graces	7
Culture	10
Family factors	10
The therapist system	10
Experiences which lead to help-giving	9
Therapist factors: Impact of work on therapist	10
Models & theories	10
Service context	9
Social graces	4
Trauma as loss of meaning	8
Trauma disturbs family's meanings	8
Work and wider context disturb therapist's meanings	2
Meaning-making through the therapeutic encounter	10
Therapist positioning	10
Consultation to networks	6
Trust	6
Risk	4
Working with interpreters	7
Conversations about trauma	10
Meaning-making	10
Active witness	8

Note. *Number of participants for which component/subcomponent has been coded is stated for information.

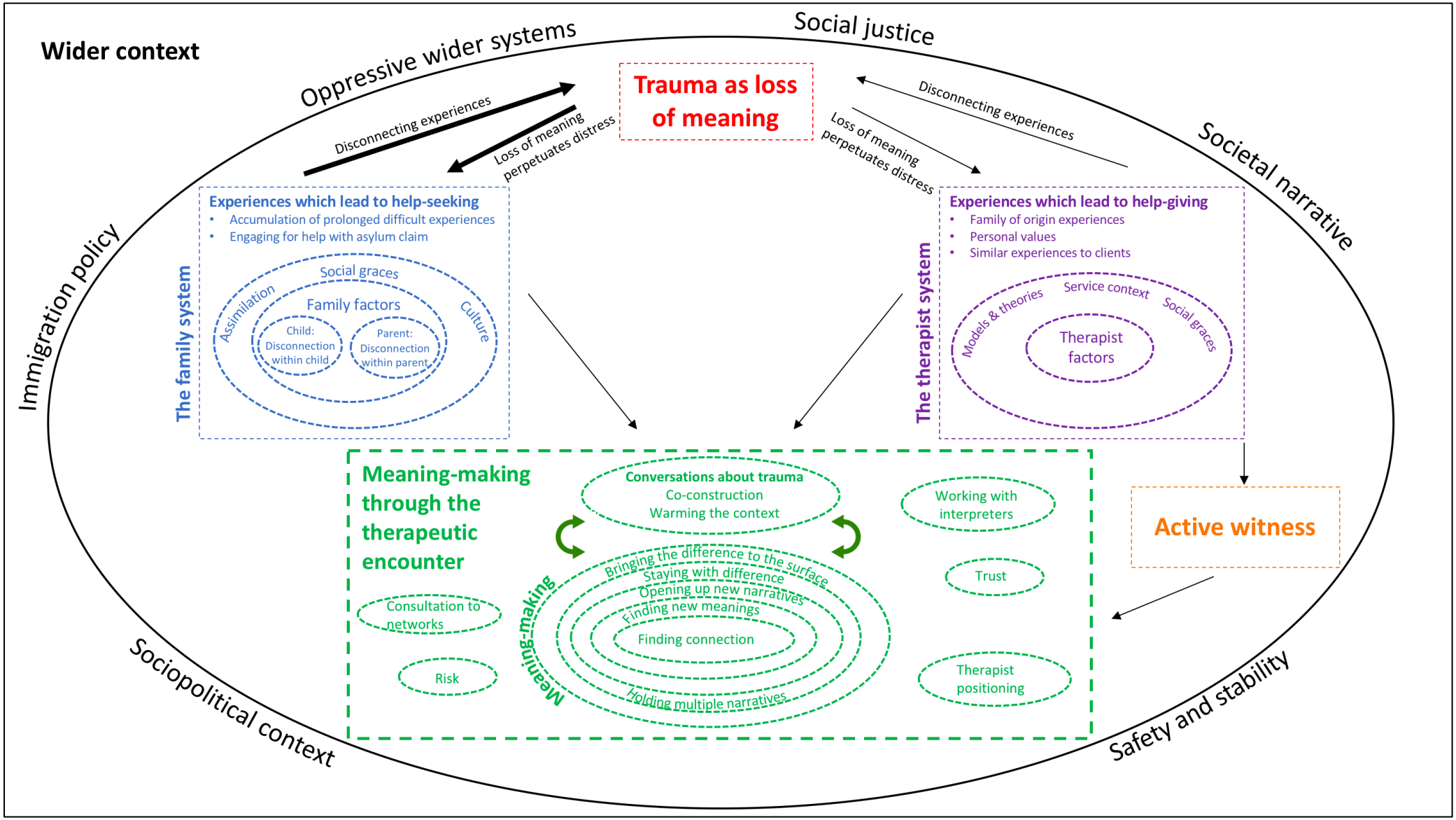

Figure 2. Conversations about trauma in systemic family therapy with families from refugee and asylum-seeking backgrounds.

The family system – *(blue)*

Experiences which lead to help-seeking

Accumulation of prolonged difficult experiences. Participants understood trauma as the effect of the accumulation of multiple traumatic experiences, beyond a single traumatic event, emphasising difficult pre-flight, during flight, and post-flight experiences families often endured.

> "I think for most of the families that we're seeing we're not talking about single events." (Daniel)
>
> "and there is the trauma in general where is less on a continued process. So if you have a timeline, so the trauma is... going through that line" (Adele)

The impact of this was considered to be greater and more complex than experiencing a single traumatic event, as the accumulation of traumatic events was thought to "ricochet onwards in every step of the journey" (Patricia). Though pre-flight experiences were highlighted, participants emphasised the importance of placing these within the broader 'disconnected' asylum experience.

> "Um.. because it's ongoing for so long, for many of them." (Patricia)

Traumatic experiences in exile were particularly emphasised, such as the harmful effects of the shame, fear, uncertainty, and lack of safety associated with the asylum-seeking process and being an isolated "non-person" (Joan) in a new country. Data suggested that families are often preoccupied by the future and struggling with poverty, unemployment, and housing difficulties:

> "so it's a double whammy in a way, you're not safe, and you could go back to an unsafe environment" (Bisi).

A further level of trauma was associated with living in a society where one experiences powerlessness – often replicating the powerlessness experienced in home countries – racism, and xenophobia. Most participants also emphasised loss as a prolonged trauma for families:

> "the trauma of loss of home, trauma of loss of a sense of self… and purpose and community and… culture" (Bisi).

Engaging for help with asylum claim. Participants outlined that families often came to services after being told to by other professionals, presenting a rehearsed story which they hoped would help them with an asylum claim:

> "…they feel that they have to disclose because that will help them with… their immigration status…" (Adele).
>
> "You know, that sometimes you have to stick very strongly to a very um specific story so that it's clear for all the different agencies." (Alice)

Assimilation, culture, and social graces

These higher-level processes were core to making sense of families' experiences. Culture was seen to influence families' beliefs and understandings of distress, wellbeing, and the self. Participants also emphasised how 'social graces' (Burnham, 2013) can shape people's experience of events and the world around them. Assimilation was characterised as an added pressure on families:

> "it's that type of… management of… those whole sort of adjusting processes that's really our… key work with families." (Daniel)

Family factors

Participants understood experiences described above to intensify emotional distress in the family, creating a sense of disconnection. Different coping styles and difficulties with communication can lead members to misunderstand each other and feel disconnected. Family members aim to protect each other from the effects of harmful experiences by disconnecting, but this creates fragility in the family system, characterised by processes such as distress being located in one family member or disrupted family hierarchy:

> "parents want to try and protect their children from um, they can almost feel like the trauma they've experienced, the pain they are experiencing is... infectious in some way" (Bisi)
>
> "She wanted to protect her children from it, the awfulness of what she'd seen." (Arthur)
>
> "…children or teenagers… will kind of know more than the parents think they know. But they're often trying to protect parents from distress by not talking about those difficult experiences… and then parents… are also trying to protect children from those traumatic experiences." (Ciara)

Parent: Disconnection within parent. Participants outlined that traumatic experiences could result in parental emotional distress, characterised as a disconnection within one's internal world:

> "Fundamentally… what I think is that in the moment of trauma, in the moment of being overwhelmed, one loses the capacity to be meta-cognitive... and not only meta-cognitive but meta-emotional" (Arthur).

Participants understood this internal disconnection to cause parents to become isolated and emotionally absent, finding it difficult to parent:

> "I would say that the parents are not able to be emotionally present... So they will cook and do the basic care, but emotionally they're not going to be present." (Adele)
>
> "with the parents, in their mind, their ability to keep the children in mind and manage behaviour and be present" (Heather).

Child: Disconnection within child. Participants understood children to become traumatised when they experienced events which they could not attach meaning to, leading to symptoms such as behavioural and sleep difficulties as expressions of distress:

> "because the, for the child, because they might… sense the anxiety but don't have a narrative to kind of put around that lived felt sense of anxiety or trauma" (Ciara)

> "children often blame themselves if their parents are struggling... particularly if they haven't got a narrative to make sense of it, and so it might impact on the young person's self-esteem, or... sense of themselves" (Bisi)

Summarising, participants outlined individuals and families experienced trauma when difficult experiences fostered an intense sense of disconnection.

The therapist system – *(purple)*

Experiences which lead to help-giving

Many participants outlined that experiences in their own families of origin influenced their choice of career, describing the importance of working in a profession aligned with their personal values:

> "I've been raised with the idea that your context is very influential on you… it can really make a difference to how you feel and how you act." (Alice).

Participants from minority backgrounds (Bisi, Adele, Daniel, Louisa) highlighted personal stories of marginalisation, suggesting this may have attracted them to working with this client group.

Models & theories, service context, social graces

Participants were very aware of their own culture and privilege, of how they might

be influenced by broader psychological frameworks, and of the impact of service contexts:

> "the context that I'm working in… informs what I'm allowed… to ask about and what they're... expecting to talk about" (Alice).

Therapist factors

Participants outlined the emotional impact of working with families, explaining they could often feel stuck and uncertain when working with complexity, describing the "humbling" (Bisi, Adele, Patricia, Heather, Ciara) experience of witnessing families' resilience, which fostered hope and strength within them.

> "I used to think 'oh my god! what am I gonna to do with all this?' but, obviously I was doing something..." (Heather)

Trauma as loss of meaning – *(red)*

Trauma disturbs family's meanings

As outlined above, participants understood difficult experiences to disturb individuals and families by fostering disconnection. These experiences of disconnection lead to a loss of meaning which characterises trauma, understood as a loss of identity and sense of self in the world. Experiences which lead to a loss of meaning and identity, shattering peoples' sense of the world, are therefore likely to lead to trauma for refugees (and may also apply for other populations).

> "… existentially, what it means to lose everything that gives you… that orientates you and gives you foundation and, almost like wallpaper, it's kind of there, but you don't notice until it's gone" (Bisi)
>
> "they're left struggling with… how to be whole again, how to make sense of… what has happened to them" (Adele)

Work and wider context disturb therapist's meanings

Two participants' accounts suggested a comparable process for therapists, with other participants' views appearing to support this. Witnessing first-hand a reality that most people in society are blind to whilst operating within an arguably abusive socio-political system which perpetuates clients' distress was suggested to disturb therapists' existential sense of things and foster a sense of disconnection from wider professional and social systems:

> "it's like a whole layer of reality that you're party to that, that most people aren't, and it's really painful to live like that." (Bisi).

Meaning-making through the therapeutic encounter – *(green)*

In response to a loss of meaning resulting from difficult experiences, therapy was understood as a process of reconnecting to meaning and finding new meaning.

Therapist positioning

Therapist positioning enabled families and therapists to work together despite differences in contexts and meanings. Participants described adopting a non-judgemental, person-centred approach, encompassing warmth, respect, honesty, and

clarity. A relativist stance helped participants engage in meaningful conversations with families despite differing cultures. Crucially, therapists did not understand themselves to play a directive role in opening up conversations about trauma, outlining that these conversations did not have to be the 'end goal' of therapy.

> "There isn't necessarily a right or a wrong, everything is kind of relative… trying to understand someone else, where they're coming from… and try and work from that point rather than from your point" (Alice).
>
> "the systemic model... allows for the therapist to be curious and take a not knowing position in relation to those experiences"

Participants described adopting a position of boundaried flexibility, working flexibly in terms of appointment locations but also adopting roles which might not be traditionally associated to therapists' remit:

> "… it does require us to move a bit more from… our narrow remit. It means that we can't just be therapists, we've also got to be advocates or... you know, liaison officers, social workers... we have to do that type of work because… otherwise people won't get… the sort of proper service. Because actually their problem might be more in relation to... a lack of housing… or... they may need a letter for the solicitor to argue their case in court. Sometimes we get commissioned to write... court reports and things... so yea, it is wider than just psychological therapy" (Daniel).

Trust, consultation to networks, risk, and working with interpreters

Participants described the importance of "building trust in the relationship" (Adele) with families. One participant explained, "what I'm doing is kind of consultation to networks" (Patricia), and participants outlined the need to "sometimes be directive" (Bisi) when dealing with risk. The added element of working with interpreters was emphasised.

> "it's much better if you can work with - if the interpreters can be trained and you can work together" (Louisa)

Conversations about trauma

Co-construction. All participants outlined co-construction as an essential foundational element in the therapeutic encounter. Data suggested that family and therapist shape the process of therapy together, through collaboration. This means talking and thinking with families about the presenting problem, so that the therapist does not impose their own assumptions. Participants outlined taking a "decentred" position (Adele), holding a position of curiosity, talking tentatively, and helping families to explore the stories they deem important. In this way, families hold the power and lead the way. Therapists work with families' cultural meanings rather than imposing their own assumptions of what the therapeutic encounter should be like or aim to achieve, understanding that some conversations (e.g. talking about trauma) might never happen. Co-construction is therefore a key factor influencing how conversations about trauma are navigated in therapy.

> "The collaborative approach is very much about asking people 'what do you think?'" (Bisi)
>
> "Cause they're the expert of what they need to talk about, from my perspective, that's my belief, and so I tend to follow their lead" (Alice)

Warming the context. Participants outlined a series of processes, collectively understood as 'warming the context', as an essential foundation which could enable families to feel comfortable speaking about traumatic things that had happened to them if they wished to. This key process influenced how conversations about trauma emerged in therapy. Factors outlined which might be taken into account when thinking about whether talking might be beneficial (and therefore promote connection and not disconnection) included the stage the family might be at in the asylum process, the situation in the family's home country, whether the family had processed reasons for fleeing, the age of any children present, the nature of what might be talked about (e.g. sexual violence), and whether someone in the family was acutely mentally unwell.

> "so I guess the idea is, from a systemic perspective, to try and kind of warm the context for them to be able to do the work together" (Ciara)

Therapists took time to understand families' needs by asking questions, listening, and checking understanding to understand family relationships, individual members' struggles, and what may have already been discussed.

> “very carefully plot the, you know, what can be spoken of or not spoken of” (Arthur)

This might mean having separate sessions with parents and children or preparing individuals before family work can take place (e.g. providing an individual space for a family member who is particularly struggling before family work begins, or alongside it, so that the individual can engage in family work). Attending to these factors can therefore promote helpful conversations about trauma which encourage connection within families.

The process of speaking the unspoken was understood as an important element which could aid families in the course of meaning-making and foster connection, if negotiated safely. When families indicated an inclination towards this, therapists outlined talking around the trauma, understood as talking about the emotional impact of the trauma rather than going into details about what the trauma might actually be, and exploring with the family what it might be like to talk about the trauma. This might mean exploring the benefits and risks of talking or not talking, thinking about how information might be shared in a way that all family members can understand, and referring to the unspoken without actually speaking about the details. Therapists might use circular questioning to give family members the choice to participate in a conversation. If families wish to talk about things that have been previously silenced, scaffolding around the trauma might help families to slowly move towards a position where they feel able to talk. In this process, therapists might help families to slowly unpack a story in a stepped approach; initially working in the here

and now, moving onto superficially speaking about a story, and perhaps using metaphor to slowly and indirectly arrive in a position where families feel freer and readier to talk, simultaneously checking with the family how the process of putting things into words is being experienced. Participants discussed how therapists navigate this process by continuously tuning into individual reactions to talking. Scaffolding and talking around the trauma were therefore key processes influencing how conversations about traumatic experiences were navigated.

> “So it's… that gentle movement towards that place where there's... a sense, ‘yea we can talk about this stuff can't we? we can say’” (Arthur)

> “ ‘You don't have to tell me what that secret is... but... what do you think the effect of there being a secret might have – or the fact that you've talked with that person but not that person – how do you think that might affect how they see their relationship with you?’ ” (Louisa)

Meaning-making

The process of meaning-making, which could lead to a newfound sense of connection for families, was a key mechanism of change identified by participants.

Bringing difference to the surface. Therapists aimed to bring all family members’ voices to the surface to explore difference, and might disclose their own beliefs, or use reflective teams, to introduce additional difference. Participants suggested that making it acceptable to talk about difference could move families forward.

> “it is trying to bring in a difference that isn't there, if it is the case that the family's stuck in a way of being that isn't moving them forward” (Bisi)

Staying with difference. Participants explained the importance of allowing families to stay with the (sometimes distressing) experience of talking, understanding family therapy as a space for ‘being with’ difference rather than a therapeutic approach aiming to directly promote wellbeing or make families ‘better’.

> “It's often a case of... holding what is, and just trying to find as much meaning as you can” (Patricia)
>
> “…systemic therapy… kind of acknowledges the differences between those contexts and how they can cause difficulties. And to have that acknowledged and to... sort through it and decide where you sit with it all... can be very helpful.” (Alice)

Holding multiple narratives. Therapists outlined holding multiple narratives to explore difference, allowing families to negotiate a new space where members’ different experiences could be acknowledged:

> “A lot of what I do is trying to multiply engage with multiple stories... almost mirroring to the family that it's possible for multiple, diverse experiences and realities to coexist and be equally valid.” (Bisi)

Opening up new narratives. Data suggested that staying in a space where difference can be tolerated can allow families to open up new complex and rich narratives instead of holding onto 'thin' stories of trauma, thickening stories of resilience and strength.

> "a kind of idea of double listening so listening to the effects of the trauma but also the way the person has responded to it and what resources they've managed to develop in order to do that." (Patricia)

Finding new meanings. Participants outlined how opening up new narratives might help families develop different meanings from traumatic experiences, freeing people up to position themselves in relation to a story of trauma rather than being defined by it. Participants posited that connecting through new understandings can promote change in family relationships and increase individuals' wellbeing. Families think together and create a richer multi-faceted understanding of their experience, which reconnects people with meaning in their lives. This is a key mechanism of change.

> "But I think through the conversations in the therapy they were almost able to develop a new narrative, a shared narrative about strengths and… how they faced adversity." (Ciara)

Finding connection. Data suggested that these processes can help families to connect to their experience in a different way, connecting past and present, and ultimately re-establishing connections within the family. Rebuilding connections was a key process which promoted change for families. Participants described helping families to make links and connect up their experiences. Rebuilding connections could bring new meanings to a life completely stripped of meaning.

> "Ultimately the transformational quality is to understand that… something called love continues and can be discovered in the present... and… the richness of the inner life… can be rediscovered with all its pain and joys." (Arthur)
>
> "So… I suppose we were putting pieces of the jigsaw together for them… so that they could have a more coherent understanding of what happened." (Joan)

At the same time, therapists described finding a sense of connection within themselves from the work:

> "I am more open, I am curious… I am more 'me'." (Adele)

Active witness – *(orange)*

Data suggested therapists also engaged in meaning-making by shifting from a position of 'passive observer' to 'active witness', becoming politically active to spread

awareness and influence policy, challenging oppression and influencing socio-political contexts. This helped some participants to reconnect with themselves and with a sense of meaning. Some described merging professional and political identities.

> "…shifting from a position of passive observer to active witness... I think, you know, we've been feeling that that's what we want to be doing." (Patricia)
>
> "I find it hard to talk about working with refugee families, asylum seeking families… in a purely psychological way, and... so I think in that way it's heavily shaped my professional identity, that I now see my professional identity as a… hugely political identity." (Bisi)

Wider context – *(black)*

Participants emphasised the central influence of the wider context, emphasising families' need for safety and stability before work can take place, highlighting effects of socio-political contexts, immigration policy, social justice, and societal narratives:

> "the wider context is always impacting and informing… what is and isn't possible" (Bisi).

Discussion

This study sought to develop a theoretical understanding of how systemic family therapists and families from refugee and asylum-seeking backgrounds negotiate conversations about trauma, attempting to draw out key components of this therapeutic process to better understand the mechanisms at play. The history of systemic theory has been one of transition, succumbing to many influences (Hoffman, 2002). Key systemic principles and influences are therefore highlighted in the discussion to set the model of working presented here apart from other theories and therapeutic practices with refugees and asylum seekers. It is hoped that conclusions drawn will contribute to the research base so that this approach can be evaluated and built on, given the current lack of evidence base in this area (Coulter, 2013; Slobodin & de Jong, 2015) and the potential this approach shows for this population. Central elements of the resulting theory relating to the research questions are discussed below.

Participants were predominantly white British females working in the UK, and data were influenced by participant backgrounds and contexts. Interestingly, participants from minority backgrounds suggested their own experiences of marginalisation may have led them to work with this population. The study sample may not be representative of professionals working in this field, but may highlight that professionals working in this area in the UK are not representative of this diverse client group.

Understandings of trauma

Results suggested a broad understanding of trauma, beyond narrow understandings of trauma as 'PTSD only' typically endorsed by the literature considering refugee mental health. This supports the argument proposed by Papadopoulos (2007), which categorises trauma under three degrees of severity. Trauma was understood to result from an accumulation of prolonged difficult pre-flight, during flight, and post-flight experiences. In line with perspectives which understand refugee trauma as a loss of existential sense of meaning (Alcock, 2003; Slobodin & de Jong, 2015), participants understood families to struggle with a sense of disconnection and loss of meaning resulting from traumatic experiences. Disconnection was also understood as a mechanism by which family members aimed to protect each other from the effects of traumatic experiences, and could be considered a 'failing solution' (Watzlawick, 1974). Indeed, the literature suggests that traumatic experiences and political violence can affect family communication and relationships as well as connections with the wider community (Dekel et al., 2005; Henry et al., 2011; Nelson Goff et al., 2007; Weine et al., 2004). A broad range of experiences can therefore be experienced as traumatising, and trauma is understood broadly as a 'loss of meaning'.

Conversations about trauma

Therapists aimed to collaboratively co-construct the therapeutic encounter, empowering families to work with their own meanings rather than following therapists' frameworks; 'talking with' rather than 'doing to' (Goolishan & Anderson, 1992). This is a strength of the systemic approach, given critiques which outline that Western psychological approaches can disempower clients by negating non-Western

knowledge systems (Summerfield, 2008). Rather than understanding themselves as detached, objective observers with specific agendas (e.g. for families to talk about trauma), participants outlined adopting a relativist 'not knowing' and 'curious' position, positioning the client as the expert (Anderson & Goolishian, 1992). Therapists aimed to develop an open space and facilitate a dialogical process in which new conversations could emerge. Conversations about trauma were therefore viewed as one of many possible new conversations. These central concepts align with a social constructionist and dialogical approach to systemic family therapy, which emphasises the role that language and dialogue play in the construction of meaning (Anderson & Goolishian, 1988; Seikkula & Trimble, 2005).

Therapists attended to various factors to enable families to feel more 'ready' to speak, for example having separate sessions with parents and children, or providing an individual space for a family member who is particularly struggling. When families expressed ambivalence about speaking about a silenced trauma, therapists supported families to 'talk about talking' (Burnham, 2005), i.e. talk about the emotional impact of the trauma, consider the impact of not talking about the trauma, or explore what it might be like to talk about the trauma. Circular questions (Tomm, 1988) can give individuals the choice of participating in a conversation. Therapist questioning might 'scaffold' the development of new conversations; slowly unpacking a story, initially working in the present, moving onto superficially addressing a story, perhaps using metaphor to slowly and indirectly arrive at a place where families might feel freer and readier to speak the unspoken. This relates to the 'scaffolding' described in Michael White's (2007) narrative approach, which outlines how therapeutic questions can provide 'stepping stones' for new dialogues and stories to emerge. These processes

were collectively understood as 'warming the context', a term coined in the systemic literature by Burnham (2005). These findings broadly align with the concept of 'modulated disclosure' suggested by Dalgaard and Montgomery (2015), providing an important initial understanding of how modulated disclosure might be facilitated in family therapy with traumatised families from refugee and asylum-seeking backgrounds.

Mechanisms of change

The process of meaning-making, which could lead to a new-found sense of connection, was a key mechanism of change identified. This aligns with the wider literature, which understands refugee trauma as a loss of existential meaning, suggesting meaning-making as a key component of trauma work, family resilience, and refugee coping and adjustment (Figley & Figley, 2009; Kramer & Bala, 2004; Walsh, 2002). Indeed, the discovery of meaning is understood as an element of post-traumatic growth (Tedeschi & Calhoun, 2004), and evidence shows the benefits of cognitively processing traumatic experiences into something meaningful (Bower, Kemeny, Taylor, & Fahey, 1998).

The process of therapeutic meaning-making centred on the emphasis of difference (Selvini, Boscolo, Cecchin & Prata, 1980) and on the development of new narratives. Thickening stories of resilience can open complex stories, enabling families to free themselves from 'thin' stories of trauma (Morgan, 2000) to develop new narratives. Evidently influenced by narrative approaches to working with trauma (White, 2004, 2005; Geertz, 1973), this approach aligns itself with the dialogical framing of family therapy with refugees and asylum-seekers proposed by De Haene

et al. (2012), which understands therapeutic conversations as dialogical spaces from which clients can develop new meanings and re-author their lives.

Theoretical developments

Therapists could experience a loss of meaning when working within an arguably abusive wider socio-political system, and often understood their professional and political identities as one, regaining meaning by becoming 'active witnesses', challenging oppression and actively influencing the wider socio-political context. Liberation psychology has long argued psychologists should address systemic oppression and injustice instead of focusing on the individual (Dykstra, 2014; Martín-Baró, 1996). More recently, Afuape (2011) has discussed how narrative therapy, systemic, and liberation psychology approaches can be drawn together in therapy with survivors of trauma.

Importantly, the integrative approach outlined in this study may be reflective of a growing critical transformation within the field of systemic family therapy, where clinicians are increasingly intervening in wider systems beyond the family (Gosnell et al., 2017). The Galveston Declaration (Gosnell et al., 2017) has captured the essence of family therapy and broader empowering practices such as narrative therapy and liberation approaches, proposing a shift from distinct approaches to a collective identity, committed to the shared values of pluralism, flux, opening space, and responsibility. The dialogic family therapy approach presented in this study, drawing on liberation and narrative perspectives, may illustrate this contemporary transition.

Limitations

Study results could have been strengthened by theoretically sampling refugees' and asylum-seekers' experiences of this model of working. This was

unfortunately beyond the study's scope given limited resources. A service user perspective would give valuable insight on the suitability and value of this model; it is difficult to ascertain the utility of a model without considering clients' experiences of it.

Crucially, the field of systemic family therapy encompasses various approaches succumbing to different theoretical influences. This study provides one perspective specific to practice in the United Kingdom. Though results may help clinicians navigate some of the challenges which might present when working with families from refugee and asylum-seeking backgrounds who have experienced trauma, this is one perspective of many. The analysis is also a result of the author's engagement with the data, and other interpretations may be equally valid.

Future Research

It would appear valuable for future research to investigate the views of service users who have experienced this model of working. In an economic climate prioritising evidence-based practice, research investigating the effectiveness of systemic family therapy interventions with this client group is required, given the potential value of this approach with refugees and asylum seekers and its current under researched status. Individualised approaches in this field, which currently dominate, place emphasis on symptom reduction, an outcome which is easily quantifiable. Future research may need to investigate how other outcomes (e.g. concepts such as 'meaning-making') can be captured. Though the philosophy underpinning approaches described in this study may be incongruent with the evidence-based practice approach (Afuape, 2011; Harper, Gannon, & Robinson, 2012), these approaches may need to pragmatically adapt so that their value can be accessible to consideration by

funders and commissioners.

Practice Implications

The present study highlighted the crucial importance of attending to and actively engaging with the wider socio-political context when working with this population. Though mainstream psychology has typically distanced itself from politics (Fox, Prilleltensky, & Austin, 2009), this may be a luxury which can no longer be afforded given the current socio-political context. Crucially, therapists working with this client group need to work flexibly, linking up with other professionals and adopting roles more traditionally associated with advocates, liaison officers, or social workers. A 'counsellor-advocate' role may more appropriately describe the role of clinicians providing psychological therapy for this population (Watters, 2008: p. 130), and service models promoting such roles should be encouraged. Australian agencies offer a helpful example, employing 'counsellor-advocates' who provide a number of interventions in addition to therapy (FASSTT, 2011; VFST, 1998). Ultimately the challenge lies in finding "ways of clinical thinking that contribute to social and political justice" (Woodcock, 2000: p. 237).

Supporting conclusions outlined by Dalgaard & Montgomery (2015), focusing on disclosure of traumatic experiences as an end goal may be unhelpful. Instead, psychological interventions should emphasise the timing and manner in which traumatic material is spoken about. Importantly, refugee mental healthcare needs to be understood more broadly, beyond PTSD. Diagnostic-led individualised approaches might be helpful for some, but further research is required to make sense of the diverse needs of this heterogeneous population, so that clinical practice can accurately addresses the needs of service users requiring support.

Conclusions

The present study aimed to build a theoretical understanding of how conversations about trauma emerge in systemic family therapy with families from refugee and asylum-seeking backgrounds. Dialogical and social constructionist understandings influenced the therapeutic approach. Therapists aimed to develop an open space where new conversations could emerge, and outlined attending to several factors which might enable families to feel 'readier' to speak. Incorporating narrative and liberation approaches, therapeutic work centred on the re-establishment of meaning. Directions for future research and implications for clinical practice have been outlined.

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Section C

Appendix of supporting material

Appendices

A. NICE public health guidance qualitative checklist

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Appendix A

NICE public health guidance qualitative checklist. (NICE, 2012)

Containing a checklist developed specifically for qualitative studies, this framework allows for studies to be rated using a three-point system. Studies fulfilling all or most of the checklist criteria (and whose conclusions are unlikely to alter where criteria have not been fulfilled) are considered good and obtain a description of '++'. Studies fulfilling some of the checklist criteria (but whose conclusions are unlikely to alter because of this) are considered fair and obtain a description of '+'. Studies fulfilling few or none of the checklist criteria (and whose conclusions are likely or very likely to alter because of this) are considered poor, and obtain a description of '–'.

Scoring procedure

1. Is a qualitative approach appropriate?

2. Is the study clear in what it seeks to do?

3. How defensible/rigorous is the research design/methodology?

4. How well was the data collection carried out?

5. Is the role of the researcher clearly described?

6. Is the context clearly described?

7. Were the methods reliable?

8. Is the data analysis sufficiently rigorous?

9. Is the data 'rich'?

10. Is the analysis reliable?

11. Are the findings convincing?

12. Are the findings relevant to the aims of the study?

13. Conclusions

14. How clear and coherent is the reporting of ethics?

15. Overall assessment: As far as can be ascertained from the paper, how well was the study conducted? ++ / + /

Study	1	2	3	4	5	6	7
Bernardes et al.	Appropriate	Clear	Defensible	Appropriately	Unclear - do not consider relationship between researcher and participants, somewhat describes hor research was explained to participants but not fully.	Unclear - no demographics for participants.	Reliable - mixed methods which aids triangulation. Methods investigate what they aimed to.
Bettmann et al.	Appropriate	Clear	Defensible - clear rationale for sampling in particular (why male/female, Somali/Somali Bantu)	Appropriately	Not described	Unclear - not much demographic information. Setting and where participants recruited from not clearly defined.	Reliable - Only did interviews, no justification for lack of triangulation, but methods investigate what they claim to. But checked themes with participants through 'member checking'.
De Anstiss & Ziaian	Appropriate	Clear	Defensible - though no clear justification of why chose focus groups and why analysed using a thematic approach.	Appropriately	Not described	Clear	Reliable - no trinagulation but member checking used to establish quality of interpretation during and after data collection.
Ellis et al.	Approproate (n.b. study is mixed methods)	Clear	Defensible - outline sampling strategy, chose qualitative methods for in depth focus.	Appropriately	Not described	Unclear - not much demographic info, context not described.	Reliable - used individual interviews and focus groups, as well as quantitative methods. But don't explicitly outline justification for triangulation.
Fazel, Garcia & Stein	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Not sure- no triangulation but interviewed 29 individuals and methods seem clear and reliable. Addressed in limitatations.
Maier & Straub	Appropriate	Clear	Defensible - good on sampling but don't explain why chose analysis method they did.	Appropriately	Unclear - mention interviewer reaction to participants	Clear	Not sure - no triangulation

Majumder et al.	Appropriate	Mixed	Indefensible	Not sure/inadequately reported (no details of interview questions)	Not described	Clear	Not sure - no triangulation.
Mirdal, Ryding & Sondej	Appropriate	Clear	Indefensible - don't explain design enough and rationale for chosen design, as it's quite particular (therapists choosing most successefu/least successful cases). Introduced bias as least successful did not want to participate so had to choose other less unsuccessful - however authors address this.	Appropriately	Not described	Clear	Not sure- no triangulation
Misra, Connolly & Majeed	Appropriate	Clear	Defensible	Appropriately	Not described	Unclear - community representatives only	Not sure - no details, but quantitative methods as well.
Persson & Gard	Appropriate	Clear	Defensible - explain whty chose qualitative approach	Appropriately - translated by bilingual interviewer (not professional translator)	Unclear - speak about bilingual interviewer which is good	Clear	Not sure - no triangulation
Piwowarczyk et al.	Appropriate	Clear	Defensible - state limitations in sampling in discussion	Not sure - did not record focus groups because of conerns it would be uncomfortable for participants, so relied on detailed notes	Not described	Clear	Reliable - don't address triangulation but mixed methods study and investigate what they claim to.

				taken by a notetaker and the group leader. Query re. whether this was systematic enough.			
Posselt et al.	Appropriate	Clear	Defensible	Appropriately	Clearly described - address researcher bias and describe how research presented to participants.	Clear	Reliable - use triangulation and explain why. Very good.
Valibhoy, Kaplan & Szwarc	Appropriate	Clear	Not sure - seems fine but not described (apart from sampling)	Not sure (if systematic) - some interviews were not recorded and only notes were taken (as participants did not give consent to recording).	Not described	Clear	Not sure - investigate what claim to but don't use triangulation (though address this in limitations).
Valibhoy, Szwarc & Kaplan	Appropriate	Clear	Defensible - theoretical saturation used, design appropriate, sampling rationale given.	Not sure (if systematic) - some interviews were not recorded and only notes were taken (as participants did not give consent to recording).	Not described	Clear	Not sure - investigate what claim to but don't use triangulation (though address this in limitations).
Vincent et al.	Appropriate	Clear	Defensible - rationale for why qualitative and for anaylsis.	Appropriately	Not described	Clear	Unclear - say that a second researcher provided

							triangulation but don't say what this was.
Palmer 2006	Appropriate	Clear	Not sure - not much detail, no info on sampling and selection of cases.	Appropriately - though no mention of whether record keeping was systematic	Not described	Clear	Reliable - multi-methods approach (triangulation) - very good on this
Palmer & Ward	Appropriate	Unclear	Defensible - though no rationale for data analysis.	Inadequately reported - unclear	Not described	Clear	Not sure - not reported
Palmer 2007	Appropriate	Clear	Defensible - though no rationale for data analysis.	Appropriately	Clearly described - very good	Clear	Not sure - say multi-method but don't provide data

Study	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
Bernardes et al.	Not sure - seems rigorous and had second author checking themes, but no description of how themes were derived from the data.	Rich	Reliable - though do not say how differences were resolved, simply say that differences were discussed and an agreement was reached.	Convincing	Relevant	Adequate	Appropriate	++
Bettmann et al.	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
De Anstiss & Ziaian	Rigorous	Rich	Not sure - talk about 'member checking' but not much else.	Convincing	Relevant	Adequate	Not sure - only mention that participant consent was sought for a support worker to be present in focus groups to assist with communication difficulties.	++
Ellis et al.	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++

Fazel, Garcia & Stein	Rigorous	Rich	Reliable - very good	Convincing	Relevant	Adequate - good discussion of limitations.	Appropriate - very good	++
Maier & Straub	Rigorous	Rich	Unreliable - only one researcher coded data, participants did not feed back on data.	Convincing	Relevant	Adequate	Appropriate - good	++
Majumder et al.	Not sure	Rich	Not sure - state data independently coded, but no further details.	Convincing	Relevant	Adequate	Approproate - approved by ethics committee, but don't mention anything else.	+
Mirdal, Ryding & Sondej	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Misra, Connolly & Majeed	Not reported - only say used grounded theory but no description	Not sure	Not reported	Convincing	Relevant	Adequate	Not reported	+
Persson & Gard	Rigorous	Not sure	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Piwowarczyk et al.	Rigorous - good description	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate - very good	++
Posselt et al.	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Valibhoy, Kaplan & Szwarc	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate - very good at relating to rest of literature	Appropriate - very good	++
Valibhoy, Szwarc & Kaplan	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate - very good	++
Vincent et al.	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	++

Palmer 2006	Not reported - say used 'framework method' but nothing more.	Rich	Not reported	Convincing	Relevant	Adequate	Not reported	+
Palmer & Ward	Not sure - not reported	Rich	Not reported	Convincing	Relevant (but vague aims)	Not sure - speak more about suggestions and not conclusions of research	Appropriate - very good	+
Palmer 2007	Not sure - no details reported though say used 'framework method'	Rich	Not reported	Convincing	Relevant	Adequate	Appropriate - very good	++

Appendix B

Theme frequencies

Themes	Number of studies identifying theme
Barriers and facilitators to engagement	18
Cultural factors	13 (Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Ellis et al. 2010; Maier & Straub, 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al. 2013)
Support networks	16 (Bernardes et al., 2011; Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Ellis et al. 2010; Fazel et al., 2016; Maier & Straub, 2011; Majumer et al., 2015; Mirdal et al., 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al. 2017a; Valibhoy et al. 2017b)
Stigma	15 (Bernardes et al., 2011; Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Ellis et al., 2010; Fazel et al., 2016; Maier & Straub, 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al. 2013)
Trust	12 (Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Fazel et al., 2016; Majumer et al., 2015; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Persson & Gard, 2013; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b)
Structural factors	12 (Bernardes et al., 2011; Bettmann et al., 2015; Fazel et al., 2016; Majumer et al., 2015; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Persson & Gard, 2013; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b)
Not being understood in context of refugee experience	4 (Misra et al., 2006; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al. 2013)
Hopes and anticipations	17
Lack of anticipations	15 (Bettmann et al., 2015; Fazel et al., 2016; Maier & Straub, 2011; Majumer et al., 2015;

	Mirdal et al., 2011; Misra et al., 2006; Persson & Gard, 2013; Piwowarczyk et al., 2014; Valiboy et al., 2017a; Valibhoy et al., 2017b)
Desperate hope	3 (Maier & Straub, 20111; Persson & Gard, 2013; Valibhoy et al., 2017b)
Medicalised care	10 (Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Ellis et al., 2010; Fazel et al., 2016; Maier & Straub, 2011; Majumer et al., 2015; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Persson & Gard, 2013; Piwowarczyk et al., 2014; Posselt et al., 2017; Valibhoy et al., 2017b; Vincent et al. 2013)
The limits of services	18
Caring services' understanding of culture and context	11 (Bernardes et al., 2011; de Anstiss & Ziaian, 2010; Maier & Straub, 2011; Majumer et al., 2015; Mirdal et al., 2011; Misra et al., 2006; Persson & Gard, 2013; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al. 2013)
Medication can be helpful but is not a panacea	8 (Bernardes et al., 2011; Bettmann et al., 2015; Maier & Straub, 2011; Majumer et al., 2015; Mirdal et al., 2011; Palmer & Ward, 2007; Palmer, 2007; Valiboy et al., 2017a)
Ambivalent views about the experience of talking	17 (Bernardes et al., 2011; Bettmann et al., 2015; de Anstiss & Ziaian, 2010; Ellis et al., 2010; Fazel et al., 2016; Maier & Straub, 2011; Majumer et al., 2015; Mirdal et al., 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2007; Persson & Gard, 2013; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al., 2013)
Social factors take precedence	14 (Bernardes et al., 2011; de Anstiss & Ziaian, 2010; Fazel et al., 2016; Mirdal et al., 2011; Misra et al., 2006; Palmer & Ward, 2007; Palmer, 2006; Palmer, 2007; Persson & Gard, 2013; Piwowarczyk et al., 2014; Posselt et al., 2017; Valiboy et al., 2017a; Valibhoy et al., 2017b; Vincent et al., 2013)

Appendix C

Themes and example quotes

Themes	**Examples of supporting quotes**
Barriers and facilitators to engagement	
Cultural factors	"Stress doesn't exist in Somalia" Somali participant (Palmer, 2006) "No (I will not go) cos they are not from my background, they are not from my culture. They don't know." Afghan male adolescent (de Anstiss & Ziaian, 2010) 'You are between the doctor and the community. You don't know what to do about it.'' Congolese young woman (Piwowarczyk et al.)
Support networks	"Because in here everything is different in England…. in Iran I don't think is like someone like, if I have problem, I don't think it's like someone like help me, is only my parent or someone else." 16-year-old refugee boy from Iran (Majumder, O'Reilly, Karim, & Vostanis, 2015)
Stigma	"The stigma attached to mental ill-health attaches to the whole family of the sufferer; they only seek help when the problem reaches a critical stage." Somali community leader (Palmer, 2006)
Trust	"…that whole trust thing... the same doctor might see the rest of the community, so they fear that he might go and tell … like the Assyrian community, like most people are related, and so it's more than just a professional-client relationship". Young Assyrian refugee service user (Valibhoy, Szwarc & Kaplan, 2017) "we always hear it, is that sometimes people are afraid if they go and reveal their information, they might get sent back". Young refugee, unknown background (Valibhoy, Szwarc & Kaplan, 2017)
Structural factors	"Maybe they meet somewhere else like in a park one day and not in the hospital every time. When you walk the environment it feels good and then you feel you can talk about whatever you want." Refugee young person living in Australia (Posselt et al., 2017) "The more I repeat the same thing that they ask me I get more depressed, because I'm bringing out the same thing again and again, and it's making me more emotional. So every time I went or somebody new came I would not talk." Betoto, refugee young person living in Australia (Valibhoy, Kaplan & Szwarc, 2017)

Not being understood in context of refugee experience	"You can't take someone like refugee and someone Australian ... as counsellor, just say, 'this is gonna help you'— no. There's some Australian they just grow up here— they have everything, they doesn't see fighting, they doesn't sleep no eating ... [refugees] eat, like a brick, you know, you eat like something because you need like your stomach to come to feel like you have something to eat. They're suffering ... fighting is still there ... yesterday there are people dying there." Christina, refugee young person (Valibhoy, Kaplan & Szwarc, 2017: p. 10).
Hopes and anticipations	
Lack of anticipations	"The first time I came here I didn't know at all what to expect. I had no clear expectations." 34-year-old woman asylum-seeker from Cameroon (Maier & Straub, 2011: p. 240).
Desperate hope	"I wish help to come out of my isolation. I have no one to talk to. I am all alone, also with my thoughts. I wish for a better life, psychological peace, and to live a normal life, like other people." Male participant of unknown origin (Persson & Gard, 2013: p. 289).
Medicalised care	"I had, in fact, no clear concept [about the treatment in our clinic], but I thought that maybe with medication, an improvement, they use to give drugs. I knew drugs. Because I knew that, for example when a person is suffering from headaches, he will go to a doctor, family doctor, who will prescribe medication. And I was thinking that a psychiatrist will do the same. One goes there and he will prescribe medication." (Maier & Straub, 2011)
The limits of services	
Caring services' understanding of culture and context	"I could feel that [the therapist] respected me and liked me as a person" Refugee participant of unknown origin (Mirdal, Ryding & Sondej, 2011: p. 448) "They really don't understand us, about our journey, about the life we had" Ahmed, young male refugee of unknown origin (Valibhoy, Kaplan & Szwarc, 2017: p.11)
Medication can be helpful but is not a panacea	"I think medication can calm you down unless you have real pain or something. When I found myself again, I realized that drugs cannot really help with the problem I am suffering from. When your mind is not good, that is, when you are not well morally, then this is not really helping. I have taken tablets, but I still wasn't feeling accepted or so…. The tablets, they don't really help with that." 34-year-old woman from Cameroon Maier & Straub, 2011: p. 242)

Ambivalent views about the experience of talking	"They ask you one question, they ask you one word like ten times, they keep asking. They know everything but she just keep asking, I said I can't do this. If you are keep doing this … end of 2012 you're going to kill me, I said I'm going to do it." (Participant in Majumder et al., 2015: p. 132). "I lost my family I had a lot of problem (.) ….. I was telling her a lot of things …… but she didn't help me." (Participant in Majumder et al., 2015: p. 132) "One should not wake up the demons (djinns). There are things one should not talk about. It makes you feel worse" Refugee of unknown background (Mirdal, Ryding & Sondej, 2011: p. 454)
Social factors take precedence	"…they (the general public) say, ''You're (from) Afghanistan. Terrorist! Terrorist!' and (they) keep blaming, keep always… harassing him so he will also get a mental illness." Afghan male refugee adolescent (de Anstiss & Ziaian, 2010: p. 33)

Appendix D

Study consent form

Centre Number:
Study Number:
Participant Identification Number for this study:

Consent Form

Title of Project: How do clinicians using systemic family therapy interventions to work with refugee families understand and facilitate trauma disclosure?

Name of Researcher: Sofia Gerbase

Please read each statement below and initial each box if you agree to give your consent:

1. I confirm that I have read and understand the information sheet dated 16/08/16 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I agree for my interview to be audio-recorded. I understand that this tape will be transcribed and anonymised, and saved onto a password-protected computer. ☐

5. I agree that anonymous quotations from my interview may be used in a report for the university and in published reports of the study findings [if applicable] ☐

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

Name of Participant_____ Date_____

Signature _____

Name of Person taking consent _____ Date_____

Signature _____

Appendix E

University ethics panel approval letter

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Appendix F

Health Research Authority approval letter

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Appendix G

Original interview schedule

Semi-structured interview schedule

Subsequent to introductions and discussion of any issues arising from the participant information sheet, and after consent has been checked and obtained; the semi-structured interview will cover the following areas:

How do clinicians understand and perceive disclosure of trauma in refugee family work?

- Can you give me examples from your work with refugee families where there have been events from the past which have been traumatic, and which have brought the family to therapy?
    - Prompt questions: Can you tell me how you have understood the traumatic events to have had/ be having an impact on the family?
    - In what ways have you perceived trauma disclosure to be helpful or otherwise to refugee families?
    - How is working with trauma disclosure in refugee families different from other family work around trauma disclosure you may have done?
- What communication patterns have you observed in non-Western refugee families? Have you noticed aspects of difference (e.g., culture, gender, age) having an impact?
    - Prompt questions: Can you say anything about how traumatic events have been spoken about in the families you've worked with, as varying by culture, gender, age, or other aspects of difference?
    - Does this differ from more Western styles of communication? In what ways?
- In what ways has trauma impacted on family relationships?
    - Prompt questions: In what ways does parental trauma affect children? Can you give me some examples from your own experience? (If unsure, prompt, e.g. through changes in behaviour? Communication?)
- What have you noticed about the ways in which the refugee families you have worked with approached the disclosure of trauma?

  - Prompt questions: Have there been differing views on whether traumatic incidents from the past should be disclosed? Concerns about disclosing the trauma? Who was most worried about disclosure? Is this a typical pattern you see with families?
  - Could you tell me a bit about working with non-Western refugee families, cultural values, and how these might differ from your own models/Western models of understanding and alleviating difficulties?

Which factors influence timing and manner of disclosure? How do clinicians enable and facilitate therapeutic disclosure of trauma when working with refugee families?

- What factors are important when considering facilitating the therapeutic process of trauma disclosure?
  - Prompt questions: under what circumstances might it not be helpful? Are there theoretical perspectives that guide your decision-making, or a model/structure that you hold in mind?
- How do you go about facilitating the process of trauma disclosure when working with families?
  - Prompt questions: Can you tell me a story of a time when you felt that trauma disclosure was facilitated well?
  - Can you tell me a story of when you felt that trauma disclosure didn't feel helpful/didn't go so well?
  - How do you judge the timing of disclosure in family work?
  - What manner of disclosure has been most therapeutic for the families you have worked with?
  - How do you navigate ambivalence around trauma disclosure? What therapeutic skills do you find useful when facilitating disclosure?
  - What do you find challenging about facilitating disclosure? What dilemmas have you faced?

To what extent does the concept of 'modulated disclosure' fit with how clinicians view the therapeutic process of disclosure?

- When facilitating trauma disclosure, do you ever take into account how in tune a parent is to their child's needs? If so, how? Why is this important?
- How important do you think the child's developmental status is with regard to work around trauma disclosure?
- Does the family's reunion status (whether some families are still in home country/other countries) affect how you work with the family and your consideration of trauma disclosure?

The perceived effect of trauma disclosure

- What therapeutic gains do you think trauma disclosure within families achieves?
- Are there any possible negative impacts of trauma disclosure? If so, which?
- How have the families you've worked with experienced therapeutic work around trauma disclosure?

Broad societal impact on work

- Do factors outside the therapy room impact on your work with families (e.g. home office, immigration status)? If so, how?
- Do broader societal narratives around refugees have an impact on your work? If so, how?
- If yes to the above, how do you incorporate this in your practice?
- Have broader societal narratives around refugees impacted on your professional identity? If so, how?

Prompts to be used to elicit more information:

- Could you tell me a bit more about that?
- Could you explain that a bit more?
- Could you expand on that?
- Was there anything else you wanted to add?
- Could you give me an example of that?

Appendix H

Revised interview schedule

Semi-structured interview schedule

Subsequent to introductions and discussion of any issues arising from the participant information sheet, and after consent has been checked and obtained; the semi-structured interview will cover the following areas:

Ask participant:

- Number of years worked with refugee families using a systemic family therapy approach, and approximate number of families worked with
- Approximately how many refugee families (including a child aged 4-18 years) have you worked with, where there had been trauma?
- Overview of backgrounds (ethnicity and nationality) of the families worked with.

How do clinicians understand and perceive disclosure of trauma in refugee family work?

- Can you give me examples from your work with refugee families where traumatic events from the past have brought the family to therapy?
    - How have you understood the traumatic events to impact on the family?
    - Tell me a bit about the role of trauma disclosure when working therapeutically with refugee families.
    - In what ways have you perceived trauma disclosure to affect refugee families?
    - How is trauma disclosure with refugee families different from other family work around trauma disclosure you may have done?
- What communication patterns have you observed in non-Western refugee families? Have you noticed aspects of difference (e.g., culture, gender, age) having an impact?
    - Have you observed patterns in how traumatic events have been spoken about in the families you've worked with, as varying by culture, gender, age, or other aspects of difference?

    - What do families do that show you that this is the case?
    - Does this differ from more Western styles of communication? In what ways?
    - How do you take these differences into account in your therapeutic practice?
- In what ways has trauma impacted on family relationships?
    - In what ways does parental trauma affect children? Can you give me some examples from your own experience? (If unsure, prompt, e.g. Through changes in behaviour? Communication?)
- What have you noticed about the ways in which the refugee families you have worked with approached the disclosure of trauma?
    - Have there been differing views on whether traumatic incidents from the past should be disclosed? Concerns about disclosing the trauma? Who was most worried about disclosure? Is this a typical pattern you see with families?
    - Could you tell me a bit about working with non-Western refugee families, cultural values, and how these might differ from your own models/Western models of understanding and alleviating difficulties?

Which factors influence timing and manner of disclosure? How do clinicians enable and facilitate therapeutic disclosure of trauma when working with refugee families?

- What factors are important when considering facilitating the therapeutic process of trauma disclosure?
    - Under what circumstances might it not be helpful? Are there theoretical perspectives that guide your decision-making, or a model/structure that you hold in mind?
- What factors might create the best conditions for therapeutic trauma disclosure to take place?
- How do you go about facilitating the process of trauma disclosure when working with families?
    - Can you tell me a story of a time when you felt that trauma disclosure was facilitated well?

  - Can you tell me a story of when you felt that trauma disclosure didn't feel helpful/didn't go so well?
  - What did you notice in the family that showed you it went well/not well?
  - How do you judge the timing of disclosure in family work?
  - What manner of disclosure has been most therapeutic for the families you have worked with?
  - How do you navigate ambivalence around trauma disclosure?
  - What therapeutic skills do you find useful when facilitating disclosure?
  - What do you find challenging about facilitating disclosure? Have you faced any dilemmas?

To what extent does the concept of 'modulated disclosure' fit with how clinicians view the therapeutic process of disclosure?

- When facilitating trauma disclosure, do you ever take into account how in tune a parent is to their child's needs? If so, how? Why is this important?
- How important do you think the child's developmental status is with regard to work around trauma disclosure? Why is this important?
- Does the family's reunion status (whether some families are still in home country/other countries) affect how you work with the family and your consideration of trauma disclosure?

The perceived effect of trauma disclosure

- What therapeutic gains do you think trauma disclosure within families achieves?
- Are there any possible negative impacts of trauma disclosure? If so, which?
- How have the families you've worked with experienced therapeutic work around trauma disclosure?
- Could you tell me a bit about the impact of working with traumatised families on you as a therapist?
  - For example, how might this affect your own contexts such as personal life/family life/work relationships?
- If so, how do you deal with such impacts?

Broad societal impact on work

- Do factors outside the therapy room impact on your work with families (e.g. home office, immigration status)? If so, how?
- Do broader societal narratives around refugees have an impact on your work? If so, how?
- If yes to the above, how do you incorporate this in your practice?
- Have broader societal narratives around refugees impacted on your professional identity? If so, how?
- Could you tell me a bit about your own personal/professional values, how these have led to your choice of career, and how these impact on your work with refugee families?

Prompts to be used to elicit more information:

- Could you tell me a bit more about that?
- Could you explain that a bit more?
- Could you expand on that?
- Was there anything else you wanted to add?
- Could you give me an example of that?

Appendix I

Example of theoretical memos

- There may be a sequential relationship to how families experience trauma: Trauma impacts individuals' sense of meaning. This loss of meaning impacts individuals' feelings/emotional life. Individuals experience difficult feelings which then impact on their behaviour and ability to communicate with other family members. This makes it difficult for families to form shared meanings together, impacting on others in the family and the family as a whole.
- Therapists outline that some individuals can hold a belief that trauma is infectious in some way, and that if it is talked about, it will sully other family members. This makes family members not talk, and this lack of communication breeds disconnection.
- There appears to be a relationship between 'loss of meaning' and a traumatic event. Broad traumatic experiences seem to create a loss of meaning.
- People are more likely to be referred to services when the impact of trauma causes physical symptoms.
- Therapist curiosity and exploratory questions helps to open up new narratives for families and to create hypotheses. This appears to aid meaning making.
- Curiosity and collaboration appear to be central in building a strong therapeutic alliance between therapists and families.
- Family therapy seems to help families to form a secure base, helping the family to become individual members' secure base, which has been lacking due to refugee experience. The refugee experience disrupts people's sense of the world, but family therapy can strengthen families so that individual family members reconnect with their place in the family. This reconnecting serves as a secure base from which the individual can make further meaning in other areas of their life. Trauma is understood as a loss of meaning. Family therapy allows people to rebuild meaning. In order to engage in a process of meaning-making, families need to feel safe. Family therapy allows people to create a safe space within the family when they are in a completely unsafe situation due to refugee condition.
- Shameful traumas like rape appear more difficult to talk about. It seems that these traumas are the ones that get most silenced.
- It appears that talking allows people to create new meanings and free themselves from unhelpful/disturbing meanings.
- Family therapy allows families to consider multiple stories. Some of these may be stories which take into account the wider context (e.g. considering socio-political issues). Bringing in the wider context allows families to create new stories which may centre less on personal shortcomings, self-blame and guilt.
- Therapists always consider families' meanings (narratives) and the impact of those narratives on what individual members do and how they feel. Therapists describe bringing different narratives forward and helping people to understand different narratives, which they say gives space for new meanings. New meanings can then free people up, and impact positively on people's feelings and behaviours.

- Therapists describe attending to a theoretical hierarchy of context (coordinated management of meaning). This theoretical grounding helps them to structure their thinking when considering the wider context.
- There appears to be a relationship between therapist personal experiences of feeling marginalised and their interest in wanting to help marginalised people. Therapists who have experiences of being marginalised want to help those that have also been marginalised.
- Therapists make it clear that talking about trauma is not necessarily the end goal of therapy. Indeed, it seems that families' situations are often too unsafe to discuss painful events and emotions, given the uncertainty inherent to obtaining leave to remain.
- Therapists juxtapose the construction of childhood in UK with the construction of childhood in other cultures/in families where children have experienced war and persecution. The young people they work with may be more mature than their age may indicate, and this can affect how they are treated by immigration officers (having to undergo age assessments)
- The difficulty of conveying the meaning of experience can act like a wedge between individuals in families, disrupting relationships. Open up understandings of different meanings can therefore help to bring connection in family by shifting this wedge.
- Participants describe holding what is (multiple narratives) to find as much meaning as possible within those multiple narratives. If trauma is a loss of meaning, then finding meaning and helping people to connect with their underlying values, meanings and lost values/meanings is what helps to heal trauma. A narrative approach helps individuals to find new versions of themselves, linking that with the wider community so that people can regain meaning in their lives.
- Participants outline that theoretical paradigms and models other than the systemic model are rooted in Western views of the self. The systemic model is less rooted in Western meanings as it allows for multiple understandings. Therefore, it is less likely to impose Western meanings on clients from non-Western backgrounds.
- Shifts in home office policy (e.g. changes in the definitions of threat levels in different countries) can increase uncertainty as at any moment people could be deported back to a country because its threat level has been lowered.
- Therapists describe the importance of working with networks (the wider system) to resist damaging societal narratives.
- Therapists describe importance of just 'being' with families. It is the act of sitting with their distress, and in doing so holding multiple perspectives and narratives, that can enable change.
- Therapists outline how they work to bringing differences in families out. By acknowledging those differences and validating them, families are allowed to sort through them and individual members can better position themselves and decide where they sit within the differences.

Appendix J

Research diary excerpt

03/06/17

Completed first interview today (used as pilot). Concerned that my questions do not fit with a systemic approach – I ended up rephrasing all questions during the interview in order to get the best out of my interviewee. My questions are framed in a way that suggests that the therapist has a goal in mind where they would like the family to get to (e.g. disclosure) and this clashes with the systemic way of working. However, by changing the wording of some questions, the interview went really well. Concerned that my research question is not valid anymore as therapists may not think facilitating disclosure is appropriate. Can I alter the title of my study – take out facilitate? Just say 'how do systemic family therapists understand trauma disclosure when working with refugee families?'. May actually be okay though and I could keep facilitate, as if families do want to talk about past traumas then a therapist will engage them in that in some way, and that process could be called facilitating.

Really interested in interviewees use of language. Said 'families from refugee and asylum seeking backgrounds' throughout. Very useful feedback as well after the interview suggesting I have a bit of a blurb in the beginning about not coming from any particular theoretical perspective. This will be really useful and I will do this, as questions may lead interviewee to assume that I believe disclosure to be always therapeutic/beneficial and needed, and that therapist has this in mind throughout work. Questions may come across a bit 'first order' and non-collaborative. Need to make sure interviews know that I am not coming from a particular theoretical background and that they are free to disagree with the questions and question the questions as well.

Really inspiring interview! Came away quite moved, unsure what it struck in me that made me feel this way. Great interviewee, extremely inspiring.

17/08/17

Reading up on grounded theory methodology. Thinking about my questions and the fact that I have come into interviews with an open mind as I am following grounded theory methodology and have not overly examined the literature before beginning my study. Explains the tension I have been feeling in interviews (feeling like my questions don't quite hit the mark at times, that interviewees disagree with my questions), but this may be good as it means I am not influencing the data I am collecting. Feeling more positive and sure of this as I have the grounded theory framework to support this. (p. 29 Urquhart).

I have not imposed a particular framework/model/theory on my data collection (e.g. systemic) and my questions sound 'naïve' perhaps at times, but this will allow the theory to emerge less biased by my preconceptions (though uncomfortable for me at times when interviewing).

18/08/17

Thoughts while transcribing interview 3. I might need to ask more specifically about intergenerational transmission of trauma as this is something that I seem to be wanting to get at in the interviews but do not ask specifically about it? I also need to ask more follow-up questions about therapeutic skills, techniques, processes: interviewee saying worked with family to rebuild relationships – HOW? WHAT DID YOU DO? HOW DID YOU NOTICE THIS HAD AN EFFECT? WHAT DO YOU CONSIDER? WHAT KINDS OF QUESTIONS DO YOU ASK TO ACHIEVE THIS? Do this more in next interviews.

Interesting that it seems to take participants a bit of time (half an hour into the interview?) to settle into the questions and the role of interview – seems like start off by defending their position in a way and then at some point in the interview once they feel they've gotten enough across about the wider system and it not just being about working in the room with someone with trauma, they begin to answer questions more specifically and actually address the question I am asking – indicated maybe how much they want to convey that it's not just about them and the client in the room – that is almost secondary to everything influencing families outside the room, wider system and environment. This process is in itself conveying something about the work and perhaps the final theory that will come out of this project?

15/02/18

Coding – I find myself wanting to not include people's approaches that are more directive and prescriptive – because this clashes with what has been said in other interviews but also because I think this is less aligned to my way of working.

Appendix K

Study information sheet

Study Information Sheet

How do clinicians using systemic family therapy interventions to work with refugee families understand and facilitate trauma disclosure?

My name is Sofia Gerbase and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study, which constitutes a part of the requirements for my doctoral degree. Before you decide whether you would like to be involved, it is important that you understand why the research is being done and what it would involve for you.

Please read the following information before deciding if you wish to take part. If you have any questions, please contact me. My research supervisors are Dr Kate Foxwell and Dr Zuhura Mahamed.

Part 1 - This part of the information sheet tells you the purpose of this study and what will happen to you if you take part.

What is the purpose of the study?
This study aims to explore what factors impact on how clinicians working with traumatised refugee families understand and facilitate the disclosure of trauma. The study aims to increase our understanding of how trauma disclosure is facilitated, to inform clinical practice.

Why have I been invited?
You are being asked to take part because you are a:

- Family & Systemic Psychotherapist, Family Therapist, or Systemic Psychotherapist

  OR

- A clinical psychologist, counselling psychologist, or psychotherapist who has completed an Association for Family Therapy & Systemic Practice (AFT) accredited Foundation and Intermediate Systemic Training Course

You have more than one year post-qualification experience and have worked with at least one traumatised refugee family where a child was involved. A family is defined as at least two family members, one of whom is a child (4-18 years old). A broad definition of 'traumatised' is used in this study, encompassing political repression, detention, torture, other kinds of violence, disappearance of relatives, separation and loss, hardships and exile.

Do I have to take part?
It is up to you to decide whether you would like to join the study. You may ask me any questions you might have by telephone or email. If you agree to take part, I will then ask you to sign a consent form when we meet in person. You will have received the information sheet before this meeting and time will be allocated to answer any questions you might have

before you sign the consent form. You are free to withdraw at any time, without giving a reason.

What will happen if I take part?

1. I will contact you by telephone or email and will be available to answer any questions you might have. Once you tell me that you are happy to participate in the study, we will arrange a convenient time and location for our interview. This may be at your place of work, or other location that is convenient for you. Interviews may also be conducted on Skype, if you prefer. When we meet, if you are still happy to participate, you will sign the consent form giving official consent to participate in the study.
2. The interview will last up to one and a half hours, During the interview, I will ask you about your views on the disclosure of trauma in family therapy sessions.
3. Time will be allocated at the end of the interview to answer any questions you may have, and to debrief if necessary.
4. This research should be complete in July 2018. A summary of the research findings will be sent to you if you wish, and you will be given the opportunity to comment on the results of the study by sending comments to me via email.

Expenses and payments

If you need to travel locally in order to be interviewed, your expenses will be covered (up to £10).

What are the possible disadvantages and risks of taking part?

It is hoped that you will not find the interview distressing, as it will focus on your professional views of therapy processes around the disclosure of trauma with refugee families. However, it is understood that such topics can be emotive, and should this be the case, I will pause the interview if felt to be helpful, and check in with you whether you would like to continue. If required, we can agree to end the interview prematurely and, consider any further support you might need.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2 – This part of the information sheet gives you more detailed information about the conduct of the study.

What will happen if I don't want to carry on with the study?

If you withdraw from the study, we would like to use the data collected up to your withdrawal. However should you withdraw your consent for us to do so, you can request for the information from your interview to be destroyed. There will be no negative consequences for you personally if you do not wish to continue with the study.

What if there is a problem?

If you have a concern about any aspect of this study, please ask to speak to me and I will do my best to answer your questions [Tel. 07551 974244]. If you remain unhappy and wish to

complain formally, you can do this by contacting the lead supervisor for this project, Dr. Kate Foxwell. Her contact details can be found at the end of this information sheet. Please know that we will try our best to deal with your concerns, however should you wish to make a formal complaint, you can do this by contacting Professor Paul Camic (Research Director, Salomons Centre for Applied Psychology) at the following address:

Canterbury Christ Church University,
Broomhill Road, Tunbridge Wells
Kent, TN3 0TF

Telephone: 0333 011 7114
Email: paul.camic@canterbury.ac.uk

Will my taking part in this study be kept confidential?
Yes. Interviews will be audio-recorded. This study requires precise recordings of what has been said in the interviews. Audio-taping is the most efficient way of achieving this. Audio-recordings will be transcribed as soon as possible after the interview and stored on a password-protected computer, and recordings will then be erased from the recorder.

Your transcript will be allocated a study identification number, which only myself, the lead researcher, will know corresponds to you, so that it remains anonymous. All data will be coded anonymously and stored securely. All information which is collected about you during the course of the research will be kept strictly confidential. Any personally identifying information from the recordings will be changed in the transcription so that you are not personally identifiable in the transcripts

Are there any circumstances where you may pass on information about me?
If, during the interview, you reveal information which suggests that someone might be at risk of serious harm, then I am obligated to discuss this with my supervisors, and agree an action regarding passing this information onto whoever the most suitable person or agency is agreed to be.

What will happen to the results of the research study?
If you agree, you will be sent a summary of the study's main findings in Spring 2018. You would be welcome, and encouraged, to give feedback on these findings. The study will be submitted for examination in May 2018, and subsequently published in a peer-reviewed journal. Participants will not be named or identifiable. Anonymised quotations from the interviews will be used in published reports.

Who is organising and funding the research?
This research project is funded by Canterbury Christ Church University.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by the Salomons Research Ethics Committee.

Who do I contact for more information?
For any further information, please contact me on s.weidenbach-gerbase701@canterbury.ac.uk. If you wish to speak to the project's supervisors, please contact Kate Foxwell on kate.foxwell@canterbury.ac.uk or Zuhura Mahamed on zmaham@essex.ac.uk.

I have decided to take part in the study. What is the next step?

Please phone me on 07551 074244 or email me at s.weidenbach-gerbase701@canterbury.ac.uk so that we can arrange a convenient time to meet for an interview.

Thank you for considering this study and taking the time to read this information sheet. I look forward to hearing from you.

Sincerely,

Sofia Gerbase
Trainee Clinical Psychologist

Appendix L

Participant demographic form

Please answer the questions below.

- How old are you?

- What is your nationality?

- Please describe your ethnicity/cultural.

- Please briefly outline your professional title(s), qualification(s), and any significant additional training.

- What type of service do you currently work in? Please list the services you have worked in where you have worked with refugee families.

Appendix M

Supporting quotes for components of the grounded theory

Construct	Supporting quotes
Wider context	
Always considering the wider context	Yea, so, well, I would certainly talk with families about it in sessions, and think about how the context them influences them, you know. (P5) how does uh.. you know, lay um.. their relationship with other people that come into their life, how do they behave? what do the geographical context, you know, the part of the world they're coming, how that.. affect, affect them, you know, when we, when we do, for example, group work, you know, bringing Kurdish and Iraqi together, you know, is that something we need to bear, bear in mind. If we've got Iraqi family, what, they, they are aware of the British media, you know, discourse about them, so, how that affect them? (P2)
Immigration policy	Um.. and then you suddenly get a shift in home office policy (P4) well, where do I start! I mean, Britain has a policy of 'you're welcome, but when you're here, we, we're gonna make it as difficult for you as possible and um.. (P7)
Intolerant society	I.. I live in a context that is so increasingly racist, xenophobic, fearful (P1) because sometimes the, the compounding effect of some of the societal pressures on people, on top of their trauma (P5)
Oppressive wider systems	the connection to the abusive, oppressive systems, and experiences, war, those sorts of things, rape. (P1) or, or oppression from their governments. (P4)

Social justice	and their sense of social justice in all different ways that that might be expressed in terms of um... you know, housing and um.. feeling kind of part of the community and welcomed and integrated and that kind of thing, rather than marginalised. (P1) and, the sense of social justice as well, that is something as well that is quite important because when you experience discrimination and racism, you need to, you know, you wanna fight back, you wanna fight back, and you wanna (P2)
Societal narrative	is that whatever conversation that is, is happening in the moment, is never only about this conversation, this conversation is a part of many other conversation. So, when, when uh.. when we talk about to, when we talk about rape, and then you are, you are a black woman, a black refugee woman, so there are all the story with the media, the wider context, wha- so, people are aware that, yea okay, "I'm a refugee, does that mean that they think that I'm this, I'm that?" so all the... context come to the, the.. the conversation that you are having in the moment, and you, as a therapist you need to be aware 38:33 of those different stories that are impacting on the conversation you are having in the moment. (P2) Yes massively. Because there's such a... you know, the popular press is so disgusting in the way it talks about people, you know, stealing jobs, you know, all of that kind of narrative((P4)
Safety and stability	The minute they come they, they'll find them a school, they'll be in school, so there's that sense of normality, and a way for the children to.. you know, to attend school, to make friends, and, and they pick, they pick up on the language very quick compare, compared to the parents (P2) so the usual with families is sort of saying to people, saying - if the school is worried about a boy who has just arrived from Syria or something, saying "well look, let's monitor it for a month or two and see how it goes, see whether the behaviours have, say, of hiding under a desk or... or being very startled by loud noise - think, see whether that's actually resolved itself as the child feel safe physically. If it doesn's after a month or two, we will definitely see them and see whether, see whether there's something we can do" (P3)
Sociopolitical context	Partly because I think that the sociopolitical context is a huge one, and often doesn't get, I feel like doesn't get highlighted enough (P1)

	You know I think, these things have to be thought about, um, very globally, and very much in terms of politics. (P4)
The family system	
Experiences which lead to help-seeking	
Accumulation of prolonged difficult experiences	But certainly people talk about um.. huge, multiple, extreme, intense, um.. cumulative adversity, and... um... massive challenges and distress, yea (P1) and there is the trauma in general where is less on a continued process. So if you have a timeline, so the trauma is, is, is going through that line (P2)
Engaging for help with asylum claim	Because somebody told them they will have to come in and see, and see me. (P2) so is it that that thin, that thin rehearsed story, they're kind of used to telling that story, they come to services with that story (P6)
Assimilation	and how they were gonna be sort of children growing up between these two cultures and how they negotiated that as children, as adolescents, how did the parents help them negotiate that. (P10) You know, the family has a very rural background where the father was a shepherd and the boy would help him, you know, uh, round up the sheep. So they's be walking for hours everyday and etc... so... so the idea really of actually settling, sitting *laughs* you know, in a classroom and having to learn... (P3)
Social graces	the social graces, what does it mean to be male, female, or um.. of a particular ethnic group (P1) So thinking about, kind of, ethnicity, gender, um, education (P9)
Culture	Uh.. and they couldn't talk about it, the impact of it, and because there wans't, the, there wasn't um, there wasn't a language within either their, their original Islamic culture or within their left wing culture to speak about it. (P10) But many of these people's cultures, you know, there's a very strong sense of duty in terms of keeping the family together, you know. (P4)

Family factors	
Parent: Disconnection within parent	Um.. um... parents feeling unable to parent the way they want to parent (P1) Uh, that's one of the things we noticed at the XXX was, there were mothers and fathers, or particularly fathers, who were regarded as being, you know really outstandingly good loving parents. But in post-trauma, post-torture, the children would talk about, you know "he looks the same as my daddy and smells the same but he's not, he's not the same" (P10)
Child: Disconnection within child	because children often blame themselves if their parents are struggling (P1) hmm... I mean, you know, children will clearly show their trauma through their behaviour and in a more indirect way, they won't say directly about things that might have happened so... um... some of the young kids from... from Syria, you know, when they hear a loud noise like that, then they sort of go straight under a table in the classroom. (P3)
The therapist system	
Experiences which lead to help-giving	
Family of origin experiences	and what I discovered in the middle of all of that was something I knew anyway, was that I myself had had a profoundly traumatic childhood - it wasn't something that I was.. unaware of, um... my um... uh... my mother suffered from, um, bipolar disorder, and I spent many many periods in care as a child. (P10) and.. so uh.. and, I mean, one of my experiences was to have a childhood that was not the best (P8)
Personal values	You know, those are all ideas I've been raised with (P5) and so that fitted in with, you know that sort of ideal. (P7)
Similar experiences to clients	so I will talk about my own experience of being a refugee (P2) and yet interestingly enough, you know, I'm from a background where myself, sorry, my mother was um.. a hidden child in the Holocaust. So she has all sorts of stories from that time. (P3)

Therapist factors: Impact of work on therapist	For you to be - as a therapist - to be able to understand what is happening to you in the moment. (P2) I think I feel much more humble. I feel, uh... my goals are small. (P4)
Models & theories	Um... and um... but I think what's fantastic about systemic thinking is the way in which it provides a really rich um.. what I would call contextual scaffolding (P10) I use quite a lot of um, narrative techniques (P5)
Service context	But I think the fundamental difficulty is a different idea about what constitutes healing and what constitutes trauma…Actually, which I don't think the team is able to address. (P4) But I think also there's something about the context that I'm working in that also informs what I'm allowed if you like to ask about and what they're expecting to talk about (P5)
Social graces	But it also connects me to my privilege deeply. (P1) Um... I as an English man (P10)
Trauma as loss of meaning	
Trauma disturbs family's meanings	Um.. um.. the trauma of loss of home, trauma of loss of a sense of self, um... and purpose and community and.. culture and all the things that can kind of... people's sense of meaning (P1) she couldn't really make sense of life here (P2)
Work and wider context disturb therapist's meanings	it can be very uh... uh.. disturbing to your existential sense of things. (P1) to have seen that first hand and how people struggle. (P5)
Meaning-making through the therapeutic encounter	
Therapist positioning	respecting the individual, respecting their cultural connectedness (P4) You had to be prepared to go outside your role, and not say "oh that's nothing to do with me because I'm a psychiatrist" sort of thing (P6)

Consultation to networks	Um, so the work is often liaison, connections (P4) But also I do join up with other services outside the therapy room. So we have like, um, early intervention social work. So like a family, they're called family support workers. It's not statutory, but they help people - keep people in the services. You know, I might refer someone to them, or to an employment agency, or a refugee group - you know, I try and recommend other things outside of the room, practical things, as well as doing sort of therapeutic work. Cause I think that can be as helpful to mental health as sitting with me for an hour, often. Yea. (P5)
Trust	mmm but they paid for it uh.. by.. and they... I suppose it made them not... not trust - they didn't know who to trust I think that was true. (P8) Um.. they'd need to trust my, me. (P7)
Risk	So then there's problems of what's going to happen next, making themselves homeless, um... a concern about suicidality. (P4) and, so there's loads of factors I think that affect engagement - or people might feel really distressed but then be worried about what if they do disclose, what if they say they're struggling with parenting, will their kids be taken away? which I think often is a message that's goes round communities (P9)
Working with interpreters	um.. I think.. what else... I suppose also I did a lot of work with interpreters, (P7) Not least because you've got the problem with interpreters which just slows everything down so much. That's a real challenge. (P4)
Conversations about 'trauma'	

Co-construction	"…and then she started to talk about her story, but it happened... it wasn't forced, the process wasn't forced but I think that when she was able to tell her story, she was able to tell it in a position where she had more agency, where she felt that she had, she could, she, she had more power over the story, and she chose what story to tell, and that I think was quite important uh.. process I think… and I think that the reason it happened like that is because I didn't, I didn't force it" (P2) and it's about the therapist taking a position that is not centred, more decentred (P2)
Warming the context	so I guess the idea is, from a systemic perspective, to, to try and kind of warm the context for them to be able to do the work together (P9) "…and anybody who's comfortable with that who is, almost in a sense tensely awaiting something to be said. Uh... to be wondering out loud, 'can we say this next thing? I wonder if you can imagine what, what, wha... what it is we're intending to speak of next' yea? um... yea, to, to be using metaphors to wonder about it, so one arrives at it more obliquely." P10
Meaning-making	
Bringing difference to the surface	"I think the systemic approach allows - well, requires you to engage with that, those kind of areas of difference and not kind of - and that helps I think to not other the family or other the young person." (P9) as women, and in terms of self-disclosure, I do, I do self-disclose, so I will talk about my own experience of being a refugee, and I will disclose my experience of being a mother (P2)
Staying with difference	And it took a very long time. And during that time it was a matter of simply just being there with them and accompanying them and trying to help them keep their anxieties at a level that was manageable. (P3) I think that's one of the things about systemic therapy, is it kind of acknowledges the differences between those contexts and how they can cause difficulties. (P5)

Holding multiple narratives	and uh, and so, one had to sort of work with both.. both understandings really. Both the girl's, the girl's desire to see her father and... you know one can explain it in all sorts of ways, but... she was comforted by the notion of some sort of genie. Some sort of... uh... spirit. Um... and the mother did, mother, mother was... more... more inclined to see that as not, not true but she would, she might accept a more sort of psychiatric type explanation as to why the daughter might be hallucinating or seeing things like that (P3) So it feels as though, um... it's often a case of kind of holding what is (P4)
Opening up new narratives	"But I think through the conversations in the therapy they were almost able to develop a new narrative, a shared narrative about strengths and how he faced adversity, how they faced adversity." P9 "I think people can get very bound up in telling this or, the, the negative aspects of their story that it's, it can be really helpful to pull out – 'actually, are there things you've learnt about yourself from this experience? what helps you get through it? how's that helping you now?' you know, those sort of questions can be really useful and really open up new ideas for people, new ways of feeling about things." P5
Finding new meanings	But can, but can the overwhelming nature of the emotion be somewhat dissolved and um... pulled in - not pulled but sort of understood in its many aspects (P10) and just trying to find as much meaning as you can. (P4)
Finding connection	"But then also just being able to be much warmer to each other without.. much less distance between them. It felt very um, positive." (P6) "So… I suppose we were putting pieces of the jigsaw together for them… so that they could have a more coherent understanding of, of what happened." (P8)
Active witness	Um, and the whole group took part in um the um, uh, the discussions that took place. And my colleague, the psychoanalyst, went down and participated in that. Yea so we, we were very much active politically and culturally outside of the clinic, and that was very much part of the uh... what fed, um, the richness of the work that we did. (P10)

	um.. I think most of the time is makes us... sort of... I don't know, what's the word... that the, that the sort of strength of feeling is, is directed in a positive way towards, you know, I mean trying to, being determined in trying to do something about what's happening. Um... you know sort of channelled helpfully. (P3)

Appendix N

End of study summary for ethics panel

Background: The systemic model has been proposed as particularly relevant for addressing the mental health needs of refugees and asylum-seekers. Clinicians working with families from refugee and asylum-seeking backgrounds who have experienced trauma may wish to encourage family communication to promote resilience, but may find it difficult to know whether to address traumatic memories. A need for further research in this area has been highlighted by the literature.

Summary of results: The resulting theory contributed to understandings of how systemic family therapists and families from refugee and asylum-seeking backgrounds negotiate conversations about trauma. The model depicts the circular and dialogic nature of relationships and systems within the areas identified, focusing on two key constructs: 'trauma as loss of meaning' and 'meaning-making through the therapeutic encounter'.

The therapeutic encounter is understood to emerge from a meeting of two systems, 'the family system' and 'the therapist system', which operate within different contexts and experience different pressures. Both the family and therapist have different experiences which have contributed to help-seeking and help-giving. Refugees and asylum seekers can experience specific traumatic events, but trauma is also understood more broadly as the accumulation of prolonged difficult pre-flight, during-flight, and post-flight experiences, which promote a sense of disconnection within individuals and families and between individuals and their wider contexts. These experiences of disconnection can cause people to lose meaning in their lives, precipitating distress. Therapists can also experience a sense of disconnection between their own values and the values of the wider socio-political and legal

system, precipitating a loss of meaning which can cause discomfort.

The therapeutic encounter is therefore understood as a process of meaning making, both for families and therapists. Therapists and families co-construct conversations about trauma. If families indicate wanting to talk about trauma, therapists take time to 'warm the context' before these conversations happen. Through a process of meaning-making, families can connect with new narratives and meanings. This can promote a new-found sense of connection and wellbeing. Therapists also engage in a separate process of meaning making, becoming 'active witnesses' to influence the wider context. The influence of the wider context is ever present.

Clinical implications: This study highlighted the crucial importance of attending to and actively engaging with the wider socio-political context when working with this population. Crucially, therapists working with this client group need to work flexibly, linking up with other professionals and adopting roles more traditionally associated with advocates, liaison officers, or social workers. Service models promoting such roles should be encouraged. Focusing on disclosure of traumatic experiences as an end goal may be unhelpful. Instead, psychological interventions should emphasise the timing and manner in which traumatic material is spoken about. Importantly, refugee mental healthcare needs to be understood more broadly, beyond PTSD. Diagnostic-led individualised approaches might be helpful for some, but further research is required to make sense of the diverse needs of this heterogeneous population, so that clinical practice can accurately addresses the needs of service users requiring support.

Sofia Gerbase
Trainee Clinical Psychologiost
Salomons Centre for Applied Psychology
Canterbury Christ Church University

Appendix O

End of study summary letter to participants

How do clinicians using systemic family therapy navigate conversations about trauma with refugees and asylum-seekers?

Dear [participant],

Thank you again for taking the time to participate in my study. It was a real privilege to meet you and to have the opportunity to listen to all of your experiences and views. The study has now come to an end, and I have put together a brief summary for your information. I would be very interested to hear about any comments you might have on the findings. If you have any comments or would like to ask me any questions, please do not hesitate to contact me:

Email address: sw701@canterbury.ac.uk

Many thanks,

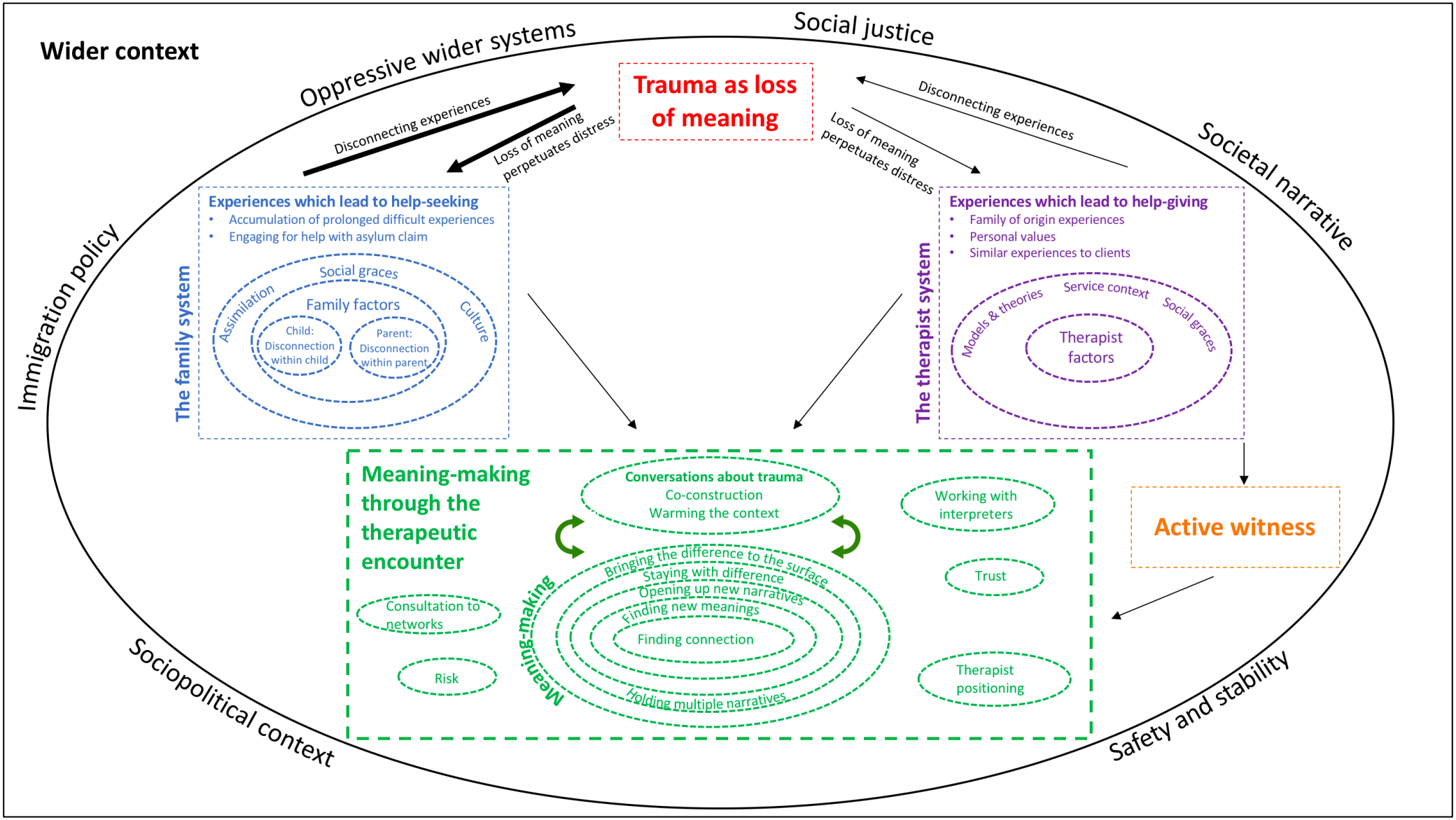
Sofia Gerbase – Trainee Clinical Psychologist

Summary of results:

The colour-coded diagram (overleaf) presents the resulting theory, which contributes to understandings of how systemic family therapists and families from refugee and asylum-seeking backgrounds negotiate conversations about trauma. The model depicts the circular and dialogic nature of relationships and systems within the areas identified, focusing on two key constructs: 'trauma as loss of meaning' (depicted in red) and 'meaning-making through the therapeutic encounter' (depicted in green).

The therapeutic encounter is understood to emerge from a meeting of two systems,

'the family system' and 'the therapist system', which operate within different contexts and experience different pressures. Both the family and therapist have different experiences which have contributed to help-seeking and help-giving. Refugees and asylum seekers can experience specific traumatic events, but trauma is also understood more broadly as the accumulation of prolonged difficult pre-flight, during-flight, and post-flight experiences, which promote a sense of disconnection within individuals and families and between individuals and their wider contexts. These experiences of disconnection can cause people to lose meaning in their lives, precipitating distress. Therapists can also experience a sense of disconnection between their own values and the values of the wider socio-political and legal system, precipitating a loss of meaning which can cause discomfort. The therapeutic encounter is therefore understood as a process of meaning making, both for families and therapists. Therapists and families co-construct conversations about trauma. If families indicate wanting to talk about trauma, therapists take time to 'warm the context' before these conversations happen. Through a process of meaning-making, families can connect with new narratives and meanings. This can promote a new-found sense of connection and wellbeing. Therapists also engage in a separate process of meaning making, becoming 'active witnesses' to influence the wider context. The influence of the wider context is ever present.


Wider context
Oppressive wider systems
Social justice
Societal narrative
Immigration policy
Sociopolitical context
Safety and stability
Trauma as loss of meaning
Disconnecting experiences
Loss of meaning perpetuates distress
Disconnecting experiences
Loss of meaning perpetuates distress
Experiences which lead to help-seeking
Accumulation of prolonged difficult experiences
Engaging for help with asylum claim
The family system
Social graces
Assimilation
Culture
Family factors
Child: Disconnection within child
Parent: Disconnection within parent
Experiences which lead to help-giving
Family of origin experiences
Personal values
Similar experiences to clients
The therapist system
Models & theories
Service context
Social graces
Therapist factors
Meaning-making through the therapeutic encounter
Conversations about trauma
Co-construction
Warming the context
Working with interpreters
Trust
Therapist positioning
Consultation to networks
Risk
Meaning-making
Bringing the difference to the surface
Staying with difference
Opening up new narratives
Finding new meanings
Finding connection
Holding multiple narratives
Active witness

Appendix P

Journal submission guidelines

Transcultural Psychiatry is a fully peer-reviewed international journal that publishes original research and review articles on cultural psychiatry and mental health. *Transcultural Psychiatry* provides a channel of communication for psychiatrists, other mental health professionals, and social scientists concerned with the social and cultural determinants of psychopathology and psychosocial treatments of mental and behavioural problems in individuals, families and communities.

"Bridging the disciplines, *Transcultural Psychiatry* is devoted to an encyclopedic examination of the relationship between culture and psychiatry. Theoretically and geographically comprehensive, it makes indispensable reading for everyone interested in mental health." Margaret Lock, *McGill University, Canada*

"The oldest and still one of the most authoritative and important scholarly and professional resources in the study of cross-cultural psychopathology and psychotherapy... Essential reading for clinicians, researchers, and students." Anthony J. Marsella, *University of Hawaii, USA*

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"The oldest and still the most prestigious journal in the field." *Wolfgang Jilek, World Psychiatric Association*

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Transcultural Psychiatry is a fully peer-reviewed international journal that publishes original research and review articles on cultural psychiatry and mental health. Cultural psychiatry is concerned with the social and cultural determinants of psychopathology and psychosocial treatments of the range of mental and behavioural problems in individuals, families and communities. In addition to the research methods of psychiatry, it draws from the disciplines of epidemiology, medical anthropology and cultural psychology.

Transcultural Psychiatry publishes original research reports, systematic reviews, case reports, book reviews and letters to the editor on all topics relevant to cultural psychiatry and mental health, including:

- social and cultural factors that influence the origins, course and treatment of psychiatric disorders
- the mental health of indigenous peoples, ethnocultural minorities, immigrants and refugees
- indigenous psychiatric theory and practice (ethnopsychiatry) including scientific evaluation of the knowledge and methods of traditional healing systems
- cultural critique of biomedical ('Western') psychiatric theory and practice
- international and cross-national research and practice in mental health.

Transcultural Psychiatry began publication in 1956 (as *Transcultural Psychiatric Research Review*) to provide a forum for communication between psychiatrists and social scientists around the world concerned with the relationship between culture and mental health and is essential for clinicians working in multicultural or intercultural settings and for research workers in the borderlands between psychiatry, psychology and anthropology.

How to submit your manuscript

Transcultural Psychiatry is hosted on Manuscript Central™, a web based online submission and peer review system - SAGETRACK. Please read the Manuscript Submission guidelines below, and then simply visit http://mc.manuscriptcentral.com/TC_PSYCH to login and submit your article online.

Once an article has been accepted in the system, it is sent to the Editor-in-Chief and his team of Editors for scientific editing. We aim to keep any delays to online publication to a minimum but we are keen to ensure the best quality control for the journal.

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All papers except for book reviews and letters to the editor must be submitted via the online system. If you would like to discuss your paper prior to submission, please refer to the contact details below.

Transcultural Psychiatry adheres to a rigorous double-blind reviewing policy in which the identity of both the reviewer and author are always concealed from both parties. All manuscripts are reviewed initially by the Editors and only those papers that meet the scientific and editorial standards of the journal, and fit within the aims and scope of the journal, will be sent for outside review. Each manuscript is reviewed by at least two referees. All manuscripts are reviewed as rapidly as possible, and an editorial decision is generally reached within 8-10 weeks of submission.

All manuscripts should follow the style of the *Publication Manual of the American Psychological Association, 6th edition* and must be typewritten and double-spaced.

Original articles and overviews should be accompanied by an abstract of between 150-250 words and about five key words, plus a cover sheet providing authors' postal/email addresses and tel/fax numbers.

Maximum article length:

Review Articles -- text: 5000-7000 words, abstract: 250, tables and figures: 5 (total).

Articles (original quantitative research -- text: 3500-5000 words, abstract: 250, tables and figures: 5 (total).

Articles (original qualitative or mixed-methods research) -- text: 5000- 7500, abstract: 250, tables and figures: 5 (total).

(Additional tables, figures or materials can be submitted in a separate file as supplemental data for posting online, subject to meeting the requirements stated in the :

Guidelines for Authors - Supplemental data on SJO

UK or US spellings are acceptable but must be consistent.

Section headings and subheadings should use a maximum of three levels.

Quotations over 40 words should be displayed, indented, in the text.

Notes and References should appear at the end of the text. References must be in American Psychological Association format.

Tables and figures should have short descriptive titles. Line diagrams should be supplied preferably as EPS or TIFF files, 800 dpi - b/w only. Photographs should be supplied as TIFF files, 300 dpi.

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Appendix Q

Coded interview transcript

Please note that this transcript provides an example of 'scaled up' final codes (rather than open coding) as open codes were too numerous to be presented in this format.

Interview 1

S Okay um.. so, I guess um.. I wanted to um... start by asking you um.. how many years you've worked with refugee families using a systemic family therapy approach and I guess if um... you could estimate how many families you think you've... you've worked with? It's probably quite a hard thing to remember

P Yea... I'm not sure I can remember how many families

S Uhuh

P Uh.. I think that's almost... I'm not sure I could do that

S Okay

P Um.. but um.. so I worked um.. so, going backwards starting from now

S Yea

P I work one day a week in an adult mental health service, in a systemic consultation service

S Mhmm

P So I'm the kind of principal systemic therapist. And in that context um... I would say um... maybe a third of the people I see are from um... or maybe at times more... um... refugee asylum seeking background

S Mhmm

P Um... mainly people that have asylum, I don't think I've seen anybody that is seeking asylum in that context

S Mhmm

P And... three days a week I work in a child and adolescent mental health service

S Mhmm

P In the XXX. And in that context um... I probably work with fewer families. Probably because there's a refugee team as you know

S Yes

P NAME WITHHELD

S Yea

Coding Density

Meaning-making through the therapeutic encounter

Meaning-making

Conversations about 'trauma'

Co-construction

Family factors - disconnected families do not feel like real families

Use of models and theories

Opening up new narratives

Wider context

Accumulation of prolonged difficult experiences pre-flight and flight

Experiences which lead to help-seeking

Therapist factors - Impact of work on therapist

Warming the context

Being the difference - Shifting from a position of passive observer to active witness (Kaethe Weingarten)

Finding new meanings

Using more than one model

Therapist positioning

Use of models

Client GRAACES

Family's culture

Trying to change the context

Therapist holds broad view of trauma

Finding connection

Re-establishing connections within family

Risk

Speaking the unspoken

Experiences in exile as most harmful

Opening up new complex and rich narratives

Collaboration

P So a lot of families where um... there's a kind of background of um... seeking asylum or um... people who have a refugee background they go to that team

S Mhmm

P Um... and then prior to that... and I've been working in um... the XXX uh... CAMHS service for about 8 years I think and... um.. and the adult mental health service for about 9 years

S Mhmm

P Prior to that I worked for 7 years a the human rights charity for survivors of torture, so everybody was

S Mhmm mhmm

P Um... asylum seeking person, mainly asylum seeking people, and also refugee people. And I worked with individuals and families there. And um... I also worked part time in... um.. I was the um... lead and manager for a systemic service in XXX in adult mental health. So I saw adults with a severe and enduring mental health problem um... and but um... but in a systemic consultation service

S Mhmm

P So seeing them with their family members and or couple or children 02:35 um.. and quite a few of those people were... probably more than half I'd say were from refugee and asylum seeking backgrounds, mainly from refugee backgrounds.

S Mhmm, okay

P And I also worked for two years in a community psychology um... service in XXX um... setting up psychology services for transitional populations, which included, and the main bog of that client group were asylum seeking and refugee people.

S Mhmm mhmm

P But it was mainly indirect work I did other than direct work. So it was working with community groups and setting up services rather than directly working with them.

S Mhmm mhmm. Okay, great, thank you. Um... and I think

P And in terms of indirect work, I should probably mention that as well,

S Yea

P So I also supervise 03:22 um.. um.. for the past two years I think it is.. um.. people from NAME OF ORGANISATION

Coding Density

Meaning-making through the therapeutic encounter

Meaning-making

Conversations about 'trauma'

Co-construction

Family factors - disconnected families do not feel like real families

Use of models and theories

Opening up new narratives

Wider context

Accumulation of prolonged difficult experiences pre-flight and flight

Experiences which lead to help-seeking

Therapist factors - Impact of work on therapist

Warming the context

Being the difference - Shifting from a position of passive observer to active witness (Kaethe Weingarten)

Finding new meanings

Using more than one model

Therapist positioning

Use of models

Client GRAACES

Family's culture

Trying to change the context

Therapist holds broad view of trauma

Finding connection

Re-establishing connections within family

Risk

Speaking the unspoken

Experiences in exile as most harmful

Opening up new complex and rich narratives

Collaboration

S Yea

P And.. also NAME OF ORGANISATION

S Mhmm

P Um... so indirect work with that

S Mhmm mhmm. Okay. And thinking about um... so you've got a lot a lot of experience, thinking about um.. the different um backgrounds of the families that you've worked with, would you say they've come from kind of particular um.. ethnic or national backgrounds, cultural backgrounds, or has it been quite broad?

P Broad.

S Broad, yea.

P Yea, so yea um... people from around the world that have come from um... war torn, conflict areas

S Mhmm mhmm

P Or um... parts in the world where people normally flee I suppose

S Yea, sure

P Which is... yea..

S But you wouldn't say there's a particular group that, that um... springs to mind where maybe in London there, are, you know, you've worked with a lot or... in terms of cultural background

P Um.. um.. not one particular group

S Okay

P There might be sort of.. a few that I could mention but, I wouldn't say one in particular

S Sure. And if you said the few?

P Um so um.. um... so I suppose a lot of people from Iraq, Iran, um... um... um... Congo, Cameroun, Angola, Lybia, um.. Albania, um... Sri Lanka, yea..

S Okay, thank you. Um.. so, could you give me some um... examples and I think more of an overview of, from your work with um... uh.. refugee or asylum seeking families, where um. traumatic events from the past have brought the family to therapy?

Collaboration

Opening up new complex and rich narratives

Experiences in exile as most harmful

Speaking the unspoken

Risk

Re-establishing connections within family

Finding connection

Therapist holds broad view of trauma

Trying to change the context

Family's culture

Client GRAACES

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Wider context

Opening up new narratives

Use of models and theories

Family factors - disconnected families do not feel like real families

Co-construction

Conversations about 'trauma'

Meaning-making

Meaning-making through the therapeutic encounter

Coding Density

P Um... give an example? Um... Sorry, uh.. what do you mean, give an example?

S So um... so um for example, so how have you understood the traumatic events to impact on the family. Um.. or could you tell me a bit about the role of um.. kind of um.. 06:00 yea basically..

P Uh... so I suppose something like.. um... well each individual family is quite sort of unique stories

S Sure

P But so the common things would be things like having experiences, somebody in the family been tortured, or, maybe the woman being raped

S Mhmm

P Umm. and the impact that might have on the relationship with the husband or.. families where um.. um.. members of the family have been killed or left behind

S Mhmm

P Um.. or um.. families where they have um.. they have you know, um.. they have fled um conflict or persecution and had children in this country and um.. and um.. issues around um.. uh.. cultural connections and different kinds of cultural connections and.. um..

S Mhmm

P Children not necessarily having a clear understanding or um.. explanation for why their parents are the way they are, so have sort of difficulties in communication that might be the result of the impact of trauma and the impact of um.. experience in exile. Um.. um... parents feeling unable to parent the way they want to parent, so um.. come in contact with social services, or um.. mental health services

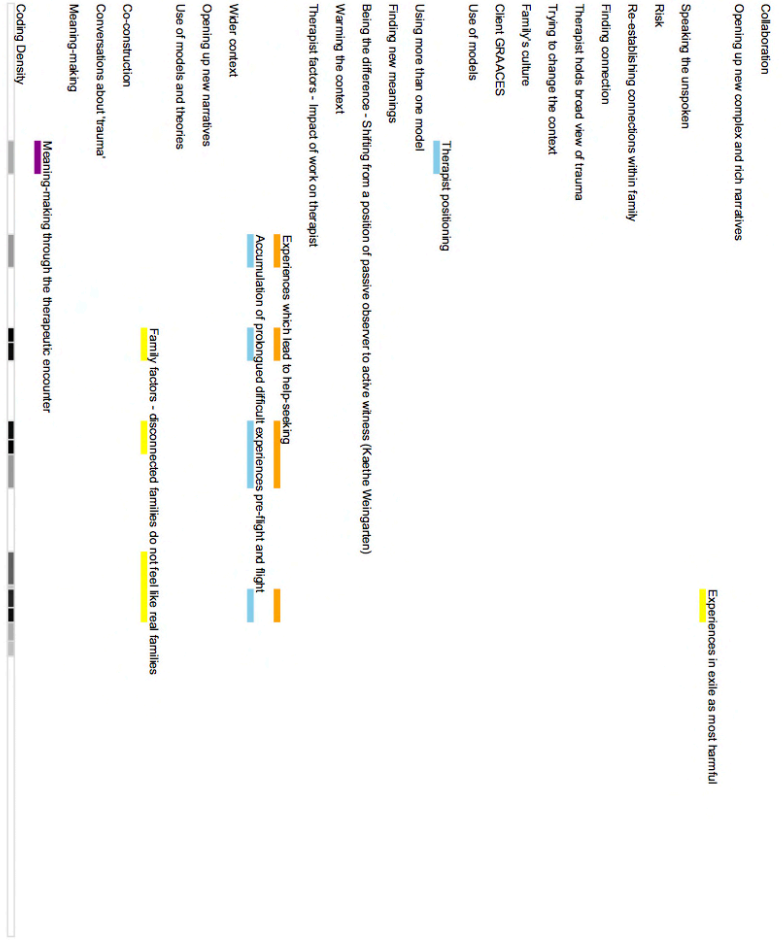
S Mhmm

P Um.. is that what you mean?

S Yes yes

P Or were you looking for something more specific?

S No, you're, that was exactly what I meant, just kind of, I know it's difficult because obviously each family is individual um.. and will have their own difficulties, but yea that's what I means, just a broad, broad overview, that's really helpful



P Okay

S Um.. um... could you tell me a little bit about the role of trauma disclosure when working therapeutically with families?

P Uh it sort of depends what you mean

S Okay

P Do you mean as a therapeutic tool, so some models are based on the idea

S Mhmm

P That um... disclosing or talking about a trauma is an important part of the therapy

S Yes

P So, if that's what you mean, then I'll give a particular answer in relation to that, but if you mean jus the process of how families talk about their experience, then that's maybe a different...

S I think I mean, I probably mean both

P Oh okay

S Yea

P So, um.. so I don't work in a way.. I don't um, follow models that have a

S Mhmm

P a base in kind of cognitive processing view of trauma

S Yea, yea

P 08:55 So um.. when I'm working with people, individuals or families, I'm not starting with the assumption that they have to talk about certain things in a particular way

S Mhmm

P Um.. I'm much more influenced by narrative um... systemic, social constructionist approaches

S Mhmm

P It's much more about co-creating with the other person how they want to do talking, um, what's most helpful to them

S Mhmm

P So, um.. I probably would say that I'm very anti approaches that emphasise the importance of disclosure

S Mhmm

P Um.. because they, I think, can be harmful, and they um.. are not necessarily about co-creating with the other person

S Mhmm

P Um.. but that doesn't mean that people don't talk about their experience, because they do

S Mhmm

P But it would come from um... it would come from them, and come at a time when they feel that they can and want to talk about their experience

S Mhmm

P And also that trauma, again, my view of trauma is not um.. narrowed to um... um.. the kinds of events that might be typically thought of when we think of um.. post-traumatic stress disorder as a kind of concept

S Mhmm

P Um.. so, so, families or individuals might talk about the trauma of, of... of racism, or living in exile..

S Mhmm

P Of the home office and experience within the home office

S Mhmm

P Um.. um.. the trauma of loss of home, trauma of loss of a sense of self, um... and purpose and community and.. culture and all the things that can kind of... people's sense of meaning

S Mhmm

P Um, so that's definitely something that people always talk about

S Mhmm mhmm

P Um, so I think I maybe... uh.. I guess I wouldn't think of it as trauma disclosure, when I think of trauma disclosure I think of a particular view of a what trauma is and of what disclosure is

S Mhmm mhmm

P Um, and the process of it. But certainly people talk about um.. huge, multiple, extreme, intense, um.. cumulative adversity, and... um... massive challenges and distress, yea

S Mhmm mhmm mhmm. I guess um... I'm um.. in this study I'm coming from a view of a kind of very broad understanding of trauma, so along the lines of, of how you, of what you mentioned, and um.. I'm coming very much from kind of a... your type of perspective, not very much from kind of a... I guess I don't know what I'm... how I would frame it but.. like a... a view of trauma that, you know, it needs to be talked about and I guess that's what I'm trying to look into in this study is... is how, how is it done in systemic practice, um... um... I guess thinking about when families talk about the difficult experiences that have happened to them, um... how do you, um, perceive that to kind of affect families and how they, I guess I could say.. yea, how do you perceive that to affect them therapeutically when they do, when the point comes where they might kind of start talking about something that's been affecting them.

P Yea. Um.. I guess one of the things that you're thinking about as a therapist is... is.. is.. um.. not just um.. how you get people to talk but the impact of talk

S Mhmm

P And particularly when you're working with a system because people are talking in front of people that are, they are close to and they have intimate relationships with

S Mhmm, mhmm

P And who might have different experiences or different understanding, and what does it mean to hear your parent talk about um.. being, feeling vulnerable or feeling um angry or scared or having experienced being violated for example for your child

S Mhmm

P Or, what does it mean for a parent to hear... similarly from children, or hearing their children talking about challenging or suffering. So I'm always conscious of, um.. what kind of takl do people want to do and how might it be be helpful

S Mhmm

P And um.. and what difference might it make to how they, kind of family they want to be, and um.. their preferences for living, so where they want to move

towards, so it's very kind of um.. varied for different.. different families, um.. in terms of what the issues might be. It might be that um.. because of what they family's experienced there are secondary effects and that's what they want to talk about

S Mhmm

P So, there might be a sense in the family of um.. um.. we just don't talk to each other enough, and no one understands anybody else's perspective of what they're doing, they don't feel like a real family

S Mhmm

P They feel very disconnected so it might be about helping the family think about what it looked like to be more connected and what kind of things would you be doing, or what kind of things would you we talking about and what's getting in the way of that

S Mhmm

P And, and that might be things like, um, you know, if, if a parent is experiencing a lot of, so re-experiences and nightmares and very much in their own world or their own experience

S Mhmm

P That might14:36 be experienced by other people outside, um.. their children or their partner as them withdrawing

S Mhmm

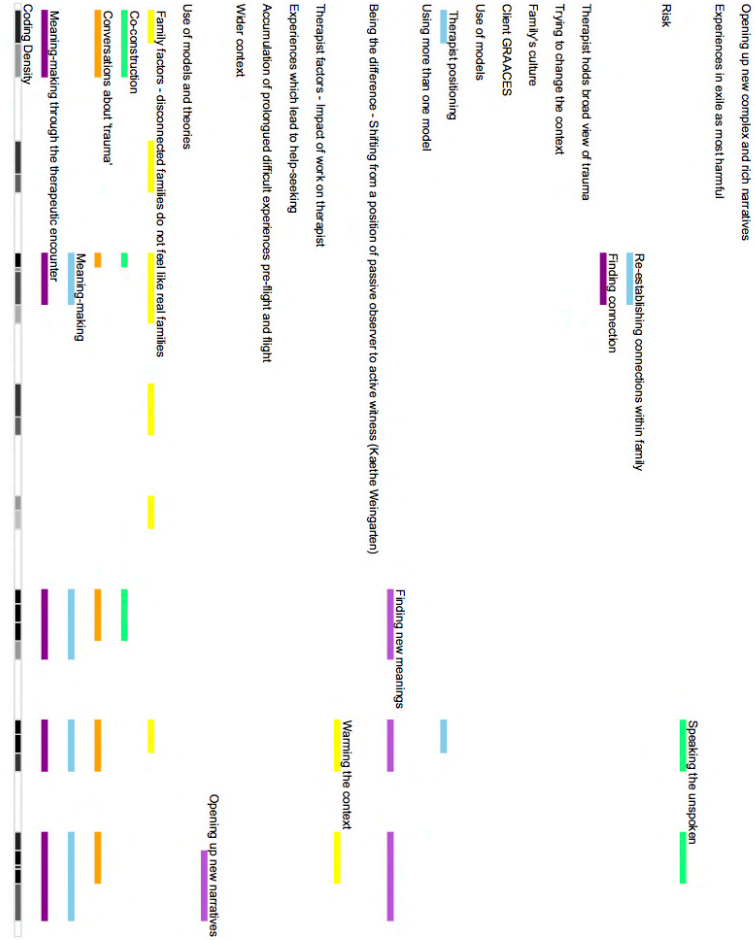
P or um.. or them um.. you know, abusing alcohol, or them being very angry all the time, um.. so how do you um.. find a way of helping people to create narratives that help people understand and facilitate the kinds of relationships that they um.. want to have

S Mhmm

P Um.. so, so there's a lot of thinking about preferences for them as individuals and preferences in relation to them as a family but also thinking about um... what's it like to hear that, you know

S Mhmm

P Um.. when you, when you heard them talking that way, what, you know, what did that make you feel? what did that make you think? um.. what sorts of things are difficult to talk about? um.. but also trying to highlight people's responses, and their resilience as well, so, um.. what does that say about you that you've been able to have such a happy child even though you are struggling so much?



S Mhmm

P Or you, um... are very distressed, you know, where does that come from? and where does that? and charting the kind of history of that quality or resource.

S Mhmm

P Um... so yea, it's kind of, I suppose it's multivarious in a way the kinds of conversations that you might have and the place of a trauma within that, that you might be reflecting on the impact of trauma, but you might also be reflecting on how people respond to trauma and what does that say about them.

S Mhmm mhmm. Rather than focusing on, if there has been an individual trauma, rather than focusing on that

P Yea, and it might be that you do focus on it

S Mhmm

P But there's also lots of other aspects, um, around that as well

S Mhmm, the repercussions of it within the system?

P Yea, repercussions, how people respond, how does the response link to their values, what's important to them, um.. wider context

S mhmm

P Um, the social graces, what does it mean to be male, female, or um.. of a particular ethnic group

S Mhmm

P Or um, skin colour, or sexuality, or class, and how those impact or, um, shape the experience they've had, and also how they responded to it

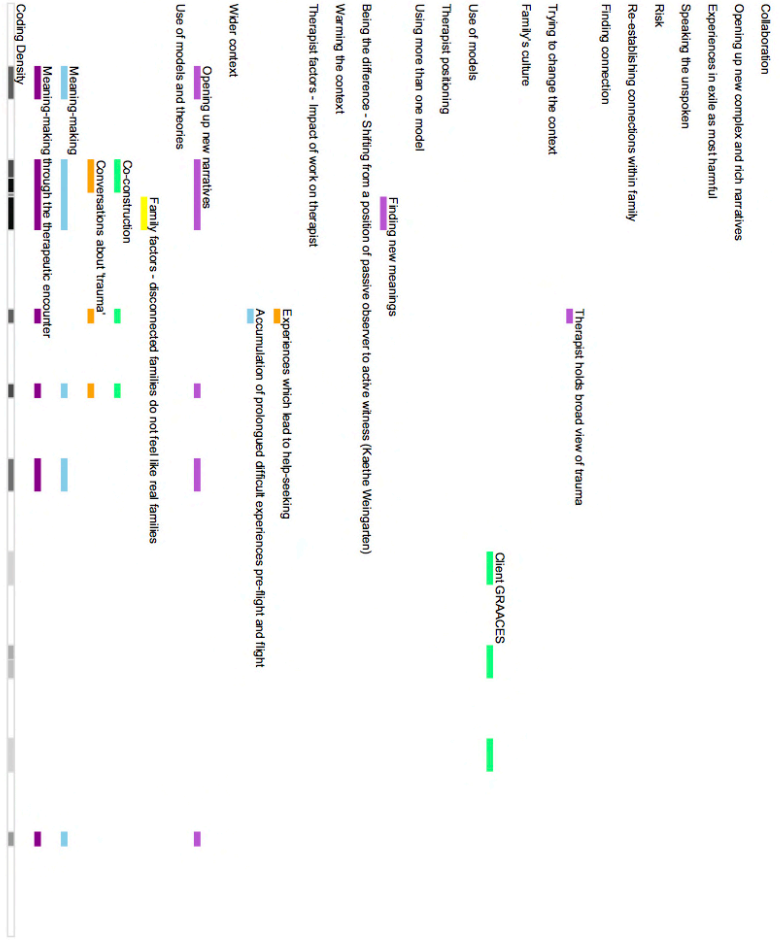
S Mhmm

P Um, so what's it like for a man, for example, to feel vulnerable, what's it like for a woman to be angry, and..

S Mhmm

P So reflecting on those things as well

S Mhmm, okay Um... um... my next question is around, kind of patterns of communication and if there are any patterns that you have observed in the families that you've worked with.



P Um... I think um...

S So have you observed any um, patterns in how um.. um.. difficult um.. past events have been talked um spoken about in families you've worked with? Um.. what do families do that show you that this is the case? Um.. how do you take these difference into account in your therapeutic practice, if there are differences between um... if you've noticed different patterns

P Um.. I suppose, tell me if I'm not answering your question

S Mhmm

P Um. but I suppose when I think of patterns I'm thinking of um.. how um.. extreme events that are out of your control, how they impact on your sense of yourself and how you relate to others

S Mhmm

P And on how you communicate, so, um... so it might be that um.. a lot of the couples or families might have issues around communication or, or.. how, you know, not so much trust but how much to say and how much not to, the, um..

S Mhmm

P The 'to talk, not to talk' kind of, um dilemma

S Mhmm

P How much do you say, and what's the implications of what you say, um, are quite kind of common themes.

S Mhmm

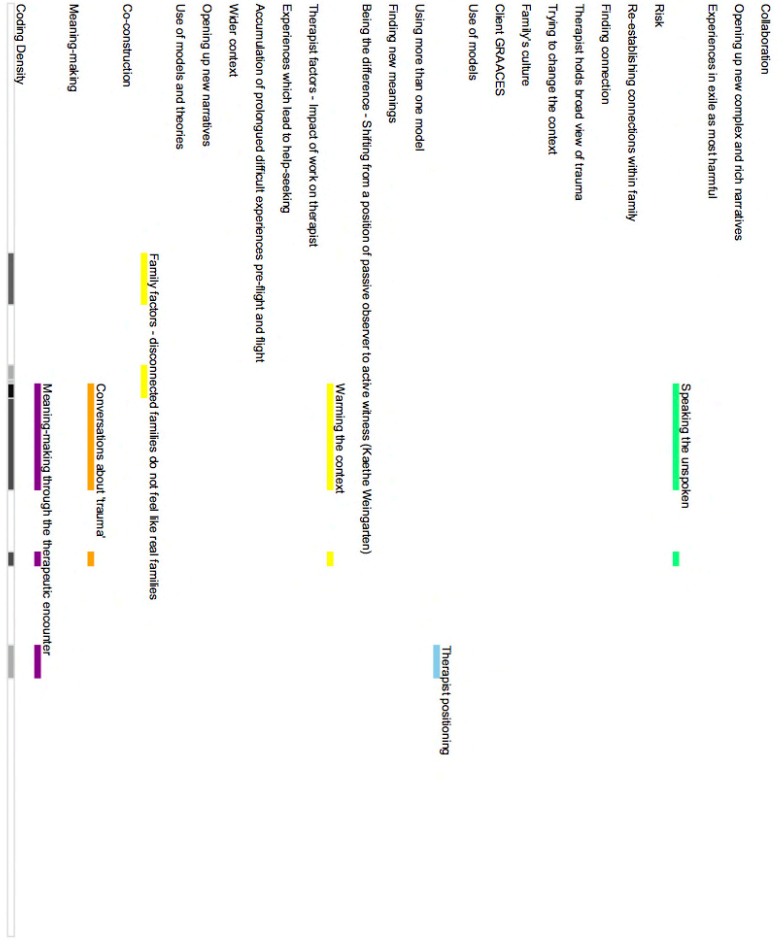
P Um.. but I guess it's difficult, I find it, I find I sound like I'm trying to.. I find myself... I find it difficult to talk about patterns in general because um... yea, I guess, I guess I'm not sure I think of it as that, sort of.. um... maybe I'm misunderstanding the question, I don't know.

S 19:33 Um...

P Do you mean how, do you mean um.. people expressing themselves in different ways? Or do you mean how they, kind of patterns that people get locked into as families?

S Yea, yea, yea, basically.

P Yea.. um..



S I guess patterns that, of communication that might be, um.. um.. perpetuating some sort of distress within the family, and yea, have you noticed any patterns in kind of, in how, in that.

P Yea, I guess.. but, um.. I guess the reason why I'm finding it hard to answer the question is, is, I guess, because each family would have their own

S Yes

P Kind of difficult patterns, andI'm not sure if they necessarily that different to families in general, so I... um..

S I guess, I mean, it's, you can tell me about families in general as well, um.. if they're not that different, if they're not different to families in general, I'm not saying they will be different to families in general, it's just from your work. It might seem, I guess, I guess. it might be that the question 20:44 seems quite obvious to you *laughs*

P No no no it's not, not at all, it's the opposite, it's hard to, I'm finding it hard to answer, I suppose, because um.. I guess I'm um.. I suppose um.. when families come for family therapy there are um... they're coming because there's something about how they are communicating that they want to change

S Mhmm

P And they're finding distressing

S Mhmm

P or there's been a, either because um.. they've, um, from the beginning of the family, of the system, found it um.. difficult to, um, create something that they want to create

S Mhmm

P Or because there's been an event or series of events that have impacted on the family, shifted and changed the nature of how they interrelate with each other

S Mhmm

P Um... and.. so I suppose when people come for family therapy they're coming because they are... there's something about how they... the patterns of communication between them they find challenging. Um... so for example, things like feeling that they don't understand certain kinds of behaviour, or finding it hard to talk to each other about certain painful experiences or difficulties or... um... um... 22:10 yea.

S Mhmm, mhmm. Okay. Um... can you tell me a little bit about how um... how you perceive when um.. parents are having difficulties, how you perceive that to

impact on children, um.. within your experience. Um.. and could you if possible give me some examples of some families that you've worked with where that's been the case?

P Yea.. so um... um... if I suppose, um... if parents are experiencing um... low mood or um.. or um... feeling very agitated a lot of the time or anxious, then it might be very hard for them to be the kind of parent they want to be. And it might be very difficult for their children to understand why their parent is the way that they are. Um, and often parents want to try and protect their children from um, they can almost feel like the trauma they've experienced, the pain they are experiencing is um.. think it's infectious in some way

S Mhmm

P They want tot try and not infect they're children and then sometimes, families, parents talk in that way, you know, "I don't want to pass this down" or "I don't want this to be..." particularly in relation to things like rape or um.. there can sometimes be this idea that um... you've, you've sort of sullied your children and you can sully their, their future life or their um... prospects or.. um.. in.. or impact on their destiny in a negative way. So there might be a desire to protect their children from the past or the um.. the kind of traumatic or extreme experiences that they've experienced. But in doing that, um.. the other people in the family, or the children in the family, might feel more disconnected from their 24:21 parents.

S Mhmm

P Um... and um.. and so sometimes that can, um... breathe a sense of.. feeling that their parents don't care for them, or um.. they don't feel connection to their parents...

S Mhmm

P That they want to have um... or it might be that um.. but you know, there might also be lots of ways in which they're able to facilitate positive connections as well, and um.. a positive sense of who they are as a family

S Mhmm

P and.. and where they're from, and um... um... yea, but I suppose that if a parent is depressed, for example, then it's very, it's very common for a young person to feel um... to blame, because children often blame themselves if their parents are struggling

S Mhmm

P And particularly if they haven't got a narrative to make sense of it, and so it might impact on the young person's self-esteem, or um... sense of themselves, yea.

S Mhmm, mhmm.

P Is that what you meant?

S Yea, exactly, that's exactly what I meant. Um.. what have you noticed parents do that's shown you that it's the case that they're trying to kind of um.. protect their children from, in that kind of.. that they're worried that this might kind of impact on them, pass onto them in a sense.

P Um, they might say to me.

S Okay, yea

P Yea, so very much the approach that I work with is, is not so much interpreting but talking with families and, and hearing their stories

S Yea

P And um.. and thinking with them about um... so opening up a narrative really

S Mhmm

P So um... you know, what, what's.. what are the values behind something

S Mhmm

P And, and.. unearthing that can often be very poignant and powerful for a family, cause often what people in a system do is they're interacting, um... on, in, based on someone's behaviour and responding and reacting to someone's behaviour, but the underlying values or ideas or beliefs um.. and thoughts behind it don't get.. don't come to surface, don't emerge

S Mhmm

P So by discussing and talking in the family, and allowing that to emerge, it can, it can open up a very different way of um... understanding each other

S Mhmm

P So it's, yea, it's through talking, and they would, say so, rather than through behaviours, because even the behaviours, I'd be trying to think with the family about um... what, what does that mean to you, to behave in that way? That's, that's underlying.. underlying that for you?

S Mhmm. Thank you. Um... Um... 27:25 So my next question is around um... disclosure of kind of difficult events that have happened, um... in.. with, with the people that you've worked with, um... have there been um... have there been um differing views about um.. whether um... the difficult let's say that have happened

to the parents or the family should be disclosed um... have there been concerns about um.. talking about those things um.. who um.. who who in the family.. um.. is there someone in the family who tends to be more worried about um, about talking about these things openly, um.. is there again, this word "pattern", I don't know, um... but if you can um, if you can think of patterns that you see in the families that you've worked with?

P Yea, it can be the case that there are different feelings about um... what you say and how much you say. And also different people have experienced different things um.. particularly if you're, if um.. assuming that families are heterosexual families

S Mhmm

P Where you've got um... a father and a mother, and you've got um.. and so by virtue of that you've got people who've experience things differently

S Mmm

P Because they're different genders

S Mhmm mhmm

P Um... and you might also have other differences as well, so um... so they, so there is often a.. a different experience, and a different um... and also within that, it might be quite hard for them to, because so they might be having their own difficulties as a couple to, to have the space to even talk about things or think about, well, how do we talk about this? what do we talk about? and how do we um... you know, think about this together as a family? think about um.. how we want to create a narrative that's helpful for everybody in the family. That in itself might be a hard thing for the parents to be able to do.

S Mhmm

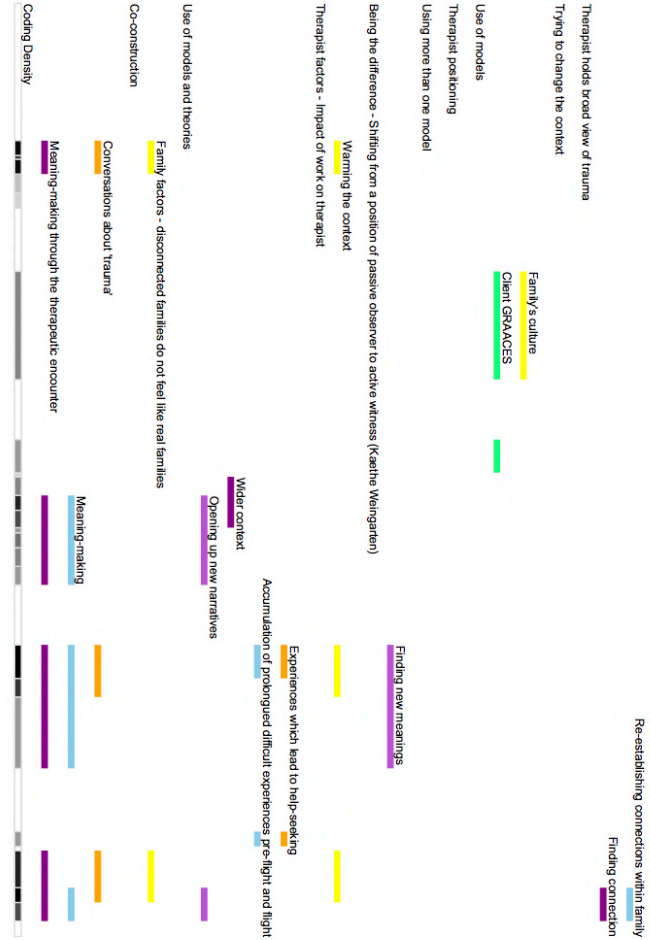
P Um... so, yea, it might be, it might be common for... say, if one member of the, if one of the parents was raped, for example, how they might feel about even discussing it with their partner

S Mhmm

P Let alone their children

S Mhmm

P Um.. sometimes the children are a result of rape as well, um.. so they may not, again, as you can imagine, in order to talk about it, on that, um... perspective. Um... um... yea, so it is a common, it is something that happens, that there are different views about what you talk about and how you talk about it30:04 and to part of, come together as a family to find a way of, not necessarily talking about



the issue, but talking about talking, talking about... what is it like, how things are now? And what might it be like if things were different? So what would it be like to um... um.. you know, say, for example, talking with the children about what they want, and the children say, "well, we want to feel more connected to our parents" or, understand their context a bit better, then you might ask the parents, what would it be like to do that? What would it look like?

S Mhmm

P Um, so, I would never sort of start off with any kind of assumptions about how people should be talking in the family, but more thinking with the family about um... hearing everybody's experience of the family and then thinking together about how, how do you then create the family together that you want to have. So, if there are certain members saying that they want to understand more, and certain people in the family who are saying "but we don't feel that comfortable sharing too much" then how do they think about that as a family, you know, what.. how they perceive given that some people want to know more, and some people um.. feel that they want to kind of protect other people from what they know.

S Mhmm

P Um... So yea, what's it like living in that kind of family rather than, yea, trying to find a way of shifting it necessarily.

S Mhmm. Mhmm. Okay. Um.. Can you tell me a bit about working with um... um... refugee or asylum seeking families, cultural values, and how these might differ from um... I guess, Western models of understanding and alleviating difficulties.

P Yea, so.. um.. I'd say that um... virtually every family that I've worked with have had, um... views of the self and of um... underst... ideas about wellbeing and um.. distress that are different from, sort of mainstream, Western psychology ideas, and um, ways of thinking about the self, what wellbeing is, what distress is

S Mhmm 32:25

P Um, so, I think it's a very... it's very rich working with um.. families from different parts of the world, from all over the world, because it, it, I think it's very humbling, and it really highlights that, that how we think um... or how we think we think, cause even in the Western context it's also very diverse and a mix, and I'm not sure it necessarily fits um.. fully in this context either, but the way in which we think we think or the way in which the dominant discourse, um, sort of, the ideas that are promoted, um... is the minority, when we think of how people generally think across the globe

S Mhmm

P So, for example, the idea of a self being um... an internal, individually bounded, entitiy or experience

S Mhmm

P Um, is a very um... it's an idea, it's um... it's not the most common idea, in the world, and it, it's the kind of foundation of, of everything we do as Psychologists, in terms of how we understand distress, how we understand healing, how we understand recovery, it's based on that idea of the sort of self-sufficient um.. self, and that the self is inside um.. so that it makes sense of why we think of um.. cognitions and logic, and helping people to feel better, and helping people to feel better esteem, um, even the idea of self-esteem

S Mhmm

P Um, whereas a lot of people I've spoken to from other parts of the world have a more relational, collective view of self, um.. so the idea of depression being in here (points to self) wouldn't make sense and it wouldn't make sense as being disconnected from a social-political context

S Mhmm

P Um... or, or collective context. So, for example, I remember an Iraqi man saying um.. "the doctor keeps telling me, keeps trying to take away my depression as uh.. it's mine, and it's not, it's, it belongs to my whole family, my whole country, and every time I turn on the news and I see Iraq being bombed" - this was a few years ago now, it's a bit different now, but um.. - "what they call depression is a natural response to what I see".

S Mhmm

P So I think even, and that's a very um.. that's one example of, um.. a variation of the same sort of comment from people, experience from different parts of the world

S Mhmm, mhmm

P They might use spiritual explanations, or political explanations, um... for either their distress or sense of wellbeing um.. as opposed to psychological, the way we understand it, um.. so I think culture is... *closes window* I should have thought of that before cause of the recording

S Hopfully it's alright

P Hopefully it's okay. Um.. it's amazing how those things tend to pick up, like, background noises, really strongly. Well, hopefully it's fine. But um, yea, with regards to culture and cultural differences, it's a huge issue when working, which is why I think it's so important to co-create with the family, cause it's so easy, unwittingly, to impose an idea, and then once an idea is set, then um, the family have, have no choice other than responding to that idea, even though it's not necessarily um.. an idea that comes from them or makes sense to tham.

S Mhmm

P Um.. so for example I've worked with lots of families 36:06where they say "oh, I didn't want to come to therapy because I had tried it before and, um..." and they felt like failures because they didn't find it helpful, it didn't connect for them and they tried really really hard but just didn't connect, and, and.. it's often because either they were being encouraged to think about something they didn't want to think about, or um the language and the questions are all around uh... a particular view of what their distress is that just doesn't fit

S Mhmm

P Um.. and so they end up feeling that they're the problem rather than, that maybe there's just um.. a lack of fit

S Mmm

P Um, yea

S Mhmm. Um... Alright um... Um which factors do you think influence um.. um.. trying to rephrase this question in the moment, but which factors do you think influence um.. how well families can, in the room, communicate and um engage in kind of meaningful conversations?

P Yea.. um.. I think it depends on whether or not um.. we're thinking about refugee families or asylum seeking families

S Yea

P Partly because I think that the sociopolitical context is a huge one, and often doesn't get, I feel like doesn't get highlighted enough

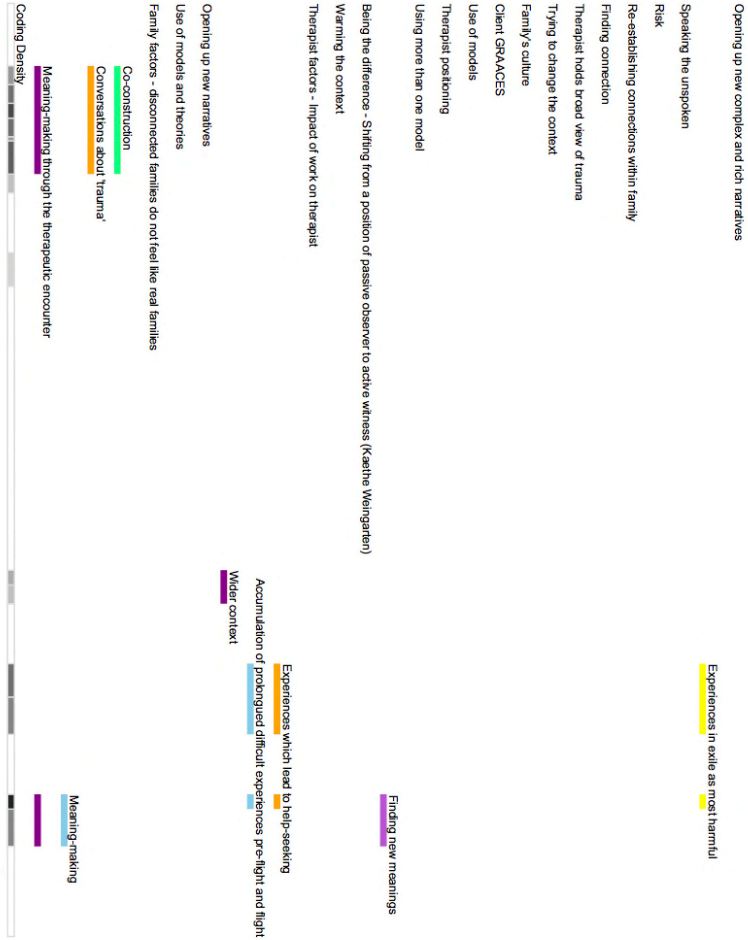
S Mhmm

P Um, so if you are a family where you have not got asylum yet and your situation is tenuous, then in a way, um, your.. your kind of psychological wellbeing, your your your communication patterns, all those sorts of things, are heavily influenced by that context

S Mhmm

P So um.. if you don't feel safe, um.. and your strategy or your way of coping with not being safe has been um.. to withdraw into yourself or to lash out or to um... be hypervigilant and anxious all the time

S Mhmm



P Or to just be in a different world and dissociate, if that's been your response, um.. previously and now, it makes sense that's going to be your response and that's going to be your experience in the family, and then that will impact on um... relationships you have

S Mhmm

P Because you might have one person that's dissociating, another person that's angry, another person who's um.. and they will all impact on each other

S Mhmm

P So I think the.. the.. question of safety and asylum and um... sort of social justice are huge and massive and incredibly pertinent. And also in relation to the idea of working with families where um a member or more than one member has a diagnosis of PTSD. Again, it's a, it's a diagnosis that's based on the idea of a memory disorder of some kind

S Mhmm

P Um.. and, and yet when we think about um the process of seeking asylum and all the traumas that are associated with that, and not yet having asylum, then you can imagine that if you're not safe and at any moment there's a very real chance that you could go back to an unsafe environment, so it's a double whammy in a way: you're not safe, and you could go back to un unsafe environment. Um.. then the, the idea of being thrown back into the past kind of makes a lot of sense, and the um... the expectation to support people to be able to um.. do away with that somehow and to be able to have a sort of normal, sort of inverted commas, um.. relationship to memory when... in that context, I think is um.. um.. unrealistic. So I think, so that's why I kind of talk about the.. the one context being um.. how safe are people and their sense of social justice in all different ways that that might be expressed in terms of um... you know, housing and um.. feeling kind of part of the community and welcomed and integrated and that kind of thing, rather than marginalised.

S Mhmm

P Um.. so that's the wider context. And I think other factors that might impact on how um.. people in families communicate are factors related to the graaaaccces, so, gender, age, um.. and I include generation in that

S Mhmm

P Um.. so, differences in age, um, and therefore often differences in experience. And you might have some members of the family that are born here and some that aren't, and they can have different experiences, different contacts, different um contacts, different world views, and that might have an impact on how people communicate.

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S Mhmm mhmm

P Because um... cause that might impact on expectations. So the, the expectations that parents might have had when you start a family is an idea about the kind of family that you're gonna have based on your own experience. If your expectation was a particular relationship to your children, and that's different because your children have a different cultural experience, that means that they relate to you differently, that can be very trauma- challenging for parents. 41:48

S Mhmm

P Say if children have more of a sense of um.. you know, their, their... right or their voice or... that's not to say that some cultures have children who don't have a sense of their rights or their voice, but it might be a very different one in terms of how they relate to parents.

S Mhmm

P Um... so, so the graaaces in terms of culture, age, um... class, ethnicity, and experience in exile as well. I think that often, um... you know, I have a bit of a bug bear about um... the way that psychologists might psychologise or individualise problems but also systemic therapists might um.. do a similar thing but on a level of the family, so we just focus on the family and we forget the wider context, and view the communication in the family as something that can be tweaked or addressed or managed or manipulated regardless of the wider context, and I think that the wider context is always impacting and informing um.. what is and isn't possible. As well as other things, like you know, you know.. I do genograms with people, it's amazing the power of drawing someone's genogram and hearing about people's different experiences that go beyond them, but the generational, you know, parents and grandparents and.. um.. stories that either get replicated or stories that people are trying to completely replace with a new story and how that then shapes what they're doing in the here and now

S Mhmm

P Um, yea..

S Thank you. um..

P I think like finances as well

S Yea

P And housing. Like, housing is a huge issue, if you're living in a very cramped environment, if it's not very nice, then that has an impact on any family I think

S Mhmm. Um... I guess the next um bit is around more kind of you're, the therapeutic skills that you use, so thinking more specifically about what you do in

the room, um, in tour practice, to help families. Um.. could you tell me a little bit about that?

P Yea, um... so um... a lot of what I do is trying to multiply engage with multiple stories and finding a way of holding them all without um.. simplifying or reducing um.. what people are sharing. And in doing that, helping the family, almost mirroring to the family that it's possible for multiple, diverse experiences and realities to coexist and be equally valid.

S Mhmm

P And, I guess uh.. as you were asking that, I was thinking "Oh no, am I going to sound wishy-washy? It's not a sort of technique, or a kind of, something I can kind of give a name to. You could.. but in a way, you could argue it's a bit deliberate because I think that um... family therapy um.. has got an um... has got a version of it that is very technical

S Mhmm

P um.. and there's a whole kind of school of thought and movement around a kind of collaborative way of working um.. that's about the process rather than techniques. And also because the idea of working with refugee people has become more and more technical. 46:13 And also so.. working with survivors of trauma but particularly torture, and refugee and asylum seeking people, I think it's become more and more technical, so there are more and more, kind of, theories out there about the techniques to use, and so um.. I find um.. I find it quite difficult knowing how to talk about what I do that doesn't sound sort of wishy-washy like I'm not doing anything *both laugh* not really doing anything, because I often don't talk in that way

S Mhmm

P Um.. but I, but I suppose it's something about um... opening up stories and making connections between things, and thinking about power and thinking about um.. the impact of power, but also um.. empowering um.. empowering individuals and systems by helping them re-tell the story that they're telling, and helping other people to retell a story and um.. so working in a very sort of narrative way I suppose

S Mhmm

P Um.. would be kind of, my main approach. But also in doing that, being open to different kinds os ways of talking. So often families will talk about spirituality, or talk about politics, or talk about um... what it means to, yea, existentially, what it means to lose everything that gives you um... orientates you and gives you foundation and, almost like wallpaper, it's kind of there, but you don't notice it until it's gone

S Mhmm

P Um.. so it's, it can be quite a.. um.. have a lot of depth I think, but you're also doing, you're always doing that in, in the frame of multiple conversations happening at the same time, and how do you invite other people to hear each other and empower that. I suppose some of the techniques I might use, having just said that, would be reflecting processes, I do quite a lot of that, whether it's um, inviting members of the family to listen in a reflecting team while I talk to a member

S Mhmm

P Um, and then inviting them back and swapping round, that's often very powerful. Or inviting other members of the wider system, so if there are issues with um.. whether it's uh.. like social workers, or psychiatrists, or other members of the wider uh.. professional system into the reflecting team. So finding ways of um... creating and developing, thickening, or creating and developing a new narrative that's helpful, but then thinking about ways of thickening that narrative by drawing on um.. um... by making that narrative... by enabling that narrative to breathe by either inviting other people into it or um... um.. thinking about how the family itself can... can... can shape that narrative together, given the different experiences and different narratives within that

S Mhmm

P Um... contextualising issues so that people don't feel that.. that um... problems are located within them. So externalising I suppose would be a technique, a narrative technique

S Mmm mhmm

P Yea

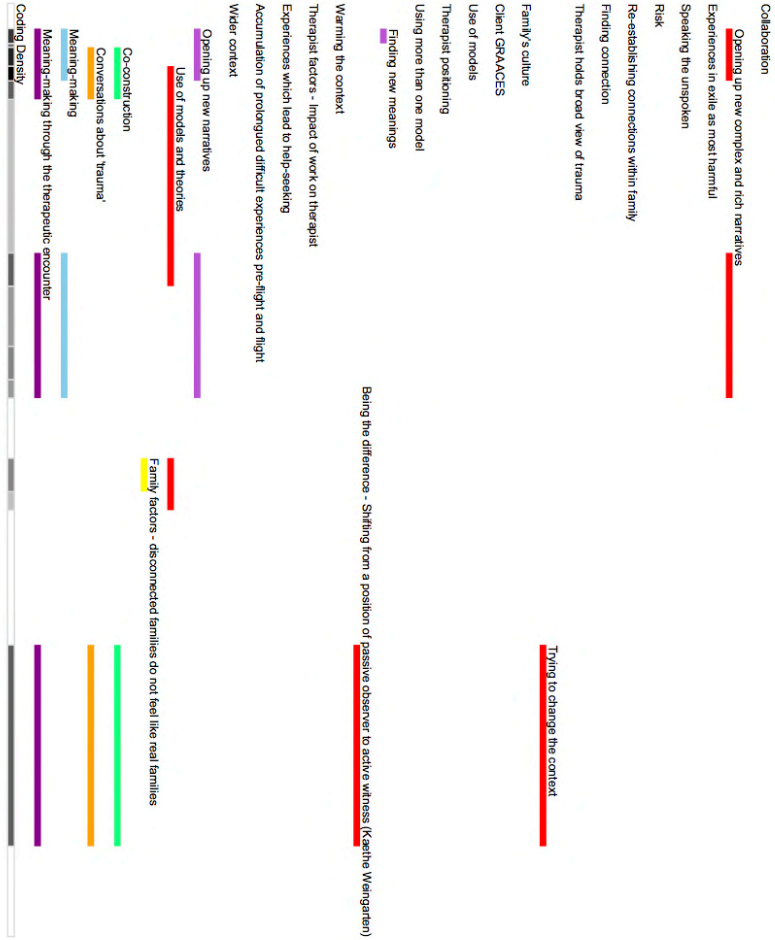
S Okay. Um...

P And active things as well. So sort of supporting people's housing applications, you know, writing... um, particularly when I was working in the human rights organisation, a big part of that would be actively trying to change the context so that it's more empowering for the family, so whether it's writing people's reports um.. - medicolegal reports, writing housing reports

S Mmhmm

P Advocating on people's behalf if they're not accessing um.. you know, or not experiencing um... fair treatment in other services, that's also a very important part of the work as well.

S Mhmm mhmm. Um.. so the next question was around how um... so the next question was around um.. thinking about um.. parents and how um... connected



or in tune they might be to their child's, children's needs um... do you ever kind of think about that, and if so, how, and how might that be important?

P Yea, cause you're always sort of thinking about reflecting on um.. the quality of relationships within the system and the family and, um.. and people's abilities to hear and see each other, and what gets in the way of that.

S Mhmm

P And talking about that, and sharing it. And the more that you name and want everyone to have a voice and that also comes out in what people might say in terms of their hopes for what kinds of relationships or contact they have with each other. So, it might be that - and it's not always between parents and children, it might be between siblings, or between um.. um.. the couple themselves.

S Mhmm

P So it's uh, yea, any member of the family feeling more or less understood or heard or.. um.. or thought about any other member of the family. Um... but yea, I suppose.. but, particularly from a kind of um.. CAMHS point of view, so thinking about, you know issues around... sort of, children's emotional development and their sort of emotional needs, and also about risk as well, about harm and um.. because harm, as you know, isn't... can be emotional harm. So that's also something you're kind of, holding and bearing in mind as well, the impact emotionally of the system on each other, and at what point does it constitute harm and needs to be sort of... and in that case other services then need to be brought in to think about with you as a family um.. so yeah, you're always sort of thinking about that as well.

S Could you tell me a little bit more about um.. when you were talking about um.. thinking of the child's um, kind of emotional development and thinking about that, could you tell me a little bit more about that?

P Yea um.. so I think you were asking me about um... um... am I interested in how parents.. the quality of the relationship between the parents and the children? Is that what you said? I can't quite remember

S Yea it was um.. yeah, how in tune a parent might be to their child's needs

P Yea, I mean it's also I guess important to think about sort of cultural differences, and assumptions that we might have about it means to be in tune and um... um.. and what that looks like, um, and it's different in different families and in different contexts um... but um.. but you're also holding in mind wellbeing as well and um.. and development, but again, thinking of development as um, not a kind of fixed thing that is universal and that it's fluid and and.. diverse in terms of different ideas about how people develop, cause again, the idea of self is different, so within the Western context there is this idea that children individuate, there's more of an emphasis on attachment and then um.. detachment in a way. And that's not always the kind of model that people have in different cultural contexts.

S Mhmm

P Um... So I think it's kind of a complex thing in a way, cause you're balancing seemingly contradictory ideas but they're not necessarily contradictory, so how you keep an eye on um.. um.. harm and risk, and thinking about development, whilst also holding in mind that it's a diverse concept and not a fixed concept.

S Mhmm

P So, if for example um... you know, at different stages of a child's life they might have different needs and it might be that a particular child in a particular family um.. of a particular age, so latency or toddler or teenage age, doesn't - isn't getting what they need

S Mhmm

P um.. from their parents, you're sort of thinking about that really in terms of that particular child's development emotional development.

S Mhmm. Thank you. Um.. Have you ever noticed any um... so first of all, what therapeutic gains do you think um.. it's a bit of a... what therapeutic gains do you think that um.. kind of, this type of work um... achieves, and secondly, have you ever noticed any um.. possible negative impacts of the work on the family perhaps.

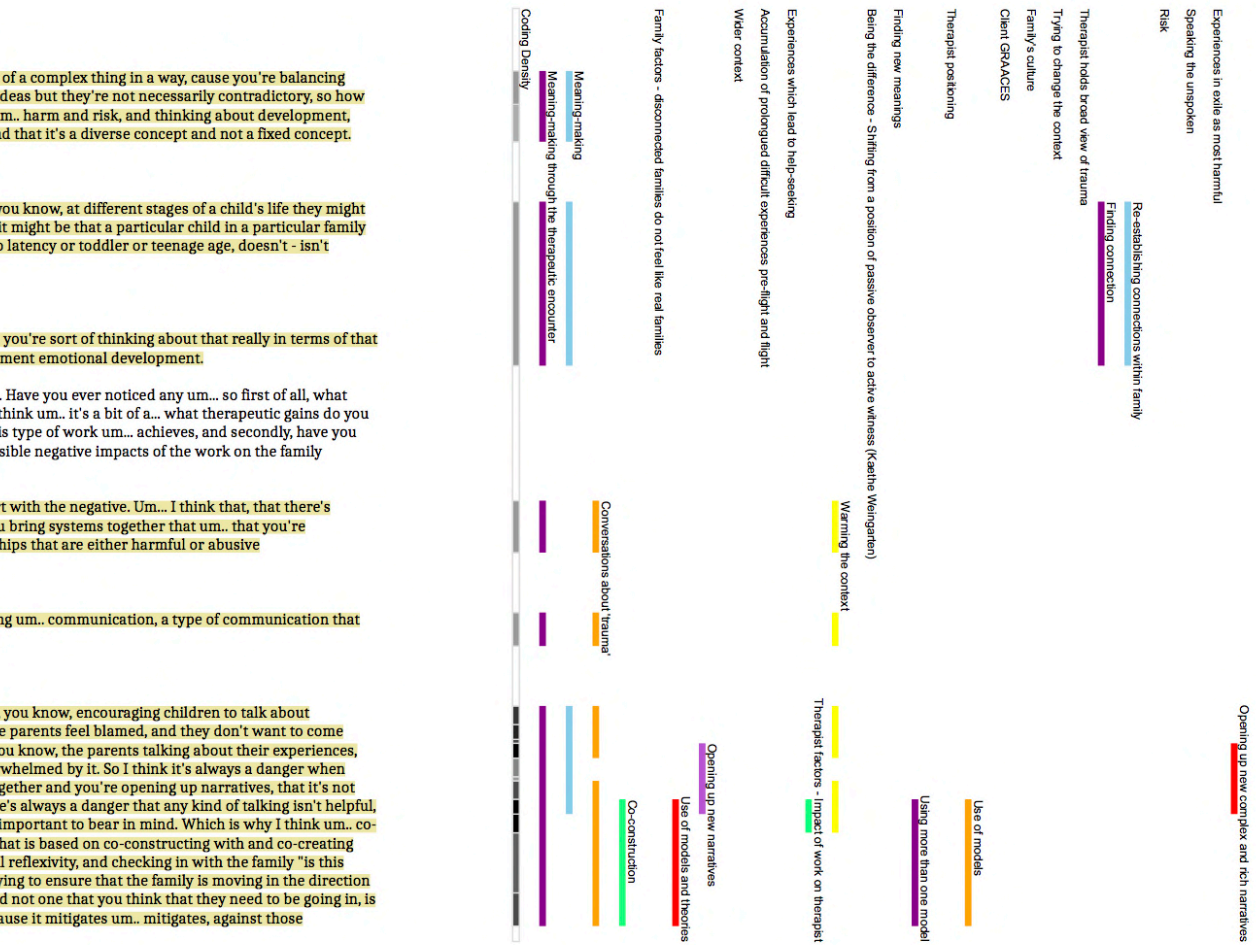
P Mmm.. yea. Well I'll start with the negative. Um... I think that, that there's always a danger when you bring systems together that um.. that you're reinforcing um.. relationships that are either harmful or abusive

S Mhmm

P Or that you're reinforcing um.. communication, a type of communication that isn't helpful to the family

S Mhmm

P So um, if, if for example, you know, encouraging children to talk about experience means that the parents feel blamed, and they don't want to come anymore, um, or if um... you know, the parents talking about their experiences, and the children feel overwhelmed by it. So I think it's always a danger when you're bringing people together and you're opening up narratives, that it's not helpful, um.. just like there's always a danger that any kind of talking isn't helpful, um.. I think that's always important to bear in mind. Which is why I think um.. co-con - you know, a model that is based on co-constructing with and co-creating um.. and, sort of relational reflexivity, and checking in with the family "is this helpful? how is this?" - trying to ensure that the family is moving in the direction that they want to go in and not one that you think that they need to be going in, is really important. Not because it mitigates um.. mitigates, against those



difficulties, cause it can't fully, but because it at least gives the onus on the family um.. to shape the therapy to support them, um, rather than an outside person shaping the family for them.

S Mhmm

P Um... Also sometimes people want their individual space, um.. they want a private space, that private space feels important to them

S Mhmm

P Either as part of the process or as a replacement to the process, um.. family therapy I don't think it indicated or helpful when there's any kind of um... violence. I'm quite clear about that with the family um.. and will talk about that with the family, you know. Um.. and obviously if there's abuse as well.. and it might sound obvious actually, I'm saying all this for you, but I have been asked many times with, with social services to see families where there's, you know, been an allegation of abuse

S Mhmm

P And yea.. so sometimes you have to explain why that's not helpful, because sometimes the idea is that family therapy is about making families better, so as if it's some kind of cure

S Mhmm

P And it's, it's not, necessarily

S Mhmm

P Any more than couple therapy is about keeping people together - it isn't necessarily about that.

S Mhm. Mmm.

P Um... the outcome is that you want the families to feel happier and to feel that they are engaging better with each other. Um.. but um.. there isn's necessarily like a direct relationship between the family therapy and, you know, sort of... I don't think um.. wellbeing is directive in that way.

S Mhmm mhmm

P Um.. in terms of the benefits um.. I've found, and I'm obviously very biased, but I've found systemic ways of working, particularly in an adult mental health context, interestingly, because I think that people often think, well obviously it makes sense in the context of children and families, somehow, gets left off the, you know, grid when it comes to adult mental health

S Mmm

P But in particular adult mental health, I've found it absolutely um.. amazing the power of opening up people's narratives, um.. and not just for the family but also for the wider system.

S Mhmm

P That people can get locked into an idea about somebody um.. when they have a label. And opening that up can be incredibly powerful and wellbeing enhancing.

S Mhmm

P And with the families, working in a child and adolescent mental health service, I think family therapy can be very helpful in giving voice to experiences and literally voice to people that, that haven't been voiced before. Um, that in itself can be um... open up the avenues for action. That's the kind of...basic systemic idea, is that, um, you're not, you can't unilaterally change anything or anyone or system, um, but you can open up avenues for action, and the more that you open up narratives, the more you open up people's possibilities um.. so you're constantly thinking about new understanding and the action that comes from that. So, the relationship between action and reflection, so um.. having that in your understanding, how does that impact on what will you do next. Or, you acting in that new way, how does that impact on a new understanding that you have? So you're constantly kind of having that conversation with people.

S Mhmm

P And, um, I think that can be incredibly, um, helpful and useful.

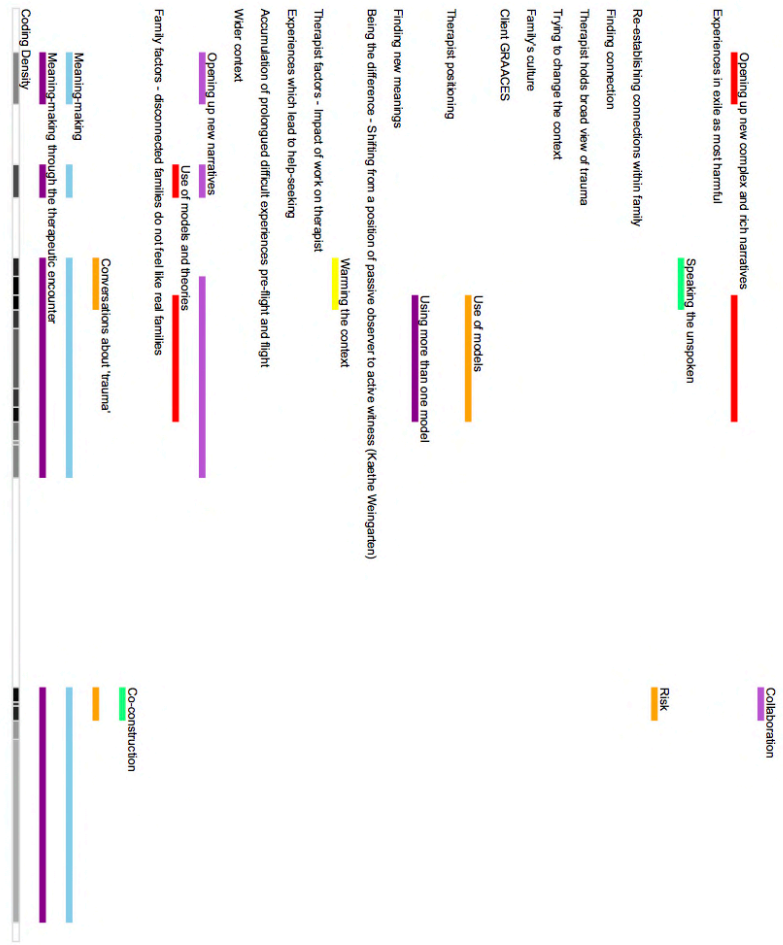
S I just wanted to pick up on something that you said about um.. um.. having, kind of, being conscious of not kind of imposing something, or kind of having, as a therapist, having a.. a way forward that you think is best, and letting that come from the family. Do you ever feel a tension in that, within yourself, and how do you manage that?

P Yea, there's often a tension, because um.. you might sometimes have to be directive, for example if there's concerns about wellbeing or harm, or, or there's a stuckness, um.. but I think that the way that you manage it is, well, if it's about stuckness I think it's just about sharing it with the family

S Yea

P And talking about it and saying, this is how we're talking, this is the way that we prefer to talk, um.. but the impact seems to be this, and I'm thinking, um, I'm wondering about that, cause that seems to be the opposite of what you say you want, let's think about that together.

S Mhmm



P So I think I always bring the dilemma to the family to think about

S Mhmm

P And... um.. that's always helpful I think, um... um.. again, I don't think there's any way of imposing that's ever helpful, cause even if it's helpful to you, if you feel imposed on, there's a natural kind of resistance you have and you're not reflecting on.. on... on necessarily what you're imposing, or what you're rejecting, you're just rejecting something that's imposed on you. So I always bring dilemmas to families and talk about it, and sometimes I'll say um.. "let's... how about if we just try doing things a bit differently, how about we try something that I suggest, and then we can come and think about it together" so it's still collaborative, and it's still inviting collaboration, and it's not assuming that I'm the expert and I know, but it is trying to bring in a difference that isn't there, if it is the case that the family's stuck in a way of being that isn't moving them forward.

S Mhmm

P When it comes to issues of risk and harm, it's just about being honest with people and saying um... "I have to x y and z" um.. so that, so I'm often very clear about what it is I do have to do, that it is I don't have to do, and there's the bit in the middle, there's always, there's always a collaborative... an, and area where you can be collaborative, even when you're talking about child protection issues, you're saying "I have to phone social services because this child is at risk of harm or is being harmed", but you can still have therapeutic conversations with people about um.. how do you feel about me now, is there a way we can still work together, is there a way I can still um, you know, what's important to you that is held in mind in relation to this process, if I can hold in mind on your behalf, or um.. that I can support in meetings, um... or whatever it might be, but um... yea.

S Mhmm. Great.

P Oh, the other tension might be when people say, the collaborative approach is very much about asking people "what do you think?" and sometimes people say "I don't know, you tell me". And so, then, again, so I always think there are opportunities um.. that being collaborative never just completely ends. Even when I say "okay I'll give some suggestions given that you've asked me" - I'll always try and give more than one, and so I give a range of offers, suggestions, I can then invite people: "which one did you connect with the most?" or "who in your family would think a and b and not c and d and why?" "what happened in your body as you heard me um... suggesting the various different things?" Cause people will often say "I don't know" but actually there's a, um, a response on a more kind of bodily level that people have. Because they do, often, have an idea in their head, that they either want you to reinforce or reject, and so it can be quite telling when you ask the question "What happened in your body when I said a?" cause people often say "I felt relieved" or "I felt anxious" or you know.. um.. so I think there are ways of responding to people's invitations to give an answer

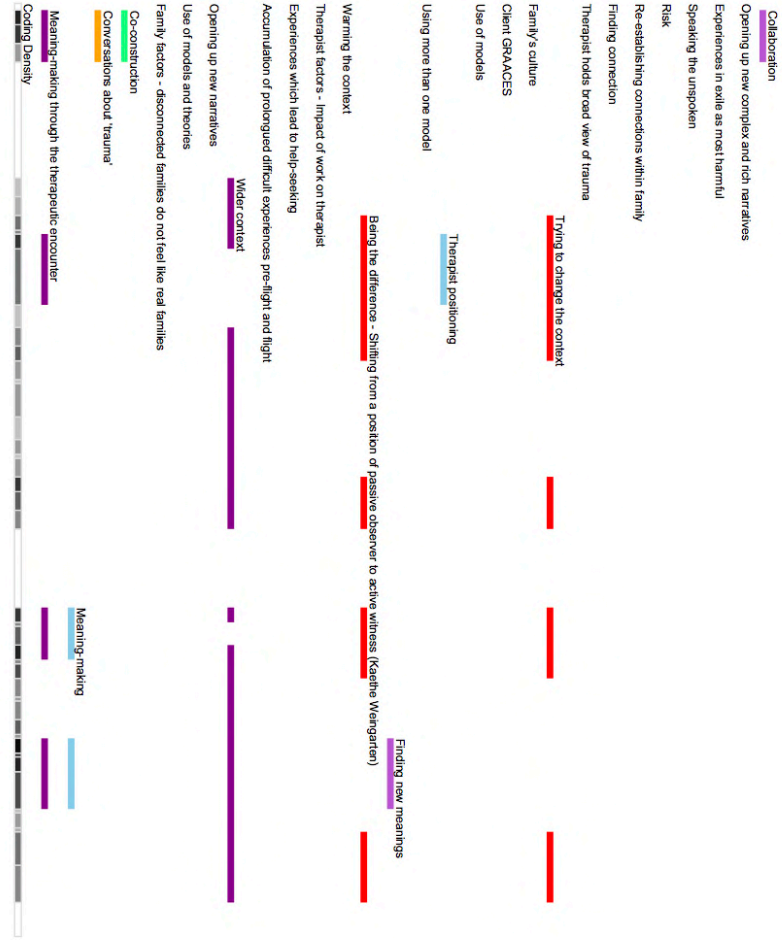
whilst still being collaborative, whilst still being true to the idea that you're the expert, ultimately, and I'm just here facilitating. Um.. your expertise, and, I'm working with you um.. yea.

S Um... I think you've covered this already, so I'l skip - the next question was around factors outside the therapy room and how they might impact on your work with families, so kind of, home office, um.. wider sociopolitical context I guess. Um.. did you want to say anything more about that?

P Well, just that I think it's a huge issue, and I think when working with families who, um, are refugee or asylum seeking people, I just think it, I can't.. I don't think you can overstate the power, the importance of those contexts, and um... and bringing it into the room, taking it out of the room, in terms of my own politics or things that I uphold, um.. being willing to be changed by the things that people have told me and people have shared, and, yea, being willing to be changed and shaped by it in terms of um... the commitments that I have outside the therapy room I think are incredibly important. Um.. so, yea. I mean, it might seem um.. not relevant but for me, things for who I vote for, and the kinds of policies that I.. you know, and how people talk about refugee and asylum seeking people as either a burden or a problem, or as um.. in terms of rights and as human beings, and in terms of um, a humane response to people fleeing um... persecution and.. and.. and.. and war and conflict. I think it's really important, and I think it would make, it would just be nonsense to disconnect those two things, to sit with families, talking about their experience, and then to vote for somebody that wants to keep people out, or talks about people as um, you know, as if they're um.. vermin or something um.. yea, so I think that context is incredibly important and, and campaigning for a change in the system, because it is so abusive and oppressive, and traumatising.

S And how do you, um, how do you incorporate - is there a way of incorporating this into your practice?

P Um.. I try to do it both with families and outside of the work with families so, and it's not like imposing it, because that might not be what families are coming with, but when people bring up these issues, the way I like to think with them about either what I can do, or connecting with, and being able to have those conversations as well, cause I think sometimes as psychologists we're often trained to feel as though politics is separate to what we do and what we have we think, and therefore it's, it can be quite uncomfortable the idea of talking about politics, but I feel like you, it's impossible not to do that. So I, so even being able to engage in those sorts of conversations and.. and um.. um.. allowing people to feel that it's not you, you're not mad, it is a mad system, it is an abusive system, and naming it as such, is really important, in the same way that then people talk about abuse. You know, we know that, from you know years of feminist research or whatever that, how important it is to name abuse, and, and particularly given that it's so often obscured. Um, so 18:36 naming it and having a commitment to challenging it, both naming that commitment in the therapy but also upholding it outside, yea.



S Um.. and have broader societal narratives around, um, refugees and asylum seekers impacted on your professional identity? And if so how?

P Um.. I think I'm much more I think I'm much bolder in stating my politics, in a way that maybe if there wasn't, you know, if we lived in a society 19:08 where... *interrupted by drilling*

S Have broader societal narratives around refugees and asylum seekers impacted on your professional identity and if so how?

P I think uh... tell me if I haven't answered your question but I think um.. um, it's, it's made me, I think if I lived in a society that, the kind of society I expect, which is that we work with people that are fleeing, um, openly, and uphold their human rights, I think I wonder if I would feel the need to, to.. talk about being a socialist or feminist or whatever, so, so boldly. But, think I feel also because I.. I live in a context that is so increasingly racist, xenophobic, fearful when we're encouraged to kind of grab hold of and hoard what we have and fear that people are taking it away, and the more we're seen to be tough on things and people that are seen as outsiders in some way then the better, I think because I live in that kind of environment, I feel it's shaped my professional identity in that I'm much more bold about bringing together my personal and professional self, and stating where I stand.

S Mhmm

P So for example, just to kind of explain and give context to how I was in the beginning, it's not you and your questions, but I think it's more maybe my fear about, my kind of fear about not knowing what to say, and feeling a bit silly, or feeling a bit like, "oh, I'll probably sound like I don't know what I'm talking about" or "I don't know how to answer that question" - and I think it's probably because, um, um.. I'm.. my identities are so merged now that, that I find it hard to talk about working with refugee families, asylum seeking families, in a, in a purely psychological way, and um... so I think in that way it's heavily shaped my professional identity, that I now see my professional identity as a, as a hugely political identity. And.. and that's a very uh.. rare and controversial, you know, position to have, and a place to be. So it can, and I often, yea exactly, sometimes feel a bit stuck in how I um.. respond to questions or, or my worries about how I might be perceived kind of thing, yea

S Mhmm, mhmm. And do you think that it's um.. um.. I'm trying to think about how I'm going to phrase this but like, um.. thinking about yourself and rest, maybe kind of, other professionals, other clinical psychologists, do you, um... has that shifted in a sense, kind of your place within the profession of clinical psychology?

P Um.. do you mean..

S I was thinking about, because of the different ways that people work for example, and, um, different models people might use, and how they might be

very different or been kind of, go against I guess, maybe the nature of the work that you do. Has that shaped kind of, your professional identity in any way?

P Uh... only in that I uh.. might feel.. uh.. it might make me question whether I am a psychologist, but not in a "oh no, am I actually a psychologist?" but more in a "do I actually see myself.. is it an identity that I hold, that I hold proudly?"

S Yea, yea

P Um.. but not, but not in a... um... but I'm quite lucky to have over time developed friendships and relationships with like-minded others. I think if I didn't have that, I think it would heavily, I think I'd be really questioning a. my own skills and abilities and b. the profession itself and whether I do feel that I want to be part of or am part of it.

S Mhmm mhmm 23:32

P So I think I'm, maybe not so much, but probably because of, um, my privilege in a way and my being fortunate to have who I have around me

S Mhmm mhmm

P Yea

S Um.. okay, last question, 23:50 could you tell me a bit about the impact of working with families, um, on you as a therapist, so for example um.. how might this um.. affect your own contexts such as personal life, family life, work relationships.

P Yea. And particularly families from refugee and asylum seeking backgrounds?

S Yea

P Uh.. on the one hand it's a kind of mixture of lots of different experiences. So on the one hand it can be incredibly demoralising and um... really impacting, and it's not the - I must be very clear - it's not the working with the families that's demoralising, it's the, it's the experiences they have, and, and often experiences they have in this country, which is even more impacting, it's, it's, you know, if it's something that's closer to home in a way and that you feel that you're part of, you're contributing to, cause it's your society, your governments, that kind of thing, um... it can be incredibly, I can go home feeling, just... a real sense of, like I have a two-year-old and I feel "what kind of world have I brought her into?" and what kind of... it can be very uh... uh.. disturbing to your existential sense of things. And I can get very distressed, and very angry, and upset, and I think about people and hold them in mind - even people I supervise, their clients, cause I work with such passionate people, and they talk about their clients, and there's such an image of them, they often show me pictures or I just have an image in my mind, and, even they I hold, I carry with me. So I feel like I carry around lots of people's experiences. And when you carry around those experiences, it's like...

um... somebody put it in this way the other day, it's like a whole other layer of reality that you're party to that, that most people aren't, and it's really painful to live like that. And I'm very lucky that my family are very political so, like, my siblings and my parents are very aware, but, you know, and a lot of my friends are, but some aren't so very aware, and that's very painful, um.. people just don't get it. And you're like "well how do I even start, where do I even begin to try and explain?" and I feel like I should, and I want to, and then I end up sort of sending these angry emails, and then that's not helpful either. So it can, I can.. that's the one hand, and on the other hand, that's the, that's the connection to the abusive, oppressive systems, and experiences, war, those sorts of things, rape. Um, but, but also working with people, despite the fact it can be very challenging, and not taking away from that, it's probably the most humanising and, um, humility inducing um.. um.. energising experience as well because people, refugee people, asylum seeking people people, families are, some of the most.. and it's such a weird thing to say "remarkable people" it's almost like, what does that say, what are you... is that another way of being prejudice in a way, or? making people other? but in.. but I think it's so true you know, to.. to experience the level of fear, the level of loss, the level of... like seeing dead bodies, seeing, experiencing violation, experiencing marginalisation, experiencing.. you know, even the subtle things are deeply painful, of loss of place, loss of sense of your self in the world, home, a sense of home. I just.. I have no idea how people do it, so I think... connecting to your question about my own family, going back to my family, um.. so it's be and my daughter and there's me and my family of origin. It makes me, um.. want to fight harder in a way... for... um.. it feel like my family's wider than my family in a way, I.. it's hard to explain. And um... And I feel my privilege deeply. On one hand it makes me, connects me to my experience of prejudice deeply. But it also connects me to my privilege deeply. Which is kind of also a strange um.. because I do have a privilege of having family, I have a privilege of having loving family, I have a privilege of a job that, that means I can survive, I have the privilege of status, I have the privilege of um... at the moment, no war. You know, there's um.. um.. but I also feel as though, yea, I kind of feel like my family is... bigger. And so, it makes me, it makes me angry at this very um.. powerful increasing discourse out there in the world that we should make our families smaller and smaller and um.. I find that quite frightening.

S Mmm mhmm

P And.. and I feel energised by ideas about making our family bigger and bigger

S Mhmm

P Um... so yea, I'm obviously very inf - I'm very kind of um.. organised by what's, you know, kind of elections and probably um.. talking in not a very coded, veiled way *both laugh*

S Do you think, how do you think that you cope with the impact of the work, do you think that um.. kind of, a sense of um, being political and kind of bringing that into into your sense of professional identity, you think that is one way of kind of coping and advocating on a bigger level, is that a way of coping?

P Yea, definitely, because I think that, similarly for 29:51 a lot of the people, families that I see, a sense of um.. um.. impotence can be, for some of them, it can be the most traumatising part of your experience. You know, you can have something awful happen to you, but there's a sense of not knowing or not having anything you can do about it that can be even worse. So I think that, um, any way in which I feel that I can be moved by or moved to action, moved to - not even just moved to action in a kind of traditional activist kind of way - that too, definitely, but also just in terms of who I am in the world and um.. and the ideas that I support and perpetuate and encourage um.. which I think contribute to the context that we all live in. Um... I think that also helps me to feel better about the world as opposed to feeling just done to by it or... um.. there's nothing I can do to change it, it's still just, you know, um..

S Mhmm

P That helps, and also um... um... I really love the idea of vicarious resilience 30:59 um.. as a kind of counter-narrative to the vicarious trauma discourse, that yes, there is definitely a vicarious trauma element, although I aways feel that it's over-emphasised, the client's story of what's happened to them in their country of origin, for me the vicarious trauma has always, nearly always been much more about people's experiences here, um. But um, there's also vicarious resilience as well, and how you take in when you allow those stories, when you see people's um.. um... resilience and ability and you allow it to breathe, and then, that's also something you take away with you as well, um.. and it also helps.

S Mhmm

P Um.. yea.

S Thank you very much

P Oh, thank you