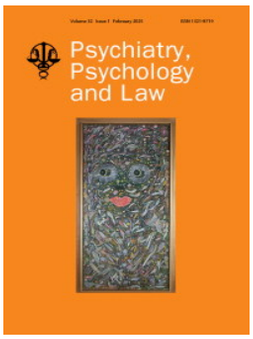

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The experiences of undergoing medico-legal assessments when seeking asylum in the UK: an interpretive phenomenological analysis

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Asylum-seekers who have experienced ill-treatment often undergo a clinical assessment for the purposes of having a medico-legal report prepared for use as evidence in their claim for asylum. The literature suggests that while this assessment process may act as a stressor, it might also provide therapeutic benefits. The study employed interpretative phenomenological analysis (IPA) to explore the lived experience of asylum-seekers who had undergone assessment for the preparation of a medico-legal report. Three superordinate themes emerged from the data: (a) uncertainty – the tension between negative and positive expectation; (b) the pain of having to share and remember; (c) therapeutic impact. The assessment process was psychologically distressing. This distress was mitigated by particular components of the process that appeared to hold therapeutic benefits. These findings have important clinical implications for clinicians carrying out assessments with asylum-seekers and highlight the need for trauma-informed approaches to care within the UK asylum system.

Keywords: Asylum-seeker experiences; clinical assessment; interpretative phenomenological analysis; medico-legal report; trauma.

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Introduction

The asylum-seeking process as a post-migration stressor

A refugee is someone with a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' who is 'unable or unwilling' to return to their country of origin (United Nations High Commissioner for Refugees, 2019, p. 18). When seeking asylum, the applicant must provide an account of persecution or threat of persecution in their home country and why this leads to a 'well-founded fear of return'. This process is often immensely challenging and can be experienced as a significant 'post-migration stressor' – that is, a psychological stress associated with the difficulties of resettling in a new country (Jannesari et al., 2020). Along with other post-migratory stressors inherent in the asylum-seeking process, including cultural dislocation and lack of social support, the challenges of the asylum claim often compound pre-existing mental health difficulties related to a history of ill-treatment (Gleeson et al., 2020).

The medico-legal report (MLR)

Where there is a history of ill-treatment (the term 'ill-treatment' is used here to refer to

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torture and other forms of abuse prohibited by international law, including inhuman, cruel and degrading treatment; International Committee of the Red Cross, ICRC, 2005) and indications of psychological trauma, the asylum-seeker's immigration lawyer may instruct a clinician (a psychiatrist, a doctor with other medical expertise or a psychologist) for a forensic evaluation and report, referred to as a medico-legal report (MLR). The importance of the MLR as evidence in asylum claims is internationally recognised as the content and conclusions of such expert reports can make the difference between being granted or refused asylum (Tullio et al., 2023). The clinician takes a detailed history of the asylum-seeker's experiences while documenting the mental health and/or physical sequelae of exposure to human rights violations. This includes assessing for psychiatric disorders, such as post-traumatic stress disorder (PTSD). The evaluation is performed through clinical interviewing, which may be supplemented using standardised questionnaires. Where relevant, a doctor may also carry out an examination of any physical scarring reported to be the result of ill-treatment. The assessment is an invasive process, given that the asylum-seeker is expected to disclose the details of their trauma, and, when physical scarring needs to be documented, they are also asked to have their body examined by the clinician and provide them with causal attributions to their scars. Clinicians are expected to follow the (recently revised) international guidelines for the documentation of ill-treatment provided by the Istanbul Protocol (IP; UN Office of the High Commissioner for Human Rights, 2022).

The evaluation process: a post-migratory stressor or a therapeutic opportunity?

The evaluation process as a post-migratory stressor

It requires 'enormous trust and courage to allow yourself to remember' (van der Kolk, 2014, p. 58) in the aftermath of severe trauma. This is particularly challenging within a legal context, where the veracity of details of one's trauma is scrutinised critically. Traumatised asylum-seekers are a vulnerable group, and many require time to establish trust before feeling able to share the potentially painful and shaming details of their experiences and to process their trauma (Bögner et al., 2007; Schock et al., 2015; Tullio et al., 2023). This need is undermined by the process of claiming asylum, in which asylum-seekers are expected to disclose all details of their traumatic experiences to multiple professionals, whom they are meeting for the first time. Research investigating the experiences of asylum interviews (government interviews forming the basis of an asylum claim) found that: the process is felt as shaming and stressful, being confronted with traumatic memories aggravates symptoms of PTSD, and stress related to the interviews has a detrimental effect on the processing of the trauma and on the process of recuperation and recovery (Bögner et al., 2007; Bögner et al., 2010; Li et al., 2016; Schock et al., 2015).

The MLR assessment process differs significantly from that of asylum interviews. While the assessor is an independent expert and must remain neutral, they have been instructed by the asylum-seekers' solicitor and so there is a reasonable expectation that the assessment will help their claim. The IP provides specific guidance to assessors to reduce the risk of retraumatisation (emotional and/or physical traumatic stress reactions triggered by exposure to reminders of past traumatic events), and clinicians should have received training in trauma-informed assessment. Clinicians conducting forensic evaluations of asylum seekers have cited their trauma-informed interviewing skills as helping to manage risk of retraumatisation during the assessment (Akinsulure-Smith et al., 2023; Baranowski et al., 2018). However, such assessments, which require detailed recall of trauma, might also act as a post-migratory stressor. The assessment process may undermine the post-traumatic avoidance strategies that many asylum-seekers adopt and which

can serve an important protective function, particularly at a time of instability. Herlihy and Turner (2006) suggest that avoidance initially functions as a 'survival strategy' and reported that many refugees stated they only managed to escape persecution and cope with migration by consciously avoiding thinking about their traumas.

Psychotherapy views reduction of avoidance as a central mechanism of recovery from trauma (Varra & Follette, 2004). Post-traumatic avoidance perpetuates intrusive symptoms, and successful processing of trauma depends on being able to access and assimilate trauma memories (Bisson, 2009). However, such avoidance reduction should be managed at a clinically appropriate pace, planned and with support. In contrast, during the asylum process, the asylum-seeker's avoidant defences are broken down in a way that can reinforce trauma, provoke intrusions such as flashbacks and hinder their subsequent ability to process the trauma (Schock et al., 2015; Tullio et al., 2023). The MLR process therefore presents a difficult 'double-bind', whereby the individual is caught in a dilemma between having to recall their traumatic experiences, which may cause distress, or not recalling the details of their trauma, which risks compromising their claim.

Traumatic experiences can hinder the ability to form and maintain trust. For traumatised asylum-seekers, placing trust in others is difficult and risky, and dominated by expectations that the trauma will be repeated (Bögner et al., 2010; Guasto, 2014). Time must therefore be allowed for engaging asylum-seekers and establishing a connection (Ehntholt & Yule, 2006). While the IP highlights this challenge in developing trust and emphasises the imperative to establish a rapport with the asylum-seeker before asking sensitive questions, this is restricted by the time constraints of the assessment process. Furthermore, the professional relationship between clinician and asylum-seeker in this context is not a therapeutic one. The clinician is assessing for legal rather than therapeutic purposes and has a duty to be impartial, meaning that trust may be compromised. Assessing clinicians have observed that asylum-seekers' past experiences of ill-treatment perpetrated by people in positions of authority and a (false) assumption that the clinician is able to decide whether to grant them asylum both impact the asylum-seeker's capacity to trust them (Baranowski et al., 2018; Tullio et al., 2023).

The evaluation process as a therapeutic opportunity

Whilst development of a therapeutic relationship is contraindicated in forensic evaluations, it is suggested that the clinician's training allows for more complete information to be obtained, and that organising the history of trauma into a coherent narrative, with attention to its psychological effects, holds therapeutic benefits (Baranowski et al., 2018; Gangsei & Deutsch, 2007; Sidhu & Shadid, 2022).

The evaluation process can be seen as an act of 'bearing witness'. Bearing witness and affirming asylum-seekers' histories is the first step towards restoring their voice and empowering them in their healing process (Gautier & Scalmati, 2010; Herman & Harvey, 1997; Patel et al., 2016; Ullman, 2006). Research indicates that lack of social acknowledgement of traumatic experiences increases risk of developing PTSD (Brewin et al., 2000; Schock et al., 2015). For many asylum-seekers, the assessment may be the first time that anyone has affirmed their experiences and acknowledged the psychological consequences. This may be a validating experience that helps the asylum-seeker to link their trauma to distressing symptoms (Fisher, 2017). The asylum-seeker not only is reporting a factual account but is also being asked to describe its emotional impact, which, with the support of the clinician, provides an opportunity to contain and process the emotion, and to provide the asylum-seeker an experience of feeling understood (Reis, 2009). Since avoidance often prevents asylum-seekers from seeking

professional help, the assessment might provide a therapeutic experience of remembering the trauma and encourage them to seek further support.

Whilst there is existing literature based on the experiences of clinicians undertaking forensic assessments (e.g. Akinsulure-Smith et al., 2023; Tullio et al., 2023), to our knowledge there have been no studies to date exploring the lived experiences of asylum seekers undergoing an assessment to have a MLR prepared in support of their asylum claim. This study aims to help establish whether the assessment process serves as a further post-migratory stressor or whether it holds therapeutic benefits, and to delineate the determinants of a therapeutic or distressing experience. This is important in order to consider the ethical issues inherent in the assessment process, including the risk that it is itself harmful (Tullio et al., 2023), and help clinicians to mitigate the risk of causing further distress and to promote recovery.

Method

Design

The present study employed a qualitative approach, using interpretative phenomenological analysis (IPA). IPA explores the 'double hermeneutic' – that is, the two-stage interpretation process examining the meaning participants attribute to their experiences as well as the researcher's interpretations of this meaning (Smith & Osborn, 2004). IPA is a dynamic process that permits salient domains of experience to emerge from the data rather than imposing assumptions about participants' experiences (Smith et al., 2009).

IPA was deemed to be a suitable method for this study, which aims to prioritise asylum-seekers' perspectives amidst a dearth of research exploring the experiences of asylum-seekers. It was chosen to mitigate the risk of imposing the researchers' assumptions on a marginalised population. The first author previously worked for the organisation where the participants had undergone assessment, and it was felt that IPA's reflexive process would help account for the author's bias and assumptions and provide an opportunity to document the authors' collective sense-making.

Furthermore, IPA's use of semi-structured interviews to elicit participants' experiences enables participants to have 'an important stake in what is covered' (Smith et al., 2009, p. 4). This is particularly important given that the asylum system in the UK limits the control that asylum seekers have over many aspects of their lives, including the way they are able to share their stories. The idiographic focus of IPA, which explores the detailed and subjective meaning that an individual attributes to a specific experience, is argued to be a particularly valuable methodology within research with refugees (Schweitzer & Steel, 2008). The emphasis on individuality contrasts the frequent deindividualisation of asylum-seekers within public debate (Cooper et al., 2021), and even within the humanitarian sector (Rajaram, 2002).

Participants

Ethical approval was obtained from Canterbury Christ Church University's Ethics Committee. Participants were recruited through the Helen Bamber Foundation (www.helenbamber.org), a third sector organisation that provides holistic care to survivors of human rights violations such as torture and modern slavery. They provide individually-tailored programmes of psychological care and medical advisory services, legal, housing and welfare support and skills and community activities to hundreds of survivors a year. The organisation is renowned for its authoritative expertise on conducting medico-legal reports. Purposive sampling was used to identify participants with experience of undergoing a MLR assessment by assessors associated with the chosen organisation. Individuals receiving other services from the organisation, such as therapy or casework, were not recruited because of concerns that their ongoing

relationship with the organisation might leave them feeling obliged to provide only positive feedback on their experience of assessment. Recruitment was limited to individuals whose spoken English was sufficiently fluent in order to partake in an interview without the need of an interpreter because it was felt that the use of an interpreter would weaken the analysis by compromising the 'double hermeneutic' – that is, the interpretative process between participant and researcher. As per the Helen Bamber Foundation's research ethics protocol, client vulnerability, the potential for the interview to cause distress and capacity to provide informed consent were issues considered by clinicians and caseworkers before deciding whether it was appropriate for a client to be invited to participate.

Twenty-nine people were identified by organisation staff as potentially suitable. Twenty-one of those approached chose not to participate, and a further two agreed to participate but later withdrew or failed to attend the interview. Those providing a reason for not wanting to participate felt it would be too stressful to talk about their assessment. Tables 1 and 2 provide details of the selection criteria and of the six individuals who consented to participate and whose interviews form the basis of the study. Of these six participants, two were assessed by a psychiatrist, one was assessed by a clinical psychologist, and three were assessed by a general practitioner.

When explaining the nature of the research to potential participants, it was emphasised that participation was voluntary and that their decision would not affect the care provided to them. At interview, written consent was obtained, and the participant had the opportunity to ask questions prior to the interview starting. It was explained that there was no expectation for them to talk about past traumatic experiences and that they could indicate if there was anything they preferred not to talk about. Participants were reminded of processes around confidentiality and their right to withdraw from the research at any time. It was ensured that a clinician was available at the time of interview in case support was required. Travel expenses were covered but no financial incentive was provided because of concerns about possible coercion.

A semi-structured interview schedule was developed. Questions were refined following consultation with a refugee, who had previously undergone a MLR assessment, and with two clinicians working with asylum-seekers. The schedule included open-ended questions, which served as a guide (e.g. What were your expectations of the assessment? What was your experience of the assessment? What were your thoughts/feelings about your assessing clinician?).

Table 1. Selection criteria.

Selection criteria
• Individuals who were 18 years or older
• Individuals with a history of trauma
• Individuals who had undergone an assessment and evaluation of their mental health for the purposes of preparing a MLR, to be used as evidence in their asylum claim
• Individuals who are not receiving other services from the organisation, such as therapy or casework, as it is felt they may feel obliged to provide only positive feedback on their experience of assessment. This was later broadened to include those receiving other services from the organisation due to recruitment difficulties
• Individuals whose spoken English is sufficiently fluent in order to partake in an interview without the need of an interpreter. It is felt that the use of an interpreter would weaken the analysis by compromising the 'double hermeneutic'

Note: MLR = medico-legal report.

Table 2. Pseudonyms and characteristics of participants.

Name[a]	Age (years)	Gender	Ethnicity	Country of origin	Immigration status	Professional conducting assessment
Akuba	47	Male	Black African	Ghana	Asylum-seeker	Doctor – general practitioner
Selvan	40	Male	South Asian	Sri Lanka	Refugee	Doctor – general practitioner
Ekele	32	Male	Black African	Nigeria	Refugee	Psychiatrist
Dalina	45	Female	White European	Albania	Asylum-seeker	Doctor – general practitioner
Sam	35	Male	Black African	Nigeria	Asylum-seeker	Clinical psychologist
Nour	43	Female	Arabic	Egypt	Asylum-seeker	Psychiatrist

[a]Names have been changed to protect confidentiality.

The interviews were conducted face-to-face, in English and without an interpreter at the organisation (except for one interview, which was carried out via video-link due to COVID-19 restrictions) and lasted between 45 and 75 minutes. None of the participants reported any distress caused by the interview, as indicated by a subsequent debrief conversation led by the interviewer.

Data analysis

Interviews were transcribed verbatim by the first author and then analysed using IPA (Smith et al., 2009). Each transcription was individually analysed in depth to ensure idiographic content was attended to. Following data immersion and familiarisation, descriptive, linguistic and conceptual comments were produced to capture phenomenological features of the participant's responses and the researcher's interpretative observations. Emergent themes were identified and organised into subthemes, which were subsequently grouped into superordinate themes. Quotes for each theme were extracted to ensure that they captured direct participant experience. Following the idiographic stage of analysis, the themes from the individual interviews were considered again together, and connecting themes across the cases were identified, capturing points of divergence and convergence between participants, to form the master table of three superordinate themes and eight subthemes. In addition, a sample of interview transcripts were independently reviewed by two research colleagues, and the emergent themes were discussed to confirm their grounding in the data.

Reflexivity was maintained through the first author's continual examination of the implicit and explicit bias and judgement inherent in interpretations. A bracketing interview was conducted, where the significant differences between the first author and participants, in terms of ethnic and cultural backgrounds and experiences of displacement, were reflected upon, and related assumptions were acknowledged. Reflective journalling allowed for ongoing consideration of how the first author's previous experience of working for the assessing organisation and associated beliefs about the asylum experience as cruel and dehumanising may bias any interpretations made, such as preconceptions about how the assessments would be experienced as distressing.

Results

Three superordinate themes, including a total of eight subthemes, were identified from the analysis (see Table 3). Evidence for each of the superordinate themes was found in all the participants' accounts.

Table 3. Table of themes.

Superordinate themes	Subthemes
1. Uncertainty: tension between negative and positive expectations	'Something that's in suspense': managing uncertainty of what assessment would entail
	'Especially worried about being asked about the past': fear in relation to talking about the past
	'It's something that's got to be done': needs must
	'This might be the right choice to make': impelled by hope
2. The pain of having to share and remember	'Vomiting these horrible things': conflicting emotions about sharing
	'Like I'm still there': remembering as distressing and retraumatising
3. Therapeutic impact	'I felt a bit lighter': release of sharing
	'Capable to hear my story': a relational experience and the importance of emotional containment

Superordinate Theme 1 – uncertainty: tension between negative and positive expectations

This theme illustrates participants' experiences of having to attend their assessment out of necessity rather than choice. Participants recounted a sense of trepidation in the lead up. This was however consistently counterposed by a tentative hope that it may help.

'Something that's in suspense': managing uncertainty of what assessment would entail

Participants spoke of feeling uninformed about what the assessment would involve. Akuba described having only a vague sense of the purpose of the assessment:

> I didn't know much about what I was coming to do . . . all I know that I'm coming to see a doctor to assess me for the trauma. . . .

This rudimentary understanding, expressed in his words 'all I know', was echoed by Ekele: *'I didn't know anything about the report, nothing, nothing . . . all I did as I was told . . . to come here'*. Ekele's description of doing 'as I was told' gives the impression of him feeling powerless and reliant on others with decisions about his future. Selvan experienced a similar lack of awareness upon finding out about the length of the assessment process:

> When I saw this appointment that said two dates . . . how come that's possible? . . . I was wondering why they need to see me for so long . . . I was thinking . . . there's a reason for that so I cannot worry about that . . . only I was thinking to get this report and . . . come to a conclusion.

Here Selvan describes a more clearly questioning and, initially, less accepting response to the invitation, requiring him to reassure himself with the thought that the assessors must have their reasons, again suggesting a need to put his faith in others' decisions. Rather than worry, he tried to maintain a single-minded focus on doing whatever had to be done in order to obtain the report that would help resolve his claim. However, concern about the unknown still crept in:

> I was worrying about the doctor actually because I didn't meet her before . . . I didn't know what kind of questions she was going to ask . . . I was not sure what to expect.

Not knowing what to expect was experienced by Dalina as '*like something that's in*

suspense'. Rather than accepting the situation, Nour appeared to manage her uncertainty by taking a more proactive approach in seeking more information:

> I didn't have an understanding . . . but when . . . the appointment was set, I did say 'please can someone give me a call just to talk me through what to expect'.

'Especially worried about being asked about the past': fear in relation to talking about the past

Participants described a fear related to the assessment process. They identified that this fear arose from the prospect of having to talk about 'the past', something that was not defined but can be inferred to be referring to the painful experiences that had led them to claim asylum. For Sam, discussing his past meant confronting experiences that he consciously avoided:

> I felt afraid. Speculatively . . . I imagined getting told to talk about the past which I always want to keep away from, yeah, I was concerned about that . . .

This concern was shared by Dalina: *I was . . . especially worried about being asked about the past'*. She expected to be *'bombarded again with questions and go through every single detail . . . '*, the use of the word 'bombarded' evoking a sense of being under attack, and her worry that she would be interrogated for 'every single detail', seemingly related to being confronted with painful memories. Nour described feeling *' . . . worried about having to open it all up'*.

Akuba described the toll that the expectation of having to discuss the past took on his state of mind prior to the assessment, stating that, 'before the assessment was very, very, very stressful'. He elaborated:

> I knew I was going to have to talk about these painful things . . . this was something I was thinking about a lot. I didn't sleep . . . I was thinking about . . . am I going there for me to go back and remember 'oh what has happening to me?' . . . so beforehand, even I wanted to tell that I don't want it . . .

Akuba's anxiety was significant enough to cause sleep loss and the desire to avoid the assessment process entirely.

'It's something that's got to be done': needs must

The uncertainty about the assessment and the fear of discussing their pasts were superseded by their need for help. For Sam:

> . . . the claim that I need to make is . . . so important that I have to sacrifice my wish of not talking about the past in order to really stand any chance of having a solid claim . . . the concern was there but it's something that's got to be done.

The feeling of having no choice meant that '*I didn't pay attention to analysing my feelings before the assessment so I was like . . . get it done and get it out of the way'*. This suggests he could not afford to attend to his feelings of concern beforehand, rather it was just something he had to get 'out of the way'.

This sentiment was shared by Selvan:

> I tried not to think about it too much . . . I just needed to go there and get it done.

This lack of choice was articulated by Nour:

> It has to be done, like the Home Office interview, it's a horrible process but it has to be done because I need to be here, I want to be safe.

Like the others, Nour's priority was 'to be safe' and so the assessment was another 'horrible process', similar to the Home Office interview, that nonetheless had to be done.

For Dalina on the other hand, her motivation to attend her assessment appeared to be drawn from the imperative to help her two children, thus acting for the sake of their needs rather than her own. Her sense of desperation was apparent in her description of the assessment as her 'last resort':

> Having children … you're not any more responsible for yourself, you don't do things for yourself, but you do it because you have two other human beings that, they only have you and they wait for your help … and I said, 'yeah I'm going there'. So, it was … like my last resort.

'This might be the right choice to make': impelled by hope

The anxiety provoked by the need to attend the assessment was offset by a hope that it would help. Sam described the hope provided by the reputation of the assessing organisation:

> I know people who have similar issues, for their testimony that … the organisation do a lot in mental health … so that actually makes me feel … this might be … the right choice to make.

Sam's understanding that the organisation 'do a lot in mental health' suggests he believed that they might provide care, rather than exacerbate distress. This provided reassurance that he was making the 'right choice' by attending his MLR assessment. Sam's language here implies an attempt to reclaim a sense of agency. Selvan also described the effect of hearing positive testimonies before attending:

> I heard some other clients … saying that they really support asylum-seekers and … they never let you go … so that kind of helped, I already heard that they are going to really help me.

Selvan's expectation that the organisation was going to 'really help' him perhaps reflected a longing to be looked after, expressed in his words 'they never let you go'. As well as having such an expectation to be supported in his claim, Ekele also appeared to hold a clear hope that he would be supported to 'tell my problems' in a way that would benefit him psychologically:

> I had this anxious feeling, but … in a happy way that I'm going to see someone that's going to help me tell my problems, to speak out and just be open-minded.

A wish to be helped to be 'open-minded' suggests a state of close-mindedness related to his struggle to 'speak out', which he wanted to be freed from. Dalina described how the prospect of the assessment did not provide something as strong as hope but reignited a sense of motivation:

> … it's not hope but it's something in there that pushes you and says 'yeah, do that thing today, get ready, start even looking after yourself because you're going somewhere' and that's something after all … that's negative, that's black and obscure that you have that shade of light.

Nour contextualised hope within her experience of helplessness as an asylum-seeker, whereby she felt grateful for the 'painful' help offered by the assessment, given the lack of support she was receiving elsewhere:

> … being an asylum-seeker, you feel you don't have the rights for a lot of things, so when you get a little bit of help you feel like 'oh at least I'm blessed, I'm getting this' although it's so painful getting this kind of help.

Superordinate Theme 2: the pain of having to share and remember

The pain of having to share experiences and the distress caused by remembering trauma were identified as related, yet distinct, processes. As described by Sam:

> It's like remembering those things, trying to talk about them, remember them. The process of remembering is different from even saying it … it's just like the struggle to remember and the struggle to say it and just wish those things never happened.

'Vomiting these horrible things': conflicting emotions about sharing

Participants experienced talking about their past as extremely challenging. Sam was conscious that if he omitted details then this may weaken his report: *'If I have withheld any information then he … might not be able to go as thorough as he needs to go in his report … even though they were tough things to say'*. This dilemma was felt acutely by Selvan who had undisclosed experiences he needed to share with the clinician:

> I had . . . very personal areas to disclose to her. That was the very hard part … kind of abusing things by the persons and then it was just really hard because she's a lady . . . I didn't want to disclose all those things but I still … managed to tell the truth to her and she was insisting because it will be helpful for her to write all these things to complete the report … very, very, very difficult.

Selvan marked out this disclosure as the 'very hard part' of his assessment. He named the clinician's gender as a primary reason that it was hard to disclose, an indication of a sense of shame about what had happened, amplified by his perception of what was appropriate to share with a female clinician. The repetition of 'very' emphasised how difficult this disclosure was, especially when he felt he had no choice.

Nour expressed more conflicted feelings, whereby on the one hand she appreciated that the assessment was 'all for my own good' but on the other hand she felt 'angry' at feeling 'forced' to tell her story:

> I started feeling angry … because I was in that situation like as if I was forced but I know I wasn't forced, I know I'm glad to be in that position because at the end of the day this is all for my own good but I couldn't help but feel angry that I had to go through that.

Nour explained how she felt rushed to share her past, reducing her 'horrible life story' to 'headlines'. She spoke of how this felt as if she was dishonouring the impact that these experiences had had on her life:

> I felt like I was … vomiting these horrible things at you that doesn't make any sense and to me it felt like I was, I was making it light … it was as if I was talking about a mundane thing but to me it was very painful …

Dalina also expressed anger that she was having to repeat her experiences:

> You just have to repeat it. Then you become … like a toy, like its enjoyment for others. You're the centre of attention and everyone else is looking through you and maybe feeling regretful . . .

The process of having to share her story again left her feeling as though others took voyeuristic pleasure in hearing her trauma while she was left feeling exposed, not wanting to be objectified.

Akuba shared this sentiment: '*It's not everyone that I want them to know everything that I've been through'*. He stressed the difficulty of discussing a trauma that was ongoing:

> How can I say my past and what I'm going through if it's not my past? I'm still going through it … It's the present … I don't want to think about it …

'Like I'm still there': remembering as distressing and retraumatising

All participants described in detail the distress caused by being brought into contact with past painful experiences. For Selvan, remembering the trauma in detail provoked a vivid reliving of the trauma:

> I felt … lots of pain when I was explaining … the pain I was going through during my torture … and the things I saw there, the way I felt them … sometimes I felt in my body kind of real-time pain … it's kind of right now it's happening kind of someone's beating [me] and I felt it in my back and my legs … it was like it was really happening … Emotionally I was like feeling very … low and then fear and then I was crying.

Selvan describes how the process triggered a distressing, visceral re-experiencing of his trauma in terms of a 'real-time pain'. The intense somatic flashbacks were referred to again when explaining how he felt '*really, really inside the prison'* adding that *'the pain you feel … in your skin'*.

Sam described being made to feel like he was: *'still within that past. Like it's something that is very near, that its part of my day-to-day reality in that moment … like I'm still there- … that it's still very fresh',* which left him feeling *'heavy … nothing else in my mind . . . no thought of any sort other than the recalling of the past'*. His mind in this moment was consumed by his past.

For Dalina, when she was not talking about the past, the memories were *'fading day by day'* but then *'In a moment, everything comes back as strong as it was … as powerful'*. She explained: '*I really got those flashbacks and that kind of feeling inside me building up … very hot and I just wanted to get somewhere, not in that room, because it was overwhelming'*.

The experience of remembering was 'horrible' for Nour and left her *'terrified for the whole process'*. She spoke of her tendency to try and forget these memories in order to '*function on a daily basis*', and how remembering *'every detail that happened*' left her with '*feelings of despair*'.

Ekele described what appeared to be a dissociative experience while recalling traumas during the assessment:

> There were times in the assessment I just go somewhere else …. There was this instance that happened to me, I went actually blank, it was black, I blacked out. But I was there but I was blacked out, man.

For Selvan, the strength of remembering also caused him to lose sense of his surroundings, requiring the clinician to intervene by regrounding him:

> I really sometimes felt like it was happening really right now and so she had to bring me back and … ask questions … like … 'Can you tell me where are you now?' … Sometimes she make me … by tapping or something . . . to bring me back to the present.

A number of participants described the aftermath of the assessment in which they continued to grapple with reawakened trauma, often at night. Ekele explained: *'The day I come here and talk about that . . . that night is messed up'*.

Similarly, for Sam: *'Later in the night I had thoughts, I had flashbacks and I was just thinking … a lot of nightmares … '*. Nour described how her nightmares left her feeling that she was going 'cuckoo': *'I'm starting going cuckoo, I'm starting having horrible nightmares … so, um, I can't say the MLR helped with that. … '*

Selvan also described how he found it difficult to cope with the intensification of his trauma symptoms after his assessment, leaving him feeling panicked and alone:

> I barely slept at night time because I couldn't close my eyes, when I closed my eyes things coming to me … all these past memories … I get a bad nightmare and then wake up and start sweating, sometimes I just want to go to toilet and then so panicking, I was panicking and no one knew.

Superordinate Theme 3: therapeutic impact

This theme captures the ways in which the participants experienced the assessment as therapeutic.

'I felt a bit lighter': release of sharing

Participants spoke of a sense of release that they experienced through putting words to their painful memories and feelings. For Akuba, '*talking about it helped me to, you know, release some pain and . . . there's a lot of pain I'm going through'*.

Sam described this release as a feeling of becoming 'lighter': *'At some point I felt . . . a bit lighter. Like . . . I didn't have to feel reluctant in talking . . . because it felt like it was a normal thing to say'*. Becoming less 'reluctant' to talk was understood by Sam to be due to a process of normalisation, where the unspeakable became speakable. He elaborated:

> There were things that I don't normally talk about and the process of unlocking them felt quite heavy but after going into it deeply it then feels like letting it out . . . it becomes like every other thing that's normal to talk about.

The things Sam does not 'normally talk about' can be inferred to be the experiences that he avoids talking about, experiences that require 'unlocking'. While this unlocking felt initially 'quite heavy', it became an outlet, suggesting that speaking about these experiences helped reduce their emotional intensity and aided re-integration of the trauma. This experience of 'letting it out' was shared by Ekele:

> I opened up . . . which was not something I was willing to do . . . going down into my personal life which was a very dark moment in my life . . . but I think it was helpful to articulate that out of my mind . . . when I talked about it, I actually came out of it . . . it helped me . . . learn to manage it. They're not gonna harm me, they're not gonna kill me, I'm here, I'm safe.

The 'dark moment' Ekele was previously unwilling to talk about reflects the strength of his avoidance, yet he found that sharing helped to 'articulate that out of my mind'. This seemed related to an experience of coming out of his past and grounding himself in the present, where he is safe and can begin the process of putting words to his experience.

'Capable to hear my story': a relational experience and the importance of emotional containment

The relational dynamic between participant and clinician was an important factor in supporting participants through the assessment.

Sam felt that the clinician demonstrated a non-judgmental curiosity and 'sensitivity' to his emotional experience:

> For the first time he asked me about how my mother made me feel and that was the first time I ever said to anyone that she made me feel mad, and he understood . . . so those things that I don't say . . . I said.

This appeared to be the first time someone had attended to the affective aspects of his experiences, permitting him to share feelings he had never shared before and to feel 'understood'. This feeling arose from a sense that the clinician empathised with his experiences: *'He just told me, "I know nobody wants to remember these things, these things are horrible . . . " it's just like empathising'*. Feeling emotionally contained throughout this process appeared instrumental in allowing him to open up:

> He was able to manage my emotions throughout the process . . . it was just everything he did to keep me alive throughout the whole thing.

The MLR clinician's containment helped '*keep me alive*' through the process, indicating that he felt he would otherwise have been overwhelmed by the strength of feelings provoked. This experience of containment was articulated by Nour as feeling the clinician could bear to hear her story:

> I felt she was capable . . . to hear my story . . . when I had the first incident with the therapy . . . I could feel that she can't

> handle it . . . I was scared for her . . . like 'oh my god I should stop there because I don't want to overwhelm her'. But with that psychiatrist I felt she was capable, knowing what to say and what not to say and when to talk and when not to talk.

Nour contrasted her experience with the MLR clinician to that of seeing a therapist who she worried would become overwhelmed by her story. This fear was alleviated by the assessing clinician, whom Nour felt was 'capable' of hearing her story. The experience of containment also came up for Selvan who described how the pre-existing relationship between clinician and interpreter helped to 'balance the situation', evoking the image of a containing parental couple:

> . . . she was there next to me and I had an interpreter and . . . they understand each other . . . they know each other very well and I'm just a new person and . . . they both kind of balance the situation.

Participants spoke of the healing effect of having painful experiences validated. Nour described how she felt the clinician went beyond her role of writing a report to help address her feeling of self-blame:

> . . . one tends to think that I'm to blame, there are things that . . . it was me. I think she sensed that and, although she didn't need to because at the end of the day she's just writing the report, she would say something along the lines of 'but you do understand this was never your fault?' . . . at the time it felt really comforting.

The reparative effect of feeling heard and believed was described by Ekele as being in powerful contrast to his experience with the Home Office:

> When you actually . . . come from a place of war, a place that you've been tortured and you try and tell someone this is who I am, I've been tortured and they tell you you're chatting shit. That breaks your heart . . . that actually breaks you . . . you look at yourself in the mirror and tell yourself 'what the heck?' So, I don't know what was in his (clinican's) mind . . . but from his non-verbal appearance . . . I knew he believed what I was saying . . . that felt nice.

The pain of being disbelieved is vividly described here, where the denial of his traumatic experiences was felt as an attack on his sense of self, making his experience of being believed feel all the more important. This affirmation was unspoken, something detected by Ekele in how the clinician attended to him.

Not all participants described the MLR assessment as having therapeutic elements. Notably, Dalina did not share this sense of validation but instead described the assessment as a repeated experience of feeling unseen and unheard:

> Like he was a bit . . . ignoring me . . . if someone doesn't pay you attention, looking in your eyes and just looking at the computer . . . doing all the time 'hmm' . . . That is not respecting the other person in the room that's just . . . 'I'm just giving you the piece of paper and just getting rid of you'. Just as they did in my country.

Discussion

The current study explored asylum-seekers' experiences of undergoing a MLR assessment as part of their asylum claim and examined whether aspects of this process are experienced as either distressing or therapeutic.

The superordinate theme *'Uncertainty: tension between negative and positive expectations'* relates to participants' internal struggle between conflictual feelings of anxiety associated with the unknown of what the assessment entails and a fear that the process would be distressing, alongside feelings of having no choice but to attend and a hope that the process might alleviate their suffering.

The uncertainties about what the assessment involves echo the wider precariousness of the asylum-seeker experience, which is full of unknowns (Morrison, 2016). This chronic

uncertainty is associated with a multitude of stressors, including a damaged sense of security (Cange et al., 2019). The finding that there is a fear of discussing the past is unsurprising given that, as discussed in the introduction, avoidance of trauma reminders is a core symptom of the PTSD diagnosis (*Diagnostic and Statistical Manual of Mental Disorders–Fifth Edition, DSM-5*; American Psychiatric Association, 2013), and wider research on trauma has found that experiential avoidance is consciously employed as a coping mechanism (Boeschen et al., 2001; Orcutt et al., 2020). Increased anxiety is therefore highly understandable when faced with having this coping mechanism undermined.

Participants describe a complex emotional experience of feeling they have no choice but to attend. Forgoing the privilege of choice in order to remain in the country captures a familiar feature of the asylum-seeker experience, where their circumstances strip them of their autonomy (Bhugra et al., 2014; Tullio et al., 2023). As stated by Kahn and Alessi (2018), such undermining of autonomy over one's narrative goes against the principles of trauma-informed frameworks of care, which emphasise restoring control to counter the sense of powerlessness experienced by trauma survivors (Bloom & Farragher, 2013). However, the prospect of the assessment as something aversive is counterposed by the hope that it might provide much needed support. Research suggests that hope is a protective process that plays an essential role in resilience and adjustment for asylum-seekers (Yildiz, 2020).

The processes of remembering traumas and sharing them with the assessor were challenging and distressing for the participants. Repeatedly having to share painful and personal experiences resulted in feeling that their experiences were being minimised or having to be packaged for consumption. This was identified as a risk within the assessment process in the wider literature, which stated the problem of invalidating the asylum-seekers' experience of living with something that cannot be easily 'articulated, commodified, and consumed' (Abbas et al., 2021; Nguyen, 2011; Strejilevich, 2006). The finding that disclosure of shameful events is experienced as distressing parallels research exploring experiences of government asylum interviews, which found such disclosure to be related to feelings of shame (Bögner et al., 2010; Chaffelson et al., 2023; Schock et al., 2015).

Participants describe how the process of remembering provoked or aggravated symptoms of flashbacks and dissociation, illustrating how remembering in the context of the assessment has a retraumatising effect. This mirrors previous findings (Bögner et al., 2007; Kahn & Alessi, 2018; Schock et al., 2015) where recalling details of trauma during asylum-related interviews induced trauma symptoms. Participants explain that being reminded of the details of their traumas caused a worsening of trauma symptoms of intrusion, such as nightmares, in the period following assessment, a consequence that has been highlighted as a concern in the wider literature (Gangsei & Deutsch, 2007; IP, UN Office of the High Commissioner for Human Rights, 2022; Tullio et al., 2023). This finding demonstrates the critical importance of upholding a trauma-informed approach to care, which involves vigilance in avoiding institutional processes and individual practices that are likely to retraumatise individuals (Hopper et al., 2010).

The superordinate theme, '*Therapeutic impact'* encompasses the ways in which the assessment was experienced as therapeutic and how fear of talking about the past was negotiated through a containing relationship with the assessing clinician. For some participants, sharing past experiences provided a release from thoughts and feelings they had been struggling with internally. This finding supports the view that the psychological evaluation of asylum-seekers presents an opportunity to help understand the necessity of

telling their story in order to begin processing overwhelming feelings (e.g. Gangsei & Deutsch, 2007; Sidhu & Shadid, 2022).

Central to this process is the participants' relationship to their assessing clinician. This emerged as an important component to their experience, as participants described how feeling emotionally contained helped them to cope with talking about the past. The experience of emotional containment refers to Bion's (1962) concept 'container-contained', which describes the need for a containing object to allow processing of feelings that would otherwise be experienced as overwhelming. This also relates to the idea of bearing witness (Gautier & Scalmati, 2010), whereby participants felt heard and their experiences acknowledged. Being listened to with respectful understanding has been found to be therapeutic in previous research on working with asylum-seekers (Vincent et al., 2013) and is particularly valuable given that they commonly encounter disbelief (Tribe, 2002).

Strengths and limitations

Adopting IPA is a strength of this study, given its explicit concern with how individuals understand and make meaning of their experiences within their personal, cultural and social context (Smith & Osborn, 2003). Asylum-seekers are a particularly marginalised group; therefore employing a methodology that privileges their perspective and involves a process of reflexivity to help account for the researcher's culture-bound biases was paramount. The consultation and refining of the interview schedule with a refugee who had undergone the assessment process is a further strength; however, the study would have benefited from more collaborative co-design and involvement of people with lived experience at each stage of the research process.

Although some IPA studies include larger sample sizes, the literature confirms that the current sample size of six is deemed to be well within the appropriate range for IPA (Pietkiewicz & Smith, 2014; Reid et al., 2005; Turpin et al., 1997). This sample size maintains the idiographic focus of IPA and enables a rigorous analysis of each participant's account (Roberts, 2013). It is, however, also noteworthy that the majority of the individuals approached declined to participate, many saying that this was because they found the subject difficult to talk about. The perspectives of those who have found the process more challenging may therefore have been excluded. Consequently, the results might not have captured some of the more distressing experiences of undergoing a MLR assessment. For example, asylum-seekers who felt too anxious to participate may not have shared the experience of the assessment as emotionally containing.

Given the high proportion of asylum-seekers declining to participate, the inclusion criteria had to be broadened to include those with refugee status. Two of the six participants had refugee status at the time of their research interview. The MLR prepared for them would likely have contributed towards securing their refugee status, and so it is possible that they held a more favourable view of the assessment process than asylum-seekers in whom the outcome was still unclear. Again, this means that the overall findings are potentially skewed towards positive experiences of the assessment and should be seen as reflecting the perspectives of those who are willing to talk about their experiences.

Of the four interviewees included in the sample who were still in the asylum-seeking process, the ongoing uncertainty of their asylum application, and related adverse circumstances around unstable housing, lack of financial support and lack of right to work, may have limited their capacity to engage in the research interview and to reflect on their experience of the assessment. A further limitation of the sample is that only two of the six participants were female. Had more women been included, then the experiences of

undergoing assessment for a MLR that are particular to being a woman may have come through distinctly in the analysis.

All interviews were conducted in English, rather than the participants' first language. Whilst each participant had a high level of English, they nonetheless had to articulate their complex and nuanced experiences in their second language. This might have obscured or distorted the intended meaning, in terms of both how ideas were expressed by the participant and how they were interpreted by the researcher, with an increased risk of meaning being approximated or imposed.

Research implications

At present, this research stands as the first study exploring the subjective experiences of asylum-seekers who have undergone an MLR. It should serve as a valuable foundation for forthcoming research and efforts to centre the perspectives of asylum-seekers when considering best practice for conducting MLRs.

The findings suggest that the process of remembering and sharing details of past traumas is a distressing component of the MLR process and that this distress is mediated to an extent by key therapeutic components. Further research is required to explicate these factors. The retraumatising experience of the assessment indicates a need for research that explores the effectiveness of trauma-informed trainings for assessing clinicians and whether trauma-informed approaches can be adequately implemented in the context of the asylum process. The finding that the relationship between the participant and clinician enabled the assessment to be a positive experience warrants further qualitative research to explore whether this is a supportive factor beyond the current sample and to explicate the central relational and therapeutic components. Future research in this area should employ a participatory action approach to help restore the power imbalance between 'observer–observed'. This would also help address the significant cultural differences between Western researchers and asylum-seeker participants. Research incorporating quantitative methodology would help ascertain the generalisability of the findings. For example, trauma measures could be used pre and post assessment in order to measure aggravation of trauma symptoms.

Clinical recommendations

The findings have implications for clinicians assessing asylum-seekers for MLR purposes. Participants experienced the assessment process as a significant stressor, and for many it was retraumatising. In order to reduce the risk of causing further distress, further consideration needs to be given to how asylum-seekers can be supported to share painful details of trauma in a way that maximises their sense of safety. Uncertainty around the process contributed to stress prior to attending the assessment. Further measures put in place for the clinician to make contact with the individual before their assessment to provide clear information about the role of the MLR assessment in the asylum process and to begin to build a rapport may help to alleviate some of this stress.

The MLR assessment process requires disclosure. It is therefore important (but also difficult) to mitigate the risk of aggravating symptoms of trauma. Whilst there is existing trauma-informed guidance and training for clinicians on assessing asylum seekers for MLRs (e.g. IP, UN Office of the High Commissioner for Human Rights, 2022; McQuaid & Miller, 2022; Witkin & Robjant, 2018), the current findings highlight the need for further work on developing training for assessors to build an awareness of the stressors that asylum-seekers may experience, and on ways to manage such stressors effectively. Systematic follow-up in the period following assessment will help to identify continued distress and whether further support is required. There are policy implications in terms of an asylum process that forces disclosure of trauma in a context that is not on the asylum-seeker's terms. Policies need to enable

progress towards a more compassionate, trauma-informed process that allows asylum-seekers to disclose their experiences whilst minimising the risk of retraumatisation.

Furthermore, when reading and evaluating MLRs as part of evidential documentation supporting an individual's asylum claim, asylum decision makers should have an understanding of the difficulties, distress and complex tensions that people face when disclosing traumatic experiences within an MLR. An improved awareness of these challenges may help decision makers to bear in mind that inconsistencies or omissions in an account may relate to the asylum seeker's psychological trauma rather than an attempt to mislead deliberately.

The findings indicate particular therapeutic components of the assessment process. Participants' relationship with their assessing clinician emerged as a key supportive factor in their experience of the assessment. A compassionate clinician provides emotional containment, which is crucial in managing the distress of remembering and sharing. This suggests that time invested in establishing a connection with the asylum-seeker and in helping to process painful emotions associated with the trauma helps to acknowledge and validate experiences. Assessing clinicians should be made aware of the potential for the assessment to have a positive, therapeutic impact, and specialist training on conducting MLR assessments should include teaching on the therapeutic component of establishing a containing relationship.

Conclusion

This study contributes to the wider research investigating asylum seekers' experiences of navigating a complex and challenging asylum process. Findings suggest that the MLR assessment is experienced by participants as a stressor, in that uncertainty, fear and a lack of choice contribute to distress, and the processes of sharing and remembering are experienced as painful and retraumatising. However, there are components of the process that appear to hold therapeutic and restorative benefits. These include a feeling of release provided by sharing their story and a positive relational experience of having the distress of their trauma heard and contained by another. Findings draw attention to the need for further development of effective trauma-informed models of care, which can be implemented within the asylum process to avoid inflicting further distress on an already highly traumatised population, and they highlight therapeutic components that require further elucidation in order to improve MLR practice and enhance the therapeutic potential of the MLR assessment.

Ethical standards

Declaration of conflicts of interest

Matthew McDonnell has declared no conflicts of interest.
John McGowan has declared no conflicts of interest.
Ella Weldon has declared no conflicts of interest.
Cornelius Katona has declared no conflicts of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee [Canterbury Christ Church University's Ethics Committee, Approval reference: V:\075\Ethics\2018-19] and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

References

Abbas, P., von Werthern, M., Katona, C., Brady, F., & Woo, Y. (2021). The texture of narrative dilemmas: Qualitative study in front-line professionals working with asylum seekers in the UK. *BJPsych Bulletin*, *45*(1), 8–14. https://doi.org/10.1192/bjb.2020.33

Akinsulure-Smith, A. M., Sicalides, E. I., & Diallo, M. (2023). Evaluating asylum claims based on female genital mutilation/cutting for immigration court – Opportunities and challenges for licensed mental health professionals. *Professional Psychology*, *54*(2), 167–176. https://doi.org/10.1037/pro0000503

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). APA.

Baranowski, K. A., Moses, M. H., & Sundri, J. (2018). Supporting asylum seekers: Clinician experiences of documenting human rights violations through forensic psychological evaluation. *Journal of Traumatic Stress*, *31*(3), 391–400. https://doi.org/10.1002/jts.22288

Bhugra, D., Gupta, S., Schouler-Ocak, M., Graeff-Calliess, I., Deakin, N. A., Qureshi, A., Dales, J., Moussaoui, D., Kastrup, M., Tarricone, I., Till, A., Bassi, M., & Carta, M. (2014). EPA guidance mental health care of migrants. *European Psychiatry: The Journal of the Association of European Psychiatrists*, *29*(2), 107–115. https://doi.org/10.1016/j.eurpsy.2014.01.003

Bion, W. R. (1962). *Learning from experience*. Jason Aronson.

Bisson, J. I. (2009). Psychological and social theories of post-traumatic stress disorder. *Psychiatry*, *8*(8), 290–292. https://doi.org/10.1016/j.mppsy.2009.05.003

Bloom, S. L., & Farragher, B. (2013). *Restoring Sanctuary: A New Operating system for Trauma-informed Systems of Care*. Oxford University Press.

Boeschen, L. E., Koss, M. P., Figueredo, A. J., & Coan, J. A. (2001). Experiential avoidance and posttraumatic stress disorder: A cognitive mediational model of rape recovery. *Journal of Aggression, Maltreatment & Trauma*, *4*(2), 211–245. https://doi.org/10.1300/J146v04n02_10

Bögner, D., Herlihy, J., & Brewin, C. R. (2007). Impact of sexual violence on disclosure during Home Office interviews. *The British Journal of Psychiatry*, *191*(1), 75–81. https://doi.org/10.1192/bjp.bp.106.030262

Bögner, D., Brewin, C., & Herlihy, J. (2010). Refugees' experiences of home office interviews: A qualitative study on the disclosure of sensitive personal information. *Journal of Ethnic and Migration Studies*, *36*(3), 519–535. https://doi.org/10.1080/13691830903368329

Brewin, C. R., Andrews, B., & Valentine, J. D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, *68*(5), 748–766. https://doi.org/10.1037//0022-006x.68.5.748

Cange, C., Calle, B., Ceren, A., & Fouad, M. (2019). Considering chronic uncertainty among Syrian refugees resettling in Europe. *The Lancet. Public Health*, *4*(1), e14. https://doi.org/10.1016/S2468-2667(18)30261-5

Chaffelson, R., Smith, J. A., Katona, C., & Clements, H. (2023). The challenges faced during home office interview when seeking asylum in the United Kingdom: An interpretative phenomenological analysis. *Ethnic and Racial Studies*, *46*(7), 1269–1289. https://doi.org/10.1080/01419870.2022.2112255

Cooper, G., Blumell, L., & Bunce, M. (2021). Beyond the 'refugee crisis': How the UK news media represent asylum seekers across national boundaries. *International Communication Gazette*, *83*(3), 195–216. https://doi.org/10.1177/17480485209132

Ehntholt, K. A., & Yule, W. (2006). Practitioner review: Assessment and treatment of refugee children and adolescents who have experienced war-related trauma. *Journal of Child Psychology and Psychiatry, and Allied Disciplines*, *47*(12), 1197–1210. https://doi.org/10.1111/j.1469-7610.2006.01638.x

Fisher, J. (2017). *Healing the Fragmented Selves of Trauma Survivors. Overcoming Internal Self-Alienation*. Routledge.

Gangsei, D., & Deutsch, A. C. (2007). Psychological evaluation of asylum seekers as a therapeutic process. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *17*(2), 79–87. PMID: 17728485

Gautier, A. & Scalmati, A. S. (Eds.) (2010). *Bearing witness: Psychoanalytic work with people traumatized by torture and state violence*. Karnac Books.

Gleeson, C., Frost, R., Sherwood, L., Shevlin, M., Hyland, P., Halpin, R., Murphy, J., & Silove, D. (2020). Post-migration factors and mental health outcomes in asylum seeking and refugee populations: A systematic review. *European Journal of Psychotraumatology*, *11*(1), 1793567. https://doi.org/10.1080/20008198.2020.1793567

Guasto, G. (2014). Trauma and the loss of basic trust. *International Forum of Psychoanalysis*, *23*(1), 44–49. https://doi.org/10.1080/0803706X.2012.762551

Herlihy, J., & Turner, S. (2006). Should discrepant accounts given by asylum seekers be taken as proof of deceit? *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *16*(2), 81–92. PMID: 17251640

Herman, J. L. (1992). *Trauma and recovery*. Basic Books.

Herman, J. L., & Harvey, M. R. (1997). Adult memories of childhood trauma: A naturalistic clinical study. *Journal of Traumatic Stress*, *10*(4), 557–571. https://doi.org/10.1023/A:1024889601838

Hopper, E. K., Bassuk, E. L., & Olivet, J. (2010). Shelter from the Storm: Trauma-informed care in homelessness service settings. *The Open Health Services and Policy Journal*, *3*(2), 80–100. https://doi.org/10.2174/1874924001003020080

International Committee of the Red Cross. (2005). What is the definition of torture and ill-treatment? Retrieved from https://www.icrc.org/en/doc/resources/documents/faq/69mjxc.htm#:~:text=The%20ICRC%20uses%20the%20broad,and%20physical%20or%20moral%20coercion

Jannesari, S., Hatch, S., Prina, M., & Oram, S. (2020). Post-migration social-environmental factors associated with mental health problems among asylum seekers: A systematic review. *Journal of Immigrant and Minority Health*, *22*(5), 1055–1064. https://doi.org/10.1007/s10903-020-01025-2

Kahn, S., & Alessi, E. J. (2018). Coming out under the gun: Exploring the psychological dimensions of seeking refugee status for LGBT claimants in Canada. *Journal of Refugee Studies*, *31*(1), 22–41. https://doi.org/10.1093/jrs/fex019

Li, S. S. Y., Liddell, B. J., & Nickerson, A. (2016). The relationship between post-migration stress and psychological disorders in refugees and asylum seekers. *Current Psychiatry Reports*, *18*(9), 82. https://doi.org/10.1007/s11920-016-0723-0

McQuaid, J., & Miller, J. S. (2022). Preparing for asylum evaluations. In K.C. McKenzie (Ed.) *Asylum Medicine*. Springer. https://doi.org/10.1007/978-3-030-81580-6_2

Morrison, D. T. (2016). Being with uncertainty: A reflective account of a personal relationship with an asylum seeker/refugee. *Counselling Psychology Review*, *31*(2), 10–21. https://doi.org/10.53841/bpscpr.2016.31.2.10

Nguyen, L. (2011). The ethics of trauma: Re-traumatization in society's approach to the traumatized subject. *International Journal of Group Psychotherapy*, *61*(1), 26–47. https://doi.org/10.1521/ijgp.2011.61.1.26

Office of the High Commissioner for Human Rights. (2022). Istanbul Protocol: Manual on the effective investigation and documentation of torture and other cruel, inhuman or degrading treatment or punishment. https://www.ohchr.org/sites/default/files/documents/publications/2022-06-29/Istanbul-Protocol_Rev2_EN.pdf. Last access 09.09.2022.

Orcutt, H. K., Reffi, A. N., & Ellis, R. A. (2020). Experiential avoidance and PTSD. In M. T. Tull & N. A. Kimbrel (Eds.) *Emotion in posttraumatic stress disorder* (pp. 409–436). Academic Press. https://doi.org/10.1016/B978-0-12-816022-0.00014-4

Patel, N., Williams, A., & Kellezi, B. (2016). Reviewing outcomes of psychological interventions with torture survivors: Conceptual, methodological and ethical issues. *Torture: Quarterly Journal on Rehabilitation of Torture Victims and Prevention of Torture*, *26*(1), 2–16. https://doi.org/10.7146/torture.v26i1.108060

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7. https://doi.org/10.14691/CPPJ.20.1.7

Rajaram, P. K. (2002). Humanitarianism and representations of the refugee. *Journal of Refugee Studies*, *15*(3), 247–264. https://doi.org/10.1093/jrs/15.3.247

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist*, *18*(1), 20–23.

Reis, B. (2009). Performative and enactive features of psychoanalytic witnessing: The transference as the scene of address. *The International Journal of Psycho-Analysis*, *90*(6), 1359–1372. https://doi.org/10.1111/j.1745-8315.2009.00216.x

Roberts, T. (2013). Understanding the research methodology of interpretative phenomenological analysis. *British Journal of Midwifery*, *21*(3), 215–218. https://doi.org/10.12968/bjom.2013.21.3.215

Schock, K., Rosner, R., & Knaevelsrud, C. (2015). Impact of asylum interviews on the mental health of traumatized asylum seekers. *European Journal of Psychotraumatology*,

6(1), 26286. https://doi.org/10.3402/ejpt.v6.26286

Schweitzer, R., & Steel, Z. (2008). Researching refugees: Methodological and ethical considerations. In P. Liamputtong (Ed.), *Doing cross-cultural research: Ethical and methodological perspectives* (pp. 87–101). Springer Netherlands.

Sidhu, S. S., & Shadid, O. (2022). Forensic psychological evaluation of asylum seekers. In K. C. McKenzie (Ed.), *Asylum medicine*. Springer. https://doi.org/10.1007/978-3-030-81580-6_4

Smith, J. A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). Sage Publications, Inc.

Smith, J. A., & Osborn, M. (2004). *Interpretative phenomenological analysis*. The British Psychological Society and Blackwell Publishing Ltd.

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

Strejilevich, N. (2006). Testimony: Beyond the language of truth. *Human Rights Quarterly*, *28*(3), 701–713. https://doi.org/10.1353/hrq.2006.0038

Tribe, R. (2002). Mental health of refugees and asylum-seekers. *Advances in Psychiatric Treatment*, *8*(4), 240–247. https://doi.org/10.1192/apt.8.4.240

Tullio, V., La Spina, C., Guadagnino, D., Albano, G. D., Zerbo, S., & Argo, A. (2023). Ethical and forensic issues in the medico-legal and psychological assessment of women asylum seekers. *Healthcare*, *11*(17), 2381. https://doi.org/10.3390/healthcare11172381

Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J. A., & Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: Suggested guidelines for trainees and courses. *Clinical Psychology Forum*, *1*(108), 3–7. https://doi.org/10.53841/bpscpf.1997.1.108.3

Ullman, C. (2006). Bearing witness: Across the barriers in society and in the clinic. *Psychoanalytic Dialogues*, *16*(2), 181–198. https://doi.org/10.2513/s10481885pd1602_6

United Nations High Commissioner for Refugees. (2019). *Handbook on procedures and criteria for determining Refugee Status Under the 1951 Convention and the 1967 Protocol Relating to the Status of Refugees.* UNHCR.

Van der Kolk, B. (2014). *The body keeps the score: Mind, brain and body in the transformation of trauma*. Penguin Books.

Varra, A. A., & Follette, V. M. (2004). ACT with posttraumatic stress disorder. In S. C. Hayes, & K. D. Strosahl (Eds.), *A practical guide to acceptance and commitment therapy*. Springer. https://doi.org/10.1007/978-0-387-23369-7_6

Vincent, F., Jenkins, H., Larkin, M., & Clohessy, S. (2013). Asylum-seekers' experiences of trauma-focused cognitive behaviour therapy for post-traumatic stress disorder: A qualitative study. *Behavioural and Cognitive Psychotherapy*, *41*(5), 579–593. https://doi.org/10.1017/S1352465812000550

Witkin, R., & Robjant, K. (2018). *The trauma-informed code of conduct for all professionals working with Survivors of Human Trafficking and Slavery.* Helen Bamber Foundation. https://www.helenbamber.org/sites/default/files/2021-05/Trauma%20Informed%20Code%20of%20Conduct_April%202021.pdf

Yildiz, A. D. (2020). The role of hope to construct a new life: Experiences of Syrian and Iraqian asylum seekers. In D. Gungor, & D. Strohmeier (Eds.), *Contextualising Immigrant and Refugee Resilience.* Advances in Immigrant Family Research. Springer. https://doi.org/10.1007/978-3-030-42303-2_8