MATTHEW MCDONNELL BSc Hons

THE CHALLENGES OF MENTAL HEALTH CARE PROVISION FOR TRAUMATISED ASYLUM SEEKERS AND REFUGEES.

Section A: What are the perceived barriers to accessing and engaging with Western mental health services for asylum seekers and refugees?

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Section B: Understanding the experiences of traumatised asylum seekers undergoing a clinical assessment for the purposes of having a medico-legal report prepared as part of their asylum claim.

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Summary page

Part A

Part A is a literature review of qualitative research exploring the perceived barriers to accessing and engaging with mental health services for asylum-seekers and refugees. A thematic synthesis of the findings from nineteen studies was carried out. Findings indicate two primary analytic themes describing barriers to mental health service utilisation: the perceived misfit of Western mental health services and the fear of opening up. These two analytic themes were composed of seven descriptive themes. The synthesis of findings is discussed in relation to the wider literature. The clinical implications are considered, and future research is proposed.

Part B

Part B is a qualitative research study employing interpretative phenomenological analysis in order to understand the experiences of six asylum-seekers who underwent a clinical assessment in order to have a medico-legal report prepared for use as evidence in their claims for asylum in the UK. Three superordinate themes were identified: tension between negative and positive expectations, therapeutic impact, the pain of having to share and remember. The findings have important clinical implications for clinicians carrying out assessments with asylum seekers and highlight the need for implementing trauma-informed approaches to care within the UK asylum system.

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Section A

What are the perceived barriers to accessing and engaging with mental health services for asylum-seekers and refugees?

Word count: 7,953 (112)

Abstract

Research reports high rates of mental health problems amongst asylum-seekers and refugees but low rates of access to and engagement with mental health services. The reasons for this are poorly understood, yet there is a growing body of qualitative research exploring the specific barriers to mental health service utilisation. This review aims to draw together the findings of the existing qualitative research. A systematic search of four electronic databases was carried out (PsychInfo, PubMed, Web of Science, and The Applied Social Sciences Index and Abstracts). Nineteen studies were identified as meeting the inclusion criteria. Thematic synthesis (Thomas & Harden, 2008) was used to guide the synthesis of findings. Two analytic themes were identified. The first analytic theme, perceived misfit of Western mental health services, was made up of four descriptive themes: mental health services do not address complexity of needs; differing cultural conceptualisations of 'mental illness' and lack of cultural competencies of Western mental health services; practical barriers; preferred sources of support and ways of coping. The second analytic theme, concern about opening up, consisted of three descriptive themes: the struggle to speak about past trauma; stigma and shame; mistrust. The review highlights significant barriers to access and engagement with mental health services for asylum seekers and refuges and considers the synthesis of findings in relation to the wider literature. The clinical implications are considered, and future research is discussed.

Key words: asylum seekers, refugees, barriers, access, engagement, mental health services.

Introduction

This paper reviews the existing qualitative literature identifying the key barriers to accessing and engaging with mental health (MH) services for asylum-seekers and refugees, from the perspectives of asylum-seekers, refugees, community leaders and service providers. The review is restricted to qualitative research as the aim is to capture detailed, first-hand accounts and to provide an in-depth exploration of the perspectives of a marginalised population. An analysis of the findings is guided by thematic synthesis (Thomas & Harden, 2008).

Refugees, asylum-seekers and exposure to trauma

Global displacement is at the highest level ever recorded. According to figures published by the United Nations High Commissioner for Refugees (2018), the number of people fleeing persecution and conflict, exceeded 70 million in 2018. In the UK, the number of refugees reached 126,720 and the number of asylum-seekers reached 45,244. Refugees and asylum-seekers often come from countries with poor access to adequate healthcare (Norredam et al., 2005) and most have experienced significant trauma, and often torture (Silove, 1999). They are subjected to further trauma through numerous post-migratory stressors, such as detention, threat of deportation, acculturation stress, unemployment, accommodation difficulties, language barriers, difficulties navigating health and social care services, racism and discrimination (Li et al., 2016). Such traumatic experiences are themselves risk factors for mental health problems (Carswell et al., 2011).

Mental health difficulties in the asylum-seeker and refugee population

Migrants who have been exposed to severe traumatic stress remain vulnerable to mental health problems as they resettle in new countries (Fazel et al., 2005; Schweitzer et al., 2006). Evidence suggests that refugees often have enduring mental health problems, notably depression and

post-traumatic stress disorder (PTSD) (Burnett & Peel, 2001; Steel et al., 2009). A review of five meta-analyses found the prevalence rates of PTSD, anxiety and depression amongst refugee trauma survivors ranged between 20% and 80%, indicating heterogeneous but high rates of mental disorder (Turrini et al., 2017). Torture severity, post-migration difficulties, and delay in receiving clinical services have been shown to be associated with higher rates of mental health symptoms (Suhaiban et al., 2019). It has been emphasised that this evidence is based on culture-bound Western psychiatric constructs of illness (Ryan et al., 2008) and the appropriateness of diagnostic criteria for migrants with different cultural backgrounds has been questioned (Summerfield, 2001). Beyond meeting certain diagnostic criteria, however, reports of difficulties with psychological health amongst traumatised refugees and asylum-seekers are widespread and consistent (Patel et al., 2016).

It is important to highlight the additional psychological stresses that asylum-seekers must cope with, compared to those with established refugee status and the protection and stability that this confers (Silove, 1999). It can often take many years and multiple legal claims before being granted leave to remain. This period of limbo, where it is not possible to make plans for the future and the fear of return is ever-present, takes a heavy toll on an individual's psychological wellbeing (Tribe, 2002). Experiences common to asylum-seekers including detention, social living difficulties and dispersal to unfamiliar areas have been found to have a harmful effect on asylum-seekers' mental health (Schweitzer et al., 2006; Robjant et al., 2009). These additional stressors are important to consider as the literature often fails to acknowledge the differences between the two groups (Bernardes et al., 2010).

Mental health service provision

Given the high rates of mental health problems in the asylum-seeker and refugee populations, provision of specialised psychosocial support is recommended (Giacco & Priebe, 2018). Asylum-seekers and refugees are a heterogeneous group, diverse in nationality, culture, ethnicity and social background. Consequently, their difficulties and needs are also heterogeneous. One shared characteristic of this population, however, is that their needs tend to be multiple and complex, and as they are amongst the most socially excluded in society they are significantly disadvantaged in terms of MH service access (Burnett & Peel, 2001). The complex nature of their circumstances presents a particular challenge to mental health services (Lavik, 1998).

Most existing research investigating the efficacy of psychological interventions for refugees and asylum-seekers has looked at interventions aimed at reducing trauma related symptoms, such as trauma-focused Cognitive Behavioural Therapy (Ehlers & Clark, 2000) and Narrative Exposure Therapy (Neuner et al., 2009). Research on the effectiveness of psychological interventions for asylum-seekers and refugees found that the majority of studies included in their reviews demonstrated improvements in psychological distress (Thompson et al., 2018). McFarlane & Kaplan (2012) highlighted a bias towards the inclusion of individuals with PTSD symptoms only and argued the need for research on interventions targeting other types of impairment and other treatment goals, including difficulties related to ongoing post-migratory stressors. Patel et al. (2016) questioned the reliability and validity of research findings on the effectiveness of NET and CBT, arguing that many studies were of poor quality. A further limitation of existing research is that there is generally no distinction made between asylum-seekers and refugees so it is not possible to examine the differences in treatment outcomes for both groups.

Under-utilisation of MH services by asylum-seekers and refugees and barriers to access and engagement

Despite the commonly reported mental health problems that asylum-seekers and refugees grapple with, they are far less likely to access and engage with MH services compared with the general population (Kinzie et al., 2006; Laban et al., 2007). For example, only 20% of refugees with PTSD in the Netherlands accessed care (Lamkaddem et al., 2014). Such underutilisation of services leaves individuals at risk of untreated mental health conditions, having a serious impact on their wellbeing (Derr, 2016). Mechanisms underlying disparities in MH service use have yet to be firmly established (Derr, 2016) and despite a growing body of research exploring the barriers, the issue remains poorly understood (Ellis, 2011). Existing research tends to focus mostly on organisational processes (Palmer & Ward, 2007) however, it is widely acknowledged in the literature that there are numerous user perceptions and beliefs concerning mental healthcare that are important barriers to help-seeking and service utilisation. Tribe (2002), for example, suggests that talking to a MH professional is likely to be perceived as an unfamiliar concept for refugees, who are more likely to approach community elders or family members for support. More recently, a survey with primary care workers found that negative views of psychiatry, fear of being stigmatised and lack of information were felt to prevent asylum-seekers and refugees from accessing and engaging with MH services (Bartolomei et al., 2016). Services working with asylum-seekers and refugees have failed to adequately address these issues (Koesters et al., 2018), suggesting that a more in-depth understanding of the barriers is needed to help develop approaches to negotiate them.

Rationale for review

Given the high rates of mental health problems reported within the asylum-seeker and refugee population, it is important to understand the different reasons for the under-utilisation of MH services, in order to find ways to facilitate access and foster engagement. The barriers to access to and engagement with MH services have been considered in two previous literature reviews (Karageorge et al., 2017; Weidenbach Gerbase, 2018), both of which addressed the broader subject of asylum-seekers' and refugees' experiences of mental health treatment. The current review includes nine studies that were not included in the previous two reviews and focuses specifically on the perceived barriers to access and engagement with MH services, to allow for a more in-depth exploration of the complex nature of this issue in particular.

By systematically investigating the perspectives of asylum-seekers, refugees, community representatives, and service providers, the review aims to identify and better characterise interrelated barriers to mental healthcare for asylum-seekers and refugees. It is essential for services to have a comprehensive understanding of these barriers in order to work effectively with these populations and to ensure equity in access to mental health care and appropriate treatment.

Aims of the review

The review aims to evaluate the existing qualitative research that addresses the following question:

What are the perceived barriers to accessing and engaging with mental health services, for asylum-seekers and refugees?

Methodology

Literature search

Four electronic databases were used to identify relevant qualitative papers: PsychInfo, PubMed, Web of Science (WoS), and The Applied Social Sciences Index and Abstracts (ASSIA). A PRISMA diagram of the search process can be found in Figure 1. The literature search was carried out in January 2020, using the following search terms:

(refugee* OR asylum) AND (mental* OR psych* OR therap* OR intervention*) AND (barrier* OR access* OR help seeking OR engage*) AND (opinion* OR belief* OR attitude* OR perception* OR expect*)

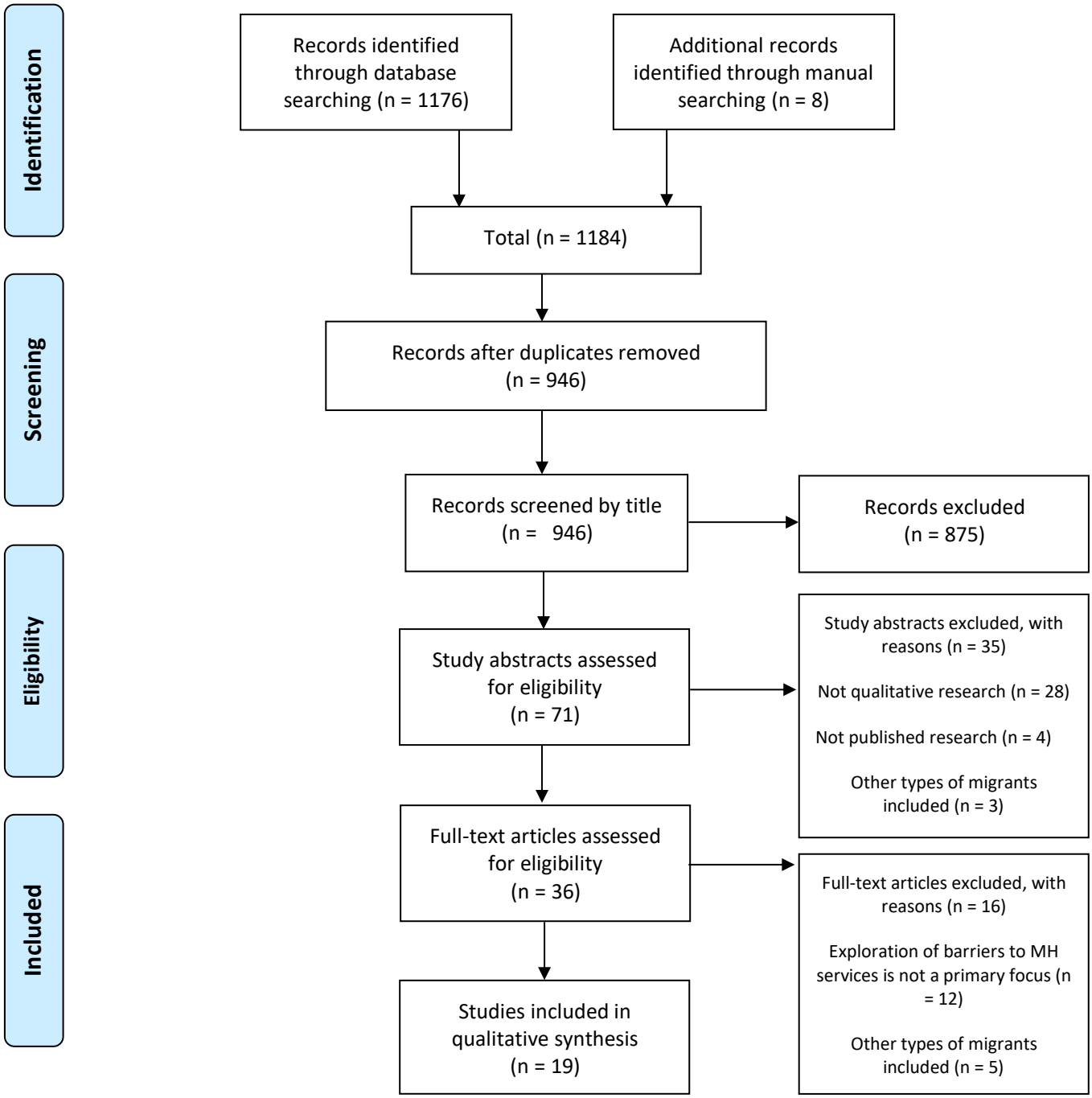
The Boolean operator 'AND' was employed to combine search terms and 'OR' was used to capture different terms. Further to these searches, a hand search of reference lists from relevant papers and a Google Scholar search was carried out in January 2020.

Duplicates of articles were removed before titles were screened. Abstracts were then screened, and full articles that seemed to meet the inclusion criteria were retrieved (Table 1). These were then screened for eligibility. Nineteen studies were assessed to be eligible for inclusion in the review.

Table 1. Eligibility criteria

Inclusion criteria	*Exclusion criteria*
Qualitative studies using either focus groups or individual interviews	Quantitative studies
Available in the English language	Reviews
Primary research	Commentaries
In peer-reviewed journals	Dissertation abstracts
Factors associated with barriers to seeking-out, accessing and engaging with mental health services are a primary focus of exploration	Book chapters
Included participants who have first-hand knowledge of experiences of asylum-seekers and refugees: service users, asylum-seekers and/or refugees, community spokespeople, mental health professionals	Where the barriers relating to asylum-seekers and refugees were not distinguished from other kinds of immigrants (e.g. migrant workers)
Has an explicit focus within the research on asylum-seekers and/or refugees	
No restriction placed on when or where study carried out	

Figure 1. **PRISMA diagram of literature search process**



Data extraction and analysis

Studies were appraised using Kmet, Lee and Cook's (2004) quality assessment criteria for evaluating research papers (Appendix A). This framework helped to assess the quality of the studies and to aid extraction of relevant data.

Structure of this review

The studies' characteristics are first presented and then critiqued. The synthesis of findings, guided by thematic synthesis (Thomas & Harden, 2008), are then presented. In the discussion, the findings of the synthesis are discussed in relation to the wider literature, the strengths and limitations of the review are presented, and the clinical and research implications are considered.

Review

Study characteristics

Twelve of the nineteen studies included in this review used a qualitative methodology. The other studies employed mixed methodology, with the main body of the studies comprised of qualitative research with supplementary quantitative research included to provide descriptive statistics. As the quantitative components of the mixed methods studies do not provide further insight into the nature of the barriers to MH services, these are not discussed in this review. Descriptions of the quantitative components are included in the summary table below (Table 1) to help provide context.

A range of qualitative data collection approaches were used. Eleven of the studies used individual semi-structured interviews, four of the studies used focus groups and four used both individual interviews and focus groups. The method of data analysis varied, with the majority

using thematic analysis (n=12). The participants recruited to the qualitative components in eight of the studies were restricted to refugees. Two studies recruited only asylum-seekers and two studies recruited both refugees and asylum-seekers. One study recruited services providers, two studies recruited service providers and refugees and one study recruited service providers and asylum-seekers. Two studies recruited community representatives.

The nine studies not included in the two previous reviews are: Asgary & Segar (2011); Colucci et al. (2015); Kahn et al. (2018); Omar et al. (2017); Palmer (2006); Papadopoulos et al. (2004); Savic et al. (2016); Shannon et al. (2015); Slobodin et al. (2018). These studies all explore the perspectives of asylum-seekers, refugees and service providers on the barriers to accessing and engaging with MH services, thus broadening the range of views and providing added depth and insight to the overall analysis. Table 1 summarises the main characteristics of the nineteen studies.

Table 2. *Summary of reviewed studies*

Study no.	Author (date) Title	Country in which study took place	Aims	Design	Sampling method	Participants	Sample ethnicity/ nationality	Data collection	Data analysis
1.	Asgary & Segar, (2011). Barriers to health care access among refugee asylum-seekers.	United States	To investigate the perspectives of asylum-seekers, health care providers, and experts working closely with them, to identify interrelated barriers to care for asylum-seekers living in New York.	Qualitative	Purposive sampling	Asylum-seekers (n = 35) Gender: Female = 14% Male = 86% Service providers (n = 15)	Asylum-seekers: Cameroonian (n = 4) Chadian (n = 4) Guinean (n = 4) Pakistani (n = 3) Bangladeshi (n = 2) Congolese (n = 2) Kosovan (n = 2) Senegalese (n = 2) Sierra Leonean (n = 2) Egyptian (n = 1) Eritrean (n = 1) Ghanaian (n = 1) Indian (n = 1) Ivorian (n = 1) Lebanese (n = 1) Malian (n = 1) Mauritanian (n = 1) Nepalese (n = 1) Russian (n = 1) Service providers: Ethnicity/nationality not provided	Focus groups (n = 14) Semi-structured individual interviews (n = 36)	Thematic analysis (not referenced)
2.	Bernardes, Wright, Edwards, Tomkins, Dlfoz & Livingstone, (2010). Asylum-seekers' perspectives on their mental health and views on health and social services: contributions for service provision using a mixed-methods approach.	United Kingdom	To investigate asylum-seekers' symptoms of psychological distress and their subjective experience of the asylum process, its potential impact on their mental health, and participants' suggestions for tackling mental health problems.	Mixed methods	Sampling method not specified	Asylum-seekers (n = 29) Gender: Female = 10% Male = 90% Mean age: 29.5 years	Iranian (n = 9) Zimbabwean (n = 3) Afghan (n = 3) Iraqi (n = 2) Sri Lankan (n = 2) Eritrean (n = 2) Ethiopian (n = 2) Guinean (n = 1) Moroccan (n = 1) Cabindan (n = 1) Sudanese (n = 1) Kuwaiti (n = 1) Turkish (n = 1)	Mental health screening measures (n = 29) Semi-structured individual interviews carried out one month after measures completed (n = 8)	The free association narrative interview method (Hollway & Jefferson, 2000)

3.	Bettmann, Penne, Freeman & Lecy, (2015). Somali refugees' perceptions of mental illness.	United States	To investigate Somali refugees' perceptions of mental illness and its treatment.	Qualitative	Purposive and snowball sampling	Refugees (n = 20) Gender: Female = 50% Male = 50%	Somali refugees who identified as Somali or Somali Bantu	Individual semi-structured interviews	Thematic analysis guided by grounded theory (Strauss & Corbin, 1998)
4.	Colucci, Minas, Szwarc, Guerra & Paxton, (2015). In or out? Barriers and facilitators to refugee-background young people accessing mental health services.	Australia	To explore the barriers and facilitators to engaging young people from refugee backgrounds with mental health services.	Qualitative	Purposive sampling	Service providers (n = 120) Gender: Female = 74% Male = 26% Mean age: 38.6 years	Ethnicity/ nationality not provided	Focus groups (n = 115) Key informant interviews (n = 5)	Thematic analysis (Pope, Ziebland & Mays, 2000)
5.	De Anstiss & Ziaian, (2010). Mental health help-seeking and refugee adolescents: Qualitative findings from a mixed-methods investigation.	Australia	To investigate refugee adolescent mental health service utilisation and help-seeking.	Qualitative	Convenience and snowball sampling	Refugee adolescents (n = 85) Gender: Female = 48% Male = 52% Age range: 13-17 years	Afghan (n = 16) Bosnian/Serbian (n = 10) Iraqi (n = 17) Liberian (n = 15) Persian (n = 14) Sudanese (n = 13)	Focus groups	Thematic analysis (Krueger & Casey, 2000)
6.	Ellis, Lincoln, Charney, Ford-Paz, Benson, Strunin, (2010). Mental health service utilization of Somali adolescents: Religion, community, and school as gateways to healing.	United States	To examine the utility of the Gateway Provider Model in understanding service utilisation and pathways to help for Somali refugee adolescents resettled in the US.	Mixed methods	Purposive sampling	Refugee caregivers and adolescents (n = 295) Gender of adolescents: Female: 37% Male: 63% Age range of adolescents: 11-20 years	Somali refugees who identified as Somali or Somali Bantu	Adolescent report of service utilisation (n = 144 adolescents) Parent report of service utilisation (n = 144 parents/caregiver) Mental health screening measures (n = 144 adolescents)	Thematic analysis (Patton, 2002)

								Individual semi-structured interviews (n = 14 adolescents) Focus groups (n = 16 adolescents)	
7.	Kahn, Alessi, Kim, Woolner & Olivieri, (2018). Facilitating mental health support for LGBT forced migrants: A qualitative inquiry.	Canada	To explore facilitators and barriers to mental health care in Canada for forced migrants who are LGBT through the perspectives of service providers and forced migrants.	Qualitative	Purposive and snowball sampling	Service providers (n = 22) LGBT refugees (n = 7) Age range: 22-51	LGBT refugees: Bahamian Bangladeshi Iranian Lebanese Arabic Ghanaian	Individual semi-structured interviews	Thematic analysis (Braun & Clarke, 2006)
8.	Maier & Straub, (2011). "My head is like a bag full of rubbish": Concepts of illness and treatment expectations in traumatized migrants.	Switzerland	To explore traumatised migrants' concepts of illness and expectations concerning medical treatment.	Qualitative	Purposive sampling	Asylum-seekers (n = 8) Refugees (n = 5) Gender: Female = 38% Male = 62% Age range: 22-53 years	Bosnian (n = 2) Kosovan (n = 2) Turkish (n = 1) Turkish Kurdish (n = 1) Iranian Kurdish (n = 2) Afghan (n = 2) Cameroonian (n = 1) Sudanese (n = 1) Chechnyan (n = 1)	Individual semi-structured interviews	Content analysis (Mayring, 1990)
9.	Majumder, O'Reilly, Karim & Vostanis, (2015). 'This doctor, I not trust him, I'm not safe': The perceptions of mental health and services by unaccompanied refugee adolescents.	United Kingdom	To explore the views and perceptions that unaccompanied minors hold about mental health services.	Qualitative	Sampling method not specified	Asylum-seeker adolescents (n = 8) Refugee adolescents (n = 8) Gender: Female = 13% Male = 87% Age range: 15-18 years	Afghan (n = 11) Iranian (n = 2) Somali (n = 2) Eritrean (n = 1)	Individual semi-structured interviews	Thematic analysis (Boyatzis, 1998)

10.	Misra, Connolly, Majeed, (2006). Addressing mental health needs of asylum-seekers and refugees in a London Borough: Epidemiological and user perspectives.	United Kingdom	To undertake a needs assessment of mental health services for asylum-seekers and refugees in Haringey, to estimate accurate numbers of asylum-seekers and refugees who need mental health services and to understand their perspective on mental health needs and services.	Qualitative	Purposive sampling	Leaders and key members of the refugee community organisations representing the main refugee groups in Haringey (n = 10)	Albanian Kosovan Turkish Kurdish Turkish and Greek Cypriot Somali Iraqi Afghan	Individual semi-structured interviews	Grounded theory (not referenced)
11.	Omar, Kuay & Tuncer, (2017). 'Putting your feet in gloves designed for hands': Horn of Africa Muslim men perspectives in emotional wellbeing and access to mental health services in Australia.	Australia	To examine Horn of Africa Muslim men's understanding, experiences and views on the causes of emotional difficulties, barriers to seeking help, access to mainstream mental health services and traditional African treatments in the Australian context.	Qualitative	Sampling method not specified	Muslim refugees from the Horn of Africa (n = 36) Gender: Female = 0% Male = 100% Age range: 18-60 years	Somali (n = 17) Ethiopian (n = 2) Djiboutian (n = 3) Saudi Arabian (n = 5) Eritrean (n = 6) Sudanese (n = 2) Unknown (n = 1)	Focus groups	General inductive approach (Thomas, 2006)
12.	Palmer, (2006). Imperfect prescription: mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them.	United Kingdom	To assess the Somali community's own perception of mental illness and some of the barriers to accessing and utilising services in the London Borough of Camden.	Mixed methods	Sampling method not specified	Refugees (n = 7) Gender: Female = 57% Male = 43% Mean age: 34 years Somali community groups (n = unknown)	Somali	Semi-structured interviews Database for recording demographic information	Framework approach to thematic analysis (Richie & Spencer, 1994)
13.	Papadopoulos, Lees, Lay & Gebrehiwot, (2004). Ethiopian refugees in the UK: migration, adaptation and settlement experiences and their relevance to health.	United Kingdom	To explore Ethiopian refugees' and asylum-seekers' experiences of migration, adaptation and settlement in the UK and their health beliefs and practices.	Mixed methods	Quota and snowball sampling	Refugees & asylum-seekers (n = 106) Gender: Female = 52% Male = 48%	Ethiopian	Semi-structured questionnaire Individual semi-structured interviews	Thematic analysis (Patton, 1990)

14.	Piwowarczyk, Bishop, Yusuf, Mudymba & Raj, (2014). Congolese and Somali beliefs about mental health services.	United States	To examine the conceptualisation and experience of mental illness, the attitudes and beliefs towards mental health treatment and the barriers to treatment utilisation among Congolese and Somali refugees.	Mixed methods	Convenience and snowball sampling	Somali and Congolese community members (n = 327) Gender: Female = 100% Male = (0%) Age range in focus groups: 18-59 years	Focus groups: Democratic Republic of Congo (n = 15) Somalia (n = 16)	Anonymous community-based survey (n = 296) Focus groups (n = 31)	Grounded theory (Glaser & Strauss, 1967)
15.	Posselt, McDonald, Procter, Crespigny & Galletly, (2017). Improving the provision of services to young people from refugee backgrounds with comorbid mental health and substance use problems: addressing the barriers.	Australia	To investigate the barriers and facilitators to culturally responsive comorbidity care for refugee youth and whether the MH and AOD services were equipped to provide such support.	Mixed methods	Purposive and snowball sampling	Refugee young people (n = 15) Gender: Female = 75% Male = 25% Age range: 12-25 years Service providers (n = 71)	Refugee youth participating in semi-structured interviews: Afghan (n = 9) African (n = 4) Bhutanese (n = 2) Service providers participating in semi-structured interviews: Ethnicity/ nationality not provided	Individual semi-structures interviews Survey regarding service provision for refugee background clients aged 12-25	Thematic analysis (Braun & Clarke, 2006)
16.	Savic, Chur-Hansen, Mahmood & Moore, (2016). ‘We don’t have to go and see a special person to solve this problem’: Trauma, mental health beliefs and processes for addressing ‘mental health issues’ among Sudanese refugees in Australia.	Australia	To explore the mental health beliefs of resettling Sudanese refugees.	Qualitative	Sampling method not specified	Key informants (n = 20) Gender: Female = 70% Male = 30%	Australian (n = 14) South Sudanese (n = 6)	Individual semi-structured interviews	Framework approach to thematic analysis (Richie & Spencer, 1994)
17.	Shannon, Wieling, Simmelink-McCleary & Becher, (2015). Beyond stigma: Barriers to	United States	To explore refugees’ perspectives on why it is difficult to discuss the mental health effects of political violence in order to provide a	Qualitative	Sampling method not specified	Refugees (n = 111) Gender:	Bhutanese (n = 34) Karen (n = 23) Oromo (n = 27)	Focus groups	Thematic categorisation (Spradley, 1979)

	discussing mental health in refugee populations.		greater understanding of factors affecting mental health service utilisation in refugee populations.			Female = 48 Male = 63 Age range: 18-78 years	Somali (n = 27)		
18.	Slobodin, Ghane & De Jong, (2018). Developing a culturally sensitive mental health intervention for asylum-seekers in the Netherlands: a pilot study.	The Netherlands	To investigate asylum-seekers' needs and expectations in the mental health field to develop a culturally sensitive psychosocial intervention.	Mixed methods	Sampling method not specified	Asylum-seekers (n = 28) Gender: Female = 14% Male = 86%	Focus groups: Syrian (n = 17)	Expectations from therapy questionnaire (n = 11) Focus groups (n = 17)	Phenomeno-logical analysis (Colaizzi, 1978)
19.	Valibhoy, Szwarc & Kaplan, (2017). Young service users from refugee backgrounds: their perspectives on barriers to accessing Australian mental health services.	Australia	To examine barriers to accessing mental health services, from the perspective of young people of refugee background who have been service users, and to suggest strategies to improve access to mental health services.	Qualitative	Purposive sampling	Refugees (n = 16) Gender: Female = 56% Male = 44% Age range: 18-25 years	Iraqi (n = 5) Afghan (n = 3) Iranian (n = 2) Sudanese (n = 1) Pakistani (n = 1) Tanzanian (n = 1) Ethiopian (n = 1) Ivorian (n = 1) Congolese (n = 1)	Individual semi-structured interviews	Thematic analysis (Braun & Clarke, 2006)

Quality assessment

Quality assessment tool

The Kmet et al. (2004) quality assessment tool was used to help inform a narrative critique of the studies. The tool provides specific criteria for scoring the quality of the study. Studies which achieve a score of 75% or above are considered to be of good quality and those scoring below 55% are deemed to be of poor quality. None of the studies scored below 55% and 18/19 scored 75% or above. Although the numerical scoring was used here, it only provides an approximation of the quality of the studies as there are inherent problems in weighting different quality domains equally in total scores (Higgins & Green, 2011) and meeting specified criteria does not guarantee the quality of qualitative research (Hannes et al., 2015).

Study aims and design

All studies aimed to explore the perceptions, beliefs and experiences of asylum-seekers and refugees with accessing and engaging with MH services. Therefore, qualitative methodology was the most appropriate design (Sofaer, 1999). The specific aims of each study were clearly outlined, and the objectives were informed by the relevant theory and existing research. The majority of the studies (n=11) were designed and implemented without the involvement of asylum-seekers and refugees, meaning that the power differential between the researcher and the subject is left unaddressed and the findings are only presented through the prism of the researchers' viewpoint. This is an important issue in research involving this population, who are a marginalised group with different cultural backgrounds to Western researchers. Five of the studies (e.g. De Anstiss & Ziaian, 2010; Shannon et al., 2015) consulted with community representatives on different stages of the research and three of the studies (e.g. Ellis et al., 2010; Posselt et al., 2017) drew on principles of participatory action research, involving asylum-

seekers and refugees in every stage of the research. This helps to create a collaborative approach which diminishes the unequal 'observer and observed' divide.

Participants and sampling

A number of the studies (n=7) did not specify their sampling method, meaning that it is unclear whether participants were recruited using the appropriate method. Ten of the studies did not describe how participants were identified and approached, meaning it is unclear whether there were issues of selection bias. The other studies provided some description, which generally involved researchers attending community centres and clinics to invite people to participate directly (e.g. Asgary & Segar, 2011; Piwowarczyk et al., 2014). This approach may have led to a sample who were more predisposed to speaking about their experiences and may not have captured the voices of those less inclined to share their views. Two of these studies (Bettmann et al., 2015; Posselt et al., 2017) used community leaders and MH workers to encourage participation which raises an ethical question of whether individuals felt obliged to take part.

Overall, the studies provided reasonably detailed demographic information. The five studies including service providers may have more limited value given that their views on asylum-seekers and refugees' experiences are inevitably influenced by their own sociocultural background, which was not considered in the majority of the studies. Nine studies recruited a heterogenous sample in terms of participant nationality, helping to capture the core experiences of asylum-seeker and refugee groups. The remaining studies recruited homogenous samples in terms of nationality. In some cases, this was justified given that these studies aimed to explore the experiences of particular nationalities. Other studies (e.g. Majumder et al., 2015) would have benefitted from a more diverse sample in order for findings to be more generalisable.

Ethical considerations

Nine of the studies did not report whether or not ethical approval had been granted. While not necessarily undermining the findings, this is concerning as ethical approval is critical for ensuring the protection of the participants' dignity, safety and well-being (Department of Health, 2011), and particularly important given the vulnerability of the population under study. Three studies (e.g. Misra et al., 2006) did not mention any ethical considerations made in the design of their study. These omissions are worrying given that consideration of ethics is particularly important within qualitative research, where the data tends to be personal and from a small number of individual participants (Twining et al., 2017).

Data collection

Whilst the majority of studies gave detailed descriptions of how the data was collected, some lacked important information, such as whether or not interpreters were used (e.g. Palmer, 2006). All of the studies except four (e.g. Piwowarczyk et al., 2014; Omar et al., 2017) provided a clear outline of the interview guide, demonstrating transparency. The use of focus groups was not justified in any of the studies and no consideration was given as to how the group setting can inhibit an individual and influence the way an answer is given (Acocella, 2011). The impact of the use of interpreters on how comfortable people felt to share their experiences or on the accuracy of the data collected (Wallin & Ahlstrom, 2006) was not considered in any of the studies. The majority of the studies audio-recorded the interviews, however, some studies took notes for some or all of the interviews (e.g. Bernardes et al., 2010). The possibility of inaccurate data recording and risk of bias, in terms of what researchers chose to record, was not mentioned in these studies.

Data analysis

Four studies (e.g. De Anstiss & Ziaian, 2010; Kahn et al., 2018) provided a clear account of the analysis process, helping to understand how the themes were derived from the data. Five studies (e.g. Colucci et al., 2015; Majumder et al., 2015) provided a simple account of how data was analysed. The lack of detail provided means it is not possible to assess the rigor the analysis and whether it adhered to the chosen method. The majority of studies (n=18) provided no rationale for the chosen methodology. All studies referenced the guidance that they followed (e.g. Braun & Clarke, 2006), apart from two studies (Misra et al., 2006; Asgary & Segar, 2011) who described using thematic analysis and grounded theory respectively but provided no reference. All studies included direct quotations, helping to relate emerging themes to the original data.

Data validation

Following recommendations for qualitative research (Yardley, 2000), the majority of studies (n=15) validated data through other researchers, via audit trails, investigator triangulation and independent researcher checking. A limitation of co-researcher checking is that the researcher's voice continues to dominate that of the participant (Mason, 2002). Respondent validation, the process of having participants check findings for accuracy and resonance with their experiences (Birt et al., 2016), was used in three of the studies (e.g. Bettmann et al., 2015), helping to reduce researcher bias. Four studies consulted community representatives, service providers and refugees to help check researcher assumptions. Four of the studies did not report any method of data validation (e.g. Maier & Straub, 2011; Slobodin et al., 2018).

Reflexivity

Only one study (Kahn et al., 2018) demonstrated reflexivity (i.e. describing how they sought to examine their positions and underlying assumptions throughout the data collection and analysis). The lack of demonstrated reflexivity in the other studies is a significant shortcoming as it is unclear whether the impact of the researchers' assumptions and views have been considered. This is particularly important in research involving marginalised groups, such as asylums seekers and refugees. Reflexivity helps to build an awareness of asymmetries in power between researcher and participant and reduces the risk of misrepresentation (Block et al., 2012).

Methodology of the synthesis

Thematic synthesis (Thomas & Harden, 2008) was used to guide the analysis of the findings from each study. The results sections of the studies were coded to help identify themes and to allow for the translation of concepts from one study to another (Britten et al., 2002). Both verbatim quotes of the different groups of participants (i.e. asylum-seekers, refugees, community representatives and service providers) and interpretations by authors were coded. Seven descriptive themes were identified. These were then organised under two analytic themes (see Table 2 below). A table of example quotations for each theme is presented in Appendix B.

Synthesis of findings

Table 3. Table of themes.

Descriptive themes	Analytic themes
MH services do not address complexity of needs	Perceived misfit of Western MH services
Differing cultural conceptualisations of 'mental illness' and lack of cultural competencies of Western MH services	
Practical barriers	
Preferred sources of support and ways of coping	
The struggle to speak about past trauma	Concern about opening up
Stigma and shame	
Mistrust	

Perceived misfit of Western mental health services

All studies discussed the perceived misfit between Western MH services and the mental health needs of asylum seekers and refugees. This is captured by four descriptive themes, discussed below.

MH services seen as not addressing complexity of needs

Asylum-seekers and refugees described the cumulative effect of multiple traumas, related to experiences in individuals' home countries and their subsequent integration into a new country, which contribute to mental health problems (e.g. Palmer, 2006). Commonly, current mental health problems were associated with post-migration stressors. Asylum-seekers and refugees spoke of significant anxiety whilst seeking asylum, created by insecurity about the outcome of their asylum application, an unfamiliar legal process and fear of return (e.g. Bernardes et al.,

2010; Slobodin et al., 2018). Central to the asylum-seeker experience was difficulty of having to remain dependent on others while striving for independence. Asylum-seekers reported feeling unable to progress in their lives without knowing the outcome of their asylum claim, as if they were 'waiting in limbo' (Bernardes et al., 2010). This experience of enforced passivity and lack of control was described by asylum-seekers as a major source of psychological distress (Slobodin et al., 2018).

Asylum-seekers and refugees cited social living difficulties, such as problems with language, lack of work opportunities and accommodation as having a detrimental impact on mental health (e.g. Maier & Straub, 2011; Omar et al., 2017). Experiences of discrimination and racism were also identified as significant stressors (e.g. Omar et al., 2017). According to refugees and community representatives, for individuals who have had status for some time, there are often emergent mental health issues arising from adapting to a new culture (e.g. Papadopoulos et al., 2004; Misra et al., 2006). Asylum-seekers and refugees frequently related emotional difficulties to profound loss: loss of their home country, of their culture, their families, homes, professions and communities, which were a source of support and connection (e.g. Slobodin et al., 2018).

All groups of participants across a number of studies reported that concerns about these complex needs take precedence over accessing mental health services (n=7). Asylum-seekers and refugees articulated political and social and solutions to their mental health problems, including improvements in living conditions, having opportunities to work and alterations to the asylum system (e.g. Asgary & Segar, 2011). It is felt that there is not enough focus on the link between these challenges, experienced as a result of migration or resettlement, and mental health problems. Community representatives and refugees explained that, whilst the

opportunity to discuss the experience of trauma is potentially therapeutic, support in the social aspects of their lives was seen as more beneficial (e.g. Savic et al., 2016). Concerns were voiced about poor fit between cause and solution and that merely talking cannot cure the very real sociocultural and political problems that cause distress (Valibhoy et al., 2017).

Differing cultural conceptualisations of 'mental illness' and lack of cultural competencies of Western MH services

Service providers recognised that a lack of understanding about how asylum-seekers and refugees conceptualise their mental health problems, and the presumption of a shared construct of 'mental illness' across cultures, act as a barrier to service engagement (Colucci et al., 2015). Refugees and community representatives suggested that cultural interpretations of distress must be taken into consideration to help reach a shared understanding (e.g. Palmer, 2006). A number of refugees were unfamiliar with the terms "mental health" and "mental illness" (De Anstiss & Ziaian, 2010). Asylum-seekers and refugees made a distinction between 'normal' everyday stress and mental illness (Papadopoulos et al., 2004), which was frequently referred to using words such as "madness" and "crazy" (e.g. Bettmann et al., 2015, Valibhoy et al., 2017). Participants gave varying descriptions of the manifestations of psychological distress which often included observable, erratic behaviours (e.g. Piwowarczyk et al., 2014). It was felt by some that only in these more extreme cases would help be required (e.g. De Anstiss & Ziaian, 2010) leading individuals to view their difficulties as not sufficiently serious to warrant assistance (Valibhoy et al., 2017). Asylum-seekers and refugees often described their problems in terms of somatic complaints, such as headaches and digestive disorders (e.g. Bernardes et al., 2010). It was suggested that this provides an alternative description for their mental state, whereby difficulties were attributed to parts of the body rather than to emotions (Majumder et al., 2015).

The causes of mental illness were regularly attributed to God (e.g. Maier & Straub, 2011) or to supernatural causes (e.g. Papadopoulos et al., 2004), such as being possessed by an evil spirit. It was proposed that this view of mental health problems as a spiritual issue rather than a medical or psychological one, was a contributing factor to low take-up of Western services (Palmer, 2006). However, it was argued by community representatives that this is likely to be a traditional explanation held by those from rural areas or with less education (Savic et al., 2016). Some asylum-seekers conceptualised mental illness along classical Western lines, using terms such as 'depression' (Ellis et al., 2010), or as a medical problem, treatable by Western medicine (Maier & Straub, 2011). This highlights the diversity of views amongst asylum-seekers and refugees, and the necessity for diverse responses.

All groups of participants highlighted an expectation amongst asylum-seekers and refugees that services will lack cross-cultural awareness and competencies and will be unable to understand or relate to their particular experiences (e.g. Shannon et al., 2015; Kahn et al., 2018). The sense that treatments are not culturally appropriate left individuals feeling that services are disinclined towards them (e.g. Omar et al., 2017; Posselt et al., 2017). It was suggested that the culture of therapy might be at odds with the cultural backgrounds of asylum-seekers and refugees. For example, making eye contact and speaking one's mind freely may be challenging for those from cultures where directness is discouraged (Valibhoy et al., 2017). Service providers felt that asylum-seekers and refugees would experience their approach negatively, for example, it was thought that being asked multiple questions might evoke experiences of interrogations (Colucci et al., 2015). Refugees suggested that there was a lack of understanding amongst healthcare professionals about why it is hard for them to share

information about their mental health problems which means that they are not initiating the appropriate conversations to facilitate this (Shannon et al., 2015).

Asylum-seekers' and refugees' lack of knowledge and awareness about the purpose of MH services and relevance to their needs was identified as a barrier (n=7). It was felt by all groups of participants that asylum-seekers and refugees are uninformed and so have limited insight into the role of MH services and the kind of difficulties they can help with (e.g. Bernardes et al., 2010, Asgary & Segar, 2011). Refugees and community representatives felt that there was a perception amongst asylum-seekers and refugees that MH services are provided for people culturally different to them (e.g. Omar et al., 2017). However, a number of younger refugees were interested in learning more about the impact of trauma on their health and would want to talk to professionals about this if it is was felt to be beneficial to their wellbeing (Posselt et al., 2017).

Practical barriers

Practical issues around accessibility were said to impede engagement. These included the appearance of services and appointment systems. The procedures services require were said by refugees and service providers to prevent engagement through their rigid inclusion criteria, appointment-based services and the time-limited nature of interventions, therefore failing to accommodate asylum-seekers and refugees, who may require more flexibility in order to engage (e.g. Posselt et al., 2017). Service providers described a lack of an enabling environment in MH services, which were seen as too sterile and clinical, set in closed rooms which risk evoking negative experiences of confinement among asylum-seekers and refugees (e.g. Colucci et al., 2015).

Inadequate interpretation emerged as an important barrier to accessing services, as all groups of participants discussed problems asylum-seekers and refugees have communicating with providers (e.g. Misra et al., 2006; Palmer, 2006,). Asylum-seekers talked of occasions where interpreters were not provided, meaning that family members had to translate for them, inhibiting discussion of confidential matters (Asgary & Segar, 2011) and being uninformed of choices about their treatment due to language barriers (Bernardes et al., 2010). Some refugees spoke of feeling fearful that their lack of English would lead them to being misunderstood by professionals (Bettmann et al., 2015). Community representatives explained that, even when interpreting services are available, it is harder to receive effective treatment for mental health problems when the clinician has to communicate through an interpreter (Misra et al., 2006) and there was a concern amongst refugees that interpreters may not interpret accurately (Shannon et al., 2015). Services providers explained that some services could not fund use interpreters and those that could were sometimes discouraged from using them due to the high costs (Posselt et al., 2017).

Preferred sources of support and ways of coping

All groups of participants believed that there was an expectation amongst asylum-seekers and refugees for support to be provided by the individual's family, friends and community, rather than through MH services, helping them to manage trauma in an environment where they share a language, history, and culture (e.g. Piwowarczyk et al., 2014; Omar et al., 2017). Refugees considered community support to be important given the potential for community to break isolation and loneliness (Kahn et al., 2018). Community representatives shared a belief held by asylum-seekers and refugees that the traumas experienced were not something requiring professional help (e.g. Savic et al., 2016). They suggested that issues associated with psychological distress were not necessarily considered abnormal, but rather were a part of

everyday life, requiring non-professional responses from family and community (e.g. Misra et al., 2006). Belief in healing through religion emerged as a key theme within the interviews (n=8), with approaches including prayer, reading the Qur'an and talking to the Imams, pastors or church elders (e.g. Ellis et al., 2010; Omar et al., 2017).

Refugees and community leaders indicated that sources of support such as family and community actively discouraged involvement of professionals (e.g. Valibhoy et al., 2017) and the notion of talking to a stranger from a different culture, was unacceptable for some (Piwowarczyk et al., 2014). A number of refugees criticised this view and disagreed with the traditional approaches to treatment, especially when they are an obstacle to services (Valibhoy et al., 2017). Other refugees emphasised the importance of handling their problems on their own, which appeared to be related to a wish to hide their difficulties and avoid burdening others (e.g. Ellis et al., 2010).

Concern about opening up

The challenge for asylum-seekers and refugees to open up to MH professionals was described in all of the studies. These challenges related to the difficulty of discussing past trauma, the stigma and shame of 'mental-illness', and mistrust of MH services.

The struggle to speak about past trauma

Asylum-seekers and refugees cited a wish to avoid talking about past traumatic experiences and the belief that talking about the past would not provide any benefits, as an important reason why they do not access services (e.g. Bernardes et al., 2010, Majumder et al., 2015). Refugees and community leaders described a belief that talking about trauma might be retraumatising and exacerbate difficulties, with some refugees fearing that it would cause them to experience

intrusive memories or to “lose control” (e.g. Misra et al., 2006). For some refugees, the desire to forget what had happened and the wish to move on contributed to avoidance of talking about their trauma (e.g. Valibhoy et al., 2017). This avoidance was seen as particularly understandable given that reexperiencing of trauma is a significant source of distress. A number of refugees who had been imprisoned for speaking out about their political beliefs felt that it would be too difficult to begin speaking about their suffering, even after obtaining safety in a different country, having spent years being silenced about their experiences (Shannon et al., 2015). The belief that no one could understand or relate to their experiences and the risk of being disbelieved was also articulated by asylum-seekers and refugees as a barrier to talking about the past (e.g. Valibhoy et al., 2017). However, some asylum-seekers did express a readiness to process trauma in a therapeutic setting (Slobodin et al., 2018).

Stigma and shame

Stigma and feelings of shame surrounding mental health problems and help-seeking were seen as significant barriers to MH services in all of the studies. Stigma appears to be rooted in a negative perception of MH services in participants’ countries of origin, which are seen to be reserved for people with severe mental health problems (Bernardes et al., 2010, Ellis et al., 2010). The language used to describe people in need of these services invariably had derogatory and negative connotations, inviting prejudice (e.g. Majumder et al., 2015). The terms ‘mental illness’ and ‘mental health’ were associated with labels such as “mad”, “crazy”, “lunacy”, and “dangerous to society” (n=8).

Asylum-seekers and refugees expressed concern with being perceived as “crazy” if they were to seek psychological support (e.g. Shannon et al., 2015; Posselt et al., 2017). Studies suggested that stigma becomes internalised as shame, making it difficult for people to share their

psychological difficulties (n=7). It was suggested that shame causes individuals to be secretive about their problems, avoidant of asking for help (e.g. Kahn et al., 2018) and wary of being honest with professionals about their difficulties (Shannon et al., 2015). Asylum-seekers and refugees feared that if they spoke openly, they would be hospitalised, separated from their families or ostracised by their community (e.g. Bettmann et al., 2015). They explained that people seen as "crazy" are kept inside the home, away from others, as a way to protect them from public ridicule and to protect the public from the potentially dangerous behaviours of people with mental health problems (e.g. Palmer, 2006). Given the level of stigma, it was felt that mental health issues may manifest in other culturally sanctioned ways which are less shameful, including physical health problems (e.g. Savic et al., 2016; Slobodin et al., 2018).

For some there was a deeper sense of shame associated with discussing emotional problems with strangers as it was felt that these issues should be kept within the family in order to preserve social status (e.g. De Anstiss & Ziaian, 2010). Participants expressed how upset their family would be with them if they were to share their problems with "outsiders" (e.g. Valibhoy et al., 2017). Some discussed the importance of managing one's distress by oneself in order to avoid being seen by others as unable to cope, leading people to isolate themselves (Ellis et al., 2010, Shannon et al., 2015). It was felt that the sense of shame around seeking help left people keeping everything inside, unable to communicate about their problems. It was suggested that this can result in people trying to cope with their problems alone, through drugs and alcohol or in some cases can lead to suicide (e.g. Slobodin et al., 2018).

Mistrust

Fear and distrust of MH services and professionals were felt by all participant groups to be a major barrier to disclosure of mental health problems and past trauma, and to effective

engagement with treatment (n=8). Asylum-seekers and refugees cited a number of reasons as to why they are mistrustful of services, largely based on feeling "dehumanised" and "marginalised" (Majumder et al., 2015). Refugees held negative beliefs about professionals' capacity and willingness to help (De Anstiss & Ziaian, 2010) and felt that they cannot be trusted as they are strangers (e.g. Valibhoy et al., 2017). Some felt mistrustful due to past experiences of discrimination on the basis of race and being undocumented, leading to MH services being viewed as unwelcoming and disempowering spaces (e.g. Bernardes et al., 2010; Asgary & Segar, 2011). Asylum-seekers and refugees felt that they would not receive the same level of care as legal citizens nor would their information be protected in the same way (e.g. Posselt et al., 2017) causing fears about confidentiality and further distrust (Valibhoy et al., 2017).

Studies suggested that the psychological consequences of prior traumatic experiences create insecurity, fear of authority and a breakdown in the ability to trust others (e.g. Papadopoulos et al., 2004; Palmer, 2006). Service providers felt that previous traumatic experiences may have created fear of undergoing formal assessments and providing personal information (Colucci et al., 2015). They may have experienced hostility from authorities during their migration, leading to lack of trust in professionals and institutions, including people in uniform and MH services (e.g. Posselt et al., 2017). Service providers suggested people have likely experienced situations where authorities misused information or where sharing personal details with a stranger had endangered them (Colucci et al., 2015). Some refugees worried that if they were to talk about their problems with a professional it could affect their opportunities for employment or may reach immigration authorities, leading to return, so they choose to hide their difficulties (e.g. Valibhoy et al., 2017). Others worried that their communities were infiltrated and that opening up to interpreters at appointments would be unsafe and potentially put their families at risk (Shannon et al., 2015). It was suggested that asylum-seekers and

refugees may be cautious of mental health professionals or interpreters from their own country, who are potentially known to their broader community and who may disclose personal information (e.g. Kahn et al., 2018).

Discussion

The current review identifies and explores the barriers to accessing and engaging with MH services for asylum-seekers and refugees. The different factors are broadly in line with those outlined by related reviews (Karageorge et al., 2017; Weidenbach Gerbase, 2018), however, the specific focus on barriers and the inclusion of nine studies not previously reviewed has enabled a more in-depth analysis of these factors. With methodological limitations of the reviewed studies in mind, some tentative conclusions can be drawn in relation to the themes identified.

Perceived misfit of Western mental health services

The findings suggest that asylum-seekers and refugees commonly experience a range of mental health problems related to both previous trauma and post-migratory stressors, in keeping with existing research which emphasises the significant influence of post-migratory factors on poor mental health (Carswell, 2011; Li, 2016). The perception that MH services do not address the chronic socio-political problems faced by refugees, and even more so by asylum-seekers, is frequently cited as a reason why accessing services is not a priority. Resettlement challenges as a barrier to seeking care has been documented elsewhere (e.g. Cleveland et al., 2014). Advocacy to reduce social adversity is a central part of a holistic approach to treatment for asylum-seekers and refugees, and MH services should include interventions that support individuals in securing immigration status, housing, employment, and integration, given that

these are understood to be fundamental to recovery (Li, 2016; Sonne et al., 2016; Kronick, 2018).

Differing conceptualisations of mental health problems across cultures, in terms of causes and symptoms, are seen as an important reason why asylum-seekers and refugees do not consider MH services as catering for their needs. MH services are perceived to lack cultural competencies and awareness of how Western models of care may deter people from engaging with services. These concerns map onto the challenges of providing culturally competent care discussed by McKeary and Newbold (2010), who emphasise that Western health services are premised on the 'universal' patient body, with minimal consideration of the social identity and context of that body. They suggest that cultural competency is in urgently required in order to care for the specific needs of refugees. Cultural interpretations of distress must be considered carefully to help make services appear relevant. For example, participants often described their psychological difficulties in somatic terms rather than mental health symptoms, a finding consistent with the wider research which indicates that refugees exhibit more unexplained somatic symptoms than the general Western population (Rohlof et al., 2014).

Lack of knowledge about MH services as a barrier to access has been discussed more widely in the literature in terms of mental health literacy (MHL) (Jorm, 2000), whereby poor understanding of mental health issues is seen to impede seeking-out support (Goldney et al., 2001). The idea of a need to promote MHL has been criticised in relation to working with non-Western populations. Summerfield (2008) has argued that the imposition of a Western psychological discourse represents a kind of colonisation of the non-Western mind. Care therefore needs to be taken about making assumptions about a need to promote MHL. However, as indicated by a number of participants, there is an interest in psychological

approaches if they may be of benefit. It is therefore important that efforts are made to provide information about these approaches so that individuals are empowered to choose and to avoid exclusion.

Practical factors, including inflexible service procedures, lack of an enabling environment and inadequate provision of interpreters were identified as barriers to access and engagement. The wider research literature also points to the issue of rigid service procedures, such as the expectation that asylum-seekers and refugees, unaccustomed to Western healthcare systems, should keep to appointment dates scheduled far in advance (Guerin et al., 2004). Previous studies found that a flexible approach, including drop-in services, facilitates engagement (Watters, 2010). Research outlines how inadequate interpretation is common and complicates the clinical encounter, leading to decreased rapport, fewer empathetic responses and less patient satisfaction (Ngo-Metzger, 2007; Macfarlane, 2008).

The expectation for support from family and community helps to understand why MH services might not be sought out. The preference for informal support networks for managing mental health problems is identified elsewhere in the literature (e.g. Donnelly et al., 2011) and appears to reflect a belief in a collective approach to healing, whereby the community takes responsibility for supporting the individual. Research emphasises the importance of community-based healing, arguing that effective culturally based solutions should not be replaced with unfamiliar mental health treatments (Miller & Rasco, 2004).

Concern about opening up

An avoidance of talking about the past and a belief that it will not help, or might make things worse, is a commonly reported reason for not accessing services. The wish to avoid talking

about trauma is a legitimate concern. Trauma therapy tends to focus on reducing avoidance as this is understood to be a 'maladaptive coping mechanism' which perpetuates distressing intrusive memories of trauma (Littleton, 2007). However, opinion is divided on the appropriateness of trauma-focused work with asylum-seekers and refugees, given the ongoing instability and lack of security they face (Vincent, 2013) and given the risk of retraumatisation (Zeidan et al., 2019). At the same time, a need to avoid the past must not be assumed given that, as indicated by a number of participants, some wish to process past traumas and evidence exists to suggest that effective trauma-focused work can be carried out with asylum-seekers and refugees who are experiencing ongoing instability (e.g. Grey & Young, 2008).

The finding that stigma and shame hinder engagement is supported by the wider literature which suggests that stigma constitutes a significant barrier to the utilisation of MH services (Corrigan, 2004; Ojeda & Bergstresser, 2008). The World Health Organization (WHO, 2001) identifies stigma and discrimination in relation to mental health problems as "the single most important barrier to overcome in the community". It is understood to hinder help-seeking and result in low self-esteem and social isolation (Weine, 2011; Marquez, 2017). The literature suggests that culture has an important influence on the impact of people's stigmatising beliefs and actions (Rao et al., 2007; Abdullah & Brown, 2011). In countries where these beliefs are common, the potential of seeking help from MH services is constrained. Many are afraid of being ostracized by their communities, suggesting that it is not just that they will become devalued but they will become disconnected (Shannon, 2015).

Mistrust of mental health services and professionals is related to experiences of discrimination and persecution in both people's country of origin and host country. Breaches of confidentiality is a concern for many participants, as they feared that information shared with health

professionals and interpreters may be shared with immigration authorities or their community. Experiences of interpersonal trauma often leads to a profound breakdown in capacity to trust, particularly if the trauma is prolonged and repeated, as is often the case with refugee survivors (van der Kolk et al., 2005). This is then compounded by numerous post-migratory experiences of discrimination, racism and being disbelieved.

Methodological limitations

Overall, the studies included in the current review are of good quality. However, methodological limitations within the studies need to be held in mind when considering the outcomes. Most of the studies use the terms 'asylum-seeker' and 'refugee' interchangeably, failing to acknowledge important additional stressors and insecurity faced by asylum-seekers and making it difficult to delineate the specific differences in their experiences. The conflation of the terms leaves a lack of clarity about the specific perspectives and mental health problems that may come with the position occupied by asylum-seekers (Bernardes et al., 2010). The majority of the studies fail to evidence a process of reflexivity, therefore assessing the influence of the researchers' subjective assumptions on the data analyses is not possible. This results in an increased risk of misrepresentation of participants' views (Block et al., 2012).

Clinical implications

The findings highlight a number of implications for improving provision of MH services. There is a need to develop alternative approaches and opportunities for engaging asylum-seekers and refugees with MH services, particularly asylum-seekers who face a certain set of challenges which may prohibit their engagement with treatment. Services need to be active in acknowledging and helping to address socio-political stressors by providing a holistic approach to care and to ensure that they are not attempting to treat mental health problems, divorced

from their context, which risks being over-pathologising. Promotion of a holistic approach to care which integrates psychological interventions with advocacy and practical support may increase likelihood of individuals accessing services by acknowledging their primary needs and concerns. Given the concern that MH services would not be able to understand the difficulties faced by asylum-seekers and refugees, services must find ways to promote collaborative ways of working with both the individual and the wider communities in order to foster a person-centred approach to formulating difficulties (Kronick, 2018), rather than imposing a Western framework of understanding. A collaborative approach will also help to establish trusting relationships.

In line with this, services must consider the ways in which our conceptualisations of mental illness are imposed on asylum-seekers and refugees from different cultures. Developing cultural competency is seen as necessary, although the idea of being culturally competent has itself been challenged as it misleadingly implies that there are set rules (articulated largely in a Western context) for learning about understanding and working with people from different cultures. Cultural competence is better conceptualised as an attitude, "a willingness to understand that each individual brings his or her own explanatory model to the exchange and that this model has been shaped by culture" (Savic, 2016). This skill is therefore something to be developed and maintained through a process of ongoing reflection rather than a skill to be acquired through training.

Alongside developing cultural competency, the findings suggest a need for improving MHL. This could be achieved through individual and community-based interventions providing psychoeducation, which respects individual belief systems, while empowering with choice of alternative ways of addressing distress and helping to destigmatise mental health problems.

A flexible approach to service systems that allows for outreach work and drop-in services will help to facilitate engagement. Provision of trained, competent interpreters, which is sensitive to individual preference, such as dialect, is necessary to facilitate open communication and foster trusting relationships. Concern about discussing past trauma requires careful consideration on an individual basis and promotion of choice, to ensure that trauma-focused therapy is only provided when it can be experienced as safe and reparative rather than retraumatising. In addition, services should provide a range of therapeutic interventions that do not centre on trauma-focussed therapies.

Research implications

The barriers outlined in this review highlight the need for further research into approaches that will help to overcome them. The concern that MH services do not give sufficient consideration to significant socio-political stressors, which are a very high priority for asylum-seekers and refugees, suggests a need for research exploring holistic interventions that have the potential to address both mental distress and the underlying socio-political contributors to distress. The finding that a fear of talking, including worry about re-traumatisation, stigma, shame and mistrust, is a significant barrier to accessing mental health services also requires further research in order to explore how practitioners are currently trying to navigate this fear and to evidence effective approaches.

The majority of studies included in this review fail to distinguish between the experiences of asylum-seekers and refugees. Given the increased stressors experienced by asylum-seekers, namely the lack of social support and ongoing threat of return, research which explores this group's particular needs and ways in which MH services can facilitate access and provide effective support is needed. Finally, given the significant lack of reflexivity demonstrated in

the studies included in this review, future research on the perspectives of asylum-seekers and refugees must explicitly consider the position and influence of the researcher on the research process.

Conclusion

By drawing together existing qualitative research, this review illuminates the different barriers to accessing and engaging with MH services for asylum-seeker and refugees. Seven descriptive themes were identified and organised under two analytic themes. These findings highlight: the necessity for mental health services to provide holistic approaches that address the immediate practical needs of asylum-seekers and refugees; the importance of different cultural conceptualisations of mental health problems, and the need to bridge these differences through building of collaborative relationships; a need for establishing approaches that help acknowledge and navigate fears associated to talking about trauma and mental health problems. This is important for ensuring that asylum-seekers and refugees have the best opportunity to access services which may make a crucial difference in helping them to manage their psychological distress.

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Section B

Understanding the experiences of traumatised asylum-seekers undergoing a clinical assessment for the purposes of preparing a medico-legal report for use in their claim for asylum

Word count: 7,979 (270)

Abstract

Background: Traumatised asylum-seekers often have to undergo a clinical assessment for the purposes of having a medico-legal report prepared for use as evidence in their claim for asylum. The existing literature suggests that this assessment process may act as a further post-migratory stressor and/or may hold therapeutic benefits. This study aims to investigate how traumatised asylum-seekers experienced undergoing a clinical assessment as part of their claim for asylum.

Method: This study employed a qualitative design, using interpretative phenomenological analysis to explore the experiences of six asylum-seekers who had undergone a clinical assessment process for the purposes of having a medico-legal report prepared.

Results: Three superordinate themes emerged from the data: tension between negative and positive expectations, therapeutic impact, the pain of having to share and remember.

Conclusions: Findings suggest that the clinical assessment process was experienced as psychologically distressing for the participants. This distress was mediated to an extent by particular components of the assessment process which appeared to hold therapeutic benefits. These findings have important clinical implications for clinicians carrying out assessments with asylum seekers and highlight the need for implementing trauma-informed approaches to care within the UK asylum system.

Key words: Asylum seeker experiences, trauma, clinical assessment, medico-legal report, qualitative

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, 1951). When seeking asylum in the UK, the asylum-seeker 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 long and immensely challenging. The burden of proof lies with the asylum-seeker, and submitted evidence is frequently discredited. 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 (Silove et al., 2007; Carswell et al., 2011).

The medico-legal report (MLR)

Where there is a history of ill-treatment (the term ‘ill-treatment’ is used here to refer to torture and other forms of abuse prohibited by international law, including inhuman, cruel and degrading treatment (ICRC, 2005)) and indications of psychological trauma, the asylum-seeker’s immigration lawyer might instruct a medical doctor, psychiatrist or psychologist for a MLR which documents psychological and/or physical impact of past ill-treatment. The assessing clinician undertakes a clinical interview taking a detailed history of the asylum-seekers’ traumatic experiences and assessing for psychiatric disorders such as post-traumatic stress disorder (PTSD) and depression. The psychological evaluation of asylum-seekers is performed through clinical interviewing, which may be supplemented by the use of standardised questionnaires and semi-structured interview schedules. Where relevant, a medical doctor will carry out an examination of any physical scarring claimed to be the result

of physical ill-treatment. The clinical evaluation can be considered to be an intrusive and 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 required to undress in order to have their body examined by the clinician.

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) in the aftermath of severe trauma. This is likely to be particularly challenging within a legal context, where the details of one's trauma are scrutinised. Traumatised asylum-seekers are a particularly 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 (Bogner et al., 2007; Schock, 2015). This need is often undermined early in the asylum process, when asylum-seekers must undergo a Home Office (HO)/asylum interview in which they are expected to disclose all relevant facts related to their asylum claim, including their traumatic experiences.

Research investigating asylum-seekers' experiences of asylum interviews found that the process is felt as shaming and stressful (Laban et al., 2004; Bogner et al., 2007; Bogner, 2010; Schock, 2015; Li, 2016). Asylum-seekers are fearful of the consequences, such as removal (Nickerson et al., 2011), and being confronted with traumatic memories can aggravate symptoms of PTSD (Bogner et al., 2007). Stress related to these asylum interviews detrimentally affects the recuperation process and the processing of the trauma (Schock, 2015).

The assessment process for a MLR differs significantly from an asylum interview. 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 be helpful for their claim. In addition, the assessor is clinically trained, helping them to develop trusting therapeutic alliances (Gangsei & Deutsch, 2007). However, such assessments, which also require detailed recall of trauma, might act as a further post-migratory stressor. As with the asylum interview, the assessment process may undermine posttraumatic avoidance 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 past traumas.

Recalling traumatic events cannot be avoided while providing testimony, undermining the use of such avoidance as a coping mechanism and potentially causing distress (Pitman et al., 1996). Psychotherapy views reduction of avoidance as a central mechanism of recovery with individuals suffering with PTSD (Varra & Follette, 2004), but with support and at a clinically appropriate pace. During the asylum process, avoidance is often broken down forcibly in a way that might hinder the asylum-seekers' subsequent ability to process the trauma and potentially reinforcing trauma and provoking intrusions (Schock, 2015). This is supported by the high levels of dissociation reported by asylum-seekers' during HO interviews (Bogner et al., 2007). The MLR process therefore appears to present a difficult 'double bind', whereby the individual is caught in a dilemma between having to recall their traumatic experiences, which may be painful and distressing, or not recalling the details of their trauma, which risks undermining their claim for asylum. While the individual may be managing their psychological trauma by attempting to downplay the impact of their traumatic experiences, the MLR process encourages

the individual to do the opposite, by inviting them to emphasise their distress and symptoms of trauma in no uncertain terms to try and ensure a report that will assist their claim for asylum.

Trauma theory suggests traumatised asylum-seekers' experiences of placing trust in others is difficult and risky, dominated by expectations that the trauma will be repeated (Bognor, 2010; Guasto, 2014). Time must therefore be spent in engaging asylum-seekers and establishing a connection (Ehnholt & Yule, 2006). This indicates a further reason why the assessment process may be experienced as stressful, particularly as the professional relationship between clinician and asylum-seeker in this context is not a therapeutic one, and the asylum-seeker is aware that the clinician is assessing for legal rather than therapeutic purposes, meaning trust may be compromised. Previous experiences of torture and interrogation mean that transference feelings could leave the asylum-seeker feeling persecuted by the assessor and thus more anxious (Wilson, 2004; Sandalio, 2018). A possible consequence of a distressing experience of the assessment, is that the asylum-seekers may feel less inclined to seek out and engage with mental health services as a source of support in the future.

The evaluation process as a therapeutic opportunity

Gangsei & Deutsch (2007) propose that the evaluation process can have a direct therapeutic effect. They suggest 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, has direct clinical benefits. This idea is underpinned by the psychoanalytic perspective of bearing witness as a central process in recovery (Ullman, 2006; Gautier & Scalmati, 2010) and is comparable to the Testimony Method (Cienfuegos & Monelli, 1983; Van Dijk, 2003) as a therapeutic process. This method was developed within a human rights framework as a 'therapeutic instrument', aiming to work collaboratively with survivors

to produce an account of torture which can be used in processes of justice or claiming asylum. However, little evidence exists for the effectiveness of this approach (Patel, 2016).

Herman (1997) emphasises that recovery is based on the empowerment of the survivor. Affirming asylum-seekers' histories is the first step toward restoring their voice and empowering them in their healing process (Patel, 2016). Research indicates that lack of social acknowledgement of traumatic experiences increases risk of developing PTSD (Brewin et al., 2000; Schock, 2015). For many asylum-seekers, the assessment may be the first time that anyone has affirmed their realities and acknowledged the psychological consequences. This may be a validating experience and may help the asylum-seeker to link their trauma to distressing symptoms. The asylum-seeker is not only reporting a factual account but is also being asked to describe the emotional impact. The naming of the affect, with the help of the clinician, provides an opportunity to contain and process the affect, and to give the asylum-seeker an experience of feeling understood (Reis, 2009). Trauma theories such as cognitive-processing theory (Horowitz, 1986) suggest that avoidance perpetuates intrusive symptoms and that successful processing of trauma depends on being able to access and assimilate new information within pre-existing schema (Bisson, 2009). As avoidance often prevents asylum-seekers from seeking professional help, the assessment might provide a helpful experience of remembering the trauma and encourage them to seek further support.

Study aims

The aim of the study is to explore asylum seekers' experiences of undergoing a mental health assessment for the purposes of having a MLR prepared in support of their asylum claim. This will help to establish whether this process, which has not been researched previously, serves

as a further post-migratory stressor or whether it holds therapeutic benefits, and to delineate the determinants of a negative or positive experience. The following questions will be explored:

a) How do asylum-seekers' experience undergoing a MLR assessment as part of their asylum claim?
b) Do asylum-seekers experience any aspects of the assessment process as distressing and, if so, in what ways?
c) Do asylum-seekers experience any aspects of the assessment process as therapeutic and, if so, in what ways?

Method

Design

The present study employed a qualitative approach, using Interpretative Phenomenological Analysis (IPA) for an in-depth exploration of how individuals make meaning of their lived experiences (Smith et al., 1999). IPA explores the 'double hermeneutic', the two-stage interpretation process examining the meaning participants attribute to their experiences as well as the researcher's interpretations of this meaning (Smith & Osbourne, 2004). IPA was chosen as the study aims to prioritise the asylum-seekers' perspectives on their lived experience. This is important considering the dearth of research that explores the experiences of asylum-seekers, as distinct from refugees, and given the potential risk of imposing researcher's meanings on a marginalised population. Semi-structured interviews were used to elicit participants' experiences.

Participants and sampling

Participants were recruited through a third sector organisation, providing holistic care to survivors of human rights violations. Purposive sampling was used to capture participants with experience of undergoing a MLR assessment. Twenty-one individuals approached chose not to participate, and 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. Table 1 and Table 2 provide details of the selection criteria and the six individuals who consented to participate. They included four males and two females ranging from 32 to 47 years old. The final sample is heterogenous in terms of ethnicity and cultural background, going against the recommendation for homogeneity (Smith et al., 2009). However, homogeneity is found in the shared experience of significant past traumas in their countries of origin, involving torture and/or severe ill-treatment, as well as the numerous peri-migratory and post-migratory stressors.

Table 1.

Selection Criteria
• Individuals with a history of trauma • Individuals who had undergone an assessment and evaluation of their mental health for the purposes of preparing a medico-legal report, 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 (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'.

Table 2.

*Pseudonyms and characteristics**					
Name	*Age*	*Gender*	*Ethnicity*	*Country of origin*	*Immigration status*
Akuba	47	Male	Black African	Ghana	Asylum-seeker
Selvan	40	Male	South Asian	Sri Lanka	Refugee
Ekele	32	Male	Black African	Nigeria	Refugee
Dalina	45	Female	White European	Albania	Asylum-seeker
Sam	35	Male	Black African	Nigeria	Asylum-seeker
Nour	43	Female	Arabic	Egypt	Asylum-seeker

* names have been changed to protect confidentiality

Ethical approval

Ethical approval was obtained from Canterbury Christ Church University's Ethics Committee (Appendix C). The research followed the British Psychological Society Code of Human Research Ethics (2018). Client vulnerability, the potential for the interview to cause distress and capacity to provide informed consent were issues considered with organisation staff before deciding whether a client would be invited to participate. 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 as this may have pushed individuals, who would otherwise not want to take part, into participating.

Procedure

Recruitment took place over 18 months. Members of staff at the organisation compiled a spreadsheet of potential participants. Those included were then contacted via phone. The nature of the research was explained, and it was emphasised that participation was voluntary. Those willing to participate were then sent an information sheet (Appendix D). At interview the participant had the opportunity to ask questions. 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. Written consent (Appendix E) was obtained before starting the interview.

Interviews

A semi-structured interview schedule was developed (Appendix F) and questions were refined following consultation with a refugee who had previously undergone a MLR assessment, and two clinicians working with asylum-seekers. The schedule included open-ended questions which served as a guide, while allowing for the participant to articulate their experiences in their own words. Interviews were conducted at the organisation (except for one interview which was carried out via remote video-link due to Covid-19 restrictions) and lasted between 45-75 minutes. None of the participants reported any distress caused by the interview. Interviews were audio recorded and data was stored according to ethical guidelines and data protection. Recordings were transferred to an encrypted memory stick and anonymised transcripts were password protected.

Data Analysis

Interviews were transcribed verbatim and then analysed using IPA. Using Smith et al. (2009) as a guideline, a detailed understanding of experience was achieved through a number of steps. Data immersion and familiarisation was achieved through transcription and repeated reading of each transcript. Descriptive, linguistic and conceptual comments were produced to capture phenomenological features of participants' responses and the researcher's interpretative observations. Comments were recorded alongside the transcript to ensure they were grounded in the data (Appendix G). 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.

Quality assurance

For quality assurance, the guidelines proposed by Yardley (2000) were followed. The methodology adhered to IPA guidelines (Smith et al., 2009) and separate stages of data collection and analysis were documented, ensuring 'commitment and rigour' (Appendix I). A research colleague and a supervisor independently reviewed and audited a number of transcripts. Initial codes and emergent themes were discussed to confirm their grounding in the data. Inclusion of an annotated transcript, an illustration of theme development and direct quotes supporting the themes, help to provide transparency and facilitate evaluation by others. Reflexivity was maintained by conducting a bracketing interview (Appendix K). This allowed for reflection on my preconceptions and assumptions which may bias interpretations, including an assumption that the assessment was either particularly distressing or particularly therapeutic. Keeping a research diary (Appendix L) and having regular reflective discussions with colleagues facilitated an ongoing process of considering my position within the research.

Results

Three superordinate themes, including a total of nine subthemes, were identified from the analysis (see Table 3). The superordinate themes were represented in each of the participants accounts. They will be discussed here and illustrated with example quotations.

Table 3. Table of themes

Superordinate themes	*Subthemes*
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
Therapeutic impact	‘I felt a bit lighter’: Release of sharing
	‘Capable to hear my story’: A relational experience and the importance of emotional containment
	‘These are the symptoms, these are normal’: Benefits and limits of psychoeducation
The pain of having to share and remember	‘Tough things to say’: The struggle to share
	‘Like I’m still there’: Remembering as distressing and retraumatising

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 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 somewhat powerless and reliant on others with decisions about his future. Selvan appeared to experience something similar 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 trying not to worry, reassuring 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'* and Nour tried to manage this uncertainty by actively 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.

"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…"

For Sam, discussing his past meant confronting experiences that he consciously avoided. 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’ here 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 clearly 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…”

The anxiety experienced by Akuba was significant enough to cause him to lose sleep and left him wanting to avoid the assessment process entirely.

‘It's something that's got to be done’: Needs must

The uncertainty about what the assessment would involve and the fear of having to discuss their past were feelings they could not turn away from as their need for help took precedence. 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"*. As for 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, her feelings of worry had to be set aside for the sake of her children. 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 they might provide care, rather than exacerbate distress. This provided reassurance that he was making the 'right choice' by attending, his language here implying 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'. Beyond an expectation to be supported in his claim, Ekele wanted to be supported to 'tell my problems':

"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 helpless experience of being an asylum-seeker, whereby she felt grateful for the 'painful' help offered by the assessment, given the lack of support from 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".

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. 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 it lost some of its emotional intensity. 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.

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

The relational dynamic between participant and clinician was understood to be an important factor in supporting participants through the assessment. Sam felt that the clinician demonstrated a 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 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 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 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.

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"

'These are the symptoms, these are normal': The benefits and limits of psychoeducation

Participants spoke of how they felt helped by the information and advice they received, related to their trauma and psychological wellbeing. Ekele described how a psychological perspective helped him to understand the nature of his difficulties and normalise them:

"He helped me understand my trauma symptoms… I told him what I was going through and he told me well these are the symptoms, these are normal…"

Akuba spoke of how advice and encouragement of the clinician to find small ways to reengage with life has benefitted his mental wellbeing:

"She said she knows it's not easy, but I have to go out, leave the house, try and talk to people… So, I go out a lot, I do not stay at home much, like before."

Akuba noticed how intervention motivated him to bring about change to his daily living which has been enduring. He described how this has helped him feel more connected to others: "*It's helped me a lot… I say 'hello' to people and they're looking and smiling… it helps me feel better"*

Selvan also experienced advice on ways to break his isolation as helpful. He described feeling unable to engage with others at the time: *"She understand that I'm alone at home day and night and that… I just don't want to talk to anyone"* and how this kept him trapped in his past traumas: *"because of that reason things came to me again and again, my past memories"*. He described how the clinician helped him to consider ways of being with others, providing the impetus he needed:

"She was saying you can just attend these groups… just to come and see… you don't need to feel worried about anyone else and what they think about you… because they're all in your situation…so it kind of dragged my attention"

Ekele spoke of the grounding techniques he has continued to find helpful since the assessment: *"One helpful thing he said, 'look at yourself and tell yourself you are here…. try sometimes pressing on the ball and understand like you're in control''*

However, he was clear on the limitations of psychoeducation, which he felt failed to take into account the difficulty of his circumstances, possibly in a way that felt insensitive: *"I was scared*

for my life as an asylum-seeker… so if someone tells me 'oh this is just part of what you're going through', you're like 'okay… cool'". He believed that, while the threat of removal remained, psychoeducation could only 'sugar-coat' his problems:

"…if you still have the threat that you're going to get killed, how is that going to help?... You can always sweet talk them or sugar-coat their problems and try to get them out of it but if the threat is still there it's hard…"

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"

'Tough things to say': The struggle to share

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, indicating that he held 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 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 pleasure in hearing her trauma while she was left feeling exposed, not wanting to be the object of others' pity.

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 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 reexperiencing 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 dissociating (a complex trauma response involving a disconnection from time and place) while recalling traumas during the assessment. For Ekele: *'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 help to reground 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".

Discussion

The current study explores asylum-seekers' experiences of undergoing a MLR assessment as part of their asylum claim and examines whether aspects of this process are experienced as either distressing or therapeutic. The findings are discussed in relation to these aims and the wider literature.

The superordinate theme *'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 echoes 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, 2019). The finding that there is a fear of discussing the past is unsurprising given that avoidance of trauma reminders is a core symptom of the PTSD diagnosis (DSM-5, 2013) and wider research on trauma has found that experiential avoidance is consciously employed as a coping mechanism (e.g. Boeschen, 2001). Increased anxiety is therefore highly understandable when faced with having this coping mechanism undermined.

A number of 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 & Gupta, 2014). As stated by Kahn (2017), undermining autonomy

over one's narrative is contraindicated by trauma-informed frameworks of care which emphasise restoring control to counter the sense of powerlessness experienced by trauma survivors (Bloom & Farragher, 2013). 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 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 of the participants, sharing past experiences provided a release from thoughts and feelings they had been struggling with internally. This finding supports Gangsei & Deutsch's (2007) suggestion 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.

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, 2013) and is particularly valuable given that they commonly encounter disbelief (Tribe, 2002).

A number of participants felt encouraged by the psychoeducation received during the assessment as it enabled them to break their isolation and apply techniques to cope with trauma symptoms. This is supported by previous research demonstrating the effectiveness of psychoeducational interventions for asylum-seekers (Murray et al., 2010). However, the limitations of psychoeducation in the context of the profound instability of asylees' circumstances were also highlighted, emphasising the imperative to attend to an individual's basic need of safety before specialised intervention can be fully effective (Herman, 1992; Rousseau & Frounfelker, 2019).

The processes of remembering traumas and sharing them with the assessor are challenging and distressing for all 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" (Strejilevich, 2006; Nguyen, 2011). The finding that disclosure of shameful events is experienced as a distressing parallels research exploring experiences of the HO interview which found disclosure is related to feelings of shame (Bogner, 2010; Schock, 2015).

Participants describe how the process of remembering provoked symptoms of flashbacks and dissociation, illustrating how remembering in the context of the assessment has a retraumatising effect. This mirrors previous findings (Bogner, 2007; Schock, 2015; Kahn, 2017) 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 was highlighted as a concern by Gangsei & Deutsch (2007). This finding demonstrates the impossibility of upholding a trauma-informed approach to care, that involves vigilance in avoiding institutional processes and individual practices that are likely to retraumatise individuals (Hopper et al., 2010).

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. However, the study would have benefitted from service user involvement in the data analysis and validation process.

The study aimed to recruit ten participants, however the majority of the individuals approached declined, citing the reason of finding the subject difficult to talk about. While the smaller sample is not in itself a weakness, given that IPA is primarily concerned with a detailed account of individual experience (Smith et al., 2009), the perspectives of those who may have found the process more challenging are precluded. Consequently, the results likely do not capture some of the more distressing experiences of undergoing a MLR assessment. For example, asylum-seekers who felt too anxious to participate in the research 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 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, compared to asylum-seekers. Again, this means that the overall findings are potentially skewed towards positive experiences of the assessment. Due to recruitment difficulties, there is heterogeneity in the sample in relation to traumas experienced and country of origin. The sample's heterogeneity and size limit the generalisability of the findings.

Research implications

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 some key therapeutic components. Further research is required to explicate these factors. The finding that the relationship between the participant and clinician enabled a helpful experience of the assessment warrants further qualitative research to explore whether this is a supportive factor beyond the current sample and to explicate the central relational 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 using a 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 implications

The findings have implications for clinicians assessing asylum-seekers for the purposes of a MLR. 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, 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 information and to begin to build a rapport may help to alleviate some of this stress.

The MLR assessment process requires disclosure and therefore it is difficult to mitigate the risk of aggravating symptoms of trauma. Specific training for assessors will help to build an awareness of the stressors asylum-seekers may experience and ways to manage these. Systematic follow-up in the period following assessment will help to assess for 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 set out a compassionate, trauma-informed process which allows asylum-seekers to disclose their stories whilst minimising the risk of retraumatisation.

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 affects associated to the trauma helps to acknowledge and validate experiences. Whilst therapeutic benefits may be restricted in the context of the MLR assessment, psychoeducation was experienced as helpful, suggesting that this may be valuable to include as a formal component of the assessment.

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 stressor, whereby 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 appeared to hold therapeutic and restorative benefits. These include: a feeling of release provided by sharing their story, an understanding of their psychological trauma and ways to manage this, and a positive relational experience of having the distress of their trauma heard and contained by another. Findings draw attention to the need for trauma-informed models of care to be implemented within the asylum process which avoid inflicting further distress on an already highly traumatised population and they highlight therapeutic components that require further elucidation in order to enhance the therapeutic potential of the MLR assessment.

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Section C

Appendices

Appendix A: Kmet, Lee, and Cook (2004) Quality scoring of qualitative studies

	1. Question / objective clearly described?	2. Design evident and appropriate to answer study question?	3. Context for the study is clear?	4. Connection to a theoretical framework / wider body of knowledge?	5.Sampling strategy described, relevant and justified?	6.Data collection methods clearly described and systematic?	7. Data analysis clearly described, complete and systematic?	8. Use of verification procedure(s) to establish credibility of the study?	9.Conclusions supported by the results?	10. Reflexivity of the account?	Total
Asgary & Segar (2011)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	No (0)	15
Bernardes, Wright, Edwards, Tomkins, Dlfoz & Livingstone (2010)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	17
Bettmann, Penne, Freeman & Lecy (2015)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	18
Colucci, Minas, Szwarc, Guerra & Paxton (2015)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	No (0)	16
De Anstiss & Ziaian (2010)_	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	18
Ellis, Lincoln, Charney, Ford-Paz, Benson, Strunin (2010)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	16
Kahn, Alessi,	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	20

Kim, Woolner & Olivieri (2018)											
Maier & Straub (2011)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	No (0)	Yes (2)	Yes (2)	No (0)	15
Majumder, O'Reilly, Karim & Vostanis (2015)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	No (0)	Yes (2)	Yes (2)	No (0)	15
Misra, Connolly, Majeed (2006)	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Partial (1)	Partial (1)	No (0)	Yes (2)	No (0)	12
Omar, Kuay & Tuncer (2017)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	20
Palmer (2006)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	No (0)	Yes (2)	No (0)	15
Papadopoulos, Lees, Lay & Gebrehiwot (2004)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	20
Piwowarczyk, Bishop, Yusuf, Mudymba & Raj (2014)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	17
Posselt, McDonald, Procter, Crespigny & Galletly (2017)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	20
Savic, Chur-Hansen, Mahmood & Moore	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	17

(2016)											
Shannon, Wieling, Simmelink-McCleary & Becher (2015)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	Yes (2)	Partial (1)	Yes (2)	Yes (2)	No (0)	15
Slobodin, Ghane & De Jong (2018)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	Yes (2)	No (0)	16
Valibhoy, Szwarc & Kaplan (2017)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	No (0)	18

Appendix B: Table of illustrative quotations relating to descriptive and analytic themes

Analytic themes	Descriptive themes	Illustrative quotations
Perceived misfit of Western mental health services	MH services do not address complexity of needs	*"When I get my documents then I can go and take care of all my problems"* (Study 1) *"If at least I could work I could get some help with mental health, some sort of relax"* (Study 2) *"The most important thing that stresses me is my immigration case. I sometimes have nightmares about it. I wonder if they are going to reject me"* (Study 13)
	Differing cultural conceptualisations of 'mental illness' and lack of cultural competencies of Western MH services	*"If you take me to the doctor and I don't speak English and I tell you my problem and you tell the doctor this and you say she has mental problems because I don't want them to know. Because if they know, they will take me to a different hospital and I can't see my kid or parents"* (Study 3) *"When we talk with different cultures, like the new arrivals, or the refugee people, what is their understanding about mental health? Is it exactly like what we say here, or is it something different? So, I think, first of all, we have to try to understand the other"* (Study 4) *"I recently sat in with a client on a psychiatrist's appointment and that was basically a 30 minutes*

		interrogation… for a refugee, for someone that has experienced persecution in their past, I can't even imagine how terrifying that would be" (Study 4) *"Even if we do tell them our problems, I don't think they'd understand . . . they can't relate to it"* (Study 5) *"Okay, you know back home? Mental health – people are crazy who dance (in the street) and shit? Aha! Those are the people we are talking about. Those ones who run around. Over there, we don't call them mental, just people who are crazy . . ."* (Study 5) *"A man with depression whom I met told me that government gives injection straight away soon they identify that you have mental problems"* (Study 11) *"Depression doesn't exist in our language"* (Study 12) *"...when I first came and then I started hearing something called 'depression' I thought 'gosh that is white man's sickness, we don't have that' because we don't have a name for such a thing as depression, we don't"* (Study 16)
	Practical barriers	*"They were very helpful, but the reason why I don't go there very often is that they don't have interpreters"* (Study 2)

		"… it's hard to explain to them also. Some people who can't speak English so they don't know how to tell them, they don't know how to say some words in English." (Study 15) *''The doctors are not listening to us, they give us only fifteen minutes or probably the interpreter is not telling them right''* (Study 17) *"The organisation says ok this particular client seems like they are not interested in engaging with us, they look like they don't need help but of course deep down they do need help, they just don't know how to express it in a timely manner- in our time frame"* (Study 15)
	Preferred sources of support and ways of coping	*"Some people can find healing through 'thikri' [remembering of Allah] ... Performing 'qiyaamu-layl' [mid- night prayer] ... solves all our problems ..."* (Study 11) *"People don't believe in mental health. They might talk about problems to a close friend or family. The close friend might say this is how it is and you have to deal with it. So you deal with it. Most family/friends will tell 'you to deal with it'''* (Study 14) *"If I have problem or issue I talk to my aunt, my cousin, my grandma, my whatever, my neighbour and we talk about it and that's it, it's finished. So we don't have to*

		go and see a special person to solve this problem" (Study 16)
Concern opening up	The struggle to speak about past trauma	*"That doesn't helps me… that makes me more hard because um the all the time I was talking about the past… so every time I went there… reminding me after I went home again"* (Study 9) *"Talking may bring out old wounds, which may not be good"* (Study 10) *''We are so angry about what happened in the refugee camp, we don't want to go back. We don't want to talk about it. We are tired of refugee camp. Very painful in the camp''* (Study 17)
	Stigma and shame	*"If another person going to seek help, some people might take it in a negative way. Like, "Oh he probably can't handle his problems, so he needs somebody else to help him," so they take it more into a negative thing then a positive thing"* (Study 6) *"In my country people will suspect you when you go to a psychiatrist. People think it is something very serious, that you must be mad"* (Study 8) *"In the Middle East, men should be strong and respected, so you don't show any sign for weakness. Men should not act this way. Sometimes mental health*

	problems appear as physical problems, which are considered less shameful" (Study 18)
Mistrust	*"I don't trust anyone. No other person, any person, anyone, particularly Somali person"* (Study 12) *"The level of mistrust crosses class lines and caste lines and so on, but there's also, you know, "Is this person actually a government informer who's actually made it to Canada? Will they be somebody I know? Will they let my husband know where I am? Will they betray me in some way?"* (Study 7) *"Some people think 'no, they are working for immigration and they want to find out something'"* (Study 19)

Appendix C: Approval of ethics

(This has been removed from the electronic copy)

Appendix D: Participant information sheet

Participant information sheet

Hello, my name is [redacted]. The following research is being conducted as part of my clinical psychology doctorate at Canterbury Christchurch University. My research supervisors are [redacted] of Canterbury Christchurch University and [redacted] of the [redacted]. You are being invited to take part in this research and this information sheet is to explain the research and help you to decide whether you would like to participate.

Before taking part, it is important for you to understand why the research is being conducted and what it will involve. Please take the time to read the following information carefully, and feel free to discuss it with others if you wish. If there is anything unclear, or if you require further information, please feel free to ask.

What is the purpose of this study?

Many people who claim asylum within the United Kingdom will undergo a psychological or psychiatric assessment and based on this a report will be prepared and used as part of their evidence in their claim. The assessment and evaluation process involves exploring and documenting an individual's past experiences and current mental state.

There are reasons to suggest that this could be a distressing experience (e.g. it requires remembering traumatic experiences and discussing these experiences with a stranger). There are other reasons to suggest that the assessment and evaluation process could be a therapeutic experience (e.g. provides an opportunity to process and begin to make sense of traumatic experiences with a mental health professional). It is therefore important to explore individuals' experiences of undergoing psychiatric/psychological assessment and evaluation to help understand which aspects of the process are felt to be therapeutic or distressing. This will help to better understand how this process is experienced.

You are therefore being asked to take part in a single interview as part of this research. This interview aims to explore with you your experiences of undergoing psychological/ psychiatric assessment and evaluation as part of your asylum claim, in order to establish the potential therapeutic or detrimental effects of this process.

What does taking part involve?

If you agree to take part, you will be asked to sign a consent form.

For this study, I would like you to engage in an interview that will last approximately an hour. The interview will explore your experiences of undergoing psychiatric/psychological assessment and your perspectives (opinions, thoughts and feelings) on the process.

An audio recording of the conversation will be made to make sure that information is recorded accurately. My supervisors and I will be the only people to have access to the recording. Once the analysis of the interviews has been completed, the audio recordings will be deleted permanently. The recording files will be stored safely and securely until the time when they can be deleted. All of the information from the interview will be completely anonymous, except for your gender, race and country of origin. This means that no one, apart from the researchers, can identify any individual taking part in the research.

There is no additional involvement or further expectations on your part, other than participating in this single interview. However, once the research has been completed, I will contact you to provide you with a summary of the findings and there will be an opportunity for you to ask further questions about the research.

Why have you been chosen?

Individuals who are having a medico-legal report report prepared as part of their asylum claim are eligible to take part in the study. This group have been recruited via the organisation that was originally instructed to prepare the report.

What will happen to your information?

All information collected about you during the course of the study will be kept strictly confidential and stored on secure premises. Your name and contact details will be stored separately from the data collected. Both sets of information will be kept securely according to the requirements of the Data Protection Act 1998 and the new General Data Protection Regulation 2018.

Confidentiality is within the usual professional framework, which is to say that if there is anything that gives rise to concern about your or other people's safety, I would discuss this with you and my supervisors with a view to possibly needing to share the information with the relevant bodies.

It is anticipated that the results of this study will be published: however only anonymised results will be presented. Nothing that can identify you will appear in any publications or reports about this research. Your participation is strictly confidential.

Do you have to take part?

No, it is up to you whether or not to take part in this study. In other words, this is voluntary. If you are able to take part, you are still free to stop your participation at any time and have any research data withdrawn. If you can take part, you will be given this information sheet to keep and be asked to sign a consent form.

Are there any risks?

As you will be asked to think about potentially difficult experiences of being clinically assessed at the (name of organisation), which some may find upsetting, there is some risk to taking part. However, it is important to make clear that you will only be asked questions about your experience of the clinical assessment and you will not be asked any questions about your experiences leading you to claim asylum. Furthermore, you are not required to discuss anything you do not wish to discuss. If you feel upset or concerned about participating in an interview, please share your concerns with me and I can offer a space to debrief afterwards. I am also able to direct you to sources of potential support contacts who may be able to help.

What are the benefits of this research?

By taking part in this study, you will help develop understanding of the experiences and perspectives of individuals undergoing psychiatric/psychological

assessment and evaluation as part of their asylum claim. This may aid the psychiatric and psychological professionals to reflect on assessment and evaluation in this context and consider the potential therapeutic or distressing aspects of the process.

What happens when the research study stops?

You will be contacted by telephone after the research has been completed and provided with a summary of the findings. Any further questions you may have can also be answered at this point.

If you have any concerns or wish to make a complaint

If you have concerns about any aspect of the way you have been approached or treated during your participation in the research I will do my best to address your concerns; please contact me to discuss this. If you are not satisfied by my response and wish to make a complaint, Canterbury Christ Church University complaints process is available to you. To make a complaint please contact: [redacted], Research Director at Salomons Centre for Applied Psychology, Canterbury Christ Church University: [redacted]

Next steps

If you have read through this information sheet and are happy to take part, then please complete the enclosed consent form and bring it to the research team on arrival of the interview.

Contact details

If you need any further information to help you decide whether to take part in the study, or if there is anything you do not understand, please contact me:

[redacted]

Email: [redacted]

Thank you for taking the time to read this information sheet.

Appendix E: Consent form

Consent Form

Title of project: Asylum seekers' experiences of undergoing psychological assessment and evaluation for their asylum claim

Participant Consent Form

Participant ID number:

Please initial below

1. I confirm that I have read the information sheet dated *** and have been given a copy. I have had the opportunity to consider the information and ask questions, and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason. ☐

3. I understand that this study uses an interview to explore my experiences of undergoing psychological assessment and evaluation as part of my asylum claim. I understand that the interview will be recorded and that the audio recording will be deleted once the analysis has been carried out. ☐

4. I understand that relevant sections of data collected during the study, where my privacy has been protected, may be looked at by the research supervisors, [redacted] and/or [redacted]. I give permission for these individuals to have access to this data. I understand that such information will be treated as strictly confidential. ☐

5. If I withdraw from the study at any time, my data will also be withdrawn from the study, up to the point of analysis. I understand that no one will be able to identify me from this information. ☐

6. I agree for my data to be used if this research is entered for publication in the future. ☐

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

Name of Participant (*please print*) Signature of Participant

_____ _____

Date _____

Appendix F: Semi-structured interview

Interview Schedule

KEY OVERARCHING QUESTION:

What are asylum seekers' experiences of undergoing psychiatric/psychological assessment as part of their asylum claim?

(1) What were asylum seekers' expectations of the assessment?

Please tell me about what your expectations of the assessment were before attending your appointment.

How did you feel about going for an assessment?

Did you have any hopes or concerns?

Did you notice any difference in how you were feeling in the period leading up to your assessment?

(2) What were asylum seekers' experience of the assessment?

Please tell me about your experience of the assessment.

How did you feel at the beginning/during/at the end of the assessment (physically, emotionally, mentally)?

Could you tell me what you thought/felt about your assessing psychiatrist/psychologist?

Did you find any aspect of the assessment particularly challenging?

Did you find any aspect of the assessment particularly helpful?

How did you feel after the assessment was over?

Appendix G: Example coded transcript (REMOVED)

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Appendix H: Table of themes for one participant (REMOVED)

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Appendix I: Table of theme development (REMOVED)

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Appendix J: Extended list of quotes by superordinate theme and subtheme

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Appendix K: Reflections from bracketing interview (REMOVED)

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Appendix L: Excerpts from reflective diary (REMOVED)

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Appendix M: End of study report for ethics panel

Dear [redacted]

Please find attached the end of study report for my research project titled:

'**Understanding the experiences of traumatised asylum-seekers undergoing a clinical assessment for the purposes of preparing a medico-legal report for use in their claim for asylum.'**

This study was granted ethical approval by the Salomons Centre for Applied Psychology ethics panel in July 2019. Data collection was carried out from September 2019 until October 2020 and no ethical issues or concerns were raised. The study was completed in December 2020.

Yours sincerely,

[redacted]
Trainee Clinical Psychologist

Understanding the experiences of traumatised asylum-seekers undergoing a clinical assessment for the purposes of preparing a medico-legal report for use in their claim for asylum.

Introduction:

When an asylum-seeker reports a history of ill-treatment and there are indications of psychological trauma, the asylum-seeker's immigration lawyer might instruct a medical doctor, psychiatrist or psychologist for a medico-legal report, which documents psychological and/or physical impact of past ill-treatment. The assessing clinician undertakes a clinical interview taking a detailed history of the asylum-seekers' traumatic experiences and assessing for psychiatric disorders such as post-traumatic stress disorder (PTSD) and depression. The existing research and literature suggest that this assessment process could be experienced as significantly distressing and/or therapeutic.

Aims:

The aim of the study was to explore asylum seekers' experiences of undergoing a clinical assessment for the purposes of having a MLR prepared in support of their asylum claim to help establish whether this process serves as a further post-migratory stressor or whether it holds therapeutic benefits. The study considered the following questions:

1. How do asylum-seekers' experience undergoing a MLR assessment as part of their asylum claim?
2. Do asylum-seekers experience any aspects of the assessment process as distressing and, if so, in what ways?
3. Do asylum-seekers experience any aspects of the assessment process as therapeutic and, if so, in what ways?

Methodology:

The study employed a qualitative approach, using Interpretative Phenomenological Analysis (IPA) for an in-depth exploration of how individuals make meaning of their lived experiences (Smith et al., 1999). IPA explores the 'double hermeneutic', the two-stage interpretation process considering both the meaning participants give to their experiences and the researcher's interpretations of this meaning (Smith & Osbourne, 2004). IPA was chosen as the study aimed to prioritise the asylum-seekers' perspectives on their lived experience. Six participants were recruited and interviewed.

Findings:

Three superordinate themes emerged from the analysis. These were:

1. Tension between negative and positive expectations
2. Therapeutic impact
3. The pain of having to share and remember

Participants described an experience of fear prior to attending their assessment related to feeling unsure of what it would entail and not wanting to have to talk about past experiences. This was in conflict with a sense that the assessment was something they had to do as well as a hope that it would benefit them. The assessment process appeared to provide certain therapeutic benefits which included: the release of sharing, a relational experience providing emotional containment and feeling helped by psychoeducational aspects of the assessment. The process of remembering and sharing past traumas was experienced as particularly challenging as this caused significant emotional distress.

Conclusions:

The study contributes to the wider research investigating asylum seekers' experiences of navigating a complex and challenging asylum process. The findings draw attention to the need for trauma-informed models of care which avoid inflicting further distress on an already highly traumatised population and highlight therapeutic components that require further elucidation in order to enhance the therapeutic potential of the MLR assessment.

Feedback to participants:

The participants will be contacted via telephone and provided verbal feedback of the findings and conclusions of the study. In addition, participants will be sent a written summary of the findings and conclusions.

Appendix N: Research summary to be sent to participants (in addition to follow-up phone call)

Dear Participant,

Thank you again for meeting with me and taking part in my research project. I'm really grateful for your time and for your thoughtful responses to my questions. Please find a summary of my research findings and conclusions attached.

Please do not hesitate to contact me should you have any questions or want to discuss the research further.

Best wishes,

[redacted]
Trainee Clinical Psychologist, Salomons Centre for Applied Psychology

Aims

The research study aimed to understand asylum seekers' experiences of going through a clinical assessment in order to have a medico-legal report prepared for their asylum claim.

Method

Individual interviews were carried out with six participants, explored their experiences of the clinical assessment. The interviews were analysed in order to understand how participants made sense of their experience.

Findings and conclusions

From the analysis three main themes were identified. These were:

1. Tension between positive and negative expectations
2. Therapeutic impact
3. The pain of have having to share and remember

Participants described an experience of fear before their assessment which was related to feeling unsure of what to expect and not wanting to talk about past experiences. There was a tension between this feeling and a sense that it was something they had to do as well as a hope that it would be helpful. The process of having to remember and share painful experiences was very difficult. At the same time, having someone to listen to and understand their experiences, and finding ways to manage their feelings was found to be helpful. Recommendations are made on the basis of these findings to help professionals to take care to not cause distress when providing assessments.

Appendix O: Journal of Refugee Studies author submission guidelines

1. Submission of articles

Articles must be in English and should be submitted via the ScholarOne site.

Authors may not submit articles under consideration for publication elsewhere. The preferred maximum length is 8000 words. Shorter articles may 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. Please ensure that you list at least three recommended reviewers when you submit your paper. For the purposes of double-blind review, we request that you suitably anonymize your manuscript and remove any self-identifying 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.
8. Avoid footnotes.
9. Two levels of subheadings are used: the first in bold and the second in italic. Subheadings are not numbered or lettered.
10. In order to meet your funding requirements authors are required to name their funding sources in the manuscript. Further information on this process and the CHORUS initiative is available on our CHORUS page.
11. References should confirm to the journal's style (please see 5. References below).
12. Provide a cover letter (in Word/PDF format) to accompany your manuscript submission. Your covering letter should include the following statements:
    1. I confirm that the attached manuscript is suitably anonymized and includes no references to my own previous works.
    2. I confirm that I have read the Instructions to Authors and that my manuscript complies to the journal's submission guidelines.

3. 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.

13. Once you have ensured that you have met all of the above requirements, please submit your article on the ScholarOne site.

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.

5. References

The Harvard System is used (see papers in an issue and examples below). All references must be listed alphabetically at the end of the paper.

Please note: A great deal of editorial time is spent correcting references when these are not prepared in the style of the Journal. The correct format is:

- Author's name (in capitals)
- initials
- date in brackets
- title
- place
- publisher
- website and last accessed date for online references.

Please ensure that all citations in the text appear in the list of references and vice versa.

LEONG, F. T. L. and LAU, A. S. L. (2001) 'Barriers to Providing Effective Mental Health Services to Asian Americans'. *Mental Health Services Research* 3(4): 201-214.

LEVY, S. (1999) 'Containment and Validation: Psychodynamic Insights into Refugees' Experience of Torture'. In Ager, A. (ed.) *Refugees: Perspectives on the Experience of Forced Migration.* London: Pinter, pp. 237-257.

ROTER, D. L. and HALL, J. A. (1992) *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits.* Westport: Auburn House.

For online references please add the website details as follows: Available at <...> (accessed DATE).

If you use EndNote to facilitate referencing citations (not required for submission), this journal's style is available for use.

6. Quotations

Quotations longer than two lines are indented. Where quotation marks are required, these should be single not double.

7. Proofs

When a final version has been accepted for publication, authors will receive proofs for correction. No changes to content are permitted at this stage and alterations are restricted to correction of typographic errors.

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