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REFUGEE WOMEN IN THE UK: FACTORS AFFECTING ENGAGEMENT WITH MENTAL HEALTH SERVICES

Section A: A Critical Evaluation of Theoretical and Research Understandings of Refugee Women's Post-migratory Mental Health and Service Utilisation

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Summary of Portfolio

Section A

This paper opens with a broad overview of theoretical and empirical literature on refugee mental health. It highlights a relative weakness in the understandings of post-migration mental health, particularly in the context of female refugees. The paper then focuses on three areas of refugee women's mental health, critically evaluating theoretical and empirical literature: 1) risk factors and prevalence of mental health difficulties 2) coping strategies, 3) mental health service utilisation. Gaps in the extant literature are highlighted and suggestions are made for future research.

Section B

This paper describes a qualitative Grounded Theory study which aimed to explore refugee women's experiences of distress and their encounters with mental health services in the UK. Two theoretical models are presented, grounded in the data obtained and analysed from semi-structured interviews with ten refugee women. The paper reflects on the relevance of these models in the context of existing theory, before raising clinical and theoretical implications and drawing conclusion.

Section C

This paper offers a critical appraisal of the Grounded Theory study reported in 'Section B' of this portfolio. The paper reflects on the research skills and abilities developed by the principal researcher and considers areas for development in terms of future clinical and research work in this field.

Section D

This section presents appendices relating to the whole portfolio.

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Section A: A Critical Evaluation of Theoretical and Research Understandings of Refugee Women's Post-migratory Mental Health and Service Utilisation

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Abstract

This paper conducts an enquiry into theoretical and empirical literature into the factors affecting mental health service utilisation among refugee women. A range of searches are conducted progressing an enquiry through the literature. An initial exploration into the refugee background context highlights gender differences, indicates a less thorough understanding of refugee women's issues compared with men's and a smaller appreciation of post-migration factors (adjusting to life in the host country) compared with pre-migration factors (conflict related trauma). The enquiry moves towards an evaluation of theoretical and research literature on risk factors, prevalence and coping strategies for mental health problems among refugee women during post-migration. The review culminates in an evaluation of the literature on refugee women's mental health service utilisation. It emerges that women may not utilise services due to a range of factors including predominantly cultural and spiritual factors. The review concludes that overall, the psychological literature base on refugee women's mental health and service use would benefit from further enquiry and partnership with agencies working with refugees, to draw on their expertise and experience. Implications for UK mental health service provision are raised and suggestions are given for future studies to address gaps in the extant literature.

This review aims to evaluate theories and research pertaining to refugee women's mental health, leading to an evaluation of studies of refugee women's mental health service utilisation. The review will commence with a broad overview of the refugee mental health context, highlighting gender differences, and then go on to theoretical developments in understanding of refugee women's mental health. The review will then specifically evaluate three areas relating to refugee women in the post-migration stage: 1) risk factors and mental health prevalence, 2) coping strategies, and 3) mental health service utilisation, paying attention to theory and research. Conclusions will be drawn, clinical and research implications highlighted, and suggestions made for future research.

Background Context

"There is no greater sorrow on earth than the loss of one's native land" (Euripides, 431 BC, as cited in United Nations High Commission on Refugees (UNHCR), 2011a).

Definitions and Statistics. A refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his/her nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (UNHCR, 1951: article 1A (2), as cited in UNHCR, 2002). Refugees have been granted leave to remain legally in a different country, referred to through the literature as a 'host country'. Asylum seekers are those who have yet to receive a decision awarding status (Bennett, Heath & Jeffries, 2007).

The UK in Context. There are currently an estimated 269 363 refugees and 11 900 asylum seekers residing in the UK (UNHCR, 2011b). The Home Office decision about granting status can take several years ((Information Centre about Asylum and Refugees, IACR, 2008). Until a person has been granted refugee status, they are not eligible for work. Healthcare is available for those seeking asylum, but the extent often varies within NHS Trusts. Thus, for people seeking asylum life can be characterised by poverty, reduced access

to healthcare, and uncertainty regarding the risk of deportation (Pourgourides, Sashidharan, & Bracken, 1996).

Gender Differences. There is an absence of data on women refugees in the UK (IACR, 2008). A 2010 Home Office report documents that between 2005 and 2007 approximately forty percent of refugees were women (Cebulla et al., 2010). However, the precise ratio of male to female refugees is contested, with the UNHCR commenting that fifty percent of refugees are women (UNHCR, 2007). The lack of clarity may be explained by the fact that women are more likely to join men under immigration rules governing family reunion, and these data are not captured in asylum statistics (Dumper, 2002).

Historically, given their involvement as soldiers in wars and active membership in political groups, attention has been directed towards men. It has also been argued that there is a male bias throughout the legal process because women are not encouraged to make a claim in their own right (Ceneda, 2003). In the UK, women seeking asylum are assessed under the legislative framework of the 1951 Refugee Convention. However, in the last fifty years human rights have been redefined to reflect a growing awareness of discrimination against women. Refugee law takes human rights legislation into consideration, including the Universal Declaration of Human Rights (1948) and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW; 1979). Thus, whilst the law remains the same for both genders, understandings of human rights issues for women are developing.

Rationale

This brief outline of background literature on the refugee context points towards the complex history that refugees hold, including their reasons for fleeing home and also the challenges and uncertainty involved in the process of being granted refugee status. Differences have emerged between men and women, with less information on female

refugees compared with men. In 2008, UNHCR published the 'Handbook for the Protection of Women and Girls' in an effort to improve the situation for female refugees (UNHCR, 2008). In response to this, the present review aims to explore the research and theoretical literature pertaining to the mental health of refugee women. Search terms are outlined in Appendix 1.

The Refugee Mental Health Context:
A Broad Overview of Empirical and Theoretical Literature

Risk Factors

The literature suggests that the majority of people seeking asylum originate from countries that are in conflict (Fitzpatrick, 2002) and that considerable numbers of these individuals have been exposed to traumatic experiences and human rights abuses (Hollifield et al., 2002), including torture, witnessing massacres, and the disappearance of family and friends (Burnett & Peel, 2001; World Refugee Survey, 2009). Given their exposure to such atrocities, refugees are considered to be vulnerable in terms of their mental health (Department of Health, 1999).

Women's reasons for seeking asylum are often different to those of men (IACR, 2008). Women tend to flee from gender specific issues such as sexual violence, female genital mutilation or gender-related persecution (Crawley, 2000), or owing to their relationship with male political activists (Crawley, 2001). The UNHCR has identified refugee women as a high-risk group for developing psychological problems (Refugee Women in Development, 1990).

Research on Prevalence of Mental Ill Health

The National Service Framework for mental health (NSF) identifies post traumatic stress disorder (PTSD) as the most common mental health problem affecting refugees (Department of Health, 1999). However, studies have indicated wide variation in the estimated prevalence of PTSD among refugees, from three percent (Hauff & Vaglum, 1994) to eighty-six percent (Carlson & Rosser-Hogan, 1991). Such discrepancy has stimulated much debate in the research literature. A systematic review found that methodological factors in studies, especially the approach used for sampling and diagnosis, seemed to influence the range in prevalence rates (Fazel, Wheeler & Danesh, 2005). Overall, in the twenty included studies, the review found that nine percent of refugees were diagnosed with PTSD, five percent with major depression, and two percent with a psychotic disorder.

A later systematic review incorporated forty studies in which methodological factors accounted for approximately thirteen percent and twenty eight percent of variability in prevalence rates for depression and PTSD, respectively (Steel et al., 2009). This review also identified history of torture as the main factor associated with PTSD. This supports the notion of trauma exposure being an important factor for consideration in the mental health of refugees. However Steel et al. (2009) included studies of conflict-affected people, rather than specifically refugees. Therefore, its findings are held tentatively in the context of the present review.

Research on Gender Differences in Distress

There is robust support for gender differences in mental health in general (e.g. Hollander, Bruce, Burström, & Ekblad, 2011). Higher prevalence rates have been found in women compared with men for depression (e.g. Piccinelli & Wilkinson, 2000) and PTSD (e.g. Breslau & Anthony, 2007; Tolin & Foa, 2006), and according to the National

Comorbidity Survey, the risk of developing PTSD after a traumatic event is approximately eight percent for men and twenty percent for women (Kessler, Sonnega & Bromer, 1995).

A range of studies support the notion that refugee women experience greater mental distress than refugee men. For instance, Punamaki (2011) administered the revised Impact of Events Scale (Weiss, 2007) on seventy-eight refugees and found that women had higher scores for PTSD and depression. However, the sample was unevenly matched in terms of gender, so findings should be interpreted with caution. Refugee women are often thought to be particularly vulnerable to sexual violence and sexual trafficking (Sam, 2006; WHO, 2000). The experience of physical and sexual violence has been linked to a range of women's mental health problems, including depression, anxiety, substance abuse, and PTSD (Cabral & Astbury, 2000; Cortina & Kubiak, 2006), and this may contribute to higher incidence of mental health problems in female refugees.

Contrastingly, in their meta-analysis of the association of torture and traumatic events with mental health outcomes, Steel et al., (2009) found that after adjusting for methodological factors, gender was not associated with PTSD prevalence rates, although, notably, they do not report the number of studies that included female refugees, nor the proportions of females. The discrepancy arises again, however, in a large study of two-hundred refugees in Sweden. Thulesius & Hakansson (1999) found no significant gender differences in self-reported PTSD, although they did not use recognised measures, which would have strengthened the validity and reliability of their findings.

Overall, given the disparity in the literature, it appears that considering refugee women's mental health from a purely trauma perspective may limit the understanding of their mental health needs. Thus, it seems valuable to consider theories on refugee women's mental health in search of broader conceptualisations.

Theoretical Developments in Understandings of Refugee Women's Mental Health

The majority of research into refugee mental health has centred on the adverse effects of trauma experienced in the home country, highlighting PTSD as a major consequence (Basoglu, 2006; Nicholl & Thompson, 2004; Silove, 1996). Similarly, theories on refugee mental health have tended to be grounded in a 'medical model' in which psychopathology is understood as relating to a post-traumatic response to human rights abuses (De Girolamo & McFarlane, 1996).

Such a 'medical model' has been criticised (Silove, 2000, Papadopoulos 2002). Whilst understanding experiences of trauma is important in understanding the psychological wellbeing of refugees, it neglects to consider other aspects of the refugee experience, many of which persist over time, incorporating multiple events occurring in multiple contexts (Tribe, 2002), including, importantly, post-migration stressors (Renner & Salem, 2009). Indeed, Beiser (2006) has argued that stressors experienced in the post-migration stage have a greater impact on refugees' mental health than pre-migration trauma. This review will now focus on the theoretical and research literature pertaining to this stage.

Refugee Women's Post-migration Risk Factors and Prevalence of Mental Ill Health

Theoretical Understandings

Theories on adjustment. Arriving in a host country, refugee women may experience multiple geographical relocations. Additionally, given that decisions on status applications are seldom made immediately, seeking asylum can be an uncertain and stressful time during which future plans are difficult to make (Tribe, 2002). Adjusting to life in a new country is considered to be particularly stressful for women who have been separated from their families (Franz, 2003). This is supported by Eisenbruch's theory (1991), which argues that

the social and cultural framework of female refugees is eroded through the losses of language, extended family, social belonging, cultural values, social and economic status, and general connection with the community.

Theory on 'Survivor Guilt'. Bemak and Chung (2000) argue that refugee women can experience survivor guilt for successfully escaping problems whilst leaving husbands, families, and friends behind in a potentially dangerous situation. Where women are left with no information on the wellbeing of significant others at home, they can experience depression, anxiety and frustration (Benmak & Chung, 2000).

Attachment Theory. From a psychodynamic perspective, attachment theory (Bowlby, 1973) offers an understanding of the risk factors for refugee women's distress that integrates post-migration experiences with pre-migration issues. Fox (2002) asserts that inability to mourn the loss of attachments that have been left behind may be fundamental post-migration challenges. The pain of the loss may be difficult to process owing to the reason for fleeing, thus the home country may be experienced psychically as hostile. 'Melancholia'(Freud, 1957) is thought to arise when the mourning of the home country is not achieved. This is understood as a persecutory state of mind in which the hostile feelings towards the lost home are turned back on the self, thus leaving a refugee in a state of depression.

Overall, these theories indicate that, for women, distress may emerge in the context of adjustment in the host country, where issues relating to loss of relationships and multiple challenges associated with change may significantly compound the adaptation process.

Research Evidence

A review of the research literature identified studies that explored ethnic minority and refugee risk factors for mental health but were excluded from the present review because they did not focus on refugee women specifically. Similarly, a number of studies explored refugee women's responses to trauma but did not focus on post-migration issues. Nevertheless, a comprehensive review (Porter & Haslam, 2005) and two additional qualitative empirical studies (Davies, 2000; Norris, Aroian & Nickerson, 2011) have explored post-migration gender differences.

Porter and Haslam, (2005) conducted a meta-analysis of moderators of mental health outcomes. Poor post-migration conditions, such as accommodation and economic opportunity were associated with poorer mental health outcomes. Studies which involved a higher proportion of female refugees indicated slightly worse outcomes following treatment for PTSD (Laor, Wolmer & Mayes, 1996; McCloskey, Southwick, Fernandez-Esquer, & Locke, 1995; Punamaki, 1990; Rasekh, Bauer, Manos & Iacopino, 1998; Sabioncello, Kocijan-Hercigonja & Rabatic, 2000). One of these studies (Sabioncello et al., 2000) had a relatively small sample size of thirty-four, compromising its robustness. However, the other studies had samples of 70–454. Since these studies were incorporated into the Porter and Haslam (2005) review and owing to restrictions in space, they are not reviewed separately in the present review. Porter and Haslam's (2005) comprehensive review suggests that distress among female refugees seems to reflect contextual factors relating to post-migration. One limitation is that Porter and Haslam (2005) do not report comparisons across studies by post-migration host country. Given the considerable variation in host country legal and healthcare rights, a more local focus may be needed for an understanding of the particularities relating to the context of specific countries.

Davies (2000) conducted a phenomenological study of the experiences of refugee women living in Pennsylvania. Survival was a repeating theme throughout the stories relating to new ways of life. The narratives of the women interviewed reflected pre- and post-war experiences associated with tragedy, but PTSD was not a shared experience whereas difficulties associated with loss of culture and a beloved country were a dominant feature. One key limitation is that the study was small scale, which limits its generalisability.

Norris, Aroian and Nickerson (2011) explored how pre-migration trauma, post-migration stressors, and post-migration resources predicted PTSD and major depressive disorder among Arab immigrant women living in the USA. They employed a descriptive, multinomial logistic regression design and found that immigration related stressors were strongly associated with PTSD and depression. Their findings highlight the importance of post-migration stressors. However, in terms of generalisability, their research is limited by its focus on Arab women in the USA.

This literature points towards numerous factors potentially contributing to refugee women's distress post-migration. A question emerges as to how they cope with this distress.

Refugee Women's Post-migration Coping Strategies

Theoretical Understandings

Albee (1986) developed a formula regarding the incidence of psychopathology in relation to challenging life circumstances, strengths, and resources. His formula balances the deficits of 'organic' or individual factors, stress, and exploitation with the resources of social skills, social support, and self esteem (Albee & Ryan-Finn, 1993). In essence, wellbeing is understood as a function of strengths and social, material, and psychological resources in relation to risk and vulnerability factors. Albee's (1986) model can be helpfully applied to

later understandings of coping, such as Lazarus and Folkman's (1984) seminal model of 'Stress, Appraisal and Coping', in which psychological wellbeing is balanced between exposure to stressful demands and access to resources. Resources are perceived as psychological (e.g. self-esteem) and social (e.g. supportive relationships). In this sense, distress is regarded as a lack of adequate resources, rather than a mark of pathology.

Influenced by these theories, Ryan, Dooley, and Benson (2008) propose a resource based model of migrant adaptation, which regards human survival as depending on the achievement of basic needs in terms of Maslow's (1970) hierarchy of needs model. Resources (personal, material, social and cultural) are considered as necessary to achieving these needs. In this model, personal resources include physical attributes and psychological issues, material resources include possessions, and social resources include a sense of identity and belonging to a social network. These three types of resources are perceived as interrelated and levels of psychological resources are considered to change in response to stressful situations. Cultural resources include skills, knowledge, and beliefs that are learned in a particular cultural setting, including familiarity with local services and systems.

This model may be helpful in understanding refugee women's mental health as it provides a way of thinking about the range of factors affecting wellbeing. Personal, social and material resources are embedded in a cultural setting, which differs from the context in their country of origin. Uba (1994) and Eisenbruch (1991) have argued that women who have come from collectivist cultures experience a profound loss of community support (a social resource). It has also been postulated that such social isolation is further exacerbated by cultural taboos within refugee women's cultural heritage whereby women who are widowed, separated, and divorced are a threat to another woman (Mollica, Lavelle & Khoun, 1985). The relevance of this resource based psychosocial model is particularly relevant during the post-migration phase.

Research Evidence

A review of the literature revealed a wealth of studies on refugee coping, but without the focus on post-migratory experiences. Additionally several studies explored women's mental health coping strategies in the context of ethnic minority women or immigrant women broadly, but not refugee women specifically. None of these studies met inclusion criteria for the present review. Four studies were identified that focussed specifically on refugee women's coping strategies during the post-migration phase.

Renner and Salem (2009) conducted a study using psychometric measures and semi-structured interviews to explore gender differences in coping among refugees living in Austria. Women's typical coping strategies indicated a drawing from social resources (Ryan et al., 2008). For instance, women reported more often than men that contacts with their extended family, learning German, and talking to other people were helpful as well as concentrating on their children. The study provides a useful contribution in utilising both a qualitative and quantitative methodology, combining rich idiosyncratic data from the interviews with the generalisability from culturally specific reliable and valid questionnaire outcome measures. However, the qualitative aspect was a content analysis, which does not allow for the construction of meaning as much as another approach, such as grounded theory (Glaser & Straus, 1967). Additionally, the sample was comprised of twice as many men as women, reducing its applicability to the present review.

Berman, Girón and Marroquín (2006) conducted a narrative study in Canada of nine refugee women who have experienced violence in the context of war. One emergent theme was the experience of arrival in a host country, in which the women reported a loss of sense of self and identity, which reflects a loss of personal resources (Ryan et al., 2008). Women reported that coping was supported by having family members or someone to talk to about

their experiences, reflecting mobilisation of social resources (Ryan et al., 2008). One limitation in this study is that all the participants were well educated women, which means they possessed resources, which less educated refugee women may lack, so their experiences may not be shared among refugee women more broadly. Nevertheless, it emerges that for refugee women, the mobilisation of social resources is a key component in coping.

A qualitative, grounded theory study by Ross-Sheriff (2006) investigated sixty Afghan refugee women's experiences before and during war and exile. The study provides a comprehensive inquiry into coping strategies relating to the journey from pre- to post-migration. One main mechanism for coping was through focussing on holding their families together. Additionally, during flight women utilised their spirituality as a coping mechanism, from which they derived hope and resilience. Post-migration, women coped by working as a way of supporting their family. This reveals how women coped by taking on traditionally more male roles. The study also highlights the resilience of refugee women and how they draw on and bolster this as a way of coping. This study includes an impressively large sample size, but it is notable that only one researcher conducted the study and no information is given on how reliability was achieved in the data analysis, which is an important aspect of quality assurance (Elliott, Fischer & Rennie, 1999) in qualitative research and thus slightly limits the studies overall trustworthiness of findings.

Another large scale study was conducted in Ethiopia (Araya, Chotai, Komproe, & de Jong, 2007). This study involved twelve hundred displaced refugees from Eritrea residing in Ethiopia who were interviewed using closed 'yes or no' and 'agree or disagree' statements. Over sixty percent of the sample were women. Responses were analysed using factor analysis and ANCOVA. Women reported higher 'emotion-oriented coping' in comparison with men who reported higher 'task-oriented coping'. Both men and women utilised 'avoidance-oriented coping'. Although examples of each style of coping were not included, the inclusion

of this theoretical consideration of coping styles in the context of refugees is helpful. Avoidant coping strategies may not function on a long-term basis, raising implications for refugee women's MH needs in the longer term. In their discussion the authors raise the interaction between perceived social support, coping strategy and individual personality and in this regard support the resource based model of coping (Ryan et al., 2008).

Overall, these studies highlight that refugee women utilise a range of coping mechanisms when facing post-migratory challenges, relating importantly to social resources from family and personal resources from spirituality. Notably, none of these were UK studies, highlighting a significant need for more empirical research into this area. What emerges is that none of the studies indicate that seeking support from MH services is a preferred method of coping and the review now turns to this area of research.

An Evaluation of Research on Refugee Women's Mental Health Service Utilisation

A review of the research literature on service utilisation and refugee women found a clear overall picture indicating comparatively low mental health service use in refugee women compared with non-refugees and in many cases, compared with refugee men. Much of the literature on service utilisation focussed on refugees broadly without singling out women, or where studies did focus on women, they included or were specifically focussed on immigrant women, but not refugees. However, six studies investigated service use by refugee women and are included in this review.

Morris, Popper, Rodwell, Brodine, and Brouwer (2009) conducted in-depth interviews with forty participants comprising refugees, healthcare practitioners, and employees of refugee serving organisations in the USA. A thematic analysis revealed that the majority of refugees did not regularly access healthcare and that language was the major

barrier. The consistency of findings between participants highlights a value in involving practitioners in research into refugee service utilisation.

Language was also identified as a major barrier to utilisation in a New Zealand study in which twenty-nine female and twenty-five male refugees were interviewed (Guerin, Abdi & Guerin, 2003) using recognised rating scales. Women utilised services less than men, and the average proficiency in English was lower than that of men. Additionally, this study highlighted that women had the main charge of looking after children and felt that they were less able to leave the house than men. These findings are convincing, however, the specific focus on Somali refugees limits generalisability to broader refugee groups.

In a larger Dutch study, Ten Have and Bijl (1999) drew service utilisation data from patient registers and found that refugee women made considerably less use of mental health services than native-born women, but used social work facilities and crisis intervention centres more. Although this study is specific to a particular locality in the Netherlands, the indication that refugee women may prefer to utilise non mental health specific services points to the need for further research in the area to establish whether this is a consistent issue, or specific to the locality.

Another study involving staff and refugees as participants used focus groups and in-depth interviews to explore service utilisation among Vietnamese women in Australia (Stewart & Nam Do, 2003). Findings indicated low utilisation of mental health services due to language, transportation, and time, and the authors conclude that the impact of the particularities of the health care service plays a role in service utilisation by refugee women. This again points towards the importance of localised research in terms of informing local practice.

Sossou, Craig, Ogren and Schnak (2008) conducted a qualitative study of seven Bosnian refugee women's experiences as they resettled in the USA. A narrative analysis of the interview findings identified language barriers, lack of transportation, lack of access to education, and misconceptions about accessing mental health services as challenges with the post-migratory phase. Additionally, overlapping the literature on coping, resilience was identified as the central mechanism for coping, with family and religion as the two subthemes. Inter-rater reliability was achieved through two researchers independently analysing the data and also a peer debriefing to maintain objectivity.

In contrast to the studies reviewed so far, one study identified higher use of mental health service by refugee women compared with men. Chow, Jafee and Choi (1999) sourced data from a New York state-wide survey on characteristics of patients served by the state mental health system. They explored service utilisation by Russian refugees and found that older women had highest rates of service use. However, the authors do not specify overall number of refugee women compared with men in the population, making it difficult to ascertain whether in this specific group more women were present overall.

Much of the identified literature stemmed from countries outside the UK. The majority of UK studies explored service use by refugees broadly, without considering women separately. A considerable body of research explored ethnic minority service use in the UK but, again, without identifying refugees. One study by McCrone et al., (2005) assessed the mental health needs and service use of 143 male and female Somali refugees living in London. Refugees were recruited from conventional (GP surgery registration lists) and non-conventional (community cafes) sites. Although a large proportion of the sample had mental health problems, service use was found to be low. Most participants had contact with GPs whichever site they were drawn from, but more of the users of community services used specific refugee services, rather than GP services. This study provides a helpful contribution

to the relatively scarce UK empirical literature base on refugee mental health needs and service use. However neither the needs assessment nor the service use measures were standardised, reducing reliability and validity. To achieve a more balanced knowledge base of mental health service utilisation of refugee women in the UK, the review now turns to a more diverse range of sources of information than the empirical research databases provided, incorporating project work conducted by refugee organisations.

The Joseph Rowntree Foundation produced a report in collaboration with the University of Birmingham (Phillimore, Ergun, Goodson & Hennessy, 2007) documenting a qualitative study, which used interviews with 128 members of refugee communities. A third of participants were women. Approximately two thirds (68%) of participants believed that women suffered more than men with mental health problems and many reported their belief that women were restricted to the home owing to the combination of domestic and child care responsibilities and cultural norms. It emerged that in the absence of social networks and reduced access to English classes, women were less likely than men to know where to seek help and advice about how to access services. Additionally, several of the women reported that they would not discuss a mental health problem with a male doctor, which indicated a significant barrier to service utilisation. Women and men both reported a reluctance to utilise services owing to their perception that the only treatment offered for mental health problems was medication and they deemed this to indicate a lack of understanding of their problems. Owing to financial restraints, the analysis of data relied upon hand written notes by the research team. Nevertheless, the report provides a helpful insight into the interplay of cultural barriers and the perception of services, limiting service utilisation.

The Refugee Council produced a report on healthcare access for refugees (Kelley & Stevenson, 2006). Based on their extensive experience of working with refugees at the largest refugee supporting agency in the UK, the authors brought to light an important issue pertaining to access to services. Though the report is not focussed specifically on women, it claims on the basis of their extensive casework with refugees that misinterpretation of regulations regarding refugee rights to access services results in GP surgeries not registering or offering care to all refugees, which raises an important systemic barrier to mental health service utilisation.

The Medical Foundation for the Care of Victims of Torture is another key agency working with refugees in the UK. A 2007 report (Tribe & Patel, 2007) describes successful service innovations, as evidenced by their utilisation by refugee women. Services provided horticulture in combination with therapy, creative writing as a means of processing and sharing experiences, sport, art, drama, dance, and sharing traditional crafts in tandem with therapeutic ideas. Tribe and Patel (2007) argued that the success of the strategies was due to the fact that they were initiated by service users themselves or by community leaders in collaboration with mental health services. However, the authors did not comment on how language and practical barriers to do with childcare were overcome. Nevertheless, this paper highlights recent service innovations.

Finally, it is worth noting that charitable organisations working with refugees commented on reports by female refugees on the positive aspects of their post-migratory experiences in the UK, such as enjoying living in a multicultural society, and feeling safe in the UK (e.g. Phillimore et al., 2007). This provides a more balanced and hopeful picture of the post-migratory experiences of refugee women.

The relative weakness in the empirical literature of UK studies compared with other countries highlights a need for further research into the use of services by refugee women in the UK. Many studies recruited refugee women from a specific country. This is advantageous in providing an understanding of specific cultural issues but reduced generalisability of findings to refugee women more broadly. Studies employed quantitative and qualitative techniques. Quantitative studies did not always utilise standardised outcome measures and qualitative techniques often incorporated rating scales or closed questions and thus reduced the richness of the data.

Conclusion

In sum, refugees face considerable challenges and are an at risk group for mental health difficulty. Two main perceptions of refugee mental health emerge from the literature; appreciation of refugees as a group who have experienced trauma and are at risk of developing PTSD, and appreciation of the broader experience of refugees, including risk factors associated with experiences pre- and post-migration.

Focussing on post-migratory issues, the review has highlighted a relatively limited literature on issues pertaining to refugee women's mental health. Nevertheless, it has been found that coping strategies tend to rely on personal (e.g. spiritual) and social (e.g. social networks) resources. Mental health service utilisation has not emerged as a coping source of choice for refugee women.

Studies are largely qualitative in nature, which provides rich data, but is limited in generalisability. The research literature on refugee and asylum seeker mental health stems from empirical research in part, but also and significantly from research and information collected and published by key agencies working in refugee issues. One drawback with such studies is that funding limitations can restrict the research designs, limiting the robustness of

the methodology. Much of the extant literature explores service utilisation by women who have accessed some form of support, even if this involves simply being on a doctor's register, indicating a gap in literature addressing women who have not engaged in services.

Clinical and Research Implications

The growing recognition of the importance of mental health services for refugees puts increased pressure on service providers and commissioners to develop new models for intervention, training and evaluation (Weine et al., 2000). With a heightened awareness of the global emphasis on human rights (CEDAW, 1979; UNHCR, 2008) services have a responsibility to ensure that the needs of women, who have formerly been neglected in terms of provision of refugee mental health care, are met.

From a research perspective, partnering with the refugee support agencies (e.g. Refugee Council) may be a means of addressing the gaps in the psychological research literature. An important question emerges as to how to meet the needs of those women who are suffering, but for whom the barriers to seeking mental health services are considerable.

Directions for Future Research

Studies generating theories on refugee women's mental health service help-seeking behaviour are required, as the relatively small research base does not offer clear theories or models of supporting refugee women to engage with services. Thus far, the majority of empirical studies have been based outside the UK, indicating a need for more studies in this area. Emergent research questions include; what psychological factors affect the post-migration mental health and help-seeking behaviour of refugee women, what psychological processes are involved in refugee women's engagement with services and what the interplay

is between individual factors affecting mental health help-seeking (such as coping strategies) and systemic barriers (such as service design).

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Section B: A Grounded Theory Study of the Mental Health Experiences of Refugee Women and their Encounters with Mental Health Services in the UK

Word Count: 7999

UKACHI E. EZIEFULA

Abstract

Refugee women do not utilise UK mental health services as frequently as might be expected owing to their vulnerability to mental health problems. The present study investigated the MH experiences of refugee women who have encountered mental health services in the UK in order to contribute to understandings about factors affecting service utilisation. A Grounded Theory qualitative methodology was employed. Ten refugee women were recruited from a local non-governmental organisation and participated in semi-structured interviews about their experiences of distress, coping strategies and encounters with UK mental health services. A two-staged model emerged from the data. The first model depicted women's experiences of distress predominantly in the context of post-migration experiences and how they coped, drawing notably from spiritual and social resources. The second stage of the model indicated how mental health service encounters were varied and a process of engagement involved evaluation and re-evaluation at particular stages. The study concluded that understanding refugee women's utilisation of mental health services demands a multi-factorial, dynamic appraisal.

This study explores the processes involved in a sample of refugee women's engagement with mental health services (services) in the United Kingdom (UK). To set the context, key issues will be highlighted indicating a need for increased theoretical and research enquiry into the mental health (MH) of female refugees in relation to their post-migration experiences. A range of theoretical and empirical research relating to refugee women's service utilisation behaviour will be considered and gaps in the extant literature highlighted, leading to the development of research questions for the present study.

Background Context

Definitions. United Nations defines a refugee as a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group, or political opinion, is outside the country of his/her nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country" (United Nations High Commission on Refugees, (UNHCR), 1951: article 1A (2), as cited in UNHCR, 2002). The Home Office reports data on the number of refugees in the UK each year, but owing to the fact that women's claims are not always considered individually, but in relation to their husbands', the actual proportion of female refugees compared with men, is contested (UNHCR, 2007; Cebulla et al., 2010).

Gender issues. Women's reasons for seeking asylum tend to differ from those of men (Information Centre about Asylum and Refugees (IACR), 2008), reflecting gender specific issues including sexual violence, genital mutilation, forced abortion and sterilisation (Crawley, 2000). Women also flee owing to conflicts arising from low level political activities (reflecting their position in society) and being persecuted due to their relationships with male political activists (Crawley, 2001). Women have been identified as being at high risk of developing MH problems (Refugee Women in Development, 1990).

Theoretical and Research Understandings of Mental Distress in Refugee Women

Understanding experiences of war and conflict related trauma is an important feature in understanding the psychological wellbeing of refugees. However, this approach has dominated the theoretical and research literature on refugee women's MH (Summerfield, 2001), whilst post-migration stressors have been neglected. These include multiple changes, such as temporary accommodation in different parts of the country, facing language barriers and social exclusion, lower educational and employment opportunities, struggling to support children alone, managing cultural differences and missing relatives (including children) who have been left behind in the country of origin (Tribe, 2002). It is argued that such stressors are crucial when refugee women's MH is considered (Papadopoulos, 2002). Poor post-migration conditions, including accommodation and economic opportunity have been associated with poorer outcomes in refugee women compared with men (Porter & Haslam, 2005). Davies (2000) found that difficulties associated with loss of culture and of a beloved country were a dominant feature in the narratives of refugee women, although this study was small scale. A larger study (Norris, Aroian, & Nickerson, 2011) interviewing five hundred and twenty participants found that immigration related stressors were strongly associated with post-traumatic stress disorder (PTSD) and depression.

Ryan, Dooley, and Benson's (2008) resource based model of migrant adaptation helps to tie these theoretical and research understandings together. Human survival is understood as depending on the achievement of basic needs in terms of Maslow's (1970) hierarchy of needs. These needs are considered to be met by the mobilisation of personal (physical and psychological), material (e.g. possessions), social (e.g. sense of identity) and cultural resources (e.g. skills, knowledge and beliefs). This model is particularly applicable during post-migration adaptation to life in a new country when refugee women may face a profound

loss of material, social, and cultural resources, impacting heavily on their personal resources. A question arises as to how refugee women might cope with the impact this has on their MH.

Research Evidence for Refugee Women's Coping Post-Migration

An overview of research into refugee women's coping strategies post-migration reveals support for the resource based model (Ryan, Dooley, & Benson, 2008). For instance, Renner and Salem (2009) found that women coped post-migration by concentrating on their children, having contacts with their extended family, learning the local language, and through interactions, indicating a mobilisation of social resources. Berman, Girón, and Marroquín (2006) conducted a narrative study on refugee women, who relayed the importance of having needs such as housing and food met, which stresses the significance of attaining basic needs and bolstering material resources. One limitation in this study is that all the participants were well-educated women, which suggests they may have possessed resources that less educated refugee women would not. A qualitative study by Ross-Sheriff (2006) revealed the importance of spirituality as a coping mechanism, from which refugee women derived hope and resilience, thus strengthening their personal resources. Women also coped with post-migration stressors by working.

Overall, these studies highlight that refugee women utilise a range of coping mechanisms when facing post-migratory challenges, particularly drawing on social, personal and spiritual resources, and a taking on of new roles to assist in the acquisition of material resources. Notably, none of the studies found that women utilised services as a method of coping. However, none of these studies were conducted in the UK, which highlights a significant need for more empirical research in this area.

Service Utilisation

In general populations, women have a greater tendency to utilise MH services for support more than men (Horrocks & House, 2010). Given that refugee women are at risk of developing MH problems it is interesting that female refugees have been found to use services less than non-refugee women (e.g. Ten Have & Bijl, 1999), and in some cases less than refugee men (e.g. Guerin, Abdi & Guerin, 2003). This striking finding prompts an investigation into the factors contributing to the lower utilisation of services by refugee women.

To the author's knowledge, only one study has assessed the MH needs and service use of female refugees living in London. McCrone et al. (2005) found that a large proportion of Somali refugees had MH problems, and most had contact with GPs, but service use was found to be low. However, measures in this quantitative study were not standardised, compromising its reliability and validity.

Much of the UK enquiry into service utilisation among refugee women has been provided by non-governmental organisations (NGOs). For instance, a qualitative study by the Joseph Rowntree Foundation found that in the absence of social networks and reduced access to English classes, women were less likely than men to know how to access services (Phillimore, Ergun, Goodson, & Hennessy, 2007). Additionally, women reported that they would not discuss a MH problem with a male doctor, indicating a potentially significant barrier to service utilisation. Owing to financial restraints, the analysis of data relied upon hand written notes by the research team rather than interview transcripts.

The Medical Foundation for the Care of Victims of Torture reported a range of service innovations, the success of which is evidenced by their utilisation by refugee women (Tribe & Patel, 2007). Tribe and Patel (2007) argued that women used services because they

were initiated by service users themselves or by community leaders in collaboration with services. This indicates that women may consider services more appealing when they feel they can exercise a level of autonomy, which may bolster their personal and psychological resources.

Rationale

The research literature documents the strength and resilience of female refugees in terms of coping through the mobilisation of resources. However, less is understood about the factors affecting their choices to engage with UK MH services. Empirical research evidence exploring service utilisation in the UK is lacking; the dominant understandings arose from the NGO publications. To address this imbalance, this study aims to explore refugee women's experiences of distress and methods of coping during post-migration in the UK, and to develop an understanding of the factors affecting the process of engaging with services. The study aims to address shortcomings in the extant theoretical and research literature by developing theoretical propositions and thus a Grounded Theory (Glaser & Strauss, 1967) methodology will be used to explore the following research questions:

- How do refugee women experience and cope with mental distress in the UK?
- What factors influence refugee women's decisions to engage or not engage with services in the UK?
- What are refugee women's experiences of using services in the UK?

Method

Design

This study employed semi-structured interviews to explore the process of refugee women's engagement in UK MH services. Data collection and analysis was conducted using grounded theory. This approach was considered appropriate for the present study given its potential to generate rich data upon which a model/theory can be built.

Grounded theory, originally developed by Glaser and Strauss, (1967), offers detailed and systematic procedures for data collection, analysis and interpretation to facilitate the development of a relevant theory (Chamberlain, Camic & Yardley, 2004). Early grounded theorists advocated flexibility in utilising the strategies and developing research questions over the course of the research to ensure that the resulting theory is grounded in the experience of participants. This approach has been developed further by Charmaz (2006), stemming from a symbolic interactionist perspective, who claims that neither data nor theory are discovered, but co-constructed with participants (Charmaz, 2006). Given the aims of the present study to explore refugee women's experiences of engagement as a process, grounded theory informed by Charmaz (2006) was deemed appropriate.

Participants

Convenience sampling was used to recruit participants from a non-governmental organisation, (NGO) supporting male and female refugees and asylum seekers. The principal researcher attended regular mixed gender and women only group meetings at NGO sites, during which study aims were outlined and group members were given the opportunity to ask questions and volunteer. Subsequently, theoretical sampling was conducted via NGO contacts.

Ten women participated in the study, who met inclusion criteria of being refugees with an experience of at least one encounter with a MH service in the UK. An encounter was defined as an experience anywhere on the spectrum from hearing about a service to engaging. Thus, women who had heard about services but chosen not to engage were included. Participants were excluded if they did not speak English, owing to limitations in the budget for the employment of interpreters. Anonymised demographic details are summarised in Table 1.

Table 1

Demographic Information of Participants

Partic-ipant	Age	Marital Status	No. of Children	Length of time in UK(yrs)	Education	Employment
1	40 – 45	S	2	5	Nursing Degree (CO)	Volunteer nurse (UK)
2	30 – 35	Si	0	6	Primary school (CO)	None
3	45 – 50	M	0	7	Dental school (CO)	Dentist (CO) Dental nurse (UK)
4	35 – 40	S	3	4	Secondary school (CO)	None
5	40 – 45	D	2	8	Primary school (CO)	None
6	35 – 40	M	3	11	Primary school (CO)	Volunteer at NGO (UK)
7	35 – 40	M	3	12	College (CO) Basic teaching (UK)	Supply teacher (UK)
8	25 – 30	S	1	11	Nursing Degree (CO)	Nurse (CO) Voluntary Nurse (UK)
9	50 – 55	M	3	3	Finance Degree (CO)	Account manager (CO)
10	35 – 40	W	0	5	Degree (CO)	Personnel (CO)

Notes: M – married, Si – single, S - separated, W – widowed, D – divorced

Countries of origin included Zimbabwe, Sudan, Egypt, Ghana, Jamaica, South Africa, Kosovo, and Bosnia.

Research Materials

A semi-structured interview schedule (Appendix 2) was developed in consultation with healthcare professionals with extensive experience of working with refugees and conducting research. This schedule was used to guide the interviews with open-ended questions exploring broadly: women's perceptions and experiences of mental health, women's coping strategies, women's experiences of encountering services and women's experiences of recovery. Open ended questions enabled flexibility in terms of exploring emergent information. In fitting with grounded theory, the schedule was updated as the study developed to provide opportunity for further investigation of emerging categories.

Procedure

Participants were informed about the study during their regular social meetings at an NGO providing support to asylum seekers and refugees. The director of the organisation introduced the principal researcher to the groups, who then described the study aims, provided an opportunity to ask questions and distributed information packs comprising information sheet and consent form (Appendix 3). Women could indicate their interest in participation by approaching the researcher at the end of meetings, informing their case worker at the NGO or, to provide total anonymity by returning the form in a postage paid envelope to the University for collection by the principal researcher. Interested participants were contacted individually and given a further opportunity to ask questions about the research. Written consent was obtained from participants prior to interview. The recruitment processes continued until the analysis indicated theoretical saturation of categories, given the time frame.

Interviews lasted a maximum of 60 minutes and took place at the NGO premises. Interviews were recorded, transcribed verbatim with removal of identifying information, and

analysed manually. After interviews, the principal researcher made memos to capture idiosyncratic features of the interview and note and develop theoretical ideas.

Quality Assurance

Quality assurance guidelines (Elliott, Fischer, & Rennie, 1999) were adhered to throughout. To maintain awareness of personal perspective, a research diary (Appendix 4) was kept by the principal researcher as a means of recognising the author's own values, interests, and assumptions, and how these impacted upon the planning of the project and the ongoing analysis. To meet guidelines for providing credibility checks, research supervisors were consulted during the research process to check initial and theoretical coding, and final category development. Additionally, after focused coding and category development, participants in the study were invited, on a voluntary basis, to discuss initial findings and subsequent interpretations. In cases of disagreement, discussions were conducted until agreement was reached and relevant alterations were subsequently made. For details of all initial, focused, and theoretical codes and the final categories, please see Appendix 5.

Theoretical sampling was used to allow pertinent themes emerging from the data to be explored further.

Ethics

This study was assessed and granted approval by the Canterbury Christ Church University, Salomons Campus Ethics Committee (Appendix 6). The British Psychological Society (BPS) Code of Ethics and Conduct (2009) and Health Professional Council (2008) Standards of Conduct, Performance and Ethics, were adhered to throughout the research.

Data Analysis

The data obtained from interviews was analysed using grounded theory (Glaser & Strauss, 1967) informed by Charmaz (2006). This method was deemed appropriate since it places emphasis on processes, making the study of action central and constructing interpretive understandings of the data. Analysis began after transcription of the first interview and continued on an interview by interview basis.

Line-by-line coding was used to generate initial codes. The most significant and / or frequent initial codes were formed into focused codes to synthesise larger sections of data. The research diary was used to refer to and further develop memos, which informed the process of analysis and enabled the development of theoretical codes. Relationships between theoretical codes were explored through the use of further memos moving towards the conceptual development of emerging categories and in identifying relationships between categories through constant comparison (Charmaz, 2006).

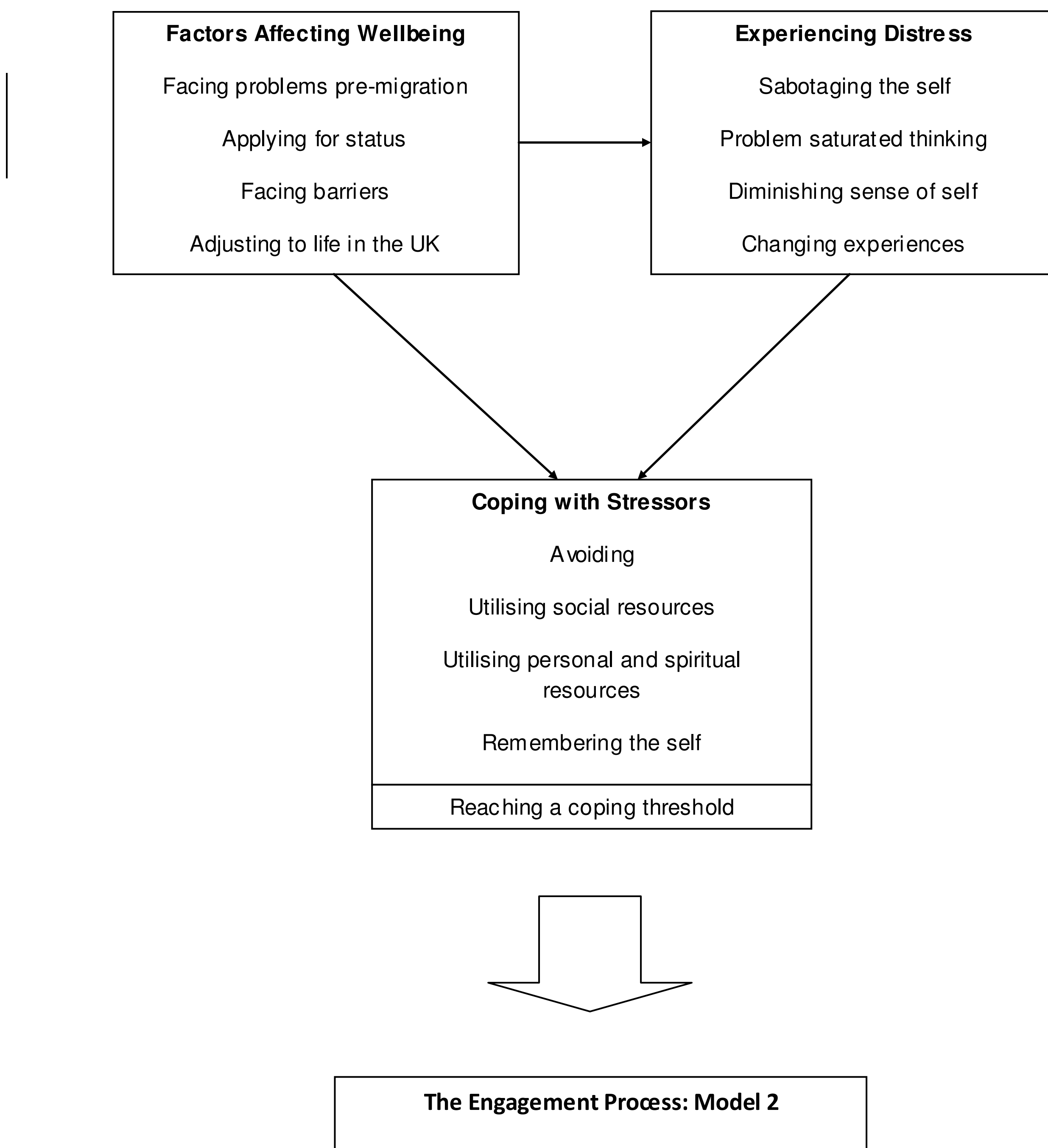
Results

A total of 141 initial codes were generated and condensed into 80 focused codes. Subsequently, 42 theoretical codes were generated and developed into 12 theoretical categories. Throughout the process, codes and categories were not necessarily mutually exclusive. Relationships between categories led to the development of two models. These will be reported here in turn using bold underline to indicate **categories** bold to indicate **theoretical codes** and italics to indicate focussed codes, where appropriate to aid the reader. One coded interview transcript is provided in Appendix 7.

Model 1: The Process of Experiencing and Coping with Stressors

Summary of Model. Women expressed a range of factors affecting wellbeing reflecting facing problems pre-migration and predominantly, once in the UK in applying for status and facing barriers leading to difficulties with adjusting to life in the UK. These factors contributed to the women experiencing distress associated with sabotaging the self, problem saturated thinking, a diminishing sense of self and inconsistent or changing experiences. It emerged that in the light of factors affecting wellbeing and experiences of distress women responded by coping with stressors through the use of a range of strategies up to a point of reaching a coping threshold. After this stage, women responded in different ways, which led to the development of Model 2. Figure 1 presents a visual representation of Model 1.

Figure 1: The process of experiencing and coping with stressors.



Category 1: factors affecting wellbeing. This category encompassed four theoretical codes. **Facing problems pre-migration** was characterised by a loss of control in which women could not locate their feelings of stress. Women also experienced fractured attachments, characterised by losing relationships with loved ones. After leaving home, in the process of **applying for status** women experienced a loss of agency, and reported facing uncertainty, feeling trapped and fearing being sent home. "You are scared they might send you back ... and for me that was really stressful" #1, "Its like throwing people into a lions den. How can you let someone in and then forget about them for 10 years?"#10

In the context of **facing barriers,** the most significant themes were a loss of role associated with being unable to work."Then I was a dentist. I had my career. I was seen as a dentist. But here ...I am not recognised as a dentist ... I can't get a job. This is affecting me."#3

Adjusting to life in the UK reflected women's experiences of worrying about children particularly in terms of feeling loss and guilt for leaving children behind and more generally missing relatives and feeling isolated. Additionally, women reported struggling with the UK climate and language barrier and experiencing cultural differences, which they believed to indicate racism. "Even the very close neighbour, I said good morning, she didn't answer me ... she didn't even look at me."#9

Category 2: experiencing distress. Women's descriptions of experiencing distress evolved into four theoretical codes. **Sabotaging the self** marked a state reported by the women of isolating, blaming and wanting to attack the self. "Sometime I feel like I want to walk in the road because I'm so stressed, angry ... frustrated, miserable actually."#5

Women described **problem saturated thinking** in which their problems would come into their awareness and they would experience distress, being consumed with problems.

“You’ve got all these things on your mind. It eats you up inside and you can’t stop thinking about it.”#4

Experiencing distress also encompassed a **diminishing sense of self** in which women experienced being unable to cope. This also reflected feeling unsuccessful and out of kilter. “I had no idea what was happening, where I was going, where I was even, like it had all been turned upside down ... I didn’t know where I was.”#8

One of the challenging features of **experiencing distress** was described by the women as an inconsistency whereby they encountered **changing experiences**. They found themselves behaving differently, being unable to sleep and becoming depressed.

Category 3: coping with stressors. Women mobilised a range of strategies to cope with stressors, which incorporated four theoretical codes**.** As a way of coping by **avoiding** difficult feelings women used strategies including sleeping and not thinking about problems. Women also described **utilising social resources** whereby they benefitted from talking to others in their social network as it showed them they were not alone with their problems. Offering support to others required women to be strong for others, which helped them to feel better about themselves. Women also described deriving benefit from NGO group membership, which was characterised by laughing with friends and feeling a family connection with other members. “You can just sit with friends, and just talk, have a laugh and that can really ease stress.” #3

Additionally, women described valuing practical support from NGOs in terms of being helped to achieve material resources. This included receiving support in Home Office applications and receiving practical and financial support. “they (NGO) ... helped me do a lot of things that I couldn’t do on my own.”#10

Utilising personal and spiritual resources was one of the most common means of coping with stressors. Most centrally having faith was a way of fostering and maintaining hope. Women's use of religion was not only a personal connection to their object of faith (God), but also gave rise to social connection; sharing religion with another, as a means of coping. "Prayer has helped me to feel stronger. It gives me a little joy within me. Helps me go on another day."#5

Remembering the Self emerged as a coping method the women employed involving thinking about past life and specifically remembering home country traditions and languages. This enabled them to feel less fragmented, making it easier for them to cope. "For me it was important to be able to speak to people in my mother tongue, it made me remember who I am, it made it easier for me to ... keep on going."#5

Women identified a point of being unable to manage determined by reaching the final straw due to an accumulation of pressure or the addition of more stressors, whereby they found themselves **reaching a coping threshold**. "I was still coping ... until I got a phone call ... saying my husband was killed ...then everything went – and I couldn't cope."#10

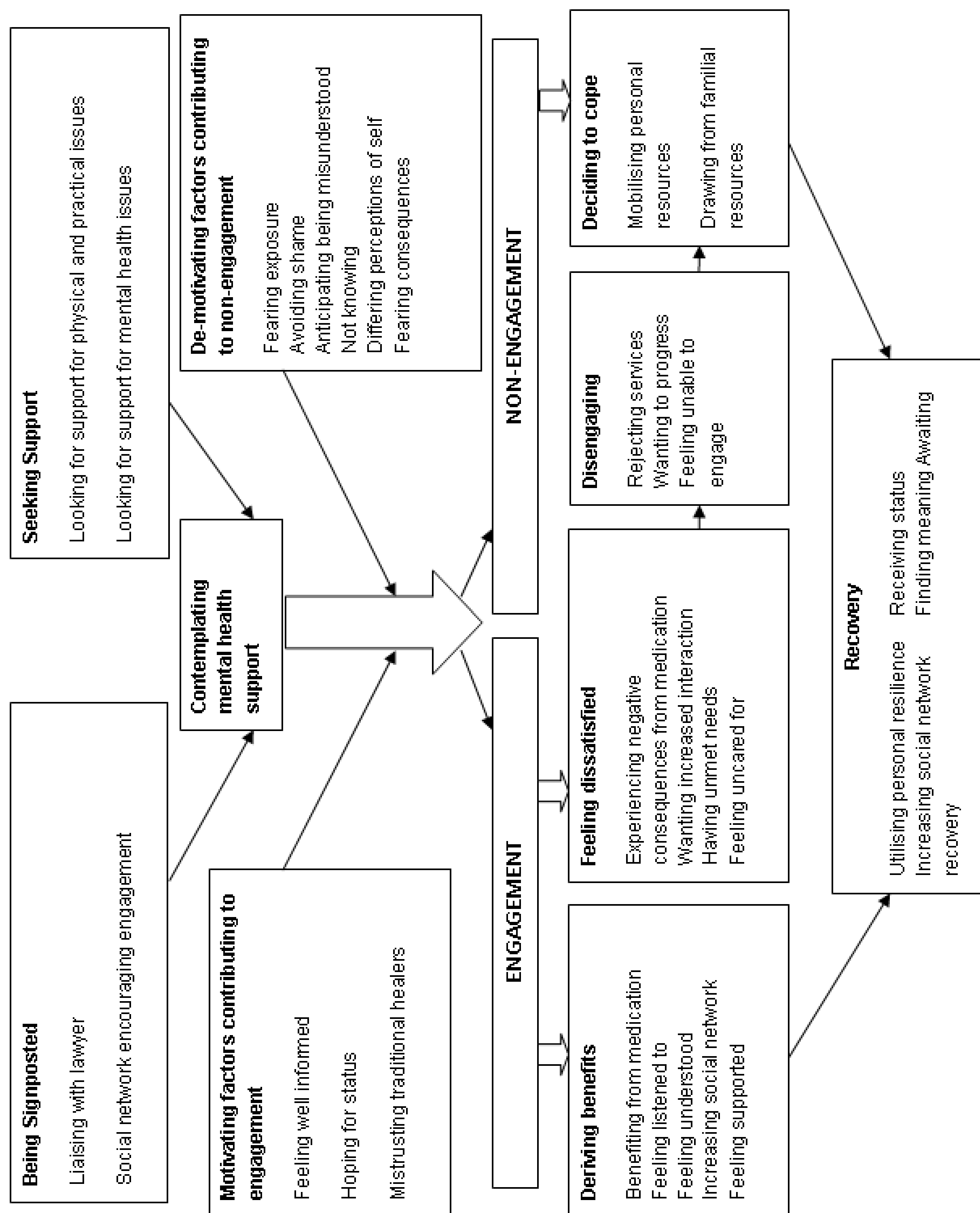
From the point of no longer coping, women then moved in a number of different directions, which developed into a second model; The Engagement Process.

Model 2: The Engagement Process

Summary of model. Women found out about MH services in the UK either by being signposted, or by actively seeking support for physical or psychological needs. Women then went through an internal process of assessing both motivating factors contributing to engagement and de-motivating factors contributing to non-engagement. Women who

engaged either found themselves deriving benefits or feeling dissatisfied and this influenced them continuing with treatment or disengaging. Women who did not engage, and those who disengaged, went through a process of deciding to cope, often reaching a point of recovery via their own means. Recovery itself was described as on ongoing process, which some women felt they were yet to complete. The model is summarised diagrammatically in Figure 2.

Figure 2: The engagement process.



Category 1: being signposted. This category included two theoretical codes. **Liaising with lawyer** occurred in the early part of women's lives in the UK, when they came into contact with lawyers in relation to their applications for asylum. They experienced being channelled to a GP by the lawyer and described either feeling alliance with lawyers or more passively, *accepting the lawyer's advice*.

A more common means of being signposted emerged from the women's **social network encouraging engaging**. Women reported hearing from friends who knew about available services and finding out about charity support groups via word of mouth, which drew their attention to available practical help as well as a social connection. Women also described being signposted to the GP by friends who had found medical services helpful. "A friend told me about this place, she said you can come here for food, clothing, shoes, advocacy, for help with the Home Office."#5

Category 2: seeking support. This category included two theoretical codes. **Looking for support for physical and practical** issues arose in the early part of women's lives in the UK. Women reported a sense of desperation in which facing destitution was a key contributor to help-seeking, particularly for women who had children. Women actively sought practical help including requesting police support with destitution. "I went to the police station, I said, look at me, I have a child, I don't have status ... I don't have rent, where should I go?"#8

Women also actively sought help from the GP, largely for physical health reasons, and often for the sake of their children. These women had found out about the GP through signposting from friends. "I only went to the GP because I was worried about my son's health."#6

Looking for support for MH issues was expressed by some women who reported visiting the GP for MH reasons. These were women who had prior knowledge of counselling support through engaging with other services (e.g. domestic violence support) but had not engaged at the time they learned about GP counselling support. "I went to my GP and I said, I need a counsellor, I need help."#8

Category 3: motivating factors for engaging. This category included three theoretical codes. **Feeling well informed** was characterised by receiving sufficient information from the GP, which women experienced as helpful and motivated them to engage. "The doctor, he explained to me what services they offer and the information that he was going to give me ... it was helpful."#4

Hoping for status was another factor contributing to engagement, in which women reported considering legal benefits in engaging, which indicated believing that MH treatment may support the asylum case. "If the doctor decided that I was you know, needing more treatment or care, that this would affect my case as well."#10

Mistrusting traditional healers experienced in their country of origin contributed to women wanting to try a new approach as they described feeling ambivalent about the benefits of traditional doctors.

Category 4: de-motivating factors contributing to non-engagement. This category included five theoretical codes. The most dominant feature preventing women from engaging was **fearing exposure.** This was characterised by having negative perceptions about confidentiality and worrying about being recognised by friends or members of the community while attending. "Maybe you will meet someone you know ... she feels uncomfortable meeting you there. And you as well, you are not comfortable." #2.

Additionally, women expressed fearing immigration issues being discussed and affecting their ability to access healthcare.

Avoiding shame was one of the main factors contributing to non-engagement and was closely related to a fearing exposure. This code was characterised by women being dissuaded by the dominant cultural discourses around the meaning behind engaging with a service for support and there was consistency around identifying shame as a cultural barrier; "In our culture, this would mean you are mad. Its not like here, its a different mentality ... its shameful."#3

Part of **avoiding shame** reflected a gendered issue, of having to be a strong woman, which further prevented women from engaging in services. "Talking from a cultural thing, you know, I'm thinking women, because from the way we are raised up, its like, women are meant to be strong." #3.

Anticipating being misunderstood emerged as women expressed a belief that doctors would not be able to understand them because they have not shared their experiences. "If you talk to the doctors, the doctors do not understand" #2 and "It is better to hear from someone who really knows what is happening. Someone who has had a similar experience." #2.

Not knowing was characterised by the women feeling that they did not have sufficient information about services. Those who were not signposted by a lawyer or health professional and had not initially sought out help eventually found out by word of mouth from friends. Women reported being uninformed or if they had some information about services, feeling unsure and not knowing what to expect.

The codes in this category came together in the final code of **differing perceptions of self,** which reflected women struggling to assimilate dominant cultural discourses from their home and their lived experience in the UK. Women reported being too proud to seek help as a way of protecting their sense of self, in line with cultural discourses about being strong women, but also disassociating from being crazy in the sense of wanting to reject the home country discourse about madness. This code reflected an ambivalence and a changing perception of self, which women struggled with. Often, due to not reconciling this, women resisted engaging.

> "Maybe in this country it seems normal, but where I come from, the term mental health, you know ... the thing that comes first in my mind is maybe I'm going crazy. I didn't totally accept this, but also, I was afraid to admit it might be true."#4

Category 5: deriving benefits. This category included five theoretical codes. **Benefitting from medication** was described in a minority of cases, where women reported perceiving medication as helpful. "The tablets, they helped me get back to sleep, and then when I went off to sleep, he (baby son) could sleep. It helped me to calm down."#8

Feeling listened to arose in the context of receiving counselling interventions. Women described appreciating being able to talk to a professional about their problems and in particular valuing home visits because of the privacy this afforded. They also expressed benefitting from follow up care because it helped them to know someone was there for them. "Talking about the feelings I had, it just helped ... talking about things, maybe your emotions ... if you opened up to somebody, it helps." #1

Feeling understood emerged from women's descriptions of being appreciated as a whole person.

"She (social worker) was amazing, she really understood what I needed, she understood me... she saved my life that one woman. She sat down and listened to me. She didn't go with the status."#8

Increasing social networks emerged from women descriptions of benefiting from group contact via service support groups. Women commented on deriving benefits from knowing you are not alone and knowing others are worse than you because it seemed more believable to the women that if others could suffer worse problems and still survive, they could manage their own problems. "when you sit and talk to a group of people and find out that they have all got more on them than you, then everything lightens up."#4

Feeling supported arose predominantly in the context of valuing counsellor input in the context of service interventions from which they reported learning that there are ways to think differently about situations.

Category 6: feeling dissatisfied. This category included four theoretical codes. **Experiencing negative consequences from medication** arose in the majority of descriptions in which women reported feeling worse with medication and eventually rejecting medication as a solution. "The tablets were terrible, they really made me suffer, tablets just kill you, they kill you, totally."#6

Wanting increased interaction arose in the context of counselling interventions, in which women described finding counselling unhelpful and how they experienced wanting a counsellor to do more than just listen. "Counselling is OK, but really the help I needed was practical, word is comforting, but action is what is important."#5

Having unmet needs was characterised by feeling passive in the context of interaction with the GP, where women described receiving medication from the GP without

understanding it and not having a choice about intervention type. In the context of support groups women also described perceiving social support interventions as unable to help with overcoming internal issues. “I mean, you can go to any woman’s group and talk to people there, but you need someone to really help you overcome what is inside you. Just sitting with women and talking isn’t really helpful.”#3

Feeling uncared for emerged in the context of women feeling ignored after taking medication and not being followed up. “The doctors do not know what is really happening to you”#2

Category 7: disengaging. Disengaging emerged as a distinct part of the process, which fell into three broad theoretical codes. **Rejecting services** was a strategy employed by women who had experienced disappointment with services and was characterised by an independent decision about stopping services. “I just stopped going to the GP ... It wasn’t helping...”#1

A different factor which led women to disengage was **wanting to progress,** which stemmed from them reaching a positive state of wanting to recover independently. “I just felt it in me. I just wanted to see how I would get along without seeing them. And I have been fine.”#4

Women identified a sense of dissatisfaction with themselves in the sense that they identified personally **feeling unable to engage** with services. This was in the context of being unable to connect with professionals, characterised by being unable to articulate problems and struggling to find the words to express the difficulty. “I don’t know how to describe the feeling I had.”#1 and “He asked me many questions and ...I became, you see ... I could not speak.”#9

Category 8: deciding to cope. This category incorporated two theoretical codes. **Mobilising personal resources** was evident particularly in women who were mothers, who reported instinctively supporting children and having to stay strong on their behalf, which indicated fostering resilience as a mother. "I said to myself, I am a mum ... holding someone's life ... and so I thought, let me help myself, so I can help him."#8

In **drawing from familial resources** women reported gaining strength through children in a way which indicated that being together with children left them feeling stronger for being with the family unit.

Category 9: recovery. Recovery was expressed as an ongoing process, with some women feeling they had achieved this state, while others expressed still being on the journey towards it. The factors which led women towards recovery emerged into five theoretical codes.

Utilising personal resilience was evident in women's accounts of regaining agency, by taking control, exercising resilience by being strong and focussing on positives. Believing in self, was aided by following GP advice not to pursue medication or counselling and involved taking sequential steps towards recovery. "I was strong enough to fight. I might have gone mad or something otherwise."#3

By **increasing social networks** women described growing stronger through relationships, which was achieved through processes of being joined by family/ forming a family network, receiving support from friends and connecting with home community groups and social occasions. Additionally, an increasing ability to engage socially emerged from increasing language aptitude such as by going to English language classes.

Women who felt they had not yet recovered described a sense of **awaiting recovery**. This was characterised by hoping to find self in the context of feeling hopeless about full recovery. "What I used to feel, I don't know if I'll ever get that back again. I have changed totally. I no longer have that, you know, the way I used to feel about life."#10

Receiving status marked another area where women's experiences were divided. Women experienced practical benefits from receiving status, which left some feeling happy about status decision, because it opened up benefits in terms of being able to access support and employment. While others reported not feeling happy about status decision, since they felt it still did not help them to get back what they had lost in their sense of self. "Actually ... I wasn't even happy about it. I asked myself, was it worth me going through all this? ... Why did I have to lose myself because of this? #10

One of the biggest contributors to the recovery process that women reported was **finding meaning**. This was achieved through finding paid or voluntary employment and women reported feeling better with work. "It feels better to have something to do, to go out and have my job ... slowly, slowly, it helps me to make sense of my life." #6

Women also found meaning in terms of coming to terms with reality of their situation. Women expressed facing reality, which moved them towards recovery. "I started to move forwards, when I actually could see that it was my life, it was reality."#9

Women also found meaning through their connection with their religion and this was a factor which helped them to believe in the possibility of recovery. "Everything happens for a reason. That is God's will. So I just wait and know that it will be ok."#4

"I know God has a plan, so I carry on each day and I know that its part of my journey."#5

Discussion

The study led to two preliminary theoretical models for understanding the processes of experiencing and coping with distress and engaging. Each model will be now be considered in turn, drawing out particular theoretical ideas and regarding their relevance in relation to existing literature.

Model 1: Relevance to Existing Literature

Experiences of distress. During the interviews, women were asked about their experiences of mental distress in their country of origin and in the UK, but women emphasised their distress in terms of the process of immigration and adjusting to life in the UK, compared with more limited accounts of distress in their country of origin. This resonates with literature which emphasises the relevance of post-migration experiences in understanding refugee women's mental heatlh (Beiser, 2006). However, it may be that women chose not to disclose about issues relating to pre-migration. A study by Bogner et al. (2007) indicated that individuals with a history of sexual violence experienced greater difficulty with disclosure during interviews than those with a history of non-sexual violence. Sexual violence is a common experience for refugee women (Keefe & Hage, 2009), and this may have contributed to women speaking less about pre-migration experiences.

Post-migration, the model highlighted facing uncertainty as a factor affecting wellbeing and this is in keeping with Lazarus and Folkman's (1984) construct of 'event uncertainty' in which uncertainty reduces 'anticipatory coping processes'. In the present study this was reflected in the women's experiences of feeling 'trapped' while awaiting a decision from the Home Office.

Coping. In this study, coping strategies used by the women demonstrated a mobilisation of personal, social and material resources, which reflected the resource based model of migrant adaptation (Ryan, Dooley & Benson, 2008) and broader literature on women seeking social support as a method of coping (e.g. Jones & Bright, 2001). The use of spirituality, which emerged as an important coping resource, is also in fitting with pre-existing literature (Pargament, 2000; Tarakeshwar et al., 2003). In particular, the study identified the role of religion in providing hope and this is echoed in a study of Vietnamese people resettling in Canada, who found that the hope that religion inspired reinforced their identity (Dorais, 2007).

The model highlighted a sabotaging of the self, including blaming the self for inflicting problems on children, which emerged as a method of coping. Janoff-Bulman (1992) asserted that self-blame may serve as a coping mechanism by fostering a sense of control after traumatic experiences. Broader psychological literature suggests a tendency for women to locate responsibilities internally rather than externally, and this has been linked to a greater propensity for depression (Weiner, 1986). It emerged from this study that such self-blame motivated women to cope for the benefit of their children.

In fitting with the resource based model (Ryan, Dooley & Benson, 2008) and also reflecting the stress vulnerability model (Zubin & Spring, 1977) when demands outweighed resources, the women perceived themselves as no longer able to cope.

Model 2: Relevance to Existing Literature

A multi-factorial model of access. The model showed how after an initial encounter with a MH service, either through signposting or seeking help independently, a range of factors influenced women's decisions on whether or not to engage. Upon engaging, women continued to evaluate their experiences leading to either continued engagement, or

disengagement. This showed engaging as a sequential decision-making process, influenced by prior perceptions as well as evaluations of recent experiences. This model contributes to existing literature on refugee women's service utilisation (Phillimore, Ergun, Goodson & Hennessy, 2007; Tribe & Patel, 2007) by indicating that a complex, dynamic, multi-factorial understanding of access and engagement is important to understanding the process of service use.

Systemic issues and material resources. Work and a valued community role emerged as pivotal in refugee women's MH in terms of identity, self-esteem, and recovery. This supports psychological theory on the links between unemployment and mental heatlh (Bracken, 2001) and strengthens arguments for the importance of community participation, support and belonging for mental wellbeing (Orford, 2008).

The relational self. The mobilisation of social resources played a large part in women's decisions to maintain engagement with services and in their recovery. This resonates with theories on the importance of the relational self. Generally, given their role in mothering, women are theorised as being more likely to have a relational self, favouring interpersonal relationships and close ties with others (Cross & Madson, 1997). The present study extends the existing understanding of the relational self in the context of female refugees in highlighting the importance of practical coping strategies, (e.g. with financial issues, gaining access to supportive services and learning English) in women's MH. Acquisition of basic material needs reflects Maslow's hierarchy (1970). Refugee women who have travelled without their husband to a host country may be left to take on traditionally male roles requiring and mobilising greater autonomy and independence in their attitudes, values and self-descriptions. This more traditionally male gendered identity, could explain their lower engagement with MH services in comparison with non-refugee women (Koydemir-Özden, 2010).

Summary

Women in this study expressed considerable differences of opinion, for instance regarding the value of medication and counselling. This supports literature identifying refugees as a non-homogeneous group, which stresses the need for an individualistic approach, as far as possible (Papadopoulos, 2001).

A key aspect emerging from both models is the importance of the balance between resources and demands, which supports broad psychosocial models of mental health (Lazarus and Folkeman 1984; Albee, 1986) and in particular Ryan, Dooley, and Benson's (2008) resource-based model of migrant adaptation. Where resources (including personal and social resilience and power) outweigh demands (including lack of financial resource, relational losses), women are in a better position to cope and recover. Receipt of refugee status and the resultant right to work may provide opportunity for resources to outweigh demands, however, some women reported feeling as though it came at too great a cost; having lost their sense of self so fully during the process that receiving status left them with a feeling of despondency.

Limitations

Given that this was a qualitative study, considering limitations in the context of quality assurance is essential. Elliott, Fischer, and Rennie (1999) present guidelines for reviewing qualitative research to aid legitimising it in terms of appropriateness and validity and these will be considered where appropriate.

Owning one's perspective. One key issue arises in participants' being informed that the principal researcher was a trainee clinical psychologist and therefore a mental health service provider. This may have had a reductive impact on participants' willingness to openly critique psychological services and may explain why there is scarce reference to the problems

with ‘psychological’ interventions, but a focus on problems with ‘non-directive counselling’. A further point arises from the early stages of the interview process where, in an effort to respect participants’ discomfort with disclosure, interview questions did not probe as deeply as they might have done. This stemmed from the principal researchers own assumptions that if women were asked too directly about their trauma experiences, they would be left in a vulnerable state. Women expressed post-migration distress more fluently than pre-migration distress, but understanding the extent to which this reflects their relative experience of distress in different stages is limited by the omission of questions probing further into their reasons for speaking in such ‘quiet voices’ about pre-migration stressors.

Situating the sample. Given the small sample size, in order to preserve anonymity, descriptive data on participants was given in a summary format and conclusions were made on the data in a way that would not disclose personal characteristics about participants. Thus for example, idiosyncrasies relating to culturally specific issues from a particular country of origin were not drawn out since doing so would have revealed the identity of women were the only participants from a particular country.

Providing credibility checks. After the data had been initially analysed and again after the models were constructed, the participants were invited to attend a meeting for the principal research to present the findings, asking for feedback, with quality assurance in mind. No women attended the first meeting, and only three the second. This was in part mitigated by the credibility checks provided through consultation with research supervisors.

Accomplishing general vs specific research tasks. The fact that only English speaking participants were included in the study means that the voices of less educated women, who may be more vulnerable in terms of their mental health, given barriers to social resources, were not heard.

Implications

Therapeutic interventions for refugee women should pay importance to the resource–demand balance in women's lives. The participants commented on finding counselling unhelpful because they knew that as soon as they stepped outside, their problems would be there again. Supporting refugee women requires that their basic needs are met as far as possible and therapeutic interventions to help them to process and recover from more existential issues.

Broad Implications for Health Services

It emerges from the present study that women are most likely to seek out support for practical problems affecting their wellbeing, including housing, financial, and refugee status related issues. This raises implications for non-MH workers who might come into contact with refugee women, as providing information to women will contribute to their awareness of services and may add to the factors motivating women to engage. Indeed, non-MH workers may be the key facilitators in helping women access MH services and manage the issues they experience in their motivation to engage, particularly supporting women who are contemplating change (Prochaska & DiClemente, 1986).

Theoretical and clinical implications for clinical psychologists

The findings of this study indicate a strong argument for Clinical Psychologists (CP) who are working with female refugees to broaden their remit in ways that enable recovery through the provision of services which empower women to achieve their basic needs. Women in this study experienced a separation of psychological help and practical help, and reflected a desire for greater integration of the two approaches. The study highlighted women's desire to be understood and supported holistically, which indicates a benefit in CPs

liaising with agencies providing more practical support, or through incorporating practical support into their modes of working. Finding meaning, through religion and social networking, emerged as important routes to coping and recovery, and these might also be incorporated innovatively into psychological programmes.

Furthermore, women considered a range of services as 'MH services'; including the GP, hospitals, counselling services, and charities such as NGOs that provided support groups and activities. This indicates a need for CPs to think broadly in terms of empowering women to access different types of support. For instance by signposting or offering integrated access to agencies which offer practical support around issues to do with housing, finance and getting registered with a GP, emerges as an important first step in terms of enabling women's (and their children's) basic needs (Maslow, 1970) to be met, before which they may be unlikely to be able to utilise psychological service input. CPs might consider offering integrated access by linking their service provision into other services refugee women are known to be likely to use, such as NGOs.

Conclusion

The material realities that refugee women are or have been dealing with pose mental health risks, especially when several factors coexist simultaneously. Women's help-seeking behaviour is influenced by the extent to which their needs are met from a Maslowian perspective (Maslow, 1970), reflecting their capacity for coping with the extent of imbalance in resources and demands (Ryan, Dooley, & Benson, 2008). Engagement is also affected by women's concepts of self and their pre-conceptions of mental health issues and treatment, based on dominant cultural discourses from their country of origin and from fellow women who have sought help in the UK. Receiving refugee status gave some women great relief, but for others, it highlighted losses in their sense of self. After an initial encounter, women's

tendency to engage with services is influenced by availability of information, pre-conceived ideas relating to cultural discourses about mental health, and on their experiences of engagement. Upon engaging there is considerable variation in what women find helpful, influencing whether they disengage or continue. Significant differences of opinion arise, indicating the idiosyncratic nature of the experience of encountering services.

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SECTION C: A CRITICAL APPRAISAL

Word count: 1959

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This paper is a critical appraisal of a Grounded Theory study conducted as part of the Major Research Project presented in Section B of this portfolio. The appraisal is guided by four key questions in turn.

Critical Appraisal

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Through the application of the grounded theory methodology employed in this research project, I have learned a range of research skills. Using grounded theory helped me to learn to be open minded and to be driven by my data, and to challenge my own assumptions, which are not always consciously accessible.

During the recruitment process, I feel that my skills of rapport building and communication developed further, given that reaching my final sample size of 10 meant overcoming a range of different challenges. For instance, the first two participants volunteered early on and after this, it took some time to recruit the remainder of the final participants. Keen to understand what was slowing things down, I arranged to attend one women's group session where I spoke with openness and curiosity to the women about what they thought about my study so far. One key issue that came to light as a reason for slower uptake was my use of the term 'mental health' for which the women preferred 'emotional health'. Another example of my research skill development during the recruitment process was in learning (by doing) how to sensitively explain to participants who came forward but did not meet inclusion criteria that they could not take part in the research.

I also feel that I developed my skills of diplomacy and transparency in conveying my research aims and objectives. When I went to meet with the mixed gender activity group at the NGO I explained my research project and invited people to comment and ask questions. One of the men raised strong opposition to my intention to only interview women. I had thought that by addressing the whole group and inviting their comments and questions, that men would feel included to some degree and I had not anticipated that my plans might offend men and I recall feeling quite on the spot. Explaining to the man, in front of the whole group, why I was focussing my study on women helped me to develop my skills of diplomacy. I feel I developed in maturity with this experience, which made me realise the naivety in my assumption that men would feel happy with such a small level of participation.

I feel I could develop further in the analytic phase of grounded theory by engaging different levels of triangulation. I would also like to do an ethnographic grounded theory study, as the notes I made in interviews showed me that much of the important communication is non-verbal. I would like to develop further in terms of my interview skills. I found it challenging in this project to maintain my position as a researcher and not be pulled into therapist role in the context of very emotional interview material. This ability did develop during the course of my project, as I see from my transcripts that I became more robust over time. However, I still see room for improvement in learning how to extract data about emotions and experiences, without also evoking a sense of providing a therapy session, which can then leave participants feeling exposed.

2. If you were able to do this project again, what would you do differently and why?

After I had explained to the mixed NGO group that I was only interviewing women, I found that over the next few weeks a number of men approached me with their views about mental health and services. If I did this study again, I would like to expand it, so that I interviewed both men and women as I think this would provide useful contrasts, which might help to develop an overall understanding of refugee gender differences. This could be done as a triangulation phase, where perhaps one or two men were interviewed in addition to the ten women.

I noted in my memo's in my research diary that at times in different interviews, I got the sense that women were reluctant to express their complaints with the health service because they knew I was a MH professional. They may have feared offending me, or jeopardising any treatment that they were currently in receipt of. If I was to do this study again, to mitigate this problem, I would like to invite an NGO caseworker to lead a focus group discussion with participants for me to later transcribe and analyse. I would look to see if responses reflected my hypothesis that my presence as a professional, made the women censor what they said and see how their responses differed in this context. This could be a source of triangulation.

In the current study, I presented my interpretations of data to a small group of the women who had participated and volunteered to give their feedback for reliability purposes. I found that fewof the women challenged my interpretations. If I was doing this project again, I would set up an anonymous feedback system so that women could respond more freely to my interpretations. I would also seek to understand why the women who did not volunteer decided not to participate in this stage as this might provide helpful data, which could contribute to the model development, this being a form of 'dis-engagement'. This could also be done via an anonymous survey.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

The women I interviewed in this project, impressed upon me the importance they place on having their needs understood and since the first encounter is often an assessment, this is a key stage. Whilst this project has focussed on refugee women, this leads me to be sensitive in all my future clinical work, to provide sufficient space for negotiating understanding. Understandably, service pressures may dictate that only one assessment session is possible, but my learning from the women in this study reminds me of how crucial the assessment phase is in terms of a service users' experience. Working with refugees in particular, I would endeavour to make sure the assessment period addressed the extent to which basic needs are being met. So that I could make appropriate interventions, I would seek to have a good working knowledge of available services in the locality I was working in, so that I could signpost refugee to these agencies to help them get their needs met.

During working on this project, I attended a conference on trauma and was inspired to learn about practitioners who use a range of mediums when working with refugees. In particular, many practitioners reported using opening prayers at the start and end of clinical groups and I have also seen through my attendance at the non-governmental organisation (NGO) group meetings that this approach is used. Given the importance of religion emerging from this project and my observations at NGO group meetings and through liaison with other practitioners at the trauma conference, I would like to also incorporate this into my practice. This would require much sensitivity since members of a group will potentially have different or no religious affiliation and indeed, the service I work in will most likely not have a religious basis in its service values and standards. So I would need to discuss and justify this with group members, and service managers to ensure that I remain within appropriate policies and codes of conduct.

If I was working in a non-refugee specific service, I would like to run peer education sessions with my colleagues to convey the importance of a sensitive assessment and overall therapeutic alliance. It emerged from this study that refugee women place great importance on feeling as if a professional cares about their work and sees and respects them as a person. My clinical experience so far is that in some services, where refugees seldom get referred, refugee issues can be so misunderstood, that professionals do not even know whether legally they are able to offer services or not when a referral is made. I would seek to bring professional knowledge up to date and to incite passion to work with this group by explaining their experience to the best of my ability. Where my role permitted, I would like to extend this to GPs, since data from this project has indicated GPs an important point of first contact. In particular, I would want to talk to GPs about factors which can contribute to motivations for engaging and not engaging, so that they might incorporate more information giving and options in their interventions.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

I did have variation in my sample in terms of women who had encountered services, perhaps through being informed about them by friends or GP who did not then engage, and those who did engage, some who continued treatment and some who disengaged. However, one voice that was missing from my study, was of women who had never had any encounter with mental health services and if I did this study again, I would like to capture their experiences and views as I think this group would offer great insights into the mental health experiences, coping and help-seeking behaviour of this harder to reach group.

To meet with women who have never encountered I would liaise with a GP practice to recruit participants who make contact with GPs for physical health reasons. To meet with women who do not also go to the GP for physical health reasons, who have no contact with services at all, I would make contact with asylum seeker detention centres to meet with women there. I would conduct the same project and compare findings to the present study.

As a different area for future research within this project area, I would like to explore the experiences of mental health staff in working with refugees (both male and female). Through conducting interviews, I discovered myself how emotionally demanding it can be to speak with someone who has encountered the sorts of difficulties refugees have faced and it made me wonder about vicarious trauma and general burn-out from working with traumatised people. Contrastingly also however, I was struck by how positive and strengthened I felt after interviews with women who were more advanced in their recovery who had used their resilience to bolster their sense of self. Given that women in this study stated the importance of the relationship with professionals, understanding the staff perspective might be helpful in providing an understanding of the factors affecting the quality of this relationship. The overall experiences of staff in working with refugees therefore emerges as an interesting area for future research. I would like to conduct a further grounded theory study with semi-structured interviews with questions tailored around the following research questions:

i) What are the experiences of mental health workers in working with refugees?

ii) How do mental health workers cope with vicarious trauma?

iii) What are mental health workers' experiences of being emotionally supported by colleagues and supervisors in their work with refugees?

It would be important to consider how 'mental health workers' was defined and I think it would be valuable to set inclusion criteria that enabled participation from 'professionals' and non-professionals who come into contact with refugees in both the statutory and non-statutory sectors since this would present a good range of contexts.

Section D: Appendices

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Appendix 1: Search Methodology

A range of searches of English language publications were conducted using the following electronic databases; ASSIA, Web of Knowledge, PsychINFO, Cochrane, MEDLINE, ScienceDirect, Social Science, with no time-limit.

Search 1 provided a broad overview of the literature. This search combined the following search terms:

1. Refugee, immigrant, migrant
2. Women, female
3. 'Mental health', distress, well-being

Search 2 provided a focus on refugee women's risk factors and prevalence of mental health problems during post-migration. The following search terms were combined:

1. Refugee, immigrant, migrant
2. Women, female
3. 'Mental health', distress, well-being
4. 'Risk factors', causes
5. Prevalence, incidence

Search 3 focussed on refugee women's coping strategies in the post-migration phase. The following search terms were combined:

1. Refugee, immigrant, migrant
2. Women, female
3. Coping
4. Managing

Studies were included if they reported mental health coping of female refugees during post-migration.

Search 4 explored refugee women's use of mental health services. The following search terms were combined:

1. Refugee, immigrant, migrant
2. 'Mental health service', 'service use', 'service utilisation', 'access'
3. 'Help-seeking'

Studies were included if they reported on mental health service use among female refugees during post-migration.

Identified studies were manually searched for additional references. A small number of studies were identified so to broaden the scope of the review, a Google search was conducted to include literature contributed by statutory and non-statutory agencies working in the context of refugees and asylum seekers.

Appendix 2: Semi Structured Interview Schedule

These are guideline questions - the consultation group will advise on appropriate language and more detailed questions.

Mental Health Experiences

Can you tell me what emotional health or mental health means to you?

Can you tell me about any time you have experienced this?

(prompts: did you have these problems before / after you came to UK / what differences were there)

What impacts did UK life have on your mental health?

What was life like when you received your refugee status?

(How did things change/ how did this affect your mental health?)

Mental health coping

How did / do you cope with emotional health difficulties?

(in the UK / in your country of origin / what differences were there)

What did you feel you needed?

What was helpful / not helpful?

Mental health service experiences

How has being a refugee affected your mental health?

Where do you turn for help if you are struggling with your mental health?

(Prompts: faith, social networks, traditional cultural beliefs)

How did you come to hear about mental health services?

(Prompts: how did you hear about it, what interested you)

What made you chose to engage or not?

Can you tell me about your experience of using mental health services in the UK?

(Prompts: What type of support did you receive? What problem or problems were addressed? Was it helpful? Did you feel the problems you wanted to focus on were addressed?)

What can you tell me about how the therapy you encountered in the NHS focussed on your experiences before and after you came to the UK?

What was helpful / unhelpful about this approach?

What would have helped more?

What do you think mental health services should do to help female refugees?

Appendix 3: Information Sheet and Consent Form

Faculty of Social and Applied Sciences

Clinical Psychology Doctoral Programme

Canterbury Christ Church University

Tunbridge Wells Campus

Appendix I: Ethics Materials - Participant Information Sheet and Consent Form

Information for Participants

Title of Project: **Developing a model of engaging female refugees in therapy.**

Name of Principal Researcher: [redacted]

I am a trainee clinical psychologist and I would like to invite you to take part in a psychology research study that I am conducting. Before you decide whether to take part or not, you need to know why the research is being done and what it would involve. Please take time to read the following information carefully.

Aim of Research

The aim of this research is to develop a model for engaging female refugees in therapy. Few refugee women use mental health services and I would like to understand what mental health services could do in their first encounters with refugee women to increase the likelihood that women will engage as this could ultimately improve their wellbeing. I would like to talk to 12 refugee women about their experiences of encountering UK mental health services and to hear their ideas about how the initial contact period might be structured to make it more likely that women will decide to engage in treatment.

Taking part

If you decide to be a part of the research, it will involve talking with me for 1 hour at [redacted] in an informal research interview. This means I will have a range of questions to ask you, which you can look at beforehand. The questions will ask what it was like for you when you experienced mental distress in the UK and how and whether UK mental health services supported you. I would like to hear your ideas about whether there are different ways that services might approach refugee women to make it more likely that they will engage in services. I will encourage you to say more if I have not asked the right questions. The interview will be sound recorded to help me remember what you say (if you prefer for this not to happen, instead I will write down your responses). I will give you up to £5 towards your travel.

It is possible that talking about your experiences of when you had contact with mental health services might bring difficult feelings to the surface. If you do feel distressed during or after the interview, please let me know so that I can arrange for your [redacted] caseworker to support you. If you find it too difficult and you want to stop the interview, please tell me and we will stop. Please be aware that you can withdraw at any time should you feel too distressed to continue. If you decide not to take part in the study, I will destroy all documents with the information you have given and this will not affect your involvement with [redacted] or any mental health services.

If during the interview you say something that suggest to me a risk of harm to yourself or to someone else, it is my responsibility as a trainee clinical psychologist to report this information to a relevant agency for your protection, or the protection of others. If I think this is the case, I will inform you.

Confidentiality

I will keep the information you provide strictly confidential. This means that you will not be identified at all. Your name will not be included and no address or personal contact information will be recorded so no one will know that it was you that said the things you said. Any information that is of a personal nature will be disguised (such as if you mention any names of people in your family).

After the research

After the recordings of interviews have been written down for analysis, the recordings will be destroyed. All information collected will be stored on paper or memory stick in a locked cupboard and kept for 10 years. After 10 years, the information will be destroyed.

After the research has been written-up, if you wish, you will be sent a copy of the summary via ■■■■■■■■■■. The results are likely to be published in a psychology journal. Your name will not be used in any reports, published articles or presentations.

Further Information

If you would like more information about the research after it has finished or would like a copy of the full report, please feel free to contact me at Canterbury Christ Church University on ■■■■■■■■■■ or leave a message for me at ■■■

Concerns

If you have a concern about this study, please speak to me and I will do my best to answer your questions. If you are still unhappy and wish to complain formally, you can contact my supervisor ■■■■■■■ at Canterbury Christ Church University on ■■■■■■■■■■■■■■■ or ■■■■■■

Thank you for reading this information

If you are happy to take part in the research, please fill in the consent form attached

You can change your mind at any time, without giving a reason

This research has been approved by

The Salomons Ethics Committee; Canterbury Christ Church University

Faculty of Social and Applied Sciences

Clinical Psychology Doctoral Programme

Canterbury Christ Church University

Tunbridge Wells Campus

CONSENT FORM

TITLE OF STUDY: Developing a model for engaging female refugees.

Please complete the following:

1) I have read the letter which describes this study YES / NO

2) I understand about confidentiality in this study YES / NO

3) I have had chance to ask questions and talk about this study YES / NO

4) I have had all my questions answered properly YES / NO

5) I have been given enough information about this study YES / NO

6) I understand that I do not have to take part in this study YES / NO

7) I agree to take part in this study YES / NO

Signed ____Date ____________________

Name in Block Letters ____

How to contact me to arrange interview ____

Signature of Researcher____

Appendix 4: Research Diary: A collection of personal reflections, notes on interviews, observations of process and memos for theoretical and categorical development

8th November 2009

I have decided not to do the initial IRP project I planned to do as it was involving too much change. I have my internal supervisor in place and now need a new project!

I've been thinking about my earliest research proposal for my application to the clinical psychology training course. I wanted to devise a culturally appropriate / sensitive assessment tool for refugee women because I had a sense that western approaches to assessment, using standardised outcome measures, might not meet the needs of refugees – especially those who don't speak English. I think that part of my decision to stop progressing my previous IRP idea, was because actually, I feel a great desire to do my study around refugee issues. I'm interested in trauma and the lives of people who move.

15th November 2009

I want to find a way of assessing refugees without using language. I'm interested in the idea of using dance as an assessment tool – dance with music. In the initial IRP supervisor selection stage, I did approach one supervisor about this project. She was interested but pointed out how hard it might be to actually code dance steps and outcomes via dance. It feels like a big task. I'd like to find a way of working with refugee issues on this project thought, it feels important to me, perhaps because of my background – my father leaving his home country and coming to a new country to make a new life. Perhaps migration feels a part of my heritage. I've been reading some papers and it looks like most studies focus on refugees in general, but don't look at refugee women. I wonder why this is?

3rd December 2009

I had a meeting with Dr SK, a psychologist at the trust where I am on placement who does a lot of trauma work with refugees and asylum seekers. He thinks my project is trying to incorporate too much – to look at dance + refugees + assessment. I told him I was interested in women since there doesn't seem to be as much written about them. He said in his practice that he probably sees more refugee men than women. I wonder what this is about? S can't be my supervisor but has suggested I get in touch with a newly appointed counsellor here at the trust who specialises in working with ethnic minorities (HK).

4th December 2009

Had an IRP meeting with my internal supervisor and she also thinks it would help if I can funnel down a bit more. I think the idea of exploring women's issues is a good one and one that my supervisor is interested in too. I need to have a look at some previous studies – I've go the research fair coming up at placement.

10th December 2009

Had a meeting with HK to bounce my ideas around. He thinks dance is exciting, but maybe just focussing on refugee women and assessment for now, then I could always incorporate dance at another stage. I think I like the idea of dance, but at the same time, it feels too risky – its such a big step from a typical clinical psychology research project, I worry that I would not be able to meet the requirements. Also, I've been thinking about it in terms of setting up a dance based group for refugee women, but that would really be too large scale for the scope of the IRP. I think that perhaps speaking to women about their own views on assessment might be a better type of project for the size of the IRP. This could inform any future research I might undertake, devising an assessment / group treatment using movement and music, taking into account what the women say about assessment.

12th December 2009

I had a meeting with DD – an experienced art therapist who works with refugees and asylum seekers and has a number of publications. D likes the idea of the culturally sensitive assessment tool, but even if I just go with interviewing women about their experiences of assessment / treatment she would be interested in being a supervisor on this project. I've mentioned this to my internal supervisor and she feels that D would have to be 3rd author. I feel really embarrassed to ask someone so dominant in the field to be 3rd author.

5th December 2009

I think I've lost Ditty as a supervisor since she was not pleased with the idea of 3rd authorship. This makes me learn about how important it is to balance things well in research work. Ditty would be a good person to have on this project, but realistically, I think that what I can offer her is not enough for her to want to take on the responsibility. I feel sad about this and quite panicked about where to go from here.

10th December 2009

I'm feeling under pressure to come up with a project. I've had a look through some literature on refugees and still find more on men than women. Also, I'm noticing a lot of the literature is about trauma and PTSD but doesn't really look at other mental health factors. I can feel an enquiry emerging into refugee women's experiences of being assessed for mental health problems. Maybe they don't have good assessment experiences because of problems with clinicians not understanding their background? Maybe they just can't make sense of questions in assessments because of westernised concepts?

11th December

I've been thinking about approaching refugee women via a different means that NHS because I think they might be able to speak more freely about the NHS services. I've found a local NGO group really near my flat and have called to meet with the director. I've also met with a lady who runs a women's group in the city, but she said she can't help me with participants.

15th December 2009

I went to the Research Day at the Trust where I am on placement and met Karen Nicholls, who did a study on female refugees! I got her contact details and mentioned my project ideas and now having spoken to her, she has agreed to be my external supervisor. I'm so pleased!

Listening to other people's research today, I've been inspired by the idea of actually constructing a model of understanding to contribute to the literature base. My questions have been around how refugee women find being assessed in mental health services. I need to find a way of studying this with a method that will allow me to create something like my early assessment tool idea – some sort of process / model for what happens when women are assessed.

1st January

Had an IRP meeting with my salomons supervisor and I've got to get my proposal together now. I'm going to go for a model called grounded theory – I remember when we covered it in lectures its struck me as a way of doing qualitative research and coming up with something quite concrete, in a way. It appeals to me and to the plans I have to find a way of understanding what goes on when refugee women use services. I think just focussing on assessment might be too hard though – I know refugee groups are hard to recruit, would I really find enough women who could talk about assessment? Maybe I need to open it up to any experience in a mental health service, not just assessment?

8th January

Have met with the director of the local NGO and she is really keen on my research project and says I can recruit participants from her service! I can't believe it! I thought this would be so hard. She says women from lots of different countries use the NGO. They run activity groups on a Friday for men and women and she has suggested I attend some meetings as a way of letting people know about the research project.

1st Feb 2010: Research Panel Approval

I have got through the research panel stage. Such a relief.

March 10th 2010: Ethics Approval

It now feels a reality at last! I feel a sense of responsibility- towards the women who I will meet and towards the university in terms of producing the agreed study. I feel quite nervous.

May 22nd 2010: Group Session One

I went to meet the group today for the first time. Before the group starts, there is an open meal for people to meet and socialise and have something to eat together before the group session starts. The meal is provided by the organisation staff free for the members.

I went along 30 minutes before the group started to join the group for a meal. The room was a buzz. Lots of energy. People were sitting around in clusters. I noticed that in general, as people sat around the tables, women sat together and men did, but there were less groups of men and women sitting together. Several people were sitting alone. It seemed also as if people sat in groups according to their country – so there were different languages being spoken in different parts of the room.

It was difficult for me to approach people. I felt like rather an imposter – receiving a free meal when actually I could afford one. I found the women to be rather cold towards me in fact; I would smile at them and they would not respond. The men acknowledged me more readily than the women, with many saying hello, how are you. I felt quite intimidated by the women – not knowing how to introduce myself to them.

It seemed like people were unsure of me and I know I was feeling nervous so was probably giving off quite awkward vibes. I was very relieved when a man came up to me and introduced himself and sat down at my table.

I met a man who had been an academic at a university in his home town in South Africa. He was very welcoming and interested in why I was there. I told him I was at the group to do my project and that I wanted to meet women who I could interview about their experiences. He supported the idea. He said that he thinks mental health issues are very important factors for asylum seekers and refugees and that it is important for them to find ways to deal with them. He said that he thought that in his home country, people didn't really deal with mental health problems in the way that they can here. He said that people would mainly go to traditional healers for mental health problems, but that these treatments would usually not really work. He said he thought it was good here that there is a lot of different help for mental health problems. He said that he finds that talking about problems can be helpful, but that not everybody thinks this or knows where to go if they want to talk. He said he thought it was really good to be a member of ████ because it meant that you could meet lots of other people and have a sense of a family. He was very interested in my course of study, I explained how the course worked and what the project was for. He was very supportive of me doing the project.

It was then time for the group to begin and everybody went upstairs and began to sit in a circle in a large room. There were children playing in the background and people milling about making cups of tea and snacking on biscuits. It felt a lot more comfortable for me up in the group room – the seating arrangement was a circle and this seemed more equal and made me feel less conspicuous.

The group began with everybody introducing themselves in a circle. They would say their name and the country they were from. Again I noticed that people from one country would sit together in one section. One of the largest groups was Sudanese. The vast majority of this group were men. I was struck by how differently they all looked to each other, but there was clearly a strong sense of identification. Another large group was the Zimbabweans and this group was almost all women. Older women, just a few younger ones, who came with children. These were the women who had been very familiar with each other downstairs in the dining room. They seemed to hold a lot of power in the room. They held high energy, making jokes. There were two or three women from Asia, and it seemed to me that them being in a minority position made them feel slightly awkward – they were very quiet.

Children were walking around the room, playing, sometimes in the corner of the room, sometimes just wandering through the circle. I was struck by how relaxed the group were to this sort of intrusion. To me it was really wonderful – the children were not expected to keep quiet and sit in the corner, and the noises which they did make (which were few and far between) were entirely tolerated by the group. At one point, one of the children walked across the circle and the director of ████ who was starting the group picked the child up and put him on her lap and continued talking to the group as she played with him using a lego toy he was holding in his hand.

I was welcomed to introduce myself to the group. I found it so hard to know what to say. I did not want to mislead people, so I wanted them to know what my reason for being there was. But at the same time, I wanted to feel a part of the group and so in a way wanted to be

able to appear as if I too was an asylum seeker. I wanted them at least to see my Africanness, rather than focussing on my Englishness. I introduced myself as Lit from Brighton and I explained that I was training as a psychologist and that I would be telling them about myself a little more another week as I am doing a project and would like some help from the group.

June 5th 2010: Group Session Two

There were new faces in the group dining room meeting this time. More people seemed to come up and say hello and they welcomed me as if I was a potential new member of the group. They would ask me where I was from. I think because I am half African people thought I was a refugee or asylum seeker. As soon as I spoke, it felt as if I was suddenly different from them, in their eyes. I knew that this week I would be presenting my project more fully in the group session so I was keen to let people know from the start what I was doing there.

In the large group session, I told people in full detail about my research. A part of the group time was devoted to me. I asked people for their feedback about my idea. One older woman said that she thought it was a good project to do and that she thinks that people do not find it easy to go to health services for support. Most of the women were quiet. One of the men said that actually he did not understand why it was that I was only going to interview women and not men. I explained that my study was actually quite small and that I felt than in order to thoroughly interview a group, it needed to be either men or women. I had decided to interview women because I was interested in how being with a child might impact on people's mental health and I knew that women often seek asylum with their children, whereas it is more common for men to be separated from their children. Also, I explained that women seem to present themselves at mental health services less than men and I was interested in understanding why this was and what could be done to address this. He was quite angry with me. He was very outspoken. I welcomed his interest and his objections and gave him a platform to discuss. None of the women got involved in this discussion. He said that he thought that men also have problems with mental health and that being a refugee or asylum seeker is tough. He said he thought that it was important to also do a study on men.

July 9th 2010: Group Session Three

I was not presenting in the session, but I wanted to go along to see if any women wanted to volunteer. The ████ director led me up to a table of women who she thought might be interested and said to them that she thought they might be. One of them said that she would be happy to do an interview and she gave me her number. I was encouraged by this and took her number so that I could contact her to arrange a time. She seemed open in front of her peers that she was happy to do the interview, but I thought that by giving me her number

instead of arranging it then and there she was putting in an important boundary. Another woman also then expressed an interest and I took her number too.

I called both women and set up the interviews.

July 23rd 2010: Group Session Four

Before the group started I was sitting outside and one of the men approached me. He said that he had been in this country seeking asylum for 7 years. He said that he had experienced some really bad things in his home country and that when he came here his health was not good because he would often remember some really difficult things that he has seen and he could not forget about his family, who were still in his home country. He said that he did go to find help because he knew something was not right in his mind – he was not at all comfortable or well and he could not sleep or function properly. He said he was given medication and that he started to use this. But he said, after some time he decided that he was not interested in the medication. It was helping him to sleep but he knew that his problems were actually more than the problems with remembering things back home. He said that since coming to the UK he has not been able to work – no right to have a job and this is demeaning for a man. Not only this, but how is he to look after himself? He said that the thing that people in uk need to do to support people who are seeking asylum is the practical things. HE said what was helpful was to have a roof over your head and you cannot get this if you cannot work to earn money. He said he is here, ready and willing to work, capable of work, young and fit, and yet he is not allowed to do so. He said this is the hardest thing for him about being here. He said he thought that mental health services were useful, but what is the point in helping someone to sleep at night, if they are still not able to be a human being because they have no rights, no status. He said really something needs to be done about this, because he knows many people like him, some even who are doctors or dentists or other professions that this country needs, and they are just left here to rot while they wait and wait for the endless asylum process with the home office. He said that he thought the process with the home office was really offensive. They would change their rules many times, start to set up different things that you need to do in order to keep your case open and that he feels like he is treated by them like a criminal. This he said has been something that makes it difficult for him to feel like a man, like a person. So he thought that my project was useful, but that the real work should be finding ways to help people when they are in this country. Not just helping them to deal with the problems they faced in their home country. After all he said, they are here now they have made it out of that place.

August 7th 2010: Group Session Five

One of the two women from Taiwan started talking to me during the meal today. She said that she was really struggling with her mental health. She said she was trying to find a counsellor or someone who she could talk to about her problems. I gave her information about places she could go to and talk about how she is feeling to try to find help. However, she did not seem to take the information I was giving her onboard. I got the sense that she

wanted to talk to me about her health. She knew that I am a trainee psychologist and it felt like she was approaching me for a therapy session. I thought she was not clear about what the interview would be about if she was to participate in the research. It did not feel right to use her as a participant and instead to help her access the information I was giving her.

September 15th 2010: Memos on interview one

Interview One

The participant attended rather late to the session and it made things a little rushed. She was very quick to get started, not paying a lot of attention to the information sheet which I had already given her. She had no questions to ask me and just really got started quite quickly with the interview. She was talking almost throughout about a friend. I do not know whether this was her way of avoiding talking about herself as having struggled, or if it was really about a friend that she was speaking.

MEMO: Experiencing receipt of prescription / diagnosis as an indication that coping skills are not working

#1

“I had to go and see a doctor and I was prescribed medicine. Anti-depression or something.”

Her inflection moved upwards at the end of the first sentence. As if she was raising a question. It seemed like she was reflecting a feeling associated with being prescribed medication, that she was ‘ill’ or not managing, that medication was what was necessary to get her through. It was as though she did not believe she had reached the point where medication was the solution.

MEMO: Being unable to put experiences into words

#1

“I couldn’t sleep, could never sleep, restless and just, I don’t know how I can describe it. Just, low self-esteem and just depressed and I don’t know how to describe the feeling I had.”

It was as though there were no words for what she felt. Perhaps in her culture because the words or the idea did not exist, it was hard to articulate it in English. Makes me think of

describing mental health issues as part of the adaptation process. Articulating feelings in a way not done before. Its a different perception of self-hood. CULTURAL difference – actually taking on the identity as a 'sick person'.

MEMO: Reaching threshold and making a decision to start coping

#1

"After some time I just couldn't handle the pressure any more, the home office situation. I just decided, just, leave it, you know. Put it at rest and , I think that's how I got over it. Knowing that I was not answerable to anyone, you know, just forgetting about it really, forgetting about the whole case. Just finding my own way. That's what I did."

This shows an internal resource but at the same time a defence mechanism – just forgetting about it. But there is something very conscious in this process. It is as if she reaches the point at which she can no longer cope and so she consciously decides to take the situation into her own hands. It occurs to me as 'thinking positively' and marks resilience. Rather than deciding to give up because she can not cope, she puts her foot down. Overcoming difficulty through mind control / determination / resilience.

MEMO: Not knowing – seek help

#1

"i didn't know what to expect, but I was happy that you know, the professionals would diagnose whatever it was, because by then I think, I didn't know anything about it. All I had was these mixed feelings. So I didn't, I had no idea what to expect."

Not knowing what to expect from services, but also not knowing what own feelings mean. Not being able to make sense of self. Allowing an external agency, which she doesn't understand, to intervene and make sense of herself. This indicates a loss of identity. A loss of sense of self, a loss of knowing self. In the context of not knowing the system or how the system makes sense of things, its like giving up own sense making process in the hope that UK medical service will be able to explain it. This indicates an uncertainty, but also a dependence on services.

MEMO: Knowing – reject help

#1

"I knew where the stress was coming from. So I just stopped taking the tablets."

Here, she seems to be saying that when she was no longer uncertain, and no longer had lack of clarity about the source of problems, she felt that the tablets were not necessary, so again made a conscious decision to stop. Its as if medication occurs as an option when all else has failed – when own ability to make sense of things comes back into action – the medication is no longer required.

MEMO: Not wanting me to probe too deep

#1

"It was a long time ago. 8 years ago ... so my memory is not great."

I wondered at the time when she said this, whether this was her way of asking me not to probe. If she can't remember, I can't derive a lot of information from asking her the questions. I felt a little uncomfortable – like she wanted me to stop, like I was intruding.

MEMO: Having / Forming a social network as a means of coping – becoming EMBEDDED

"I think by then I had a family. My sister joined. My sister in law joined us."

She said this in response to my question about what things she did to help herself cope after she had stopped taking medication. Its as though being embedded into her support network of family was a positive social resource which helped her cope.

MEMO: Avoiding expressing dissatisfaction with Mh service

"They couldn't have done anything else really. Other than what they did"

She seems to let the service 'off the hook' even though earlier in the interview she expressed how she would have liked the GP to talk to her more about options, side effects etc. Its as

though she does not want to seem too blaming, or ungrateful. Perhaps this expresses her ambivalence about what MH services can offer, but perhaps also, she is worried about seeming too negative in front of me since I am a MH professional. Perhaps my influence on the research process is most profound in this sense. Can she really say what she wants to or does she think she'd be insulting me if she did, or that I might use what she says against her in some context?

MEMO: needing support to access support

Even if you have information to go to a mother and baby's group, you are still not confident in yourself, yeah, I was thinking, maybe it would help to make friends, but if you are by yourself..."

It seems like information about services is not enough for women who are facing the new culture, loss of friendship groups. Its hard to have the confidence to access groups if you do not have some level of self-esteem / motivation left in you.

September 17th: MEMOS on interview two

Through the majority of this interview, the participant was speaking from the third or second person 'you experience this', 'she experiences that'. It was as though she did not want to talk about it from her own perspective, and yet the information she gave was so detailed that it seemed impossible that she would not have had the experiences she was talking about. It was as if she didn't want me to probe too far. Or she didn't want to be identified as someone with MH problems, even though she had volunteered to take part. When I asked her questions about why she did not want to disclose information to the doctor – she said she didn't know. It felt like she was pushing me away from asking too much, probing too much.

Complying with doctors wishes in front of doctor, but not taking the medication when home

"I will not take them, so the tablets are just sitting at home"

"when you have someone to talk to about this and this and this, you can tell them, 'I have problems, with these pills. What can I use instead?' So when you go to counselling then at least you get used to that."

These statement indicates an inability to say no to the doctor and a preference for talking about problems with the prescription with a particular kind of professional. Somehow the counsellor seems more approachable than the doctor in this respect.

Difficulty in disclosing sexual abuse

"Men. They will take advantage of you because they know you have nowhere to stay. They will pick up anyone who wants to go with them. So you are a victim. And if you go there you know that ... (SHE STOPS)

At this stage in the interview, I was struck by how quiet she became. She did not appear comfortable with disclosing sexual abuse. In particular, to say the actual words to describe what happened. I prompted her saying, "would the men expect something from you" and she said in a low voice, yes. I think I got pulled into wanting to protect her from having to disclose. Something for me to learn in future research. I'll note this in section C.

September 30th : memos on interview three

I was struck by this interview. She talked about her loss of role as a dentist. I really had the experience as if she had fallen from a great height – having working in a senior role in her country and now not being able to convert her qualification into something recognised here. It made me think about how loosing status is such an important part of the process. Then there is also the loss of her identity in terms of working.

Lots of mention of madness – it not being ok to seek help. Also though, she was keen to point out how useless counselling is and how helpful it is that I'm a psychologist. It highlighted to me my role in the research – the fact that I'm a trainee psychologist is known to the women who take part. Maybe its hard for them to be really honest about psychology. They have talked about wanting advice – maybe they are saying this because they think that's what my job does, and so they think its something I'd like to hear.

October 1st: Memos on interview four

Reluctance to discuss immigration details

"I came to this country, and when I came here I had to leave my two children behind, so since then I've been trying to bring my children over, but its been difficult, because I can't work because of my health."

I was struck during this part of the interview, by the way she swiftly moved over the details of her move to the UK. Her speech quickened and she moved onto the theme of not having her children with her and also not being able to work. She attributed not being able to work to her health issue, with no reference to before she got status and had no right to work. It was as if she did not want to discuss this. I felt again as if I was intruding and since I had stated that I wanted to focus on experiences of mental health service use, it was as though I had not given myself permission to move the interview deeper into pre-migration issues.

AIM: To develop my understanding of the contextual background in terms of the impact on mental health I need to be more robust as researcher and ask more direct questions following from participant comments about immigration issues and how they impacted on their mental health.

No crying over spilt milk

During the interview, the participant began to feed her baby with milk from a bottle. The baby dropped the bottle and the milk spilt. I was struck by how calm she was. She paused in her speech and then resumed straight afterwards as if the incident didn't happen. There was a calmness about it. I helped her to clean up the milk. We did this together silently. When we had finished, she didn't thank me or say anything. It felt like kinship. She carried on speaking from where she left off.

Language

At one point in this interview, I found myself speaking in slightly broken English:

"So, one help was that you were given medication, and another help is that you were given information... "

I noticed this when I transcribed the interview, but not before. I think I was trying to 'speak her language' to build rapport. I know that I alter my language to match the language ability of different clients in my clinical work, but it was interesting to note this process occurring here in my research. Perhaps something to watch out for in subsequent interviews.

Fear of offending me – a MH professional

I asked her if there was anything she found unhelpful and she laughed and said,

"Um, LAUGHS, I don't think so, not in my case. "

I got the sense during the interview that she was embarrassed to say anything negative about the health service since she knew I was a part of it.

<u>October 25th 2010: Notes on women's group meeting – implications for wording</u>

I discussed with the women about the terminology change from mental health to emotional health and they verified that this term is far more acceptable and encourages women to feel more comfortable about talking through the issues, compared with 'mental health' which connotes madness, which they find shameful.

I went to the women's group today to try to recruit some more participants. I talked with the women about mental health and they seemed reluctant to talk. MJ referred to it as emotional health and they seemed to respond better. This fits with something the first lady I interviewed said,

"I think the term mental health, in a way, you know um, talking from my background, it might you know, maybe in this country it seems normal. But where I come from, the term mental health, you know is just, somehow you just, the thing that comes first in ym mind is maybe I'm going crazy"

AIM: I need to re-word my terminology in the recruitment process and interviews to reduce / avoid the term mental health and use emotional health instead.

<u>January 20th: interview 7 Memos</u>

Internalising UK culture

This participant spoke about becoming more polite, 'more British' as I understood. She valued this characteristic, it being so different from the nature of her home country. She spoke with warmth about 'becoming British', and yet, she also spoke about how she could not say she is English because she was not born here, only that she had a passport and UK citizenship. I wondered about her children, being born in England, but with a mother who holds her home country identity as dear to her, whilst also valuing the new culture in the UK.

Appreciating UK life more when you have come from a less free society

"Here, you have more rights, in my country you have no rights at all, you may have enough money to go the university, but still you will not get a place, because the government, they keep their family there. Here, you feel more comfortable, more yourself. In other countries, you can't even find water to drink."

This was the first interview where a participant had spoken so positively about the UK system and feeling good about internalising the UK culture. From what she told me about her experiences, it seemed she had travelled through many countries before reaching the UK and

had many experiences of destitution, no rights to water etc. So she showed me an example of how different the UK experience is depending on the context from which you hail.

This led to an idea for theoretical sampling to capture the experiences of a women who had come from a wealthy background, to explore how this difference might impact on her perspective of mental health in the UK.

February 20th : MEMOs interview 8

A striking part of this interview was when the participant stated that she saw a GP wanting counselling and more medication and was refused on the grounds that she could cope herself better without them. It made me think about my own practice and also this whole study. One of my assumptions has been that mental health services can find ways to better engage refugee women, to support their recovery. This interview marks an important different opinion – where in fact, a refugee women being told she can cope without support and does not need to be dependent on medication / counselling, may be a route to recovery in terms of bolstering her self confidence and self-efficacy.

#8

"I went to my GP and said to him I need a counsellor, and he looked at me and he said no – you don't need it. I actually thought at the time, no – I really need it. I was having depression tablets before and i wanted to ask for more and he said no – think about the little one. So later, I thought, maybe what he is saying is right. If I take those depression tablets, it will make me feel ... low, and I won't be able to take care of the little one in the way that I want. So i said, maybe he is right, let me go with what the doctor is saying and make myself strong and help the little one."

March 15th 2011: MEMOs interview 9

This participant had come from a background where she was a successful finance manager in a large organisation with international clients. She expressed a difficulty in adjusting to life in the UK stemming from not having servants in the house to help her with the household duties and how challenging this was for her. This strengthened my understanding of how the home country cultural context is an important factor influencing adaptation to the UK environment and mental health service provision.

She and I made several appointments before actually meeting – numerous cancellations on her part. She suggested on the days she cancelled that we could meet for 15 minutes. I said it would not be enough and it was ok if she had changed her mind. She assured me she wanted still to do the interview. When we finally met up, I was very mindful of time, keeping to the hour maximum that I had said we might need. When I mentioned we should stop as we were

near the end of the time, she insisted that we carry on, that it was fine, she would be late for what she was going to, she wanted to carry on. I was moved by this. Perhaps she hadn't realised what talking about it would be like. She enjoyed the interview once it had got started. So what had she been reluctant about before? And what made this change during the interview?

At the end, I gave her a thank you card enclosing the £5 which was agreed for travel costs. She asked what was in the envelope, I told her and she said she would take the card but not the money. I assured her that she was more than welcome to the money, entitled to it as it was part of the agreement, to cover her costs. She became tearful. She said she had enjoyed talking to me and that she would not accept payment. I felt I had insulted her.

"Here, life is ok, but everything you have to do for yourself, especially in the house, you should clean, make the shopping, in my country, sorry to say – but we have servants in the house, house people, they are low in education, like this, they work as servants, making ironing, cleaning the house, all things, you see, everything. Here I have to do it all, I've never done this before, really its a big change for me, it took me long long time to learn how to do all these things"

Use of Language

In this section, the GP asks her how she feels and she thinks he has not asked her about

her life. Its as though they are at odds her – she feels she's not been cared about. Maybe something in the way he behaved, rather than what he said conveyed to her that he didn't care.

"They didn't care about this. Just, he gave me the tablets and when I went the next time he told me to come after 2 months and they sent a letter for me and I went there and he asked how I feel, I said ok, he just like – well, I mean, he didn't say – how is your life."

April 5th : Notes on interview 10

This woman spoke about not wanting to fail people by repeatedly telling them she was not ok. She was speaking in the context of her friends, but this made me think about an implication for clinical practice with refugee women – how having outcome monitoring sheets might really put women off as it could put a pressure on them to get better, even if they are not.

Also in this interview, my thoughts about assessment became more concrete. Women have spoken about wanting to have their needs assessed and understood – the assessment itself is then potentially a very therapeutic part of the process.

June 1st MEMO WRITING

Control and Agency

Almost all the women who had taken medication reported feeling worse using it. They related this to tiredness, not being able to function. They all stopped taking it of their own volition and this action seemed to be a part of their recovery. Taking control, having agency seems to be a part of this decision to relinquish reliance on medication. Or rather, they feel worse taking medication because it lessens their agency. They feel tired, unable to act, sleeping all the time.

The women who had lost their role from their working lives in their home country seemed in particular to struggle with the loss of agency that being in the UK presented.

Fearing professionals

Being inarticulate

At first I didn't want to tell him, but with the way he was acting, because he was really worried, I ended up telling him."

This lady was finding it hard to talk to her GP and only let him know about her husband's death because the GP was so concerned. Link this to other interviews.

Not blaming them

"Counselling didn't help because... well, it was like, I never got any solutions. You know, sometimes, when you are in that situation, you want someone to give you something you can hold onto... I mean, the counsellor would just sit and listen to me. I don't blame them, thats how they do it, but at that time you want someone who can just reach out and tell you, no – do it this way, things are going to be better if you do it that way"

In this extract, she states counselling as unhelpful, but is uncomfortable with blaming the counsellor – sees it as a system issue 'thats how they do it'. Why is it so hard for her to say, the counsellor didn't help me?

Maslow's Hierarchy

This hierarchy seems to apply particularly well to the refugee women interviewed. It almost can track the journey of experience, where initial problems are associated with need for shelter – which the lack of status precludes.

Is there a hierarchy to be made for emotional needs in terms of adjusting to life in uk? A hierarchy with meeting someone who can interpret -> learning English -> accessing groups etc. A hierarchy that can take into account the coping and recovery skills / strategies?

June 15th memo writing:

The Fractured Self

Women who had work and clear roles, either work or at home, really struggled with adapting to UK life in terms of the loss of identity – the loss of self.

Systemic Change

"Its like throwing people into a lions den. How can you let someone in and then forget about them for 10 years? How do you think they can survive? A lot of refugees I have heard, have killed themselves because of all this"#10

This lady identifies a benefit in systemic change – the immigration system. Several of the women seemed able to articulate blame towards the home office and immigration system. Whereas, few could speak about blame for MH services. I think my presence affected this – if they blamed health professionals, they were also blaming me.

June 20th 2011: A personal realisation

I have been reflecting on the process from a distance, thinking about how I got involved in this research field – what drew me in. In making my model, I have gone back to the data from a distance, in a way and noticed strong voices from women about how African women are meant to be strong, expected to just cope. It made me think about my own identity as an African women – how so often I expect myself to cope with things, rather than seeking out help. This has had an impact on me. It feels separate to the research, btu something to note about how its not just that I influence the research (in choosing my subject, the questions etc), but also, the research impacts on me.

June 24th 2011: Meeting with participants to discuss theoretical codes and categories

The lady who participated in interview 2, who had talked as if the experiences had not been hers, was again quite protective of personal information in this meeting. Someone asked her how long she had been in the UK for and she said, never mind, its not important. It seemed that she really did not want to reveal too much about her situation, even in that context of a group of women, all sharing about MH issues. I had worried whether this part of the process would be difficult for the women, who may not have wanted to be identified, but I made their participation in this part of it entirely voluntary so that those who felt uncomfortable with identifying themselves as having participated, did not need to.

Appendix 5: Initial, focussed, theoretical codes, categories and extracts

MODEL 1: THE PROCESS OF EXPERIENCING AND COPING WITH STRESSORS

Category 1: Factors Affecting Wellbeing

Theoretical Code 1: Experiencing problems pre-migration

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Loss of control	Experiencing un-located stress	III	"It was a time of a lot of stress, a lot, I didn't know how to act" #1 "situations in life, er , what you go through, in life. I think that's what causes it. Problems that cause stress and you don't have a way to control it"#4 "to be under pressure, so much so that, um, you don't know how to go on with your life, or how to do some things, or how to cope."#10
Fractured attachments	Losing relationships	III	"someone lost a relative and he can't cope with that loss"#1 "I was having a lot of depression because I split up with my boyfriend who I had been with for a long time and it took me down"#2 "My dad passed away when I was thirteen ... and when my little sister was 2, my mum passed away and I tried going back to school, but I couldn't manage anymore" #4 "most people are dying and maybe you've got lots of, there are lots of orphans to look after"#3
	Identifying relationship problems as a factor leading to poor mental	I	"People are really mental when they have problems with family, fighting between mother, father, daughter, son, neighbours, you know"#7

	health		
Facing poverty	Identifying poverty as cause of MH problems	II	"Poverty, really I think that is one of the main reasons why you suffer with mental health. It really brings you down"#1 "If you don't have money, its a very hard time, a very hard life"#6
Facing discrimination	Experiencing persecution on religious grounds in home country	I	"They persecute us. They discriminate us. We felt dreadful. When we applied for our jobs, they wouldn't take us. Life was not that easy. Day to day tasks were difficult. You go shopping, they realise you are not Muslim, they treat you badly, swear at you, you know, you cannot wear a cross and because we're not veiled, they knew we were Christians"#3

<u>Category 1: Factors Affecting Wellbeing</u>

Theoretical code 2: Applying for status

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Loss of agency	Facing uncertainty	IIIII	"I had to flee my country, and without knowing what the outcome will be, well, that makes pressure" #1 "You don't know whether you can stay or if its time to go home. You don't know where you will be tomorrow. #2 "So I don't know whether I will be able to work one day, but I don't know"#4 "You don't know how long your journey is going to take and you don't know where you are going, that's hard"#7 "When you are a refugee, you can sleep anywhere, ok here is a wagon, you can sleep in a field"#6
	Fearing being sent home	I	"You are scared they might send you back ... and for me that was really stressful" #1

	Feeling trapped while awaiting a decision	IIII	"When you go to the HO to apply, you can't go anywhere until the decision is made" #2 "You can't go back home if you want to, they tend to take so much time making the decision and you can't go anywhere outside the UK"#2 "we had to wait for 7 years, my mum and I, before we got the decision. Can you imagine? Every day we were hoping the postman might send us a letter from the HO." #3 "At least if they could have given us a decision we could have travelled... #3 "To be honest, life got a lot more difficult when I came here, but now, I think if I went back home, I'd be putting my children through worse stuff all over again"#5 "just to go somewhere for a holiday and come back feeling refreshed"#3 "In my country, when I was in my country, during the whole year you will travel, I travelled a lot with my family, to America, to Cyprus, to Germany, many times. Each year we would take just 7 days to holiday, to unwind, we changed our lives for that time, it makes a good way to feel better. Here, we cannot do that, we cannot travel, the money."#9
	Feeling passive	I	"We had to do as they said, and there were no guarantees"#3
	Having no status	II	"That is where the problem started, my partner lied to me about having status, so I didn't have status, so my life started, all the problems started then"#8 "Its like throwing people into a lions den. How can you let someone in and then forget about them for 10 years? How do you think they can survive? A lot of refugees I have heard, have killed themselves because of all this"#10
Loss of authority	Being disbelieved and not	III	"The pressure comes when you are talking to someone and they don't seem to believe you,

	understood		that can cause stress" #1 "I could not believe that she didn't believe me, the doctor, I told her my problems and she said I was faking, it was terrible, I didn't know what I could do then and it made me feel worse"#7 "My husband died while I was here and I couldn't go to his family, well, you see, people back home, they don't understand what is happening here"#10
	Having to prove you are telling the truth	I	"you are really trying to prove to them [HO] that this is something that is happening." #1
Perceiving injustice	Perceiving people as faking MH problems for immigration purposes and doctors not recognising this	II	"I know some people, one I saw, who came every Tuesday to collect fresh food here, when she came here she got a walking stick, but if you see her another day she doesn't have it and she come here and say oh I'm sick, I'm sick, I'm that, many things, but if you see her in the stress she would look ok and fine. And the doctors, I can't believe that can't see who is sick and who is ok"#6 "For some people, for so many reasons, they want to be sick or mental, they don't want to be working in this country, they don't want to go back to their home country even when they have had a refusal. You need to follow who is really sick and who is not"#7
	Struggling to cope with HO interviews	I	"The most stressful was the home office … you know, these interviews, everything under pressure, its just too much, you know". #1

Category 1: Factors Affecting Wellbeing

Theoretical Code 3: Facing barriers

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Loss of role	Being unable to work	IIIIIII	"You are not allowed to work, to do this and that. Home office." #2 "I think the career is the most important. Because if someone has a good job, everything, he will feel satisfied and this will improve the mental health, it's all about a person achieving results in life."#3 "my hopes were destroyed when I came here. I couldn't work in my profession, so this affected me"#3 "and there is no jobs, so you have to be at home"#4 "I could not work and I became homeless"#5 "If you are not able to work to survive – well, that's why people kill themselves, you can't find your way, you can't survive, you can't get food to your children, that's what makes people mental"#7 "This is the problem. Here I am not working and it puts me down. In my country I was busy from morning, you see the light going small, you return home, around 6 or 7. Here I have nothing to do, no job, nothing to do. Just sitting. Doing the housework, the whole day, I was really very depressed. Because you see, I was really active before – from doing work all day to nothing. The most important thing in my life, well, it was finished. I used to get up at 5 or 6, not sleep in the afternoon, continue to 10 or 11 o clock. This was my life.""#9 "I got even more depressed with the situation, because you know how degrading it is – because I used to work for myself, I used to do my thing, I was living a good, I mean, I don't want to say we were rich or something, no, we had a good life. But then to come here and to have to start begging for things, I didn't even have a bus fare, it was just ... so ... I don't know. I got even more and more depressed"#10
	Losing professional	II	"Then I was a dentist. I had my career. I was seen as a dentist. But here I am not a dentist. I am not

	identity in the community		recognised as a dentist. My career is not recognised. I can't get a job. This is affecting me."#3 "because work is health, good health. If you are working, being productive, you are doing things to your society, you are feeling good about yourself, this is mental health"#3 "Well, in my country, I was a useful woman – working, now I have no role, nothing to offer.#9.
Facing barriers to finding new employment	Wanting a chance to reclaim professional identity	I	"They should give us an opportunity. They should take advantage of our experience, just a little bit of training and we will prove that we are competent."#3
	Facing barriers to finding employment	I	"I was met with regulations about converting the degree into a recognised UK one, but there were lots of obstacles, exams, and er ... funding... I had not training, no tutors."#3 "I could not work and I became homeless and I couldn't even find food to feed my children"#5
	Feeling disadvantaged by being female	I	"Its easier for men. Life if easier for men here, because they can find a job more easily. Because every job prefers a man really. If you go to work in a shop you need men, because there is lots of lifting, and violence from drunks – there is lifting, so men are more busy and that helps them." #3

Category 1: Factors Affecting Wellbeing

Theoretical code 4: Adjusting to life in the UK

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Worrying as a mother	Feeling loss and guilt for leaving children behind in home country	I	"I had to leave my two children behind, yeah, I had to leave my two children behind with my aunt, yeah, so since then, I've been trying to bring my children over, but its been difficult, that is what affects me a lot, its to think that my other children are still back home and I'm here. We are not a complete family" #4

	Feeling responsibility for children	II	"Everything that affects their life depends on me, its really tough, just the thought that they are all by themselves."#4 "You blame yourself for putting the children through all that"#5
	Constantly worrying about children	III	"You have the constant worry"#2 "I think its worse here (UK) for me because of the fact that I have to live without my children, I think that's the worst part. Yeah."#4 "I think the women suffer the most, because they have to do the looking after a lot, and even, I think that a woman plays a big role in the child's life. They have to look after the children, even though the man is there, but the main role for the woman is to look after the children and it makes you worry a lot actually, you worry a lot."#4
	Doubting the decision to bring children to UK	II	"You think, have I made the right decision, or have I made a mistake"#2 "I don't know if I've done the right thing for me children, so I feel tired, i feel weak, my mind wanders"#5
	Worrying about children because of leaving them in home country	I	"if you have left them you think you have to go back to them, and you can't think. Its difficult to think, yeah."
	Perceiving that own problems will become children's problems	II	"If you are depressed, the child tends to be depressed. The mother is feeling quite lonely, and the child knows it when she comes home; the mother is not smiling, she is just depressed"#2 "they would say to me, mummy, if you are sad, then we are sad. And that was so difficult for me."#5
	Being unable to provide for children	I	"I couldn't even find food to feed my children."#5 "They said they were going to put my children into case, so I would just get very depressed"#5 "you see, my daughter is 10 now, and I was scared that they would take my child from me, when I didn't have shelter of my own for them, and my worry was it was making it worse for my son"#5

Losing social power	Missing relatives	II	"You are missing your relatives, your parents, and trying to adjust" #1 "You know, sometimes I feel to cry, you know, here, no family, no sisters, no cousins" #6
	Being isolated / lonely in the UK	IIII	"if you are in a new country with no friends, its hard" #1 "I felt isolated"#3 "its just well, everywhere you go its just people you don't know, people you've never seen before. Its so hard."#6 "They all run away from me, they just leave me in the hospital, I don't understand anything, I don't have anyone, I'm just there with blood on my body in the hospital, alone"#8
	Having responsibility in the home	I	"You can't just go out and, you can go out – but not like all the time, yes. And well, or maybe meet up with a group of friends outside. You always have to be doing something at home"#4
Facing new hurdles	Struggling with the UK climate	IIIII	"because you know, where you come from your home country, that is very hot. And you just have this tiny thin sweater or whatever, you are not prepared for the coldness" #1 "The weather is so bad, you know, we are surrounded by water"#3 "Its a very hilly area and it has affected my knee. In my country, we don't have hills, we don't have steps at all. This has affected me"#9 "You know trying to adjust to the weather, the food, no friends. PAUSE. Yeah, all those things"#1 "This is the first time in my life I have had to take a bus – I just didn't go walking at home, but here, you run after the bus and you run a lot"#9 "I don't really know all the vegetables here. Actually, in my country each Friday, because it is a holiday, we go to the market, make all the shopping, from the supermarket and the market, chicken, everything. I think, I had 3 fridges, I put all in the fridges and I will divide for the whole week, the cooking for the whole week. It was organised in my country. But here, I buy the vegetables for two days, I put in the fridge – oh, its

			rotting, its all full of chemicals. I put something, you know the green vegetable, oh, the taste is totally different. Because our soil, it is very, well, you can plant things anywhere in my country."#9 "All of this, you find yourself in a different place, a different community, different language, this is what stops you, 100% you cannot find your life here at the beginning"#9
	Struggling with language barrier	II	"To start with the language"#6 "I suffered a lot when I came here because I couldn't understand anything. People would speak to me on the telephone and I had to say, please, speak slowly – because in the telephone they speak so fast. The lack of language really put me down. They speak so very fast. The GP too, and the receptionist in the GP, my gosh". #9
	Experiencing cultural differences	II	"Difference is because in my country, if you know, or don't know someone who walks in the road, you can say help – good morning, good afternoon, in my country"#6 "Even the very close neighbour, said good morning, she didn't answer me, she didn't reply, she didn't even look at me. My husband would say, why are you repeating this, she hasn't answered you – stop. But I said, no, i will not stop, because this is our life, even with my children in the house, its what we do, we say good morning to each other. So I just continued. And you know what – they have become amazing neighbours! You would not believe. If she hasn't seen me for a day or two, she knocks on the door. She has changed a lot. I think before she was scared – they feel that foreigners are no good."#9
	Experiencing racism	I	"Sometimes, the neighbours ask me, where did you come from? They say go back to your country, why did you come here?"#6 "You know, the receptionists in the GP are very bad, they deal with the foreigners in a very bad way. They deal with us totally differently to the local English people. They are polite and nice to the English people, answering their questions, telling them things. To us, they don't speak much at all, they just don't offer information."#9

	Adjusting to systems	I	"In my country, you know, we just don't have this system, we don't have a lot of letters or anything, no one cares about you, if you have money you go to a private hospital, this system here, it is all new, its a new thing to learn and its not easy"#9
Diminishing social status	Losing status and power		"Here, life is ok, but everything you have to do for yourself, especially in the house, you should clean, make the shopping, in my country, sorry to say – but we have servants in the house, house people, they are low in education, like this, they work as servants, making ironing, cleaning the house, all things, you see, everything. Here I have to do it all, I've never done this before, really its a big change for me, it took me long long time to learn how to do all these things"#9
	Facing destitution	I	"I would say that shelter has been the worst thing that has affected me"#5
Feeling disadvantaged on the grounds of gender	Believing that men cope through drinking	III	"Drinking, mmm, PAUSE. Probably they do, quite a few of them (men) I'm sure, quite a few of them do that I think." "Lots of men tend to block out their depression by drinking"#2 "most men I've noticed, the way they deal with their problems, is by drinking"#4
	Believing that coping with destitution in the UK is easier for men because they have wider social networks	II	"I think for a man, he doesn't have to think about, where I'm going to have to stay today. He can go to parties or nightclubs for the rest of the night and then take a shower somewhere else, maybe in town, and he is always having the backpack, so he can go with the friends" #2 "being with their friends, lots of friends, and like women, most women, they are always at home and they don't maybe they don't have friends around. So I think men are better in a way because they find things to do, yes, and they make friends faster than women"#4
	Feeling victimised by men	II	"Men. They will take advantage of you because they know you have nowhere to stay. They will pick up anyone who wants to go with them. So you are a victim. And if you go there you know that ... (SHE

			STOPS)"#2 "Some of the men, you know, they will take advantage of you. So i'd rather stay on my own until I'm through this patch of not feeling good. I got hurt with my children's husband, so I fear it will happen again"#5

Category 2: Experiencing Distress

Theoretical Code 1: Sabotaging the self

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Attacking the self	Wanting to harm self / commit suicide	III	"Its when people want to give up, maybe injure yourself, or even commit suicide"#5 "Sometime I feel like I want to walk in the road because I'm so stressed, angry, irritable, frustrated, miserable actually"#5 "Sometimes I was walking on the road and I thought, if a car crush me – that would be better off. People had no idea what was going on inside, inside I wanted to be gone forever so that these problems would go away, no more pain. Its temporary life, everyone will go anyway, so why wait? Why not go now? The home office, they take everything, but the child – at that time, instead of giving me the opportunity to bring my own child up, but if I am away, if I go, dead, they then will look after the child – he will be safe. If I'm away, they have to look after him."#8 "There was at time that I, well, when I wished to, well I contemplated suicide. And I don't remember what stopped me, but I think it was God"#10
	Isolating self	II	"I just used to sit in a small room" #1 "I think the more you stay at home indoors, I think it all builds up and that's when you start thinking, you think about your country and how your life was, and it just, it builds up, it builds up"#4 "Sometimes I didn't want to go outside, I wanted to stay at home because I was so upset"#6

			"I was a shadow of myself. I wasn't eating properly at the time, I wasn't doing anything. I was just sitting in my house. I wasn't eating."#10
	Blaming self	II	"You start blaming yourself, with things you, you can't solve."#4 "I was going through a lot here as well and when he died I was like, well, I ended up blaming myself somehow. That I shouldn't have come here, or maybe that I should have gone back."#9

Category 2: Experiencing Distress

Theoretical Code 2: Problem Saturated Thinking

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Thinking uncovering feelings	Being consumed with problems	I	"when you are all by yourself and you've got all these things on your mind it eats you up inside and you can't stop thinking about it because it's all in you"#4
	Feeling angry	I	"You get a lot of anger when you start thinking"#4
	Crying	II	"I used to just cry and cry, I could do nothing , I just sat and cried all the time"#5 "I used to cry a lot, when I thought about what was going on I would cry and cry and cry, I felt ill."#8

Category 2: Experiencing Distress

Theoretical category 3: Diminishing sense of self

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Being unable to cope	Feeling unsuccessful	II	"I felt unsuccessful"#3 "Everything changed for me when I came here. I used to be a finance in the travel agency, the biggest one, I was the chief account manager. We were working with, you know, United Nations, international organisations, I

			mainly worked with these people. Here now, I have nothing but housework to do – this is very difficult for me, I feel like I am not a manager anymore, like I am not the success I was"#9
	Feeling out of kilter	IIIII	"Its as if you were swimming against the flow"#3 "Everything is changed, everything different"#6 "I had no idea what was happening, where I was going, where I was even, like it had all been turned upside down, I couldn't concentrate on anything, I didn't know where I was."#8 "From November till February, my depression got really bad, because everything was all upside down. I didn't know, I don't know what was happening – just everything in my life had changed". #9 "When I look back, sometimes I laugh, I laugh, because I'm like, how did I manage/ Because sometimes I would walk like a zombie. You know, I would walk, and I didn't know what I was doing. You know I would go around and someone would say, oh, I saw you in town and I would think, really – wow? How did I get there? I was really, well, my mind was really gone"#10

<u>Category 2: Experiencing Distress</u>

Theoretical category 4: Changing experiences

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Behaving differently	Being unable to sleep	II	"I couldn't sleep, could never sleep, restless" #1 "You can't sleep"
	Feeling tired	II	"Tired."#1 "It wears me. It wears you out"#3
Changing feelings	Having mixed feelings	II	"All I had was these mixed feelings" #1 "Crying, or laughing, when there is nothing to laugh about"#5

	Becoming depressed	III	"Just depressed." #1 "Depressed every time because when you think about it you think maybe the home office will come and take me somewhere." #2 "when you are off your mind, you have depression"#5
	Having low self-esteem	I	"Just low self-esteem" #1
Comparing experience of MH difficulty in home country with UK	Finding MH worse in UK compared with home country	II	"I think it wasn't stress. It wasn't as bad as when I got here I think. If kind of got worse here." #1 "Maybe you were having problems back home, but then you come here and things get worse"#2

Category 3: Coping with Stressors

Theoretical Code 1: Avoiding

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Escaping thoughts about stressors	Forgetting about problems with HO	II	"You know, just forgetting about it really, forgetting about the whole case. #1 "I was still coping because I would tell myself, no – they will give me my papers, things will be ok, let me just hold on a bit."#10
	Forgetting about problems from the past, by degrees	II	"You know, I wasn't thinking about the situation. You know, I wasn't thinking about things. I just stayed back from thinking, this is what has happened. I gradually forgot about it"#4 "I try to just ignore it"#7
	Avoiding the problem through sleeping	I	"if it comes too much, because sometimes it's too much, I try to have a lie down in the afternoon. When I wake up then I've recharged my batteries and I feel refreshed. Sometimes I even say to my kids lets go to sleep, let's go to sleep for 20 minutes. And we all sleep. And then we just get on."

Evacuating from the mind	Self-medicating	I	“I used to drink and smoke a lot to ease depression”#5
Keeping busy	Being active to divert attention from problems	III	“I kept myself busy, looking after my mum”#3 “I would go for a walk in the park to ease stress, you know, get out of the house, keep busy”#5 “I tried to be busy. I became busy, I let my life get busy – not thinking a lot”#9

Category 3: Coping with Stressors

Theoretical Code 2: Utilising Social Resources

Focussed Codes	Initial Codes	N of P’s with initial code	Examples of quotes to illustrate codes
Talking to others in social network	Talking to family in home country	I	“talking to family back home, on the phone, it helps”
	Talking to friends	I	“You call someone, maybe a friend, and you talk and talk” #2
	Coping through talking to family, if family available	I	“Or a relative, if you have a relative”#2
	Socialising with others who have the same problem	II	“To socialise with others who also have something wrong. You can talk to them and see that there is someone else who is in the same situation as you. Maybe it can help you to know that other people have the same experience. And then you will see that ‘I am not alone – there is someone else who is in the same situation” #2 “it helps if you can meet up with people that have similar problems because then you can find er, a solution”#4
	Talking to people you	I	“I think you would only tell the people you trust and those who are close to you. Because otherwise if you

	trust: keeping private		just tell anybody, you don't know whether that people will go talking about you, or go and tell someone else or start laughing at you at the end of the day. "#4 "I don't feel comfortable discussing my MH with my friends, its hard for me to trust people"#4 "You have to be careful who you trust, just be careful who you trust, just don't go trusting everybody, you don't know whether a person is happy with you or not"#4
Offering support to others	Helping others	II	"I always try to help someone else, not just to think of my problems, but to be of use. Yes, you know, it helps me to be strong to help someone else, encouraging someone else stops me thinking about my own problems and it stops me thinking I'm alone with my problems. I think it helps to set an example of how to be strong"#5 "I try now to help other people it they have problems, together we can solve each other's problems, because I know how it is to be poor, I know what its like, so I can help someone else and I think it makes me feel better in myself, if I can help another"#7

<u>**Category 3: Coping with Stressors**</u>

Theoretical Code 3: Utilising personal and spiritual resources

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Drawing from personal resources	Finding own way to manage problems	I	"Just finding my own way. That's what I did." #1
	Not being able to identify method of coping	II	"How do I manage? Um, it just happens. *Laughs*."#8 "I can't tell you that – I don't know myself. I don't know. *Laughs"*#10
	Using inner	II	"I think what makes me strong is that I've, I've been the head of the house for, since I was very young. So I've

	resources		learned to deal with difficult situations"#4 "I am strong. I know I can cope with things"#5
	Accepting the situation	I	"I've just learned to accept, that's the way it is, although I won't stop trying, yes, I won't stop trying. #4
Drawing from spiritual resources	Having faith	IIIIII	"Now I've got church as well, praying, it helps."#1 "We have great faith in God and he always works the best for people. He turns bad things into good things, we believe. What you think of as bad, he might have thought it was the best for you at that time"#3 "I am a Christian, but I think, I pray, and I don't just give up. I always know that even when times are difficult, they will pass and there will be something better. There is a reason for everything in life." #4 "I would pray, then and even now, prayer has helped me to feel stronger. It gives me a little joy within me. Helps me go on another day"#5 "I have kept hoping and praying and saying to myself, if I'm at rock bottom, then it has to get better from here"#5 "I had faith, my bible, when these thoughts came to me I would go to my bible and read and it calmed me down."#8 "All I can say is maybe just the grace of God that saw me through. Otherwise, I don't think I could do it myself"#10 "she asked me one time if I was Christian and I said yes and she would tell em about it, sometimes she would give me a bible, or maybe bring me some gospel music, she even brought a small radio, gospel music, and she would make sure that I was playing it all the time, if she was on duty she would keep on are you listening? You know, if it was playing, it would make me feel better, because it was consoling, make me well."#10

Category 2: Coping with Stressors

Theoretical Code 4: Remembering the self

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Thinking about past life	Remembering home country traditions and language	III	"when you hear someone speak your language, you just have to go and say hello, maybe on the bus or something, it just feels so good to know that you are not the only one here and to hear the sound that you know so well, its really good to speak together"#3 "for me it was important to be able to speak to people in my mother tongue, it made me remember who I am, it made it easier for me to try and keep on going"#5 "I like it because we together made a small community and we try to live in some way like we did at home, this helps me a lot. So if you have something you need in the house and you go and you say to your neighbour may you help me, then they just have to help because they are from your country, your tradition, and that helps, it helps a lot that one. You remember where you are from and it makes it feel a bit better"#7 "She talked to me about things at home. She would say a lot of things. She would bring me things. "#10
	Choosing to deal with past problems	I	"I think for some people, their experiences maybe they might have had, you know, let's say you were raped, you were captured, kept in captivity, or whatever, those kind of experiences, I think yeah, might not just go away, then you would have to be dealing with them, trying to think about them"

Category 2: Coping with Stressors

Theoretical Code 5: Reaching a coping threshold

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Being unable to	Reaching a coping	III	"After some time, I just couldn't handle the pressure

manage	threshold		any more, the home office situation" #1 "I couldn't take it anymore, it took it for about a year, I stayed there for a year and I thought, I can't take it anymore" #8 "I was still coping at that time, until I got a phone call one day saying my husband was killed in a car accident. Then everything went – and I couldn't cope"#10

<u>MODEL 2: THE ENGAGEMENT PROCESS</u>

<u>Category 1: Being Signposted</u>

Theoretical Code 1: Liaising with Lawyer

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Being channelled to GP by lawyer	Feeling alliance with lawyer	I	"I could, because I had a lawyer, I had to you know discuss what this was doing to me and um, that's when I was diagnosed with depression, yeah." "I didn't call a doctor. Then, I think, because I had a lawyer on my side, the lawyer organised everything for me" #1
	Accepting lawyers advice	I	"They (lawyers) transferred me to, or 'referred' me to a doctor" #1

Category 1: Being Signposted

Theoretical Code 2: Social network encouraging engaging

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Hearing from friends	Finding out about charity support group via word of mouth	II	"A friend told me about this place, she said you can come here for food, clothing, shoes, advocacy, for help with the HO."#5 "I heard a lady in the park, she was speaking my language, and she told me about this project and she said, try to come there, its a very good community, you know. So I went there and you know, slowly, slowly, I met other people"#6
	Being signposted to GP by friends	II	"They said, go to the GP, make an appointment and explain everything, tell him what is happening in your home country."#6 "friends would say you have to go the GP, so I went"#7
Receiving introductions	Being introduced to groups	I	"I was introduced to some groups, support groups, where you could meet up with other people that also had depression."#4

Category 2: Seeking Support

Theoretical Code 1: Looking for support for physical health

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Looking for help with physical and practical issues	Wanting practical help with children	I	"It was mainly that I needed help (from GP) for my children, my son was sick and I needed to be able to shelter them"#5
	Requesting police help with destitution	I	"I went to the police station, I said, look at me, I have a child, i don't have status, my partner has taken everything, I don't have rent, where should I

			go?"#8
	Telephoning for support finding shelter	II	"They (the police) gave me places to call, numbers to call, so I called these places, I didn't know what they were, but I needed help, I needed a place to stay, for me and my child to stay, so I called these places"#8 "I tried phoning them (NAS), asking them – where do you want me to go? You know I don't have anywhere and you say that I should go to my home country, but they didn't give me ticket money – how could I go back?"#10 "I was standing out there, with my bags, I didn't know where to go. That's when I phoned them (HO) and said, look, you haven't even given me a ticket, where do you want me to go?"#10
	Finding support online for domestic violence	I	"I went to the internet and I found it, the domestic violence refuge for women. One of my friends had a computer so I went and said, let me see what help I can get. I went and saw a number for women who have survived domestic violence. I rang them and explained the situation. They said, yes, we are ready for you. At last, someone could hear me"#8
Making contact with GP	Visiting GP for health reasons	IIIII	"When I came here I was pregnant, and I had my baby, and then unfortunately my baby died when he was three months old. That's when my GP asked me and they referred me to mental health"#4 "I only went to the GP because I was worried about my son's health, and he looked at me and he said he was worried about me."#6 "I went to the GP because of my son's health and the GP spoke to me and he said I needed counselling"#5 "Originally, I went to the GP for health, I mean physical health, that was why I went there at first."#8 "I started having these terrible headaches so I went to see my GP"#10

Category 2: Seeking Support

Theoretical Code 2: Looking for support for mental health

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Visiting the GP for mental health reasons	Wanting a counselling intervention	I	"I went to my GP and I said, I need a counsellor, I need help"#8
	Wanting help with mental health issues	II	"I had real practical problems, so I thought if I see a counsellor, maybe they can get me a social services or community group or something"#5 "I try to be strong, but sometimes I need help to be stronger"#5 "I explained my situation because I didn't know where to go and what to do"#6

Category 3: Motivating factors for engaging

Theoretical Code 1: Feeling well informed

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Receiving sufficient information from GP	Receiving information about services	II	"the doctor, he explained to me what services they offer and the information that he was going to give me, and I think most of it was helpful"#4 "She gave me a very good idea about where to go, what to do. Because sometimes I didn't want to go outside, I wanted to stay at home because I was so upset"#6

Category 3: Motivating factors for engaging

Theoretical Code 2: Hoping for status

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Finding benefits in MH service engagement	Believing that MH treatment may support case for asylum	I	"I wasn't worried that the home office, in fact, whatever boosted my case, if the doctor decided that I was you know, needing more treatment or needing more care, that this would affect my case as well. That maybe the home office would have worried about that."

Category 3: Motivating factors for engaging

Theoretical Code 3: Mistrust of traditional healers

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Wanting to try a new approach	Feeling ambivalent about the benefits of traditional doctors in home country	I	"One will help you, but another one is bad. You can spend lots of money and say, ok, you will feel good if you do this, or that, but then ... nothing." #2 "They give you something that they take from outside their house. They tell you its medicine and they charge you a lot of money for it. And they do not want you to go to a doctor, they say you will have to take pills for the rest of your life. But its better to try to find out what the real doctor is saying, the traditional one, I think he doesn't really know" #2
	Identifying beliefs that depression stems from witchcraft	I	"Normally it would be someone who casts a spell on you if you suffer from mental health illness. If you have lots of depression, they will say someone has cast a spell on you. Me, I don't know about this. I think it has to be another way."#2

Category 4: De-motivating factors contributing to non-engagement

Theoretical Code 1: Fearing exposure

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Negative perceptions about confidentiality	Fearing identity being exposed	II	"Some doctors, or some nurses will tell your friends or your relatives that you have this problem, and maybe this is someone who you did not tell about the problem. The doctor just says, 'do you know so and so has this problem'. Then you lose trust for the doctors" #2 "If its written in your notes, your GP notes, its not nice"#3 "The nurses call your friend because they knew them, and they said, 'so and so is here because of that and that'" #2
Worrying about being recognised	Feeling exposed by attending	I	"When you go to the clinic then everyone can see that you are going somewhere for MH. Someone could see you entering there. And if the place is for these people only, then when you go in, you might want to look around to check that no one is seeing you entering there." #2
	Worrying about meeting someone who knows you	I	"When you go inside there to the service, maybe you will meet someone you know there. Whether she is in the same situations and she didn't tell you she is in the same situation, maybe she was hiding that, so when you meet her, she feels uncomfortable meeting you there. And you as well, you are not comfortable seeing someone you know in the same clinic." #2
Concerns about immigration status	Fearing immigration issues being discussed and affecting health care opportunities	I	I was scared about discussing my immigration situation in case it affected my NHS ability"#5

	Worrying that a doctor will interrogate about HO situation	I	"You worry the doctor will do something like, ask you lots of questions, like – do you have a right to be here, things like that, something you don't know."#2 "They might ask you things you do not wish to disclose about your life in this country" #2
	Wondering whether GP is connected with HO	I	"All, I know is this doctor, well, I don't know what kind of information she got from the home office in a way"
Wanting to preserve privacy	Keeping problems to self and family in home country	I	"I think its something, yeah, that you would keep private, until it gets worse and you know, maybe your family, they start worrying, that's when you talk about it"

<u>Category 4: De-motivating factors contributing to non-engagement</u>

Theoretical Code 2: Anticipating being misunderstood

Focussed Codes	**Initial Codes**	**N of P's with initial code**	**Examples of quotes to illustrate codes**
Doubting doctors ability to understand	Perceiving that doctors do not understand the real issues behind MH problems	I	"If you talk to the doctors, the doctors do not understand. He understands ok, you have this depression that is caused by this or that. #2
	Perceiving that someone with shared experience understands better than a doctor	I	"It is better to hear from someone who really knows what is happening. Someone who has had a similar experience" #2

Category 4: De-motivating factors contributing to non-engagement

Theoretical Code 3: Not knowing

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Being uninformed	Not knowing the system	IIII	"for somebody who is new in the country, its very difficult to get information"#2 "maybe some of them don't know how to access them, or don't have information about mental health services"#4 "I think not knowing where the service is, because um, unless you talk to someone, and then they advise you, or refer you" #4 "Unless someone does that, or goes and talk to a GP and tell them what they are experiencing, then they won't know anything about mental health. I think its getting more information, because, not everyone would go to a GP and talk about what they are going through, or their problems. They think maybe going to a G is just because you are sick." #4 "When I came here, I was not the first from my country, other people, friends had already come here, so I'd contact them, speak on the phone and they would say, you have to go the GP and I would say, what's the GP? They would tell me, so I went there."#7 "You know, the receptionist, she was terrible – I said to her, I'm sorry I do not understand this like you, I see the description, telling me to tick a box, but I didn't know what this means, I didn't know that you have to tick a box, she was very angry with me. I said to her, I'm a foreigner, I'm not an English speaker, just give me one minute, to explain this to me, it won't take a lot of time for you."#9
Expecting things to	Time in the UK impacting on understanding of MH	I	You are in a new country, you just think, maybe its normal, because I have just come into a new country, yes – some people might think its normal

change	coping / seeking support		to have stress or depression, but it will go away once I have sorted out my situation. Once I just, you know, get used to it.”
Feeling unsure	Not knowing what to expect	IIII	(on visiting doctor) “I had no idea what to expect” #1 (on taking medication) “It was unexpected. Something new” #1 “I didn’t know what help the GP would be”#5 “No I didn’t know anything about GPs, no one advises you.”#9 “(on social worker support) I didn’t know what to expect because this is a new thing for me”#9

Category 4: De-motivating factors contributing to non-engagement

Theoretical Code 4: Avoiding shame

Focussed Codes	Initial Codes	N of P’s with initial code	Examples of quotes to illustrate codes
Being dissuaded by dominant cultural discourse	Identifying shame as a cultural barrier	I	“In our culture it is not preferred”#3 “In our culture, this would mean you are mad. Its not like here, its a different mentality. It means they are mad and they don’t like to be looked at as this, its shameful.”#3 “If a women gets stuck – she feels depressed, but she doesn’t want to go to a service because people will think she is mad and they will look at her with shame”#3 “In my country, it is shameful to say you are depressed. People will say you are crazy.”#9
	Identifying cultural barriers to talking to professionals about problems	I	“I think most people from Africa, I don’t know others, its not easy for them to open up and tell people what they are going through. They rather stay with everything in them. Yeah. #4 “if you just keep quiet, no one will know what you are going through, so I think once, unless they talk

			to somebody or more information is given about MH services, then they feel, you now, uncomfortable to go and talk to someone"#4 "He did ask me what was stressing me and I couldn't tell him. I was going through eviction and all that, but I didn't say"#5
	Having to be a strong women	I	"Talking from a cultural thing, you know, I'm thinking women, because from the way we are raised up, its like, women are meant to be strong, that's the way it is. So i think that might also contribute to women not seeking help. Because as an African woman, you know, you are meant to be strong. You know, you are meant to handle problems"

Category 4: De-motivating factors contributing to non-engagement

Theoretical Code 5: Differing perceptions of self

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Preserving the public self image	Being too proud to seek help	I	"I think it might be that some other people might not want to take that route because they are too proud to accept that they might need help."
Avoiding help to protect personal sense of self	Disassociating from being labelled crazy	II	"I think the term mental health, in a way, you know um, talking from my background, it might you know, maybe in this country it seems normal. But where I come from, the term mental health, you know is just, somehow you just, the thing that comes first in my mind is maybe I'm going crazy"#4 "No one took tablets for depression in my home country. Something like depression, you would not even hear the word in my country"#8
		I	"In our country, only mad people seek psychiatrists. Only the mad ones, doing things that are funny. Nobody goes to a psychiatrist because of depression"#3

Category 5: Deriving benefits

Theoretical code 1: Benefiting from medication

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Perceiving medication as helpful	Feeling benefits from medication	II	"I was prescribed depression pills, which I'm still taking now"#4 "I thought I would try the tablets because I knew what I was going through. And when I tried, it helped me, because at that time, my son was a baby, and so they, the tablets, they helped me get back to sleep, and then when I went off to sleep, he could sleep. It helped me to calm down"#8

Category 5: Deriving benefits

Theoretical code 2: Feeling listened to

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Valuing being able to talk to a professional (counsellor)	Appreciating being able to talk	IIII	"Um, I would say, just talking about it. Talking about the feelings I had, it just helped ... I think when you talk about things, maybe your emotions, you feel like you, if you opened up to somebody, it helps talking to somebody." #1 "When you talk it out, it gives you that ... well, you feel comfortable" #2 "You need lots of counselling and support"#2 "When you get counselling, maybe every week or month, you know that you are stress free for that moment. You have someone to talk to when you have the actual problem. That person is like a relief" #2 "When you talk to someone then it all comes out and you feel much better"#4 "It was good, it was counselling at the GP. They

			didn't come often, they would give you an appointment date and they would meet you there, one time in two weeks and you could just talk with them, she helped, we talked about things, my life in England, she would give me advice, talk to me. I think if I'd gone on with the counselling, I'd not have needed medication, but I moved city, so it had to stop"#8
	Believing counselling is better than only using medication	I	"Counselling is better than only taking tablets"#2
	Benefitting from follow up care	I	"Just to catch up. To find out how I was feeling and whether I was better, or whether there was something else they could off me. Yeah, just knowing that there si someone out there who can listen to you and who can help you going through what you are going through"#4
	Valuing the privacy of home visits	III	"they even came to my house sometimes when I couldn't come to the office. They came to my house and er someone would call me and find out if I am ok. And ask me if am doing anything and that I should just, encourage me, not to keep to myself all the time, and maybe go out more, meet up with people more. #4 "The thing that really helped me to keep alive I think I could say was that the lady, she came to my house to visit me, you know, just to check on me, to see how I was doing, how I was getting on, that was really a big help."#3 "She visited me every week, she came to my home, that was the best thing of all. If she didn't come she would send someone else. She was amazing. It helped me to know someone was really there for me and because she came to my home, I was free, no one to listen, no one to judge me or to talk about me, just me and her."#8

<u>Category 5: Deriving benefits</u>

Theoretical code 3: Feeling understood

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Feeling understood during assessment	Deriving benefit from use of monitoring sheets	I	"It was some sheets, with, he would say how you, you should write down how you were feeling at the time, or if you were hearing voices, you know, or when you start thinking of something, when you start worrying" #2
	Being understood by social worker	I	"I got one social worker who understood life. She was amazing. She doesn't think about the paperwork she is doing, she thinks about what I am going through, she thought about protecting my son. You always get one person who is good. To help me, to help the child, thats what she did. She was amazing, she really understood what I needed, she understood me. It felt so good and it really saved my life, she saved my life that one woman. She sat down and listened to me, she didn't go with the status"#8

<u>Category 5: Deriving benefits</u>

Theoretical code 4: Increasing social network

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Benefiting from group contact	Knowing you are not alone	I	"knowing that you are not alone..."
	Knowing others are worse than you	II	"...that there are also other people that have worse depression than you"#4 "when you sit and talk to a group of people and find out that they have all got more on them than you, then everything lightens up"#4 "it helps to see when others are worse off than you, to know you are not the only one going through certain difficulties, I mean, to know that people get

			through worse"#5
	Finding different solutions to problems by being in a similar group	I	"It helps if you meet up with people that have similar problems, because then you can find er, a solution, mmm, yeah, you can try and find a solution. And maybe try different things"#4
	Deriving benefit from social contact	II	"when I started coming here, I found that you can just sit with friends, and just talk, have a laugh and that can really ease stress, you can talk about problems, share the problems, I think that helped me a lot."#5 "When I come here, I feel I'm in a family, for me [the director] is like a second mum, if God asked me to give her a year from my life, I would give it to her, how she helped me all the time, she looked after me as if I was her daughter, or her child. #6 "I come here three times a week and if you go out you are more like, comfortable, you know, you meet new people, different people from different countries, you know, talk to them"#6

Category 5: Deriving benefits

Theoretical code 5: Feeling supported

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Valuing practical support from NGOs	Receiving support in HO application		"they (NGO) have helped a lot. When I got problems with the HO, you know for the papers, they tried to phone them to explain about my family, my children, my husband, they explained how we can't go back home and you know, the mental state"#6
	Receiving practical and financial support	I	"they (NGO) were helping me financially sometimes, they helped me do a lot of things that I couldn't do on my own. Because at first I couldn't register with the GP because they were asking me for things I didn't have. They helped me with that. They also helped me if I needed, well, like if I needed bus fares, they helped me with a lot of things"#10

Valuing counsellor input	Learning that there are ways to think differently about situations	I	"It really helped a lot to know that, you know, its not just the problems that you have all the time, there can be a solution, even if you can't solve it, but there are ways to avoid thinking a lot and being stressed all the time"#4

Category 6: Feeling dissatisfied

Theoretical Code 1: Experiencing negative consequences with medication

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Perceiving medication as unhelpful	Feeling worse with medication	IIIIIII	"They seemed to make me worse actually. I was just tired." #1 "I think they make it worse"#3 "I felt so much worse with the tablets, I couldn't do anything, I was just this thing, I was not me, it was really bad with those tablets"#5 "The tablets were terrible, they really made me suffer, tablets just kill you, they kill you, totally"#6 "I found that when I took the tablets I got more sick, more angry"#7 "After a while, with the tablets, although they helped me at first, it made me feel drowsy, so feeding time for my baby, it would run late, yes. Sometimes I had to change the nappies, it would run late, it really took a long time to do the nappy, because I would need to go to bed, I was really sleepy from those tablets."#8 "They made me feel worse"#9
	Feeling ambivalent about medication	II	"well, the tablets on themselves, well, they helped in a way that I ... although I ... still felt sleepy, but I wasn't thinking, yeah, thinking about my situation, it kind of got blocked out. So I was like this baby" "Well, it was on and off and still because I would think, what's the point? Sometimes I would wake up

			and think maybe these tablets can help me get back my old self, but other days I would think, I don't want anything, I don't want to see anyone or do anything, i would close the windows, until, when I would wake up and maybe feel a bit letter so I would say, ok, let me take my tablets. So it was like that."#10
Holding negative perceptions of medication	Anticipating being on medication for long periods	II	"if you have to live with a tablet everyday, its not ok"#2 "I think they make it worse, because you can get addicted to tablets"#3 "I just imagine being this person just surviving on tablets without anything to look forward to. You're just this floppy thing. Then you know, you could go on for 5 years like that". "If you are taking tablets for MH, its a lifetime"#2
	Rejecting medication as a solution	IIII	"Mental health is not about taking a pill" #2 "I don't believe in medication"#3 "I just threw the tablets out"#7 "I took them for 10 days, then I stopped because it made me feel tired"#9 "I just couldn't see any reason why I had to you know, go on with them (medication)" "I was thinking, like, well, what's the point? I will take them and then things will still be the same."#10

<u>Category 6: Feeling dissatisfied</u>

Theoretical Code 2: Wanting increased interaction

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Finding counselling unhelpful	Wanting a counsellor to do more than listen	IIII	"She didn't offer any solutions. She just listened. She didn't interfere or anything and she didn't offer any solutions"#3 "I only know about counselling, which, but, they don't

			offer you any solutions to your problems. They just hear you. So what is the use of it?"#3 "the person doesn't say anything, they are just listening to you, and you don't know whether, you know, how to feel, so maybe if there was better counselling, I don't know."#4 "counselling is OK, but really the help I needed was practical, word is comforting, but action is what is important"#5 "Counselling didn't help because... well, it was like, I never got any solutions. You know, sometimes, when you are in that situation, you want someone to give you something you can hold onto... I mean, the counsellor would just sit and listen to me. I don't blame them, thats how they do it, but at that time you want someone who can just reach out and tell you, no – do it this way, things are going to be better if you do it that way"#10

<u>Category 6: Feeling dissatisfied</u>

Theoretical code 3: Having unmet needs

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Experiencing insufficient practical support	Perceiving hospital support as unhelpful	I	"The only people that could have helped, at the hospital, but they weren't much help"#3
	Perceiving social support interventions as unable to help with overcoming internal issues	I	"I mean, you can go to any woman's group and talk to people there, but you need someone to really help you overcome what is inside you. Just sitting with women and talking isn't really helpful"#3
Feeling passive	Receiving medication from GP without understanding it	II	"I was prescribed medicine. Anti-depression or something." #1 "She said you need to take some tablets because your mind is gone, I thought maybe she was right, because she was a GP, a doctor, she had finished lots of

			school"#7
	Receiving diagnosis	II	"I was diagnosed with depression, yeah ... all I got was a letter" #1 "I was happy that you know, that the professionals would diagnose whatever it was, because by then I think, I didn't know anything about it. All I had was these mixed feelings" #1
	Not having a choice	II	"I had to go and see the doctor and she prescribed em the anti-depressants and I just started taking them" #1 "I have to take lots of tablets, it's very frustrating"#4

Category 6: Feeling dissatisfied

Theoretical code 4: Feeling uncared for

Feeling ignored	Not being followed up	IIII	"I think that even when I stopped taking the tablets she didn't realise that I had stopped coming, maybe I should phone my patient, write to her, to find out why she has stopped."#3 "They are not interested in whether you follow what it said on the packets"#4 "the doctors do not know what is really happening to you"#2 "They didn't care about this. Just, he gave me the tablets and when I went the next time he told me to come after 2 months and they sent a letter for me and I went there and he asked how I feel, I said ok, he just like – well, I mean, he didn't say – how is your life."#8

Category 6: Feeling dissatisfied

Theoretical code 5: Facing difficulty making use of services

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Being unable to	Being unable to articulate problems	II	"He asked me many questions and I was really not interested in anything. I became, you see, I was

connect	to GP		fed up of everything, I could not speak."#9 "At first I didn't want to tell him, but with the way he was acting, because he was really worried, I ended up telling him."#10
	Struggling to find the words to express the difficulty	I	"I don't know how I can describe it... I don't know how to describe the feeling I had." #1 "I'm just like happy for 20 minutes, and the rest is just, I don't know what it is. Whether its maybe the responsibility, or maybe, its um, I don't know. I don't know what it is, but yeah."#5

Category 7: Disengaging

Theoretical code 1: Rejecting services

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Leaving with disappointment	Stopping contact with GP	II	"I just stopped going to the GP. I just stopped, yeah. It wasn't helping, the GP wasn't interested in me"#1 "It was awful, going to the GP was like going to war, she said I was pretending just to get a passport, i said – look, I already have a passport, she said a lot of things and I said I was going to complain, I went to the deputy of the local area and I complained. I got a new GP" #7

Category 7: Disengaging

Theoretical code 2: Wanting to progress

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Feeling ready	Wanting to recover independently	II	"It will go away, but its also up to me, to , to try and face it every day until it goes away."#8 "I just felt it in me, I just wanted to see how I would get

			along without seeing them. And I have been fine."#4
	Feeling like a burden	I	"I remember one time, one person, it was a doctor, he came in, he was just, well, I mean, I only saw him once in that place, I never saw him again. He just walked in, just looked at me, didn't greet me, just looked at my notes, then just wrote something down, he asked me, 'have you taken your tablets, how do you feel?'. I told him, but I was talking slowly. He said ma'am, I am talking to you, how do you feel today. I said, I told you – I'm not feeling better. And then he just walked out. It made me feel like, you know like I was bothering people, like I was a burden, because I was already feeling that way, because I was going around to people saying I need money for this and that, I just felt I was bothering everyone, burdening them."#10

Category 7: Disengaging

Theoretical code 3: Feeling unable to connect

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
	Facing difficulties again when the intervention is over	I	"Of course, you would have company, but still then, when you walk back home, you are going to be alone.
	Struggling to express the real situation	I	"sometimes I would just keep quiet and not tell the counsellor anything, because it would get to me as well. You know, at the time, I thought to myself, actually, something has to be done ... I felt the counsellor was not helping."

Category 8: Deciding to Cope

Theoretical code: Drawing on personal and social resources

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Fostering resilience as a mother	Instinctively supporting children	IIII	"Trying to provide for the children"#1 "I think as a mother you have this internal instinct whereby you wanna provide for your kids"#2 "I have decided to be a mother and a father to my children"#5 "now I have children, and I have to do something for them. They have to grow up, I have to give them an education. "All that I do, I am doing for my son, just to support him, that is my duty, it is my life, I have to try to make everything ok for him, I have to support him to grow."#8
	Having to stay strong	III	"Trying to be strong again for the children" "I had to try and make myself smile for them, just for them, even when there was nothing left in me, I had to smile. I do that using strength, faith and hope."#5 "well, I said to myself, I am a mum, there for someone, holding someone's life, and he was innocent, and so I thought, let me help myself, so I can help him."#8
Gaining strength through children	Being together with children	I	"You've got your kids with you. So whatever happens, you are all together. That's probably the main beneficial thing."
	Feeling stronger from being with family unit	I	"you are not worrying about your kids – if you had left them, you are all together and that makes you feel more strong, you have to go one for this" #9

<u>Category 9: Recovery</u>

Theoretical code 1: Utilising personal resilience

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Regaining agency	Taking control	II	"You know, I got over my situation" #1 "I just thought, let me manage by myself"#7
Exercising resilience	Being strong	I	"I don't know what else could have happened to me, but I was strong enough to fight. I might have gone mad or something otherwise"#3
	Focussing on positives	I	"I don't focus on the problem, or the situation, because it is there. I just have to try to, you know, try to see what is good in my life and let that make me step on"#4
Believing in self	Following GP advice to not pursue medication or counselling	I	"I went to my GP and said to him I need a counsellor, and he looked at me and he said no – you don't need it. I actually thought at the time, no – I really need it. I was having depression tablets before and i wanted to ask for more and he said no – think about the little one. So later, I thought, maybe what he is saying is right. If I take those depression tablets, it will make me feel ... low, and I won't be able to take care of the little one in the way that I want. So I said, maybe he is right, let me go with what the doctor is saying and make myself strong and help the little one." #8
Taking sequential steps to recovery	Recovering step by step	III	"Slowly slowly, I started to get my life back, just one thing then one thing"#6 "it was just slowly, slowly, I did it little, little and that was possible for me."#5 "I started step by step, that is how I did it, step and then step, thats all."#9 "I'd say I've found myself, but not 100%... now at least I can do things the way I want to, when I want to, but emotionally of course, well, maybe I'm still healing, I don't know, thats why I think the papers didn't help. All in all, I haven't gone back to my own self. I haven't gone back to that old me. But of

			course, I'm better now, I'm far much better than what I was. But there are times when I feel down, but even when I feel down, I don't go back to the bad place."#10
	Prioritising steps to recovery	I	"The music helped, singing the gospel, and then reading the bible too, I would say after that the counselling was helpful, but the last was medication, medication last. That was the order of things."#8

Category 9: Recovery

Theoretical code 2: Increasing social network

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Growing stronger through relationships	Being joined by family/ forming a family network	II	"I think by then I had a family. My sister joined. My sister in law joined us."#1 "you know. She was there and it helped me to know what to do. I just used to sit in a small room, and it was better when she was there."#1 "I was surrounded by people who loved me, my family was there for me" #2
	Receiving support from friends	I	"I also have some friends and I sometimes call one of them and I talk and talk"#2
	Connecting with home community	I	"in my opinion, it is better to go to communities, like to be with other people from my country, they can help you with simple things because of the language, like how to find the GP and the post office and all these things, its a big help actually"#7
Increasing language aptitude	Increasing ability to engage socially	III	"Slowly, slowly, I went to English classes, and I started to, to do something"#6 "I started to learn English and this really made a big difference, a big big difference, I could start to do things for myself"#7 "The first thing I did was that I started to go out to English lessons, this was a good idea for me"#9

Sharing with family and friends	Being understood	I	“Family or friends already know you have this problem, so she will be obviously there for you.” #2

Category 9: Recovery

Theoretical code 3: Awaiting recovery

Focussed Codes	Initial Codes	N of P’s with initial code	Examples of quotes to illustrate codes
Hoping to re-find self	Feeling hopeless about full recovery	I	And you know, what I used to feel, I don’t know if I’ll ever get that back again. I have changed totally. I no longer have that, you know, the way I used to feel about life, I don’t know if I can ...”#10

Category 9: Recovery

Theoretical code 4: Receiving status

Focussed Codes	Initial Codes	N of P’s with initial code	Examples of quotes to illustrate codes
Impact of receiving status	Feeling happy about status decision	I	“After a few years I got indefinite leave to remain here, I was so happy.”#6
	Internalising UK culture	II	“if you, well, people they say that if you have been here for a long time, then you become different. My friends, they say I have changed, that I am more patient. People say, you are different now – shame – you just put up with this crying of your children, its say, it ok, things are different. “#7 “When I came to this country, I educated myself, I know more now, I have benefited from this country”#8
	Having more rights in UK than in home	I	Here, you have more rights, in my country you have no rights at all, you may have enough money to go the university, but still you will not get a place,

	country		because the government, they keep their family there. Here, you feel more comfortable, more yourself. In other countries, you can't even find water to drink.
	Not feeling happy about status	I	"Actually, I cried, I wasn't even happy about it. I asked myself, was it worth me going through all this? Why did I have to go through all this? Why did I have to lose myself because of this? So I wasn't really happy. Some people scream and celebrate. But for me, nothing has changed. I'm ok now, but there are times when I sit down and I start thinking about all those things that I went through, and it all comes back."#10 "the only difference is that for now, I can do what I want to do, but that won't bring back what I've lost. I lost so much n that process."#10
Appreciating benefits for child	Feeling good when child is comfortable	I	"I feel comfortable – when my child has a place to run about and I can see that he is safe and he is well, then it makes me feel comfortable." #8

Category 9: Recovery

Theoretical code 5: Finding meaningful activity

Focussed Codes	Initial Codes	N of P's with initial code	Examples of quotes to illustrate codes
Finding employment	Feeling better with work	II	"I managed to get a job, which kept me going." #1 "when I got a job, things started to improve" #3
Facing reality	Coming to terms with reality	II	"Well, this was just myself, I didn't consider myself ill. This was all the things together putting me down. When you realise that this is your life and you have to adapt for everything, well, it took me time to do that. A lot of time to believe that was my life."#9 "Well, at first actually, I didn't really take much notice of it, when they told me I was like – these people, they must be joking or something, its not possible, because I was still in their accommodation. When they told me to leave their accommodation, well, other people, they were saying, that's just what they do, relax. But on the day they kicked me out

			and locked the doors, that's when it all dawned on me – this is really happening."#10

Appendix 6: Ethics Approval and Summary Letter

Ethics Approval has been removed from the electronic copy.

Summary Letter

Dr M.M. Callanan

Chair of the Salomons Ethics Panel

Department of Applied Psychology

David Salomons Estate

Broomhill Road

Southborough

Tunbridge Wells

Kent

TN3 0TG

15th July 2011

Dear Dr Callanan,

I am writing to provide a summary of my Major Research Project, which you approved on 10 March 2010 and has now been completed.

Ten refugee women were interviewed. The data were analysed as planned using Grounded Theory and for quality assurance purposes, my identification of codes and categories were presented to both my supervisors and to a small group of participants, and their suggestions discussed until agreement was achieved.

The analysis led to the construction of two theoretical models. The first model is of refugee women's process of experiencing and coping with distress. The model proposes that refugee women experience distress arising from stressors experienced in the pre and post migration phase, with an emphasis on the latter. The model indicates how women then employ a range of coping strategies, up to a point where they reach a coping threshold and feel they can no longer manage. The second model applies after this point as it considers the process of engagement. This is a multi-factorial, dynamic model to capture how women's decisions about engaging were influenced at various stages in the process by their culturally defined pre-conceptions and their experiences of mental health services in the UK. Women's main reason for engaging and continuing their engagement with services was driven by desires for social and material demand satisfaction. The study concluded, from a Clinical Psychology perspective, that therapeutic work with refugee women might benefit from partnership between mental health services and non-statutory refugee support agencies.

Please note that information sheets were amended to reflect that participants could 'opt for' a report.

Many thanks for your interest in my project.

Yours sincerely,

Trainee Clinical Psychologist

Salomons Campus at Tunbridge Wells, Canterbury Christ Church University

Appendix 7: Coded Interview Transcript

This has been removed from the electronic copy.

Appendix 8: Submission Guidance for Journal of Refugee Studies

Instructions to Authors

1. Submission of articles
Articles must be in English and should be sent by email to: jrs.editorialoffice@oup.com.
Authors may not submit articles under consideration for publication elsewhere. The preferred maximum length is 8000 words. Shorter articles can be considered, e.g. for the Field Reports section of the journal. Authors will normally be notified of the editors' decision within three to six months.
2. Preparation of articles
Please note the following requirements:
1. Your manuscript should be in Word or RTF format.
2. Figures and tables should be submitted as separate files (please see 4. Tables and Figures for more information).
3. A separate file should be submitted as your title page, containing the manuscript title, names and affiliations of all contributing authors, and contact details for the Corresponding Author.
4. Include an abstract of approximately 150 words as part of your manuscript main document.
5. The journal does not accept PDF files.
6. Pages must be numbered.
7. For the purposes of double-blind review, we request that you suitably anonymize your manuscript and remove any selfidentifying information (this can be inserted/adapted at a post-review stage). You should also check the properties of the files you are submitting to ensure that your name does not appear in them. Failure to do so will not affect the processing of your paper, but it does mean that the journal will be unable to guarantee you a double-blind review.
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9. Two levels of subheadings are used: the first in bold and the second in italic. Subheadings are not numbered or lettered.
10. References should confirm to the journal's style (please see 5. References below).
11. Provide a cover letter (in Word/PDF format) to accompany your manuscript submission. Your covering letter should include the following statements:
a. I confirm that the attached manuscript is suitably anonymized and includes no references to my own previous works.
b. I confirm that I have read the Instructions to Authors and that my manuscript complies to the journal's submission guidelines.
c. I confirm that the manuscript has been submitted solely to this journal and neither the whole manuscript nor any significant part of it is published, in press, or submitted elsewhere in any form, including as a working paper, online, in a journal or a book.
12. Once you have ensured that you have met all of the above requirements, please submit your article by email to jrs.editorialoffice@oup.com, for the attention of the Editors.
3. Dates
Because of the dynamic nature of many refugee situations, authors are requested, when relevant, to indicate clearly in the text when fieldwork was carried out. At the end of the paper, note the approximate dates when it was written.
4. Tables and Figures
These should be comprehensible without reference to the text. They should be submitted as separate electronic files, one for tables and one for figures, with the desired position of each table and figure indicated in the text. For the style of tables and captions to figures, see papers in the journal's current issue. A resolution of 600dpi is necessary for electronic versions of figures. If colour figures are provided, they will only appear in colour in the online version; if different colours are used to make distinctions, these distinctions may not show up in the black and white printed version.
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