

Doctoral Thesis

Submitted in partial fulfilment of the Lancaster University Doctorate in Clinical Psychology

**The emotional wellbeing of asylum seekers and refugees: experiences of psychological therapy and narratives of forced migration**

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**Thesis Abstract**

This research explores the emotional wellbeing of asylum seekers and refugees through investigating experiences of individual psychological therapy and narratives of forced migration and emotional distress. The thesis consists of a systematic literature review, research paper, critical appraisal and ethics section. The literature review is a metasynthesis of qualitative literature on asylum seekers’ and refugees’ experiences of individual psychological therapy. The data from eight qualitative papers were synthesized using a meta-ethnographic approach and resulted in the development of five themes; (i) the importance of recognition and validation within therapy, (ii) building safety, trust and a human connection within the therapeutic relationship, (iii) revisiting trauma, managing difficult emotions from therapy and regaining hope, (iv) the value of practical interventions, (v) “one should not wake up the djinns (demons)” – cultural stigma and accessing therapy. The results highlight multiple factors for consideration when working therapeutically with asylum seekers and refugees, specifically, the direct impact of socio-political factors on experiences of psychological distress. The research paper utilises a narrative methodology to gain an understanding of 13 refugees’ and asylum seekers’ experiences of forced migration and psychological distress. The analysis of narrative interviews resulted in the development of five themes describing different stages of forced migration and the psychological experiences unique to each stage: (i) a search for safety: leaving everything behind, (ii) the journey: walking over mountains and crossing the sea, (iii) the arrival: unbearable uncertainty, living in limbo and the asylum process, (iv) accepted: realities of living as a refugee and (v) rejected: “where to now?”. The results indicated the importance of recognising the qualitative differences in the experiences of each stage of migration and the implications this has for the psychological support of forced migrants. The critical appraisal reflects on the process and conducting the research considering personal, methodological and ethical issues.

**Declaration**

This thesis presents work that has been undertaken between June 2019 – August 2021 for the Doctorate in Clinical Psychology Programme at the Division of Health Research, Lancaster University. I declare that the content of this thesis is my own, except where reference is made. This research has not been submitted for the award of any higher degree elsewhere.

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# Literature Review

**Refugees’ and asylum seekers’ experiences of individual psychological therapy: a qualitative metasynthesis**

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## Abstract

**Purpose:** The current review aimed to synthesise qualitative literature exploring adult refugee and asylum seekers’ experiences of individual psychological therapy.

**Methods:** A comprehensive systematic search of the following databases led to the identification of eight studies for inclusion in this review: PsycINFO, PsycARTICLES, MEDLINE, EMBASE, CINAHL and Academic Search Ultimate. All selected studies used qualitative methodology to explore refugee and asylum seekers’ experiences of individual psychological therapy. Studies were appraised using an adapted version of the Critical Appraisal Skills Programme (CASP) Tool. The data from these selected studies were then synthesized using a meta-ethnographic approach.

**Results:** The synthesis of selected studies resulted in the development of five themes; (i) the importance of recognition and validation within therapy, (ii) building safety, trust and a human connection within the therapeutic relationship, (iii) revisiting trauma, managing difficult emotions from therapy and regaining hope, (iv) the value of practical interventions, (v) “one should not wake up the djinns (demons)” – cultural stigma and accessing therapy. These themes illustrated the complexities of working therapeutically with asylum seekers and refugees and the vital role of building trust and safety within the therapeutic relationship prior to engagement in therapeutic work. The results also highlighted varied responses to engaging in trauma work ranging from participants finding the experience transformative to others finding it unhelpful, some participants preferred more practical interventions. Participants’ cultural backgrounds and preconceptions around therapy impacted on engagement and therapist’s cultural competency was a significant factor in therapeutic engagement.

**Conclusions:**

Working therapeutically with asylum seekers and refugees involves a number of factors for consideration. Forced migrants’ socio-political context was seen as central to their experiences of distress and recognition of these factors was imperative for positive therapeutic engagement. This review highlights a number of clinical implications to guide practitioners working therapeutically with this community.

*Keywords:* qualitative research, metasynthesis, asylum seekers, refugees, forced migration, psychological therapy.

Practitioner points**:**

* Practitioners must recognise and acknowledge the multiple socio-political factors contributing to perpetuating and maintaining distress in refugee and asylum seeking communities. These factors were highlighted as imperative for feeling understood and validated within the therapeutic relationship prior to engaging in psychotherapeutic work.
* Practitioners must be mindful of individuals current context, asylum status and own meaning making processes when choosing interventions, particularly when addressing traumatic experiences. Where appropriate and useful, individuals’ own cultural and religious healing practices should be integrated into therapeutic interventions.
* The therapeutic relationship was seen as central in positive therapeutic engagement with asylum seekers and refugees. Practitioners should account for the time and space required to gradually build trust and rapport with individuals prior to engagement in therapeutic work.
* Considerations around cultural pre-conceptions and potential stigma around mental health support must be made to enable individuals to engage in psychological therapy. Practitioners may benefit from increasing knowledge around working with forced migrant communities and developing skills in cultural competency.

## Introduction

Refugees and asylum seekers are people who are fleeing their home countries due to experiences of persecution, conflict, disaster or human rights violations and seeking international protection. The term refugee refers to a person granted legal status to remain in a host country, while an asylum seeker describes someone awaiting recognition of legal status (UNHCR, 2020). The experience of awaiting asylum is accompanied with additional experiences of uncertainty and instability (Gartley & Due, 2017). At the end of 2020 there were 82.4 million refugees worldwide, with the United Kingdom (UK) hosting 132,349 refugees and 77,245 asylum seekers (UNHCR, 2020). The experience of forced migration involves a number of stressful events including, but not limited to, sudden upheaval of a person’s life, separation from loved ones and often difficult journeys to host countries (Gartley & Due, 2017; Kirmayer, 2002). Refugees and asylum seekers are then faced with adapting to a host country with a different culture and language and navigating health care systems (Li et al., 2016; Morina et al., 2020). The coronavirus (COVID-19) pandemic presents an additional layer of challenges and uncertainty to this already vulnerable community, including risk of over-crowded living environments and lack of access to services (Júnior et al., 2020).

Due to these experiences refugees and asylum seekers may experience a range of mental health difficulties. While it can be methodologically challenging to estimate prevalence of these experiences, studies have consistently shown a higher prevalence of mental health conditions compared with the general population (Kiselev et al., 2020). A number of systematic reviews have demonstrated higher rates of depression, posttraumatic stress disorder (PTSD), anxiety, bipolar disorder and schizophrenia in refugee and asylum seeking communities as compared to the general population (Charlson et al., 2019; Steel et al., 2009). Despite reports of high levels of mental health difficulties, access to mental health services by refugees and asylum seekers in the UK and across Europe remains low and this has been attributed to linguistic barriers, stigma towards mental health and differences in help seeking behaviours (Satinsky et al., 2019).

The National Institute for Health and Care Excellence (NICE) recommends use of cognitive interventions, in particular Trauma-Focused Cognitive Behavioural Therapy (TFCBT) as the first line of intervention for PTSD. However, the guidelines acknowledge lack of outcome data for the use of these approaches with asylum-seekers and refugees (NICE, 2005). Furthermore, refugee and asylum seekers’ experiences of ongoing threat and fear of repatriation may undermine effectiveness of this therapeutic approach which works on the premise of establishing a current sense of safety prior to therapeutic work (Ehlers & Clark, 2000; NICE, 2005; Summerfield, 2012). Other treatment approaches developed more specifically for individuals affected by conflict such as Narrative Exposure Therapy (NET) (Neuner et al., 2004) show some preliminary positive outcomes for refugees and asylum seekers (Neuner et al., 2018).

There are a number of systematic reviews on the efficacy of psychological interventions in refugee and asylum seeking populations. The most recent review by Wright et al. (2020) demonstrated the use of NET led to a reduction in trauma symptoms and interventions were most successful when using cultural adaptations. The use of NET has also been supported by a number of previous reviews; Thompson et al., 2018; Nosè et al., 2017; Gwozdziewycs, 2013; Crumlish & OʼRourke, 2010. Other supported interventions included CBT and other trauma focused models (Lambert & Alhassoon, 2015 ; Nosè et al., 2017).

A critical review of the literature provided by Nickerson et al., (2011) suggests that while trauma-focused approaches show some effectiveness in alleviating PTSD symptoms in refugees there exist limitations in methodologies of studies limiting the generalisability of results. Other reviews of psychological interventions within this community have found a lack of culturally adapted treatments affecting the outcome of interventions (Naseh et al., 2019; Tribe et al., 2019).

As demonstrated, the vast majority of evidence on effectiveness of psychological therapy with this community comes from quantitative studies using pre-defined constructs for the conceptualisation of mental health. While this information is useful, it does not elaborate on what particular aspects of psychological therapy were not beneficial, or reasons why a particular approach may not be acceptable (Nickerson et al., 2011). Therefore, this review sets out to investigate existing qualitative literature around refugee and asylum seekers’ experiences of psychological therapy. Without a thorough understanding of how a particular therapy is experienced by members of this population we are unable to expand our understanding and advance our theories around effective psychological support for refugees and asylum seekers (McLeod, 2001).

To the author’s knowledge, there has only been one previous review of qualitative literature in this area. Karageorge et al. (2017) conducted a review of qualitative literature on refugee and staff experiences of psychotherapeutic services for adults, children and families. The services ranged from individual therapy to group and family therapy (Karageorge et al., 2017). The review found factors that affected engagement with services included gaining a mutual understanding with clinicians, identifying and addressing complex needs, speaking about traumatic experiences and cultural competence (Karageorge et al., 2017). While the previous review looked broadly at both staff and refugee experiences of psychotherapeutic services the current review differs in its focus on experiences of therapy itself from the perspective of adult asylum seekers and refugees as opposed to the experience of services. Therefore this review aims to synthesise qualitative research into asylum seekers’ and refugees’ first-hand experiences of individual psychological therapy and how this impacts their psychological wellbeing by answering the following question: how do asylum seekers and refuges experience individual psychological therapy? The results of this synthesis will then be discussed in the context of improving mental health service provision for refugees and asylum seekers.

## Methods

The guidelines proposed by (Shaw, 2011) on identifying and synthesizing qualitative literature informed the conceptual framework and search strategy for this review. The Preferred Reporting Items for Systematic Reviews and Meta-analyses checklist (PRISMA) (Moher et al., 2010) was also used as a guide for the structure of this meta-synthesis.

### Scoping search

Prior to the systematic search of the literature an initial scoping search was conducted using Google Scholar and PsycINFO. The purpose of this search was to identify any previous reviews conducted in this area. The scoping search found no existing systematic reviews or qualitative metasyntheses on refugees’ and asylum seekers’ experiences of psychological therapy. This search identified three potential articles for inclusion in the metasynthesis; (Ahn et al., 2014; Al-Roubaiy et al., 2017; Valibhoy et al., 2017). The author was guided by search terms in these papers during the design of the review.

### Design

There are a range of approaches to synthesizing qualitative data (Dixon-Woods et al., 2006). The methodology of this review was chosen considering review aims and the need to synthesize data on the collective experience of psychological therapy and forced migration while maintaining the richness of individual refugee and asylum seeker experiences. Therefore, a qualitative metasynthesis was selected for this review, based on the method initially described by Noblit and Hare (1988) as ‘meta-ethnography’ and later adapted by Britten et al. (2002) for use in health research. This method of analysis has been utilised extensively across health research to synthesise service users’ experiences (Cahill et al., 2018; Toye et al., 2014)*.* It allows for synthesis of qualitative material with an aim of interpreting evidence to look for larger themes and metaphors across studies (Britten et al., 2002; Walsh & Downe, 2005).

### Search strategy

In accordance with guidelines for synthesizing qualitative literature (Harper & Thompson, 2011; Moher et al., 2010) a conceptual research tool ‘The SPIDER tool’ (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (Harper & Thompson, 2011; Moher et al., 2010) was used to identify key elements of the research questions and guide the systematic search of the literature (Table 1).

### Inclusion/exclusion criteria

Papers were included if they met the following inclusion criteria: (i) published in English or Arabic, (ii) published in a peer-reviewed journal, (iii) used qualitative data (can include mixed-method studies), (iv) reported on the experience of psychological intervention from the perspective of an adult refugee or asylum seeker, (v) focused on a psychological intervention (the aim of the intervention must be to reduce psychological distress or improve psychological well-being). The exclusion criteria encompassed the following: (i) studies using quantitative methodology or were unpublished studies, (ii) papers focusing on the experience from the perspective of mental health professionals only, (iii) studies looking at group therapy interventions and (iv) studies focusing on the experience of children.

No date restrictions were applied on the search due to the lack of previous reviews in the area. The inclusion/exclusion criteria aimed to be as broad as possible with the recognition that some of the exclusion criteria may introduce an element of bias. Papers were limited to English or Arabic due to limited resources for translation services. Furthermore, inclusion of only peer-reviewed papers was due to the additional quality assurance provided by the peer review process.

### Systematic Search

A comprehensive literature search was conducted in each of the following databases: PsycINFO, PsycARTICLES, MEDLINE, EMBASE, CINAHL and Academic Search Ultimate. All selected databases are recommended for the psychology subject area and were selected in consultation with a psychology subject librarian. Papers that were initially found through the scoping search were used to guide the selection of free text terms. Published reviews in similar areas that have been published in the Cochrane Library were also consulted to inform free text terms (Hameed et al., 2020; Uphoff et al., 2020).

Free-text terms for each topic of the SPIDER framework were combined with Boolean operator “OR”and all the topic terms were then combined with *“*AND”. All databases were searched using the title and abstract fields separately and then combined with Boolean operator “OR”. Database specific subject headings and thesaurus terms (where applicable) were also used for each of the search terms (see Table 2). The search was completed in January 2021.

The search yielded 3836 papers (PsycINFO: 1559, PsycARTICLES: 64, MEDLINE: 673, EMBASE: 221, CINAHL: 516, Academic search Ultimate: 803). After duplicates were removed, 2507 papers remained. Titles and abstracts were reviewed to determine relevance to the research question. Articles that needed further exploration were retained at this stage. Following the identification of relevant papers through title and abstract searches, 34 full papers remained. Full texts were read to determine concordance with inclusion and exclusion criteria. This resulted in the identification of eight papers. The final step included hand-searching references of these papers; no additional papers were identified. Therefore, eight papers met the criteria for inclusion in the metasynthesis (see Figure 1 for a diagram of this search strategy). The previously mentioned broader review of refugees’ and asylum seekers’ experiences of mental health services conducted by Karageorge et al., (2017) only had one paper in common with the current review (Al-Roubaiy et al., 2017).

The selected studies came from a range of countries including: the UK, Australia, Denmark, Lebanon, Hongkong, America and Sweden. The date of publication ranged from 2011 – 2020. The study sample sizes ranged from 2-26 participants, with 81 refugees and 33 asylum seekers included in the total sample. Participants came from a range of ethnic backgrounds predominantly from the Middle East and Africa. The setting for interventions varied including: outpatient mental health services, Non-Governmental Organisation (NGO) specialist services, specialised torture and trauma centre and an art therapy studio. The details of the study characteristics of the papers included in this review can be seen in Table 3.

### Quality appraisal

The quality of each of the selected studies was appraised using the Critical Appraisal Skills Programme [CASP] Qualitative Checklist tool for qualitative research (CASP, 2018). The appraisal was conducted to avoid drawing unreliable conclusions from the data by accounting for the strength of included papers prior to the analysis stage and being aware of any bias towards weaker studies. Each study was appraised using this ten-item checklist and studies were assigned a score of 1 (yes) or 0 (no or can’t tell) for each criterion on the checklist. Studies were subsequently assigned a score out of 8 (all studies received a baseline score of 2 for meeting the first two screening criteria). The scores ranged from 6-8 (See Table 4). To reduce the bias introduced by having a lone author, one third of the studies (selected at random) were CASP appraised by a peer and a final result was agreed*.*

Excluding papers based on quality appraisal is a highly debated area (Britten et al., 2002; Dixon-Woods et al., 2006). This systematic review did not exclude whole papers as each of the identified papers makes a unique and valuable contribution to the review (Jensen & Allen, 1996). However, based on the scores of the quality appraisal, a hierarchy of the strength of papers (graded from A – C) was created. Studies that were identified as being weaker in the quality appraisal were supported with data from stronger studies when contributing to themes in the synthesis (Attree, 2004).

### Qualitative meta-synthesis

The qualitative metasynthesis was conducted with guidance from the stages outlined by Noblit and Hare (1988) and Britten et al. (2002). The analysis started with reading the identified studies in full to contextualise the described therapeutic experiences of the asylum seekers and refugees. The papers were then re-read in order to extract data relevant to the research question. The extracted data was then entered into a computer software for qualitative analysis (NVivo) where the key concepts from each of the studies were organised into first, second and third order constructs (Malpass et al., 2009). First orderconstructs refer to asylum seekers’ and refugees’ interpretations of their own experiences. Second order constructs refer to the authors’ interpretations of the experiences of participants. As recommended by Noblit and Hare (1988) a list of themes from each of the studies was created based on these first and second order constructs to enable exploration and comparison of these concepts. The following stage involved identifying third-order constructs which are overarching themes based on the review authors’ interpretations of first and second order constructs. This was achieved through developing shared themes across studies through the process of reciprocal synthesis and highlighting any contradictions or differences between studies through refutational synthesis (Feast et al., 2018; Malpass et al., 2009; Schutz, 1962).Throughout this synthesis, the author remained cautious of inconsistencies between studies and reflected each paper’s unique perspective on these experiences. This process led to the resulting themes presented in this meta-synthesis. For an example of this analytic process see appendix 1-A.

## Results

The synthesis of the selected studies resulted in the development of five overarching themes: (i) the importance of recognition and validation within therapy, (ii) building safety, trust and a human connection within the therapeutic relationship, (iii) revisiting trauma, managing difficult emotions from therapy and regaining hope, (iv) the value of practical interventions, (v) “one should not wake up the djinns (demons)” – cultural stigma and accessing therapy. The contribution of papers to each theme can be seen in Table 5 and papers are labelled as S1-S8.

### Theme one: the importance of recognition and validation within therapy

This theme captures the complexity of suffering and loss associated with the forced migrant experience and the importance of recognizing these factors within therapy. For many participants, their current reality could not be addressed without having their past experiences recognised and understood:

You can’t take someone like refugee and someone Australian ... as counsellor, just say, ‘‘this is gonna help you’’— no. There’s some Australian they just grow up here— they have everything, they doesn’t see ﬁghting, they doesn’t sleep no eating ... [refugees] eat, like a brick, you know…they’re suﬀering... ﬁghting is still there (S2, p. 32).

There was an emphasis on recognising the magnitude and injustice of these past experiences and the effect this had on participants’ lives. Participants expressed a sense of hopelessness regarding their inability to change the situation in their home countries and the fears they had for those left behind:

If you have problem like with your finger, you fix it. But I feel pain about my family. When I call my sister I don’t sleep for two weeks because she tells me a lot of things, bad things ‘we don’t have food, we don’t have clothes, we don’t have safe place’. Because they live in a refugee camp and at night time guards come and they rape her, take what she has. When she tells me lots of things and I can’t do nothing, I feel very sad, I feel tired and headache and nervous... I always have neck and shoulder burning (S3, p. 366).

For this participant, psychological therapy could not work towards alleviating the source of her distress. It was important for therapists to recognise how the current and ongoing nature of trauma for some participants led to feelings of powerlessness and impacted on perceived effectiveness of psychological treatment.

In addition to past trauma, it was vital for therapists to recognise the impact of participants’ current social context on their emotional wellbeing and engagement in therapy. This included issues relating to housing instability, unemployment/not being legally able to work, discrimination, lack of basic needs; “It is terrible not to be able to buy things the children need. It is terrible to see them growing up in poverty. Then it is no use to go to a treatment. It makes me feel desperate” (S4, p.454). The daily struggles of adapting to adverse social conditions could not be disconnected from therapy and needed to be recognised;

All I can think about now is how to survive here. Will I be able to pay my rent at the end of the month, will I find myself on the streets with my family? These thoughts keep me awake at night (S5, p. 856).

Participants described a number of social factors central to their experiences of distress and there was a sense that interventions not prioritising these experiences may not be useful in the long term; “psychotherapy is good, but a job is more important. You recover for a while, and then you fall down in the deep hole of unemployment” (S4, p.454).

Both refugees and asylum seekers experienced uncertainty about their future. For refugees, there was an uncertainty regarding resettlement in another country and for asylum seekers there was an impending fear of rejected asylum and repatriation. The state of limbo experienced by participants impacted perceptions of therapy and recognition of these factors was imperative. There was a direct link between participants’ asylum status and their willingness to engage in therapy; “So there wouldn’t be a point to this if I’m just going to be sent back home again” (S1, p. 587). Other participants felt as though the majority of their distress stemmed from their immigration status; “The help is, you know, really the immigration status. That’s the problem I have. All the frustration, anxiety is caused by the immigration” (S7, p. 18). Similarly, participants emphasised that resolving this was the only way to reduce their current distress; “my only hope is to be accepted in a developed country where our rights are respected…all my fatigue and frustration will disappear…” (S5, p. 857). The recognition of the centrality of these factors was important for participants to feel understood by their therapists.

Through being recognised in context of their life experiences participants described feelings of validation. For some, validation was experienced through sharing experiences; “The therapist became my witness… what I experienced was true. I was not crazy” (S4, p. 449). When clients did not experience this validation from therapists they described feeling misunderstood; ‘‘You can tell them [therapists] but they don’t know exactly how it feels. I don’t know if they really understand that kind of fear and pain” (S7, p. 12). The lack of recognition of this context sometimes led participants to feel that interventions were inappropriate:

Go home take water, and sleeping, they’re gonna help you. Don’t worry, don’t think too much,’’ and touching [motioning patting shoulders]... How am I gonna drink water? Is it gonna help me?... My sister is dying here…me actually, I never see the help from counsellor, seriously... one told me I have to go to the shop to look the clothes... Do I have money to buy clothes? (S2, p. 33).

For this participant, the lack of her therapist’s recognition of her social context felt invalidating of her experiences. Participants’ experiences highlighted that recognition provided a necessary foundation for more directly therapeutic work to take place.

### Theme two: building safety, trust and a human connection within the therapeutic relationship

It was important for therapists to acknowledge this vital process of recognition as the foundation for building safety and trust within the therapeutic relationship, enabling participants to engage in therapy. Participants across studies described the importance of trusting the therapist in order to feel safe enough to engage in psychotherapeutic work. The development of trust was described as a gradual process. Participants described being initially apprehensive: “He forced me to trust him, whereas I am a person who doesn’t trust people and I was telling him everything. I was myself shocked…” (S2, p. 34). Being able to build trust with a therapist was described as a powerful and transformative experience. In study (S3), participants took part in various complementary therapies as part of a holistic trauma-focused intervention programme. One participant described how being able to trust her massage therapist gave her the strength to begin trusting again:

I want to emphasize that the treatment I received and the behaviour and the loving care that I received from Kate [therapist] is affecting me directly and putting a positive effect on my health, she just gives me the strength to trust again. (S3, p. 361).

When trust was lacking within the therapeutic relationship, participants described not feeling comfortable, experiencing the therapist as intrusive and feeling that there was a lack of transparency from the therapist: “psychologist should ask the client first, ‘what you like to talk, and about what you don’t like to talk?’ Don’t just ask whatever they like!’’ (S2, p. 35).

When trust developed, participants were able to form a connection with their therapists. Participants expressed the importance of experiencing a genuine human connection, the presence of which had a significant impact on the success of interventions. A genuine connection was described when therapists were non-judgmental, empathic, caring, compassionate, and showed genuine interest. For participants this connection was built upon feeling heard and understood; “ I could say everything that I had in mind, and someone listened to me and understood’ (S4, p. 449). This connection with therapists was described by some participants as alleviating their experiences of isolation and loneliness;

I think I feel supported here… I think one of the things that…probably makes my loneliness, my pain, not so intense is the fact that, like I have I have a case manager and therapist, who know—who want to know my issues and stuff and housing problems, you know? (S7, p. 11).

It was common across the studies for participants to view their therapists as family or friends based on the bond and connection they had created; “all the week I’m waiting to see her to talk and to share…actually we’ve been friends from the first time” (S2, p. 35). However this very connection contributed to distress when the therapeutic intervention ended: “I’m suffering now because our sessions came to the end just last month and I feel as if I am forbidden from meeting or seeing someone who I really, really admire and love and need” (S1, p. 587). The lack of clarity regarding the boundaries of the therapeutic relationship left this participant feeling abandoned.

It was important for participants to feel heard and understood by their therapist. When this was not the case, participants experienced their therapists as detached, having a detrimental effect on the intervention. One participant described that not experiencing a genuine interaction impacted ability to share experiences: “for me to even say the words and things like that, I have to feel this—I don’t know how to say it—connection with the person, to know that they can understand me. ’’ (S2, p. 35)*.*

Participants’ views on their therapists’ cultural competency were closely linked to feelings of being understood and respected. Participants valued therapists’ efforts to learn and accommodate their cultural and religious identities. One participant valued the experience of being able to work with a same-faith practitioner who was able to integrate psychological approaches with prayers and Qur’anic readings:

[Y]ou have the mix, but some people completely avoid adapting to the new culture and keep to themselves, the horrible things about our culture. And then others do the complete opposite thing, become completely westernised and completely forget good values in our culture (S2, p. 31).

Another participant described how she felt understood due to her therapist’s cultural knowledge:

He knows the whole refugee deal... He knew where I was coming from, he knew what was happening. So it was really helpful, he understood everything... we went back to what I remember from Africa, so it’s like the smell that I remember from Africa started coming back to me while I was talking… they needed to go back that far for them to help (S2, p. 33).

When cultural knowledge was integrated into the therapeutic process, participants felt that interventions were more appropriate and felt understood.

The experience of cultural competence was not always the case, with many participants across studies describing their therapists as lacking cultural knowledge and sensitivity. Participants described assumptions made by their therapists:

She had made up her mind from the way we are usually shown on TV as Arab or Muslim men, as basically being female oppressors…she did not really come across as someone who knew much about our culture; she just simply seemed to have this negative view (S8, p. 467).

Another participant from the same study described how their therapist’s lack of cultural awareness was interpreted as a microaggression towards him: “He had already asked about my sisters and the liberties that they perhaps don’t have, or how oppressed my mother might have been. Mind you, all of this was in the form of questions” (S8, p. 466). For another participant, their therapist’s lack of knowledge regarding their socio-cultural context obstructed therapy:

It was this idea of not really understanding that family union is diﬀerent when you have a diﬀerent cultural background... She was surprised that I still lived at home and why I cared so much for [my family]. So it was a bit hard to get through (S2, p.31).

For these participants, their therapists’ lack of cultural knowledge presented an obstacle for the formation of a meaningful connection and any subsequent engagement in therapeutic work. Participants within this theme demonstrated that the gradual development of trust allowed for a meaningful connection to form through feeling heard and understood within their cultural context.

### Theme three: revisiting trauma, managing difficult emotions from therapy and regaining hope

Building a trusting and secure relationship with therapists was a vital pre-requisite for participants to be able to re-visit trauma safely and manage difficult emotions associated with therapy. Across studies, participants valued the experience of emotional relief and catharsis related to speaking about their traumatic experiences with their therapists: “emotionally I felt better by simply letting out all of these thoughts, talking about all of these feelings” (S8, p. 466). One participant described this experience in the form of an Arab proverb “when it is shared, it is less of a burden” (S5, p. 857). For one participant who had experienced a therapeutic massage, physical relief led to a sense of emotional relief:

It made me feel that I am alive…I had been hung from my right arm and Anna said there are three spots that she can feel, I feel that she is very knowledgeable. When she is massaging these spots, when my eyes are closed, I feel her going into each spot one by one. She is aware of how I feel in these particular spots (S3, p. 368).

For these participants the therapeutic relationship was central to their ability to benefit from the cathartic effects of addressing their trauma, transcending the impact of type of therapy used.

However, this was not the case for all participants. For some participants trauma interventions were associated with re-experiencing of trauma, feelings of anxiety before sessions and feelings of shame. One participant described how it felt to speak about her trauma:

When you come, you have to really like talk about it and how you’re feeling and that brings it like to the surface and it’s really raw and that’s really hard and sometimes, you know, you don’t feel like doing that ‘cause it’s painful (S1, p. 586).

Similarly, another participant found that engaging in art therapy brought up traumatic memories that were difficult to manage: “After I draw I have been feeling bad…all the past comes in and I feel very bad” (S6, p. 80). A common factor amongst participants who found speaking about trauma difficult was the lack of a trusting relationship or a connection with the therapist. One participant illustrates this by describing difficulties of continually repeating their experience to new professionals:

The more I repeat the same thing that they ask me I get more depressed, because I’m bringing out the same thing again and again, and it’s making me more emotional. So every time I went or somebody new came I would not talk (S2, p.29).

The experience of a trusting relationship was important for participants to feel safe and supported when recounting their traumatic experiences.

Therapy sometimes offered new perspectives and understandings of distress associated with difficult emotions. For some participants engaging in therapy made them feel weak: “It makes me feel like, like I’m weak, like, you know, I’m not a strong person. ‘Cause if I was then I wouldn’t be needing someone else to help me deal with what’s happened to me” (S1, p. 584). The diagnostic culture of mental health services in some studies at times assigned diagnostic labels to participants that did not match their own conceptualisations of their difficulties: “I was sad that I am suffering from this illness. Even though, you know, I didn’t consider it as an illness before. I was just thinking it’s bad experience and trauma and I need someone’s help” (S1, p. 588). For these participants engaging in therapy brought about difficult emotions and a sense of failure and weakness. A strong therapeutic relationship would be imperative to help participants address these feelings. Alternatively, some participants found diagnosis useful, giving them a sense of direction “With this diagnosis they can lead me to the way I can deal with this illness” (S2, p. 585). Some participants experienced their trauma through somatic symptoms of physical pain. Participants described experiences of “burning all over” (S7, p.7), stomach aches, feeling tense and headaches. One participant described ways in which this pain was relieved using traditional treatments:

Maybe the sadness attacks my stomach... sometimes when I think about past problems, I feel headache, I feel stomach pain... the stomach talks... but when I relax, I try to forget everything. I say this is my fate. I take the herbal medicine and I feel better (S3, p. 369).

The varying ways in which distress was experienced throughout the studies highlighted the importance of gaining an understanding of participants’ meaning making processes prior to engaging in psychological therapy.

The ability to engage in trauma work and overcome difficult emotions through engaging in therapy was a transformative experience for some participants, giving them a new sense of hope. One participant described how she was able to make sense of her traumatic experiences alongside her therapist: “My past was in pieces. We put it together” (S4, p. 449). Participants described therapy as this life-line “It was as if I was drowning and then I was pulled at the last minute from this water” (S7, p. 9). Participants across studies described how engaging in therapy allowed them to experience hope for the future again “when I go there, I talk and my therapist says she understands. She listens and she gives me some advice on how I can struggle with things each day. So, when I leave it’s like I have some hope” (S7, p. 10). This experience is significant given the wide range of ongoing psycho-social and traumatic stressors experienced by refugees and asylum seekers. Participants demonstrated how the engagement in effective trauma work was closely linked to having a trusting relationship with the therapist, with an understanding that this intervention approach was not appropriate for all participants.

### Theme four: the value of practical interventions

Trauma work was not the only aspect of therapy that participants found useful. While some participants felt unable to engage in trauma work, they preferred practical interventions that helped improve their quality of life and manage emotions. For some participants, provision of emotional regulation skills was seen as useful for improving their daily lives: “Now I know what triggers me…she helped me to ﬁnd ways of controlling my anger” (S4, p. 449). Others found that therapy provided skills to help them relax and sleep: “I do the [mindfulness] exercise and I feel tired and then I shower and then I can sleep…without the exercise I cannot sleep” (S6, p. 79). Other participants found that their therapist helped them use proactive strategies in stressful situations:

Once I was harassed by a taxi driver; I immediately called the social worker and she comforted me, told me it was not my fault, that we can practice some protective strategies to prevent this from happening again... (S5, p. 857).

Participants described reduction of distress when therapists helped with practical issues that caused them difficulties. This was described by one study as “advocacy-based counselling” (S8, p. 466):

If I need some help regarding my accommodation or other things .. . they also give me some advice on this, like they don’t mind if I ask them something which will be otherwise look silly to someone else, like other doctors (S2, p. 34).

For these participants, having a therapist act alongside them to address social issues causing distress was seen as a therapeutic experience.

When participants felt there was a lack of practical intervention they described feeling a lack of direction. “I would have appreciated more advice. More direction about what was right and wrong to do in my condition” (S4, p. 454). This feeling of lacking information and direction was echoed by another participant: “I think that they should listen more, and then talk after they observe what you’re saying…also the information that they give you, some of them don’t give you enough information, so you feel like you’re just still lost...” (S2, p. 36). The need for more tangible suggestions to manage day to day struggles was shared amongst participants across studies.

### Theme five: “One should not wake up the djinns (demons)” – cultural stigma and accessing therapy

Not all participants felt as though they could, or wanted to, access psychological therapy. This was due to multiple factors including; not believing in psychological therapy, pre-conceptions about therapy and cultural stigmas associated with seeking psychological support. For some participants psychological approaches did not align with the way they viewed their distress. Participants in the studies came from a range of cultural, ethnic and religious backgrounds each influencing the way in which they made sense of their experiences. Some studies reported participants viewing their distress through a spiritual understanding of ‘the evil eye’ (S5) or the ‘djinns’ (demons) (S4). In one study participants viewed their distress as a result of their social situation and a collective experience, therefore not finding diagnosis and individual intervention successful:

the doctor told me I had depression. I am going through hard times, with my husband dead, having to take care of four children alone, so it is normal to feel sad... She prescribed some medication, said it would help me feel better. I don’t mind taking it, but it is not going to change my reality... I know I am not ill... I am just tired... like all the Syrian people here... we have a lot of pressure because of how we live here... (S5, p. 857).

Some participants had strong preconceptions about psychological interventions which contributed to their views on the effectiveness of psychological therapy and affected engagement in psychological support:

[Y]ou get most of your ideas from the media... The idea of you sitting down, you’re laying down on a bed and there is a person who just sits there like a statue recording what you say... I came in—with those ideas about mental health—and how it just seems like a very silly profession that would not help you at all (S2, p. 28).

There were also a range of cultural stigmas associated with seeking psychological therapy, as described by one participant, “it’s deeply rooted in our society that if you see a psychologist you’re crazy” (S2, p. 28). This cultural stigma had an impact on participants’ ability and willingness to engage in this form of support: “If you have a problem, like me, they make a joke, [...] they call me all the time, “you mad, you mad” and I’m feeling very sad” (S1, p. 588). Other cultural beliefs were expressed around the danger of speaking about trauma: “One should not wake up the djinns (demons). There are things one should not talk about. It makes you feel worse” (S4, p. 454). These experiences highlighted the importance of understanding cultural context and the complexities involved in working with culturally diverse communities.

**Discussion**

### Summary of results

The aim of the current review was to gain an understanding of asylum seekers’ and refugees’ experiences of psychological therapy in order to improve services and psychological interventions for this community. Results demonstrated the importance of recognising contextual factors specific to the forced migrant experience as central to participants’ experiences of distress. Experiences of safety and trust within the therapeutic relationship were highlighted as necessary to facilitate positive therapeutic interventions. The review found that engaging in trauma interventions was useful for some participants and distressing for others, with cultural factors, asylum status and the therapeutic relationship having an impact on this experience. There was a preference for some participants to engage in more practical interventions that contributed to reducing their distress. Finally, pre-conceptions about therapy and cultural stigma had a major impact on participants’ willingness to engage in this form of support.

Discussion of findings

As demonstrated consistently by participants in the current review, the refugee experience itself is a vital contextual factor to individuals’ experiences of distress and the effectiveness of psychological treatment was closely interlinked with the ability to recognise, validate and integrate these factors. These findings are consistent with previous research in the area that has found that post-migration experiences of employment instability, discrimination, poverty, social instability, housing issues and lack of safety are closely linked with negative mental health outcomes for asylum seekers and refugees (Ager & Strang, 2008; Alemi et al., 2017; Bogic et al., 2012; Kim, 2016). In addition to these experiences, participants in the review reported feelings of uncertainty about the future which impacted their daily life. This is described powerfully by Grace et al. (2018, p. 904) as the ‘‘violence of uncertainty’’, refugees and asylum seekers are subjected to this form of violence which is ‘‘enacted through systematic personal, social, and institutional instability that exacerbates inequality and injects fear into the most basic of daily interactions” (Grace et al., 2018, p. 904).

Having established the systemic factors contributing to and perpetuating distress in this community it is important to consider the impact this has for the choice of intervention when working with asylum seekers and refugees. Previous research highlights the tendency for interventions to focus on pre-migration experiences of trauma and violence at the expense of recognising the impact of post-migration experiences and current psycho-social stressors (James et al., 2019; Li et al., 2016). While the importance of addressing past trauma should not be dismissed, it is important that therapists consider the ethical implications of choosing interventions that may locate the ‘problem’ within the individual, while inadvertently dismissing the role of societal and systemic issues of injustice experienced by forced migrants. As seen in the current review, for some participants interventions focusing on past trauma and the use of labels such as PTSD to conceptualise distress were not seen as helpful and contributed to participants feeling weak and unable to cope. When not adapted to this specific context, trauma focused intervention models may potentially inappropriately pathologize refugee distress and further perpetuate suffering (Derges, 2003; Summerfield, 1999).

While trauma work with refugees and asylum seekers should be approached with care, this review demonstrated that for some participants engaging in trauma work was both useful and transformative. One study in particular conducted by Singer and Adams (2011) found an overwhelming positive response when integrating a trauma focused counselling approach with complementary therapies. This integrated approach to trauma when working with asylum seekers and refugees has been supported across the literature, with a push towards the integration of cultural healing practices with western models of intervention (Allotey, 2003; Tribe, 2007; Watters, 2001). It is stipulated that the move towards pluralistic models within psychotherapy and healthcare can accommodate the increasing diversity of clients accessing services and can work towards “embracing the multiplicity of beliefs that exist regarding healing and change” (Pedersen,1994 as cited in Cooper & McLeod, 2007, p. 6).

The current review indicated that the therapeutic relationship was a vital factor for the success of therapeutic interventions with asylum seekers and refugees. This finding is strongly supported by the wider literature. The therapeutic relationship is viewed as a central component to psychological therapy across clinical settings and has consistently been demonstrated to be the strongest predictor of positive therapeutic outcome (Green, 2009; Lambert & Barley, 2001; Wampold, 2001).Participants in this review described a stronger relationship with therapists who were genuine, empathic, caring, trustworthy and non-judgmental. The descriptions of the therapists in the current study map onto the positive aspects of the therapeutic bond highlighted in previous research (Bordin, 1979; Green, 2009; Lambert & Barley, 2001; Mirdal et al., 2012; Norcross, 2010).While positive therapeutic relationships were experienced, participants in the current study described this as a gradual process that took time. This is understandable given the past experiences of many refugees and asylum seekers, therefore practitioners may need to factor in the time for the gradual development of trust prior to therapeutic work (Miller, 2004).

Whilst the therapeutic relationship was highlighted as a facilitator of positive therapeutic outcome, lack of negotiation of the boundaries of this relationship can be problematic (Shors & Kroll, 2019). In the current review, it was common for participants to view their therapists as friends or family which meant ending the therapeutic relationship caused significant distress for some participants. Given this community’s experiences of profound loss and social isolation, it is understandable that forming a positive human connection is greatly valued. However therapists need to balance between forming this human connection to facilitate therapeutic change and upholding the values of their professional role (Schweitzer et al., 2015). Therefore, it is imperative that therapists sufficiently explain the boundaries and limits of the therapeutic relationship, highlighting the eventual end of therapy. This can work towards averting feelings of distress experienced by ending therapy and avoid further contributing to mistrust in professionals (Asgary & Segar, 2011).

Instances where a therapeutic relationship was not able to form between therapists and participants led to disengagement from therapy. Experiencing a lack of cultural competency from their therapists was a common experience leading to relationship breakdown. The current review found that across healthcare settings including specialist services, individual practitioners’ cultural competency was a significant factor in determining engagement in therapy. Cultural competency within mental health provisions is an issue that relates not only to asylum seekers and refugees but to multi-cultural societies more generally (Bhui et al., 2007). Leaving this issue unaddressed can further contribute to disparity in access to mental health services for asylum seekers and refugees (Satinsky et al., 2019). While there is not one single definition of what culturally competent care is, a review of cultural competence within mental health services conducted by Hernandez et al. (2009) proposes a conceptual model for mental health services. This model proposes that cultural competency arises when “there is compatibility among four important factors: community context, cultural characteristics of local populations, organizational infrastructure, and direct service support” (Hernandez et al., 2009, p. 1046).

Additional barriers to engagement in psychological therapy were identified in this review, these included; the inaccessibility and unfamiliarity with service structures, negative pre-conceptions about mental health and cultural stigma towards seeking support. Previous literature supports this link between cultural perceptions of mental health and reduced help-seeking behaviour amongst asylum seekers and refugees (Byrow et al., 2020). The current review demonstrated that participants’ wider community’s acceptance of psychological interventions had a significant impact on therapeutic engagement. This points towards the need for wider community engagement with this population. Efforts to raise awareness and de-stigmatise mental health interventions in refugee communities can work towards increasing access to mental health services (Shannon et al., 2015). The World Health Organisation (WHO, 2018) suggest a number of strategies for overcoming barriers to mental health access for refugee communities. These include the utilisation of outreach services (such as non-governmental organisations and refugee support organisations) to bridge the gap between refugee communities and mental health services and the provision of holistic care. This would work towards coordinating mental and physical health care with social needs due to the close interplay of these factors and their impact on the mental health of forced migrants (Ager & Strang, 2008; WHO, 2018). Working in partnership with refugee communities can help to improve the development of more informed, accessible and culturally competent services (BPS, 2018).

### Strengths and limitations

This qualitative metasynthesis explored the first-hand experiences of asylum seekers and refugees accessing individual psychological therapy and has demonstrated a number of factors that contribute to the lack of engagement with mental health services. The review aimed to capture all relevant research through conducting a comprehensive search of the literature utilising multiple databases. The reviewer was only able to include papers published in English or Arabic, therefore contributions in other languages may have been missed. Although a critical appraisal of the selected studies was completed, no exclusions were made on this basis. Furthermore, the review was completed by a lone author, which may introduce some element of bias. This was addressed through; keeping a clear record of reflections during the data analysis stage and the use of supervision and a qualitative research peer support group. Furthermore, the paucity of literature in this area meant that only eight papers were identified for inclusion, nevertheless the voices of participants within these studies provide valuable insight on experiences of mental health support.

**Areas for further research**

While this review focused on the provision of individual therapy to refugees and asylum seekers, the importance of the community and collective experience was highlighted. Further research into the experience and acceptability of group interventions for this population is warranted. Research specifically into the impact and experiences of cultural competency within mental health services would also be useful. This could work towards developing a further understanding of the most effective interventions for refugees and asylum seekers.

### Conclusion

This review aimed to gain an understanding of refugee and asylum seekers first hand experiences of individual therapy. Understanding individual experiences can work towards understanding barriers and facilitators to accessing psychological therapy and contribute to improving the effectiveness and acceptability of psychological services for this community. This review has highlighted a number of practical implications for clinical work. This ranged from the need for practitioners to gain a contextual understanding of refugees’ and asylum seekers’ experiences to ensure the use of appropriate interventions to gaining an understanding of the individual’s cultural heritage and developing skills in cultural competency.

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## Literature review tables and figures

### Table 1

*Key elements of research question (Cooke et al., 2012)*

|  |  |
| --- | --- |
| SPIDER Terms | Search Concepts |
| S - Sample | Refugees and Asylum seekers |
| PI - Phenomena of Interest | Experience of the psychological therapy |
| D- Design | Qualitative research methodology; |
| E- Evaluation | Evaluating refugees’ and asylum seekers’ experiences, perceptions, attitudes, views or feelings regarding psychological therapy. |
| R- Research Type | Qualitative research or mixed method research where the qualitative aspect of the research is separate. |

### Table 2

*Free- text search terms and database subject terms*

|  |  |  |  |
| --- | --- | --- | --- |
| SPIDER terms | Topic | Free-text terms | Database-specific subject headings |
| S – Sample | Refugee and Asylum Seekers | Refugee\* OR “asylum seeker\*” OR forced migrant\* OR immigrant\* OR emigrant\* OR “displaced person” OR “displaced people” | PsycINFO DE "Refugees"  PsychARTICLES DE "Refugees"  MEDLINE MM "Refugees"  EMBASE Refugee  CINAHL MM "Refugees"  Academic search DE "REFUGEES"  Ultimate |
| PI - Phenomena of Interest | Psychological therapy | Therap\* OR “psychological therap\*” OR “psychological treatment\*” OR counselling OR counseling OR psychotherapy OR “behaviour\* therap\*” OR “behaviour\* modification” OR “social skills training” OR “behaviour contracting” OR “activity scheduling” OR “exposure therap\*” OR psycho-education OR CBT OR “rational emotive therap\*” OR “acceptance and commitment therap\*” OR mindfulness OR “meta-cognitive therap\*” or compassion-focused OR “narrative therap\*” OR “narrative exposure therap\*” OR “psychodynamic therap\*” OR “insight-orientated therap\*” OR “psychoanalytic therap\*” OR “humanistic therap\*” Or “existential therap\*” OR “expressive therap\*” or “supportive therap\*” OR “non-directive therap\*” OR “integrative therap\*” OR “motivational interviewing” OR “interpersonal therap\*” OR “eclectic therap\*” or transtheoretical OR “systemic therap\*” OR “psychologically-orientated intervention\*” OR “art therap\*” or bibliotherap\* OR “colour therap\*” OR “music therap\*” OR psychodrama | PsycINFO DE "Psychotherapy"  PsychARTICLES DE "Psychotherapy"  MEDLINE MM "Psychotherapy"    EMBASE Psychotherapy/    CINAHL MM "Psychotherapy"  Academic search. DE "PSYCHOTHERAPY"  Ultimate |
| D- Design  E- Evaluation  R- Research Type | Experience  Qualitative research | experience\* OR perception\* OR attitude\* OR view\* OR feeling\* OR “emotions” OR “lived experience” | PsycINFO DE "Life Experiences"  PsychARTICLES DE "Life Experiences"  MEDLINE MM "Life Change Events"  EMBASE Experience/  CINAHL MM "Life Experiences"  Academic search DE "EXPERIENCE"  Ultimate    This concept was excluded from search as it limited the search results and researcher chose to scan the results manually. |

### Figure 1

*Flow diagram of systematic search strategy (Moher et al., 2010)*

Additional records identified through reviews of reference lists: 0

Initial search using search terms and subject headings with no database limiters: 3836 papers

(PsychINFO= 1559, PsycARTICLES= 64, MEDLINE = 673 , EMBASE = 221, CINAHL = 516, Academic search Ultimate= 803)

Screening

Included

Eligibility

Records after duplicates removed

(n=2507)

Titles/abstracts screened

(n=2507)

Excluded (n= 2473) due to not using qualitative methodology, being irrelevant to the research question.

Full-text articles assessed for eligibility and inclusion and exclusion criteria applied (n=34)

26 papers excluded due to failing inclusion criteria: using case studies, being thesis/dissertations, not looking at the perspective of the refugee/asylum seeker or being irrelevant to the research question.

8 papers retained for inclusion in metasynthesis

Final number of papers included in metasynthesis: 8

Identification

### Table 3

*Characteristics of selected studies*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Study | Author (s)  (Year) | Location of study | Type of intervention | Context of intervention | Participants and status | Country of origin | Gender | Data collection | Analysis method | Study Aim(s) |
| 1 | (Vincent et al., 2013) | England and Wales | Trauma-focused CBT (TFCBT) | Outpatient mental health services | 7 asylum seekers | Iraq, Sudan, Burundi, Zimbabwe and Afghanistan | 3 female and 4 male | Semi-structured interviews | Interpretative phenomenological analysis | Considering the acceptability of TFCBT for asylum-seekers with PTSD. |
| 2 | Valibhoy et al. (2017) | Australia | Individual psychotherapy | Ethno-specific/cultural diversity services, NGO specialist services, community mental health services and education support service | 16 refugees | Iraq, Iran, Afghanistan, Sudan, DR Congo, Ethiopia, Tanzania and Pakistan | 9 female and 7 male | In-depth interviews | Thematic analysis | Investigating the experiences of refugees who accessed mental health services and factors that influenced engagement with services. |
| 3 | Singer & Adams (2011) | Australia | Complementary Therapies and counselling (integrated trauma rehabilitation service) | The Victorian foundation for survivors of torture | 12 refugees | Iran, Afghanistan, Serbia, Burma, Iraq, Yemen and Somalia | 12 female | In-depth interview and focus groups | Thematic analysis | Aimed to understand the place of CTs for refugees in a Western health care setting. |
| 4 | Mirdal et al.  (2012) | Denmark | Individual Psychotherapy and relaxation | Clinic for traumatized refugees | 16 refugees | Iraq, Bosnia, Lebanon and Afghanistan | 9 female and 7 male | Semi-structured interviews | Qualitative phenomenological approach | To investigate how traumatized refugees perceive their experience of psychological therapy to inform change in a transcultural clinical setting. |
| 5 | Kerbage et al. (2020) | Lebanon | Psycho-social support, individual psychotherapy and psychiatry | Mental health and psychosocial support services (MHPSS) for Syrian refugees | 25 refugees | Syria | Not specified | Semi-structured interviews and in-depth interviews | Thematic analysis | Aimed to understand the perspectives and experiences of Syrian refugees (and professionals) engaging in mental health services for refugees in Lebanon. |
| 6 | Kalmanowitz (2016) | Hongkong | Art therapy and mindfulness | Inhabited studio | 2 refugees | African countries (not specified) | 2 female | Interviews, written data, art work and observations | Interpretative phenomenological analysis | To investigate the use of mindfulness and art therapy practice in the context of political violence, trauma and resilience. |
| 7 | Haas,  (2020) | America | Individual psychotherapy and psychiatric medication | Outpatient mental health services | 26 asylum seekers | 6 different countries (not specified) and Anglophone, Cameroon. | 10 female and 16 male | Unstructured interviews, life histories and observations | Thematic analysis | Understanding how asylum experience effects the use of psychotherapeutic interventions. |
| 8 | Al-Roubaiy et al.,  (2017) | Sweden | Individual psychotherapy | Outpatient mental health services | 10 refugees | Iraq | 10 male | Semi-structured Interviews | Interpretative phenomenological analysis | Investigate the experience of Iraqi men receiving psychotherapy. |

### Table 4

*Quality appraisal of research*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CASP Question | S1 | S2 | S3 | S4 | S5 | S6 | S7 | S8 |
| 1. Was there a clear statement of the aim of the research? (Y/N) | Y | Y | Y | Y | Y | Y | Y | Y |
| 1. Is qualitative methodology appropriate? (Y/N) | Y | Y | Y | Y | Y | Y | Y | Y |
| 1. Was the research design appropriate to address the aims of the research? | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 1. Was the recruitment strategy appropriate to the aims of the research? | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 1. Was the data collected in a way that addressed the research issue? | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 1. Has the relationship between researcher and participants been adequately considered? | 1 | 0 | 0 | 0 | 1 | 0 | 1 | 0 |
| 1. Have ethical issues been taken into consideration? | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 0 |
| 1. Was the data analysis sufficiently rigorous? | 1 | 1 | 1 | 1 | 1 | 1 | 0 | 1 |
| 1. Is here a clear statement of findings? | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 1. How valuable is the research? | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Total score (out of 8) | 7 | 7 | 6 | 7 | 8 | 6 | 7 | 6 |
| Grade (A-C) | B | B | C | B | A | C | B | C |

### Table 5

*Contribution of each paper to metasynthesis themes*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Theme |  | S1 | S2 | S3 | S4 | S5 | S6 | S7 | S8 |
| 1 | The importance of recognition and validation within therapy | X | X | X | X | X |  | X |  |
|  | Building safety, trust and a human connection within the therapeutic relationship | X | X | X | X |  |  | X | X |
| 2 | Revisiting trauma, managing difficult emotions from therapy and regaining hope | X | X | X | X | X | X | X | X |
| 3 | The value of practical interventions |  | X |  | X | X | X |  | X |
| 4 | “One should not wake up the djinns (demons)” - – cultural stigma and accessing therapy | X | X |  | X | X |  |  |  |

## Appendix 1-A - Example of analytic process

Extract from data extraction table for theme three

|  |  |  |  |
| --- | --- | --- | --- |
| **Overarching theme** | **First order constructs (participant quotes)** | **Second order constructs (Primary author interpretations)** | **Third order constructs (review authors interpretations)** |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “emotionally I felt better by simply letting out all of these thoughts, talking about all of these feelings” (S8, p. 466). | Participants saw value in being able to verbalise what they were feeling in therapy. Participants described these experiences as being cathartic. | Sharing trauma is cathartic  Experiencing emotional relief when sharing trauma  Safety within therapeutic relationship |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “when it is shared, it is less of a burden” (S5, p. 857). | Participants viewed their distress as shared with the wider community and a result of the current situation they are in, the proverb refers to sharing the burden and experience with others. | Shared community experience of suffering  Speaking about experiences helps with sense of relief |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “It made me feel that I am alive…I had been hung from my right arm and Anna said there are three spots that she can feel, I feel that she is very knowledgeable. When she is massaging these spots, when my eyes are closed, I feel her going into each spot one by one. She is aware of how I feel in these particular spots” (S3, p. 368). | Participants who endured physical torture held this emotional pain in their bodies. Complimentary therapies worked towards addressing the physical and emotional pain relating to experiences of torture and injustice. | Healing from past trauma through physical touch  Trust in the therapist skill/being able to trust again  Safety and security in therapeutic relationship |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “When you come, you have to really like talk about it and how you’re feeling and that brings it like to the surface and it’s really raw and that’s really hard and sometimes, you know, you don’t feel like doing that ‘cause it’s painful” (S1, p. 586). | Participants experienced ambivalence towards therapy due to the difficult emotional experiences relating to speaking about trauma. | Difficulties speaking about traumatic experience  Re-traumatisation/experiencing negative emotions  Not feeling safe within therapeutic relationship  Not finding this therapeutic approach useful  Unable to communicate needs |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “After I draw I have been feeling bad…all the past comes in and I feel very bad” (S6, p. 80). | Participants found it difficult to focus on experiences that did not elicit feelings of distress. | Difficulties in engaging in therapy due to negative emotions  Not finding this therapeutic approach useful |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “The more I repeat the same thing that they ask me I get more depressed, because I’m bringing out the same thing again and again, and it’s making me more emotional. So every time I went or somebody new came I would not talk” (S2, p.29). | Participants found continuity of care issues difficult to deal with in relation to recounting their trauma multiple times. | Lack of trust with therapist/person that they are recounting experiences to  Difficult emotions associated with speaking about traumatic experiences  Lack of emotional containment due to continuity of care issues |
| Revisiting trauma, managing difficult emotions from therapy and regaining hope | “It makes me feel like, like I’m weak, like, you know, I’m not a strong person. ‘Cause if I was then I wouldn’t be needing someone else to help me deal with what’s happened to me” (S1, p. 584). | Participants found new perspectives offered in therapy difficult to accept. | Difficulties in accepting diagnostic labels  Diagnosis making them feel weak, unable to cope  Different views on emotional distress  Meaning making process of individuals  Unhelpful/inappropriate therapeutic approach |

## Appendix 1-B - Target journal submission guidelines

PAPTRAP AUTHOR GUIDELINES

**Sections**

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

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# Research Paper

**Refugees’ and asylum seekers’ experiences of forced migration and emotional distress: a narrative analysis**

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Prepared in accordance with the ‘Author Guidelines’ for Psychology and Psychotherapy: Theory, Research and Practice

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## Abstract

**Objectives:** Asylum seekers and refugees experience a range of psychological difficulties due to the experience of forced migration. Despite a high prevalence of psychological distress within this community, mental health services remain underutilised. Research on the ways in which psychological distress is understood by this community is limited. This research aims to gain an understanding of refugee and asylum seekers’ experiences of forced migration and the ways in which individuals experience and make sense of psychological distress.

**Design:** The study utilised narrative methodology to explore the experiences of 13 participants, including: four refugees, six asylum seekers and three rejected asylum seekers. Participants took part in unstructured, in-depth narrative interviews which explored their narratives of forced migration and emotional distress.

**Methods:** Participants took part in a narrative interview about their experiences of forced migration and psychological distress. Interviews were audio-recorded, transcribed verbatim and analysed using narrative analysis.

**Results:** The analysis resulted in the development of five overarching themes which map onto the different stages of the forced migrant journey. These themes are titled: (i) a search for safety: leaving everything behind, (ii) the journey: walking over mountains and crossing the sea, (iii) the arrival: unbearable uncertainty, living in limbo and the asylum process (iv) accepted: realities of living as a refugee and (v) rejected: where to now?. Each theme describes the unique psychological experiences reported by participants in each stage of forced migration.

**Conclusions:** This research demonstrated distinct psychological experiences pertaining to each stage of forced migration. These ranged from experiences of constant threat prior to participants fleeing their home countries to experiences of uncertainty and hopelessness when navigating the asylum system in the UK. The nature of these psychological experiences have implications on the choice and appropriateness of psychological interventions at each stage of the forced migrant journey.

*Keywords:* qualitative research, narrative analysis, asylum seekers, refugees, forced migration, experiences, emotional distress, psychological therapy.

### Practitioner points:

* Practitioners need to be aware of the multiple and distinct factors affecting asylum seekers and refugees. This includes qualitative differences in experiences through the multiple stages of forced migration (experiences in home countries, journey/flight phase, arrival, refugee status or rejection of asylum cases). This understanding has implications on the choice of interventions, including the ethical implications of engaging in trauma work with asylum seekers.
* Practitioners may be able to advocate for their clients during the asylum process through disseminating psychological knowledge around the effects of trauma on memory to political and legal systems where possible.
* There is value in the integration of religion, spirituality and other culturally relevant healing practices alongside western therapeutic models where appropriate as part of a holistic intervention approach. Practitioners should develop their skills in the integration of these practices in order to create culturally appropriate interventions for individuals they support.
* There is also a need for practitioners working in this area to familiarise themselves with the legal and political systems surrounding the forced migrant experience and continue to develop knowledge in cultural competency.

## Introduction

Refugees are a diverse group of people who have the common experience of being forced to flee their home countries due to persecution, conflict, violence or human rights violations (United Nations High Comissioner for Refugees [UNCHR], 2011). The term asylum seeker[[1]](#footnote-1) is used to describe the stage of forced migration where people are not yet legally recognised as refugees while awaiting asylum case decisions (Dennis et al., 2017). Time awaiting asylum decisions can vary widely ranging from months to years with the COVID-19 pandemic introducing additional pressures on the asylum system in the UK (The Migration Observatory, 2020). The ‘refugee crisis’ has been described as one of the biggest global challenges of our time with the number of forcibly displaced people worldwide being reported at 82.4 million by the end of 2020. In the United Kingdom (UK) it has been reported that by the end of 2020 there were 132,349 refugees and 77,245 pending asylum cases (UNHCR, 2020).

While refugees and asylum seekers are an ethnically and culturally heterogeneous group of people, the forced migrant experience shares a number of common pre-and post-migration challenges. Pre-migration challenges include experiences of disaster, war, breakdown of communities and loss or separation from loved ones (Gartley & Due, 2017). Post-migration challenges include overcoming linguistic barriers, adjusting to unfamiliar surroundings (Kirmayer et al., 2011), social isolation and a loss of valued social roles (Miller et al., 2005). Furthermore, refugees and asylum seekers have recently been subjected to an increase in negative news reporting surrounding their legitimacy in seeking asylum which has contributed to hostile political environments for this community in the UK (Blumell et al., 2019). In addition, asylum seekers experience unique challenges around uncertainty of their legal status (Gartley & Due, 2017) and the inability to legally enter the labour market due to asylum status (Mayblin & James, 2019).

These experiences understandably have an impact on the mental health of forced migrants, with a wide range of quantitative literature reporting a high prevalence of mental health difficulties within this community. This has been reported as higher rates of depression, anxiety and post-traumatic stress disorder (PTSD) when compared to general populations in western host countries (Altunoz et al., 2016; Fazel et al., 2012; Gülşen et al., 2010; Heeren et al., 2012; Morgan et al., 2017; Richter et al., 2018; Shawyer et al., 2017).

While prevalence studies utilising psychiatric diagnostic frameworks provide valuable information for mental health screening and service planning (Shawyer et al., 2017), the application of psychiatric diagnosis with this population has been criticised for imposing western conceptualisations of mental health on communities with diverse world views. In addition, diagnoses provide a limited understanding of the experiences of refugees and asylum seekers (Kirmayer, 2006; Miller et al., 2006; Summerfield, 2012).

There are a number of proposed theoretical understandings of refugee trauma which contextualise the migratory experience within the socio-political-cultural context in which it occurs, with the interaction between multiple traumatic events and the cumulative stress of forced migration (Bala & Kramer, 2010; Summerfield, 1999). A transactional analytic approach to understanding trauma and migration stipulates a number of factors that impact resilience and vulnerability including pre-existing individual characteristics, migratory experiences and post-migration factors (Mazzetti, 2008). Therefore, constructs such as PTSD provide limited, medicalised and individualised understandings of trauma that “captures only part of the impact of violence, ignoring issues of loss, injustice, meaning and identity that may be of greater concern for the traumatized individuals and for their families and children or later generations” (Kirmayer, 2007, p. vi).

The use of individualised western psychological interventions, when not adapted appropriately for diverse communities, has led to unsuccessful interventions (Murray et al., 2010). A systematic review of psychological interventions for asylum seekers and refugees conducted by Tribe et al. (2017) found a lack of culturally adapted interventions and limited evidence to support the efficacy of standard cognitive behavioural therapy (CBT), Eye Movement Desensitisation and Reprocessing (EMDR) and multi-disciplinary treatments for this community. The review did identify support for the use of Narrative Exposure Therapy (NET) and culturally adapted CBT, although the evidence quality was variable.

Despite high reported prevalence of mental health difficulties, refugees and asylum seekers are underrepresented in access to mental health provisions in European host countries. This has been partly attributed to language and cultural barriers, stigma towards mental health, prioritising social needs and distrust of authority (Heidi et al., 2011; Langlois et al., 2016; Mitschke et al., 2017; Satinsky et al., 2019). However, the underutilisation of services is also due to differences in the ways in which mental health is conceptualised and experienced within refugee and asylum-seeking communities (Satinsky et al., 2019).

Although limited, research in this area highlights the pronounced differences in the ways in which culturally diverse communities understand and alleviate psychological suffering. This includes; attributing more importance to physical symptoms of psychological distress, religious explanations for mental health difficulties (Bettmann et al., 2015), explanations through supernatural possession (Markova & Sandal, 2016) and conceptualising emotional distress as part of everyday life (Savic et al., 2016). There was also a preference to alleviate distress through community support and religious leadership (Markova & Sandal, 2016), using traditional healers (Leavey et al., 2007) and seeking support from family members (Savic et al., 2016).

It is proposed that culturally appropriate mental health services can only be developed through gaining a meaningful understanding of how mental health is conceptualised within refugee and asylum seeking communities and allowing this to inform service delivery (Wells et al., 2015). The current research aims to further the understanding of refugees’ and asylum seekers’ experiences of forced migration, particularly regarding how they make sense of the impact this has on their psychological wellbeing. This research also aims to contribute to the limited qualitative research in this area using a narrative research methodology. The aims of this research are in line with the values of the profession of clinical psychology to gain an understanding of social and cultural factors that shape psychological distress and influence barriers to wellbeing (Division of Clinical Psychology, 2011). This research aims to contribute in guiding health care systems in the provision of culturally appropriate care for refugees and asylum seekers.

## Method

### Research Design

A qualitative research design using narrative methodology was chosen to address the research question. Narrative inquiry does not follow one specific method therefore this research was influenced by a number of frameworks (Creswell, 2014; Crossley, 2007; Fehér, 2011; Riessman, 1993; Weatherhead, 2011). Narrative inquiry stipulates that people use stories to make sense of their experiences and represent their subjective realities (Brown, 2017; Riessman, 1993). This method aims to examine an individual’s own narrative within the broader social, cultural and political context of the research (Fehér, 2011; Weatherhead, 2011). This is particularly relevant to research with forced migrants whose individual experiences cannot be separated from the socio-cultural-political context of fleeing persecution and seeking asylum. Narrative analysis maintains individual accounts as coherent narratives in addition to looking at shared accounts between participants’ experiences (Riessman, 1993). This fits with the aim of this research to understand individuals’ experiences of mental health in relation to the collective experiences of forced migration to inform the design and delivery of mental health services. Narrative inquiry does not assume researcher neutrality and highlights the role of the researcher and participant as collaborators in the unique narrative constructed as a result of the research relationship and process (Moen, 2006; Weatherhead, 2011). Finally, narratives are representations of the world through the experience of an individual and are therefore not examined for ‘authenticity’. This is appropriate when conducting research with forced migrants who are commonly subjected to a culture of disbelief throughout the asylum process (Eastmond, 2007).

Although very limited, narrative methodology has previously been used to explore experiences of forced migration. A study conducted in Denmark explored adolescent refugees’ narratives of pre-migration violence and conceptualisations of home in exile (Bek-Pedersen & Montgomery, 2006). Another study conducted in the UK explored the negative impact of seeking asylum on the mental health including prolonged feelings of uncertainty, loss of identity and experiencing lack of control (Jannesari et al., 2019). I am unaware of any other research using narrative methodology to explore mental health of forced migrants in the UK, therefore this study aims to further contribute to this limited evidence base.

Throughout this research a critical realist (Bhaskar, 1975) position was held as the philosophical framework. This epistemological position is compatible with narrative methodology as it does not negate the existence of a ‘real’ social world, but proposes this world is layered into different domains of reality which are accessible through an individual’s subjective experiences of it. Critical realism assumes the existence of three domains: (1) the *empirical level* which represents events as we experience, observe and understand them through human interpretation, (2) the *actual level* denoting events occurring independent of observationand (3) the *real level* which describes the causal mechanisms which lead events to occur at the empirical level. Critical realism aims to explore social structures through understanding these causal mechanisms and the impact they have on people’s experiences across the domains (Fletcher, 2017). In relation to the current research, asylum seekers’ and refugees’ experiences of emotional distress can be observable at the *empirical level* through exploring participants’ experiences of emotional distress and forced migration. *The actual level* consists of the impact of participants’ rights to protection, freedom and human rights being violated and neglected due to decisions taken by governments and the functioning of the asylum system. The *real level* can be explained through the exploration of causal power structures which impact the decisions made in the actual level such as systematic racism, injustice, oppression and capitalism (Haigh et al., 2019).

Members from the refugee and asylum-seeking community were consulted on the research design. Research materials, proposed recruitment processes and the research design were shared with an asylum seeker and refugee currently in the UK, who provided comments and feedback on this and changes were made accordingly[[2]](#footnote-2).

### Participants and recruitment strategy

Participants for this research included refugees and asylum seekers currently living in the UK who met the following inclusion criteria: over 18 years old, from any country of origin, had been in the UK between three months and three years, were able to provide informed consent and could speak English or Arabic at a conversational level.

Participants were recruited through three third sector organisations supporting refugees and asylum seekers in the North West of England. The research involved an extended rapport building phase where I attended sessions at the drop-in clinic, allowing participants to become familiar with me and develop initial trust before participating. This is particularly important when conducting research with refugee and asylum-seeking communities who, due to their experiences of marginalisation and oppression, may find the development of trust difficult (Miller, 2004). Although narrative research focuses on the analysis of themes within individual interviews as opposed to across participant accounts, the end of data collection was reached when; participants from a range of migration experiences were recruited, the quality of the data was deemed sufficient based on length and content of interview and no novel information was added (Saunders et al., 2018).

Demographic characteristics of participants are presented in Table 1. The sample consisted of six females and seven males. Six were asylum seekers, three rejected asylum seekers and four were refugees. Participants were aged between 19 and 42. The length of time participants had been in the UK ranged from four months to three years. Participants’ countries of origin included; Iraq, Egypt, Sudan, Ethiopia, Kuwait, Saudi Arabia, Afghanistan and Eritrea.

### Data collection

Data were collectedusing one-to-one narrative interviews. Narrative interviews are unstructured, in-depth interviews allow participants to freely re-tell their story about a particular life event including the social context (Muylaert et al., 2014). Narrative interviews aim to reconstruct an event from the participants’ perspective with a focus on minimising the influence of the interviewer in the re-telling of this narrative. However, the interaction between interviewer and participant is a collaborative process since the unique retelling of this story is constructed through this interaction (Creswell, 2014).

The interviews were guided by a narrative interview schedule developed by Fehér (2011) (see Appendix 2-A). This involved the use of open-ended and non-directive prompts to encourage the re-telling of narratives. Narrative follow-up questions were also used to expand on parts of the narrative relating to experiences of emotional distress where appropriate (Fehér, 2011). All interviews were conducted by the researcher in either English or Arabic and took place in the participant’s preferred location, all preferring community centres. All locations were private settings which allowed participants to speak freely about potentially distressing experiences and ensured confidentiality. Due to my professional role as a trainee clinical psychologist, I am experienced in conducting interviews that may feature distressing topics and was actively monitoring participants’ levels of distress. Participants were made aware at the beginning of each interview that they could stop or take a break at any time and were reminded of this at times where they showed distress. The interviews were completed between August 2019 and October 2019 and lasted between 24 – 93 minutes, with an average time of 58 minutes. Interviews were audio-recorded and transcribed into text for analysis. All audio recordings were obtained and stored in accordance with information governance and data protection procedures (see ethics section).

### Data analysis

The analysis for this research was guided by the composite narrative analysis tool (Weatherhead, 2011) and the work of Crossley (2007). Each interview was listened to fully prior to transcription to re-connect with the narrative. Interviews conducted in Arabic were listened to, transcribed into Arabic and then translated into English. After each interview was transcribed, a narrative summary was created highlighting the emotionally salient aspects of the narrative and the core elements of the story told (Crossley, 2007). The analysis included two main components: (1) the analysis of the construction of self of individual participants and the aspects of their narratives that have shaped these views and (2) the cultural narratives and shared experiences that interplay with each of these individual narratives (Weatherhead, 2011).

The analysis process included: (1) removing all interviewer questions and formatting the interview transcript into prose, (2) identifying the boundaries of the narrative segments (changes in topic, pauses, displays of emotion and changes in tone), (3) highlighting content and underlying themes within the narratives, (4) identifying thematic and linguistic connections/mapping out related themes and (5) noting my own reflections and feelings in relation to the narratives. The themes from each individual narrative were then mapped out into a thematic map finding commonalities across participants (Weatherhead, 2011). This process led to the development of five over-arching themes, for an example of this analytic process see Appendix 2-B. Supervisors provided feedback and reflections at multiple stages of this analysis process including the review of transcripts, analysis and proposed themes.

### Ethical Approval

This study received ethical approval from Lancaster University Faculty of Health and Medicine Research Ethics Committee (FHMREC) in June 2019 (see ethics section). All participants provided written consent to take part in the research and for the use of anonymised interview data and direct quotations.

**Results**

The analysis led to the development of five themes each describing a different stage of forced migration and unique psychological experiences identified by participants: (i) a search for safety: leaving everything behind, (ii) the journey: walking over mountains and crossing the sea, (iii) the arrival: unbearable uncertainty, living in limbo and the asylum process, (iv) accepted: realities of living as a refugee and (v) rejected: “where to now?”. For a graphical description of these themes refer to Figure 1 and for an in-depth narrative of each participant, refer to narrative summaries in Appendix 2-C.

**A search for safety: leaving everything behind**

Participants faced diverse experiences in their home countries forcing them to flee in search of safety, leaving everything behind. The psychological experiences during this stage of migration included; a constant state of threat, fear, experiencing humiliation and injustice during torture, violence and persecution.

Not all participants felt able to speak about the experiences in their home countries, but those who felt able described living in a state of constant threat and fear for their lives. Sarah, a member of the Bidoon community[[3]](#footnote-3), described her family’s life after her husband was imprisoned for participating in an anti-government peaceful protest: “they [police enforcement] began to say that “we will take you now… and you will be tortured and raped”, my children witnessed this and were terrified… and I was terrified. So, with this constant threat… we decided to leave Kuwait” (Sarah). There was a need amongst participants to portray the lack of choice they had in fleeing their countries: “it wasn’t my fault, to be a refugee or to come to this country… all of us were in danger in Afghanistan, we had to leave” (Laleh). Living in this constant state of threat was a catalyst for many participants to leave their countries.

Participants shared harrowing accounts of torture and injustice at the hands of their governments. Sultan, who also belongs to the Bidoon community, endured violence in prison due to participating in peaceful protests: “I got hit with their elbows and metal poles and so violently…they don’t have humanity. I never imagined that humans could do that to other humans” (Sultan). For Sultan, these experiences made him question his view of humanity and contributed to feeling unsafe in Kuwait. Another participant, Khaled, described how he was imprisoned and tortured in Sudan due to suspected involvement in political activities:

Four men came into my prison cell, they put a mask on my face and put me in the back seat of the car … I was tortured, beaten, insulted, humiliated for more than six months, even my family didn’t know where I was… (Khaled)

These experiences of humiliation and torture had a significant impact on participants’ sense of self-worth and ability to continue living in their home countries.

Participants described multiple losses and traumas, which led to their decision to flee, but many spoke about a single event being the catalyst. Zeinab described that her breaking point was protecting her daughter from under-going Female Genital Mutilation (FGM) in Egypt due to her own experience:

the incident of the circumcision, when it was done to me, I cannot forget it from my eyes…they did it to me and my cousin together. She went in before me and when she came out, I saw the blood coming out from her and I was terrified…I will never forget…the feeling before, after it and during it and it really affected me for the future. Because I wasn’t just circumcised a normal circumcision, they ‘scraped’ everything [referring to type 3 FGM][[4]](#footnote-4)…I don’t want my daughter to suffer the way I suffered….that was the breaking point. I had to leave. (Zeinab)

For another participant, Mohammed, who had been living under an imposed travel ban and surveillance by the Saudi Arabian government due to political activity, he felt he had to leave as he feared imprisonment: “I felt that I was in danger that I will be absent from reality and go to political prisons” (Mohammed). For Beyan, her breaking point was the murder of her husband in front of her and her two sons by Iraq and Syria Islamic State (ISIS) militant forces due to their Kurdish[[5]](#footnote-5) identity and political involvement. The impact of witnessing this event had detrimental psychological effects on her family: “every night tablets and every day tablets and it was too bad…living in fear. Every day he was too bad [son] he is looking Dad, he sees his head out and blood” (Beyan). For Beyan her sons witnessing the murder of their father and the subsequent flashbacks and constant fear led to the decision to leave. It was important for participants to portray the context of these decisions and the multitude of factors that led them to leave their home countries.

### The journey: walking over mountains and crossing the sea

Having been forced to flee their homes due to violence and persecution, participants embarked on often long and gruelling journeys in search of safety. The psychological experiences described at this stage of the journey were fear, hopelessness, perseverance, resilience and adaptation. Participants described unwavering perseverance in the face of multiple obstacles. The majority of participants did not commence their journey with the final destination of the UK in mind, instead were faced with the need to continually adapt due to poor living conditions and the lack of safety in many countries along the way. For a visual representation of the geographical stops in each participant’s journeys refer to Figure 2.

Participants faced diverse journeys to the UK. Some involved passing through multiple countries and lasted many months or even years “I left Sudan to Libya. I stayed in Libya for 3 years then I left Libya to Italy then France then Belgium and lastly arrive UK” (Bilal). Other participants described not having control over where they were going with their fate being determined by smugglers “we left from the airport in Kuwait… I thought I was going to the UK, but the smuggler didn’t take me to the UK” (Sultan). For this participant the lack of control over where he was going caused him to feel helpless and powerless.

For many participants, the forced migrant journey involved exposure to violence and inhumane treatment. Participants found themselves in countries that lacked stability and basic infrastructure for supporting the needs of asylum seekers, leaving them in extremely hard living conditions; “we sleep in the ground in the forest, it is difficult you know… especially in Belgium, sometimes the police in Belgium they hit you – they imprison you, it is difficult ” (Fekru). Multiple participants initially passed through Libya when fleeing Sudan and described similar experiences of injustice and suffering: “In Libya I had a terrible life of suffering, fatigue and misery, every day you are exposed to something new; theft, persecution and injustice, a country which has no government and no safety, you can’t make a complaint but to God” (Khaled). Khaled used religion as a way to cope with the multiple traumas he faced along his journey.

For these participants the arrival in a different country did not guarantee their safety and security, leading them to seek safety elsewhere: “We try to go to Greece… every time my son is crying, but we came from Iraq and it’s the same problem as in *Turkia*, we go to ship and we think maybe Inshallah [God willing] is better” (Beyan). For Beyan, continuing to hold on to faith enabled her to embark on the next stage of the journey. Traumatic journeys were described where participants had no choice but to survive and adapt to the current situation:

They told me we would go through the sea, and I knew it was illegal – but I would rather die or I’d rather go and try. I couldn’t just stay in Libya. So I had been in the sea, the first day like two days by the boat, we were like 24 people…it’s an open boat…just like a small one, you have to sit, it’s really hard to sit comfortably because it’s really small. So, I stayed two day… just thinking and thinking, die or for someone to help… some people were crying, some people started saying I don’t want to go. Like it’s really horrible... and the waves and moves it’s really scary. Everybody started to regret it like, why I like came here? But I didn’t regret it at all (Omar).

The only way Omar was able to overcome this journey was to continue to persevere and use a survival mindset. For Khaled, searching for a better life meant he was subjected to the inhumane treatment of being sold as a slave: “to reach Tripoli I have to pay the price, I was sold 3 times. I was sold as a slave in the slave market” (Khaled). This experience had a significant impact on his sense of self-worth and ability to trust the world. Despite this, he continued to persevere and search for his rights elsewhere, eventually leading him to the UK.

### Arrival: unbearable uncertainty, living in limbo and the asylum process

This theme describes the end of a long journey, but the beginning of a new journey through the asylum system. Participants began to recover from the adrenaline of their journeys only to experience the isolation and uncertainty of their asylum status. Participants at this stage felt they did not belong. There was also a realisation of the magnitude of loss experienced and the lack of meaningful roles in society. For the six participants still at this stage of their journey, they described feelings of powerlessness and uncertainty.

After long and often traumatic journeys participants felt an initial sense of relief at arriving in the UK: **“**It was a long breathe and like a long relax, was the best thing that I had felt in like…I found somewhere to sleep, somewhere to eat. So I got rid of the hunger, the thirst and the cold” (Omar). For Bilal, arriving in England was the first time he felt safe; “finally there was a clean place to stay, safety, shelter and warmth, people who treated you kindly and the provision of financial assistance to buy the basic things you need” (Bilal). However, this was not the experience for all participants. Derya was met with hostility when she arrived in [city in Wales] in the back of a lorry with her young son and husband:

They say we should separate you with your husband and your child, but I left my country in order to be with them…they said, because there is no place for you … you should be arrested because you are an illegal immigrant here (Derya).

This powerful initial interaction with the UK authorities impacted on Derya’s sense of belonging and made her question her rights to seek safety in the UK.

Participants struggled with the asylum interview process and felt powerless due to their inability to fully communicate their stories:

They didn’t want to know anything just “can you give one reason why you are left in your country?” this is not possible, there is not only one reason why you you’re your country…so in order to be just this gone, you say one thing in order for them to leave you and for you to go outside… because you are not in a good way… you are not emotionally stable (Derya).

Derya’s state of mind at the time of the interview also made this experience distressing. Similarly, Fekru described how he was not in the right state of mind during the asylum interview: “at that time I am not ok, for doing 10 or 11 months and what happened in Calais and in Belgium…I lose my weight and lose everything also, and my mind it was not good” (Fekru). Some participants found it difficult to recall their trauma during the interview:

…it’s stressful because when they ask you, they ask you back to your tragedy to take you back to the day you struggled and it was affecting me, they remember you your family, they make you remember everything…like and my mental health as well… remembering things and the torture, like I have been tortured in Libya – they tortured me a lot, so if a I remember these days… I can’t sleep, until today sometimes I can’t sleep and I’m just trying to avoid them (Omar).

Participants also struggled with the powerlessness they experienced over the asylum system and the lack of control they had regarding many aspects of their lives. One example was participants being unable to choose where to live; “I asked to stay together with my girlfriend, they refused based on their own rules… they didn’t give me permission to have my own accommodation and they didn’t allow me to transfer to where my girlfriend is staying” (Mohammed). This caused participants to feel they lacked freedom and independence.

Restrictions on rights of asylum seekers and the waiting process had a significant impact on participants’ quality of life. The inability to legally work and earn an income as asylum seekers affected participants’ wellbeing and sense of independence. With some asylum cases taking years to process, this led to participants feeling stagnant and powerless; “so… what I want, is I want to live a dignified life, like any human wants in this world. I want to relax, I want to be able to work” (Sultan). The process of waiting for an asylum decision also contributed to psychological distress and comparison with other asylum seekers:

I live with bad nightmares in every direction. I began to feel that I am rejected by the local community and the whole world, sometimes I have thoughts of committing suicide… but I fear God and pray. Due to family problems and thinking of my wife … seven persons came after me and were given the papers. I have been waiting for two years (Khaled).

For Khaled, his lack of refugee status made him feel unwelcome, he used religion as a way of coping with his distress. For all participants the uncertainty of the asylum process and lack of rights caused significant distress.

In addition to the difficulties of the asylum process itself, participants found adjusting to a new culture, language and health care system challenging. The unfamiliarity of the culture came as a shock to some participants “it’s difficult, but it’s just the culture is different here. Everything is different. From my country, that’s why I say different is difficult” (Amari). One of the main difficulties was the language barrier “it’s hard to communicate and you get pretty tired from the situation” (Sarah). For Omar, his difficulty to integrate due to language barriers gave him the motivation to learn English as quickly as possible:

I didn’t think about anything and I stayed for three months in the hostel and I didn’t know the language and nobody could understand me. I didn’t understand people, I can’t take a bus ticket – I didn’t know where to go, where to come from... that is really horrible… I had been isolated from people like because of the language barrier and that really pissed me off, I needed to learn. (Omar)

Despite these obstacles, most participants began to adapt and integrate themselves into the community. There was a huge value to participants in attending the community drop-in centers; “when I come here I feel very happy. Lots of people around, a community, coming from different countries different languages” (Amari). Being around people in a community setting provided a much needed relief from participants’ current situation, although Zeinab described this as being temporary in nature; “I started to come to the drop-in, things started to come together. But emotionally, I am still feeling unstable, as long as we are around people, I feel we are ok, but when we get home, it becomes hard” (Zeinab).

### Accepted: realities of living as a refugee

This theme describes the experiences of four participants who reached the final stage of their journey and were granted refugee status. For these participants this stage came with a sense of relief followed by a realisation of the continuous impact of the trauma they had experienced. Participants previously in survival mode with a sole purpose of seeking asylum now found themselves as refugees, with a multitude of emotions to process.

Participants described a sense of relief after long awaited asylum decisions. There were experiences of newfound freedoms and the hope to begin building their lives again;

It changed a lot, if you are an asylum seeker… you’re hopeless – like you can’t study, you can’t think about your future… so I was determined to study really hard and achieve something that changed my future and help anyone that needs help and I’ve learnt a lot of things in my journey (Omar).

Other participants also felt a sense of hope for the future: “Now that I have status I can finally think about work and studying and building a life here – I want to work legally and contribute to society” (Bilal).

Although refugee status brought with it a sense of relief and stability, participants continued to experience effects of the trauma they endured; “I still find myself anxious and have nightmares but feel there is more hope and opportunities now, there is a huge obstacle that is not a problem anymore…there is stability” (Bilal). Fekru continued to feel anxious about family he left behind; “I take medicine, you know I worry about my family, my wife and my kids who are in Sudan, I don’t have the information about them.” (Fekru). Omar experienced similar distress at being separated from his family and began accessing psychological support;

…the only way to get rid of your problems is to face your problems… so I tried to escape a lot but I couldn’t… honestly. Try to keep busy, but sometimes it just came back just feeling hopeless, your family – like no one here. It’s really hard to stay in a place that… you don’t have anyone (Omar).

Other participants also took steps to seek psychological support. Beyan described the psychological support her family are receiving and the gradual process of healing and dealing with their experiences;

Yeah, my son he is now going psychologist, He go two or three times they tell me he is very angry. Me one month is one time is speaking …slowly, first two times is very hard, I cry, I get flashbacks…it’s me no problem just is my sons.. is good and then, I am good (Beyan).

Beyan expressed how her healing is closely interlinked with the wellbeing of her sons, and their access to support alleviated some of her distress. Although some participants expressed interest in seeking psychological support, there were obstacles to accessing health care due to waiting times, cultural preconceptions about mental health and language barriers. Omar described his experience of waiting to access psychological therapy;

I did one but it was really hard to get an appointment it was 6 months … to apply and I got one appointment and then since that one I think it’s been like 5 months, I’m waiting for another one. (Omar).

### Rejected: where to now?

For Zeinab, Laleh and Samar who are at this stage of their journey they felt a deep sense of hopelessness. Above all, these participants felt their traumas were invalidated and disbelieved due to the rejection of their asylum claims. These participants continued to persevere and appeal their rejections due to fear of having to return to their home countries.

Participants described a sense of hopelessness and high levels of distress; “every day, I sit and I cry [participant starts to cry]. Everyday single day is harder than the day before it… I can’t think of anything… nothing can currently help [participant continues to cry]” (Samar). The experience of having their asylum cases rejected had a significant impact on participants’ wellbeing: “I have been constantly anxious. To not know if your destiny is to go back to suffering or not”” (Zeinab). The reality of continuing to live in uncertainty meant that participants’ lives continued to be stagnant. For Laleh this meant she could not pursue an education;

I got accepted at university, I want to carry on with my education, but I can’t at the moment… because of the refugee status. My friends, they all started university… and it makes me sad, because I can’t go – I’m not able to, and it’s not because I didn’t get the high marks, or I didn’t pass my exam… I’ve done so good, I just can’t get a student loan because I’m an asylum seeker (Laleh).

Participants felt their experiences were invalidated and disbelieved due to having their asylum claims rejected; “they are saying, where is your proof? If your mum got hitten by Taliban, where is your proof? …oh you can’t just like, when someone is attacking you, you can’t just stop them and take a picture” (Laleh). Laleh found the requirements of the asylum process to be unrealistic. Similarly, Samar felt her experience was disbelieved and invalidated;

If people are not convinced with someone’s story, give them an idea of this from the beginning… they asked me to say… what happened to you? I told them - I was tortured, I was raped… but they didn’t ask me, where is the proof of this torture? The proof is on my body and they tell me… they didn’t even ask me for this proof (Samar).

For Samar, the experience of waiting and being separated from her young children in Sudan made the eventual rejection really difficult.

Even through these difficult experiences, participants persevered and challenged the asylum rejections with multiple appeals; “The lawyer said I am going to do an appeal for you… because even in the reasons for rejection, they have cited things that I have never said and that’s written down on paper” (Samar). Zeinab described her experience of awaiting appeal decisions:

So… really, I can’t find anything that helps me… because nothing is going to help you more than knowing…. Imagine you are walking on your way to a place, but you don’t know where you are going? Are you going to take a right or take a left? You will remain anxious and stressed the whole way… I can’t reach where I have set off to go… I don’t know where I am going? I hope that this problem can end soon and I am able to know how the world looks like for me… (Zeinab).

Without an indication of how much longer they could stay in the UK, these participants continued to live in fear and uncertainty.

## Discussion

### Summary of results

The aim of the current research was to explore refugee and asylum seekers’ experiences of forced migration and gain an understanding of how these experiences affected participants’ mental health to inform service delivery. The analysis of the data resulted in five themes which map onto the stages of the forced migrant journey. Participants described unique psychological experiences pertaining to each distinct stage of forced migration.

### Discussion of results

The results highlight an important distinction between the psychological experiences unique to each stage of forced migration. This has implications for the design and implementation of mental health services for asylum seekers and refugees. Due to the nature of asylum policies and the significant limitation of rights while seeking asylum, participants described experiences of prolonged uncertainty and instability. Rejected asylum seekers within the study also faced an additional fear of imminent deportation. These experiences for asylum seekers have been widely reported in the literature (Al Ajlan, 2020; Laban et al., 2004; Murphy et al., 2021; Ryan et al., 2009; Silove et al., 2007). As described by Griffiths, (2014), this experience leaves asylum seekers in a “passive and desperate state of continual transience and uncertainty” (Griffiths, 2014, p. 2005).

Prolonged uncertainty for asylum seekers and refugees has been linked to experiences of hopelessness, fear, frustration, powerlessness, suicidal ideation and increased levels of anxiety and depression (Schiltz et al., 2019). The experiences described in the literature are consistent with the findings of this study. Research has shown that effects of prolonged uncertainty for asylum seekers and refugees can have a greater negative impact on mental health than pre-migration experiences of trauma (Nickerson et al., 2011). The psychological impact of these experiences of chronic uncertainty can be conceptualised using a model of emotional regulation developed by Gilbert (2010): this theory proposes that people regulate their emotions through the balancing of three systems (threat, drive and soothe) with psychological distress being attributed to the imbalance of these systems (Gilbert, 2010). Forced migrants who experience prolonged periods of uncertainty can be seen to function mainly in their threat system (motivated by fear and protection) with limited opportunities to activate their drive (achievement and motivation towards resources) and soothing systems (social connectedness and management of distress) further perpetuating psychological distress. It is proposed that mental health providers should recognise the impact of this chronic state of uncertainty through provision of uncertainty-focused training to ensure a critical awareness of these factors on the mental health of forced migrants (Cange et al., 2019). Forced migrants can also be supported to develop their soothing and drive systems through engagement in alternative therapeutic interventions such as community allotment projects or similar community based interventions. These interventions for asylum seekers and refugees have shown that occupational engagement during this period of uncertainty was valuable for increasing feelings of achievement, community connection and belonging (Bishop & Purcell, 2013).

In addition to experiences of uncertainty and instability during the asylum process many participants found the process of asylum interviews to be a source of distress and re-traumatisation. Many participants felt unable to accurately recall their pre-migration and flight experiences. The negative impact of the asylum interview manifesting through re-experiencing of trauma and increased flashbacks has been documented in the literature (Schock et al., 2015). It is well established that exposure to traumatic experiences can impact both encoding and retrieval of autobiographical memories (Herlihy & Turner, 2007). This can lead to discrepancies in asylum seekers’ testimonies which is not helped by the length, setting and mental state of asylum seekers during interviews (Herlihy, 2002). Therefore suggestions that discrepant or incomplete testimonies indicate the strength or credibility of an asylum case is questionable. It is imperative that clinical practitioners with knowledge in this area advocate for asylum seekers through disseminating their understanding of these psychological processes within political and legal systems where possible.

Participants receiving asylum rejections based on these discrepancies at the asylum interview experienced high levels of distress. Previous research is consistent with these findings and has shown detrimental effects of the asylum process, particularly rejections, on the mental health of forced migrant. This included feelings of hopelessness and despair due to fears of repatriation, invalidation and low self-worth (Mueller et al., 2011; Schoretsanitis et al., 2018). This points towards the importance of clinical practitioners taking a multi-systems approach when working with asylum seekers and refugees. Bronfenbrenner’s ecological framework supports the importance of recognising the impact of five ecological systems ranging from microsystems (immediate social systems) to macrosystems (cultural contexts) on a person’s development (Bronfenbrenner, 1992). In relation to the mental health of forced migrants it is important for practitioners to recognise the interplay of both microsystems (such as family, religious institutions and social support systems) and macrosystems (the culture of disbelief surrounding asylum seekers claims and hostile political environments) on the mental health and wellbeing of asylum seekers and refugees (Lustig, 2010).

Having established the centrality of both pre and post migration factors, it is important for services to account for the interconnectedness of these factors when designing interventions for refugees and asylum seekers. With many participants attributing their distress to the refugee experience and the asylum process itself, it is important that there is congruence between this individual understanding of distress and views of mental health practitioners (Murphy et al., 2021). With Eurocentric models of distress often understanding trauma as an individual experience through the lens of PTSD (Ehlers & Clark, 2000) the important socio-political-cultural context central to the forced migrant experience is often missed (Kirmayer, 2007). By viewing distress solely through a western lens the responsibility of social and political systems in maintaining and perpetuating this trauma is under-stated and interventions may inadvertently locate the ‘problem’ solely within the individual (Bala & Kramer, 2010; Kirmayer et al., 2011; Miller & Rasmussen, 2017; Summerfield, 1999). Understanding distress through holistic models can share this responsibility and lead to more context-centred interventions that promote resiliency within this population (Murphy et al., 2021). A proposed model for intervention is the Adaptation After Persecution and Trauma (ADAPT) model (Tay & Silove, 2017), this aims to strengthen resiliency and adaptation, address social context of distress and basic social needs in addition to integrating specific therapeutic interventions in a culturally competent environment (Tay & Silove, 2017).

There were also important conceptualisations around healing and community. This was expressed through participants wanting to feel part of a community in the UK or connecting with their families in their home countries. These needs for community integration as a form of healing were privileged in the narratives of participants often over the need for individual support. Collective healing may be beneficial for many refugees and asylum seekers who are subjected to collective experiences of trauma, breaking down of communities and systematic violence (Saul, 2013). This could point towards the value of group psychological interventions that could meet individual needs while simultaneously offering a space for community healing, contribute to feeling part of a community and continued social support (Kira et al., 2012). This is not to replace individual interventions, but for practitioners to be guided by needs of individuals when selecting appropriate treatments. Participants used religion and spirituality as a form of coping with and accepting their current situations. This was used throughout multiple stages of the forced migrant journey. Previous research supports the use of spirituality as a coping mechanism for individuals experiencing psychological distress and trauma (Calhoun et al., 2000). There is also evidence to support the use of faith-based coping strategies throughout the multiple stages of forced migration and the positive impact this has on refugees and asylum seekers (Rayes et al., 2021). Provision of holistic therapeutic approaches that integrate culturally relevant practices and faith with western models can work towards more congruent services for asylum seekers and refugees which account for the multiplicity of experiences (Allotey, 2003; Cooper & McLeod, 2007; Tribe, 2007; Watters, 2001). This can only be achieved in the context of culturally competent services with the resources for practitioners to develop these skills alongside gaining knowledge of the forced migrant experience with the recognition of the unique challenges pertaining to each stage of migration (BPS, 2018; McKenzie & Bhui, 2007; Satinsky et al., 2019).

### Strengths and limitations

This research has a number of strengths including the recruitment of a range of participants at different stages of the forced migrant journey. There was also demographic variability in the recruited participants which was representative of the refugee and asylum seeking population in the local area. I was sensitive to the needs of participants and flexibly adapted to their preferred location and setting for the interview. Asylum seekers and refugees were consulted on the design of the research and supporting materials prior to beginning data collection.

There are a number of limitations of the current study. Only participants who were fluent in English or Arabic could participate due to the lack of translation services, this could have limited sample diversity. Furthermore, although 16 charitable organisations were approached for recruitment I was only able to gain access to three organisations. While this still led to the recruitment of a culturally diverse sample, it may have limited sharing experiences of other geographic areas.

### Areas for further research

While this research aimed to contribute to the existing knowledge base through sharing the voices of asylum seekers and refugees, these voices remain underrepresented in the literature. Further qualitative research on the mental health experiences of refugees and asylum seekers from the perspective of this community would be useful. Furthermore, research into the impact of the COVID-19 pandemic on the mental health of refugees and asylum seekers is warranted.

### Conclusion

The current study aimed to privilege the narrative of asylum seekers and refugees through understanding their experiences of psychological distress in order to strengthen the evidence base and inform delivery of psychological services. Important findings were highlighted relating to the distinct psychological experiences pertaining to each stage of forced migration and implications this has on the provision of psychological support to this community. The research suggested numerous areas in which clinical practitioners can improve services for this community, ranging from improving individual clinical practice through strengthening the knowledge base on experiences of forced migrants to advocating for asylum seekers and refugees in political systems.

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## Research paper tables and figures

### Table 1

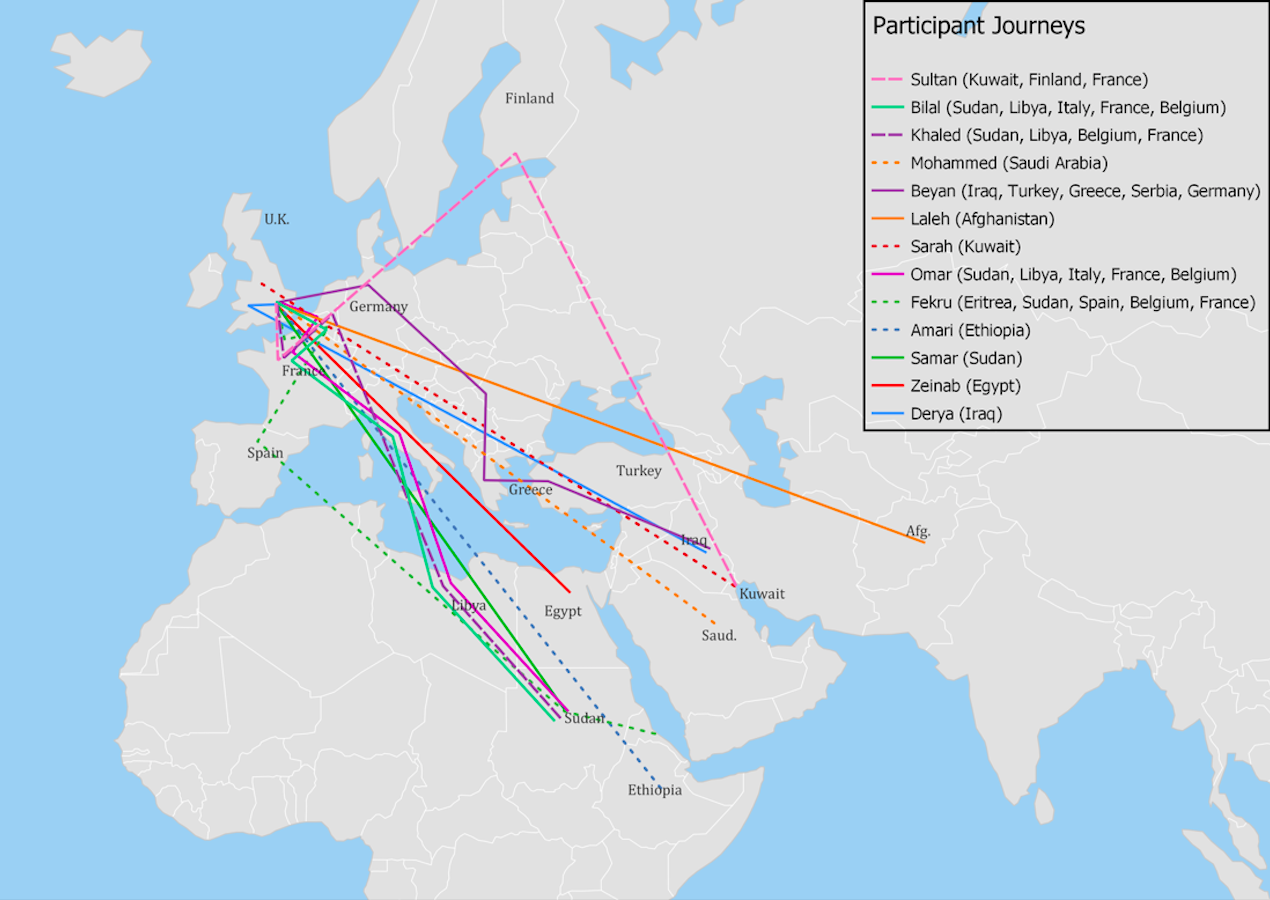
*Demographic characteristics of participants*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Participant  (Pseudonym) | Status | Age | Gender | Duration in UK | Country of Origin |
| Derya | Asylum Seeker | 30 | Female | 9 months | Kurdistan, Iraq |
| Zeinab | Asylum Seeker (rejected) | 40 | Female | 2 years and 3 months | Egypt |
| Samar | Asylum Seeker  (rejected) | 32 | Female | 1 year and 6 months | Sudan |
| Amari | Asylum Seeker | 29 | Male | 1 year and 8 months | Ethiopia |
| Fekru | Refugee | 32 | Male | 11 months | Eritrea |
| Omar | Refugee | 19 | Male | 1 year and 2 months | Sudan |
| Sarah | Asylum seeker | 39 | Female | 4 months | Kuwait |
| Beyan | Refugee | 37 | Female | 2 years and 7 months | Kurdistan, Iraq |
| Laleh | Asylum seeker (rejected) | 20 | Female | 3 years | Afghanistan |
| Sultan | Asylum Seeker | 42 | Male | 5 months | Kuwait |
| Mohammed | Asylum Seeker | 23 | Male | 11 months | Saudi Arabia |
| Khaled | Asylum Seeker | 26 | Male | 2 years | Sudan |
| Bilal | Refugee | 32 | Male | 1 year and 9 months | Sudan |

### Figure 1

*Visual representation of themes*

**Figure 2**

*Participant Journeys*

## Appendix 2-A - Narrative interview schedule

This interview schedule indicates topic areas to be discussed during the interview with

example questions. The exact questions will depend on participants’ responses and the

focus of each interview will be guided by what the individual being interviewed deems to be important.

**Introduction**

Introduce self. Revisit participant information sheet and purpose of interview. Remind them of information on consent form.

**Narrative interview questions**

This interview will be conducted using the principles of narrative enquiry and will be guided by the stages of this as outlined by Fehér (2011):

Participants will be reminded that they only need to share what they are comfortable to share:

***You only need to share as much as you are comfortable with and if you feel too upset to continue, you can stop the interview at any time.***

*Phase one:* This initial phase of the interview should entail an open-ended question that can prompt the participant’s re-telling of their narrative

***Tell me about your experience of forced migration and how this affected your emotional wellbeing? Start from when you were in your home country until you arrived here in the UK?***

Throughout this part of the interview I will engage in active listening but try and influence the narrative as little as possible. I will ask non-directive questions to prompt more information where necessary, such as:

***And what happened next?***

***Could you tell me a little bit more about that?***

***What else happened?***

*Phase two:*The second phase of the interview is called the narrative follow up and involves asking the participants to expand or elaborate on parts of the story that have been mentioned and allow the narrative to develop from these questions. I will use narrative follow up questions to elaborate on parts of the narrative relating to mental health experiences or how participants have been affected by experiences of forced migration.

Participants will be reminded at this stage of the interview that they do not need to answer any of the questions if they don’t feel comfortable to do so:

**I am going to ask you some questions about the story you just told me, if you do not feel comfortable answering my questions you don’t have to. You also don’t need to give me a reason why you don’t want to answer my questions and can just ask for the next question.**

These may include questions such as:

**When you spoke about your experiences of (particular point in participants narrative), could you tell me how that affected your emotional wellbeing?**

**When your described your experience of (particular point in participants narrative), what were your initial emotional reactions to this?**

**When you talked about (particular point in participants narrative), how did this experience make you feel?**

**When you told me about (particular point in participants narrative), how did you cope with that?**

**Conclusion**

In this part of the interview the participant will be thanked for taking part. The interviewer will follow the debrief guidance. The interviewer will ensure the participant has not been distressed by the interview and if necessary will direct the participant to sources of support on the participant information sheet and provide them with the participant debrief sheet.

## Appendix 2-B - Example of analysis and thematic map

**Individual pariticpant transcript analysis process example**

**Step one: Raw narrative / removing all interviewer questions and presenting as prose**

**Step two: Identify boundaries of narrative segments**

**Bold –** Louder tone and additional emphasis on words

***Italics and underlined*–** faster tone and faster pacing

Just underlined –slower pace and quieter tone

New paragraph = topic change/ next phase of story

**Step three: Note content and underlying themes**

Powerleness – not having any control over the situation and things being done to her and her family

Feelings of injustice – not being able to express self/but also feeling powerless within the situation

Adaptation – having to adapt and protect self – regardless of consequences

Uncertainty – not knowing what to do/ what is happening/ constant process of waiting/feelings of powerlessness featuring too as unable to change this sense of uncertainty or do anything about it

Strong feelings of psychological distress/ emotional distress

Hope – pushing forward/ moving / some sense of direction

Belonging – feeling like she doesn’t belong/ feeling on the outside/ different to home

Transitions and constantly moving

**Step four: identifying thematic and linguistic connections and own interpretations/formulations**

\*The authors interpretations were noted using the marked changes function of Microsoft Word during the data analysis process, but have been adapted to text boxes for the illustrative purpose of this appendix.

Ok… You know the first when I came here, I arrived in [city in Wales] – the first place when I arrived here it was [city in Wales] and… you know it was tragedy – we are in a lorry, me and my husband and my child, it was very disaster you know …

**Own interpretations/formulations**

Description as a tragedy – the idea of her whole family having to come here [helpless] in a lorry, use of language such as disastrous – [helpless life moment] for her and her family.

Own feelings: could visualise her child, her apprehension an fear arriving in a strange country in the back of a lorry.

and we called the police, we go to the shop and say “can you call the police for us, we are asylum and we want to seek asylum”.

**Own interpretations/formulations**

Seeking help – reaching out to other to help her navigate an alien system and know how to seek asylum.

So, the two police come… and … they just they spoke with us a little bit and after they say **we should separate you with your husband and your child**. **But I say I left my country because in order to be with them, no to separate from them…** They said, because there is no place for you or something like that or you should be arrested **because you are an illegal immigrant here… so you should arrested.**

**Own interpretations/formulations**

“illegal immigrant” strong language that represents a larger cultural narrative of asylum seekers coming here “illegally” and this dominant narrative

Own feelings: to have been exposed to this language as a first introduction to British society and how this might have felt.

So after that, I say then… really I was so crying crying … after that they say, “ok you can stay with your husband and your child and stay in a hostel”.

**Own interpretations/formulations**

The operation of power in this scenario and how the interaction elicited high levels of distress only to be told that she can stay with her husband and child after all – highlighting her powerlessness in the situation.

They … umm… we just remained for more than three days in the hostel in [city in Wales]. Nothing from Home Office, nothing from immigrant … just waiting, eating, waiting, sleeping it was disaster .. really.

**Own interpretations/formulations**

Feeling of uncertainty highlighted when participant not knowing when/where she was going to be and fearing that she is just “illegal there” – internalising the dominant narrative that she was met with on arrival.

Just I was going to the… there is immigrant near the hostel and I every day from 8 am I was going there until 11 am … just waiting is there anything from home office? No, you should wait… and we called them… **because I didn’t do anything … I was just illegal there …..** Yes, ofcourse … you know just like I don’t know what to do…

**Own interpretations/formulations**

“ I was just illegal there” – fearing she had not met with anyone yet.

Own feelings: made me feel angry as someone who fled for the safety of themselves and their families are feeling like they are illegal or illegitimate.

…and then after three days without anyone tell us anything… one man come to upstairs and they knock the door and they say “come down there is a car they will take you to the [town in England] from [city in England]…

to take you the … you know, the history why you are seeking asylum”. Then from there, you know without knowing anything just from there to [city in England] … [town in England] – we wait from 12pm until 5 I think, just waiting…

**Own interpretations/formulations**

Theme of being powerless in the process and not having any say in what is going to happen to her or where she is going to be.

**Own interpretations/formulations**

Just waiting, now knowing – again highlighting the powerlessness in the situation and her inability to change this.

Then, they did interview for us, the substantial… not substantial interview, just a little bit asking about the questions; who are you? Why did you leave your country? **They didn’t … want to know… they didn’t want anything…just.. “Can you give one reason why you are left in your country?”..** this is not possible you know… Because there is not only one reason why you are left in your country**, if there is one reason I can resolve it … why would I leave my country and be an asylum seeker here? So they want you to have just one reason, so you should minimise all your thought in just one reason and just give them if they are wanting or not… It’s not even …. How??** You cannot minimise all these things in just one reason, and I gave them… this is my reason why I left in my country .. but it was not true!

**Own interpretations/formulations**

Injustice – not being able to navigate a beaurcratic system – “we need one reason” that is not possible, simplistic narratives and ways in which people experiences are minimised. How did the participant experience this? Was she feeling as though the entirety of her story is not relevant or not important? Feeling dismissed?

So, in order to be just this gone, I… you say one thing in order for them to leave you and for you to go outside… because you are not in a good way – you know, you are not socially …nothing and you are not emotionally stable.

So we wait outside for more than one hour, two hours I think and after that they say… “Ok, you should go to [city in England]”. So, from [city in Wales] to [town in England], from [town in England] to [city in England]. Yes, yes… So from [city in England] then…they say you should stay in [town in England] for three days in a hotel, then from there you can go to [city in England].

**Own interpretations/formulations**

She chose to say one reason, to stop the interview – to stop the distress, self-protection and self-preservation. Recognising her own fragility in that moment and making that decision regardless of the consequences.

**Own interpretations/formulations**

Again, highlighting her powerlessness and uncertainty.

They will come and they will take you to [city in England]. Umm…. Then we wait there and we go to [city in England] from the hostel of [town in England]. We arrived there, I think at 9pm and they say “Oh there is no room for you in this hostel because there is a lot of Asylum Seekers there so you should go to the house in [city in England]”,

**Own interpretations/formulations**

Not being respected “there is no room for you in this hostel”/ grouping all of the “asylum seekers”/ no place space for her or her family, how this impacts on her sense of self/safety or belonging.

so I said “Ok”. So we are just waiting and sitting. Ummm… you know from the 9pm **until two days, I’m just waiting… neither I am staying in this hostel or I am going to the [city in England].** This was…. I said to myself… ***I wish I was killed in my country and didn’t have to come here…*** [Participant becomes emotional and begins to cry].

**Own interpretations/formulations**

The feeling of uncertainty/rejection/lack of stability culminated here in her feeling as though she wishes she never sought safety in the UK and died in her country. Strong display of emotion.

Going back to the initial idea of her feeling like she is an “illegal immigrant” and not truly belonging.

Own feelings: thinking about own cultural traditions of hospitality and how not feeling welcome somewhere might affect sense of self-worth? Deserving?

**Example of thematic map**

**Extract from analysis of theme three:**

*The arrival: unbearable uncertainty, living in limbo and the asylum process*

|  |  |  |  |
| --- | --- | --- | --- |
| Participant quote | Individual narrative themes | Common psychological processes | Overarching themes |
| **“**It was a long breathe and like a long relax, was the best thing that I had felt in like…I found somewhere to sleep, somewhere to eat. So I got rid of the hunger, the thirst and the cold” (Omar). | Sense of relief after journey  Safety after prolonged periods of danger/uncertainty  Basic needs being met | Relief  Safety | The arrival: unbearable uncertainty, living in limbo and the asylum process |
| “finally there was a clean place to stay, safety, shelter and warmth, people who treated you kindly and the provision of financial assistance to buy the basic things you need” (Bilal). | Sense of relief after dangerous journey  Safety after prolonged period of danger  Basic needs being met  Being treated with kindness, valued as human | Relief  Safety | The arrival: unbearable uncertainty, living in limbo and the asylum process |
| “yeah… its… maybe Serbia… its Greece too time, is very angry and no speaking bad things.. and pushing all people and it’s maybe… very different. But it’s England its too help you … umm… is go to police station is tell me and my sons … lovely son… yeah, son cry… they help us biscuit, eating, coffee, tea … juice, all is help” (Beyan). | Feelings of safety after previously difficult experiences with authority  Acts of compassion/kindness  Offering of food/comfort  Feelings of safety  Being helped | Relief  Compassion  Safety | The arrival: unbearable uncertainty, living in limbo and the asylum process |
| They didn’t want to know anything just “can you give one reason why you are left in your country?” this is not possible you know. Because there is not only one reason why you are left in your country, if there is one reason I can resolve it… why would I leave my country and be an asylum seeker here? So in order to be just this gone, you say one thing in order for them to leave you and for you to go outside… because you are not in a good way… you are not emotionally stable (Derya). | Feeling unheard/invalidated  Difficulties minimised  Unable to communicate needs due to emotional state  Emotionally unstable  Feeling the need to escape situation | Invalidation    Fear  Feeling unheard/  misunderstood  Emotional instability | The arrival: unbearable uncertainty, living in limbo and the asylum process |
| “until the interview which lasted approximately 3 hours and I just couldn’t … focus. I was tired and I was also fasting and just wasn’t able to concentrate in anything. I told them in the airport, because the lady [in Egypt] told me to say all the details that were written in my passport, that I am a manager in a bank … say everything that is on the passport. She didn’t give me more instructions than that. Of course, I wasn’t focusing at that time, I forgot a lot of details, I didn’t say enough about the threat for my daughter to be circumcised. I was trying to answer the questions and say what has happened to me, I had been fasting for two days… it was so much” (Zeinab). | Exhaustion  Inability to concentrate  Difficulties in memory due to interview circumstances  Unable to communicate needs  Emotionally overwhelmed by the situation | Feeling unheard/  misunderstood  Emotional instability | The arrival: unbearable uncertainty, living in limbo and the asylum process |

## Appendix 2-C - Narrative summaries

## Narrative Summaries

### Derya

Derya is a 30 year old asylum seeker from Iraq who arrived to the UK in the back of a lorry with her young son and husband. Derya’s first interactions with the UK authorities involved being told she was an “illegal immigrant”. These words hung over Derya like a dark cloud as she described feeling that she is nothing without asylum status, and the uncertainty of her future was crippling. Derya’s story involved a series of moves; from her initial arrival in [city in wales] to [city in England], from [city in England] to [city in England], and from [city in England] to [city in England]. After these multiple moves Derya was finally told her final destination would be [city in England]. She prepared for this move and familiarised herself with the area, only to arrive in [town in England] on the day of her move. She was told that this is where she would be living now. Derya found the uncertainty of her future and the lack of control she had over every aspect of her life unbearable.

Arriving in an unexpected place further contributed to feeling out of control. The feeling of uncertainty/rejection/lack of stability culminated in her wishing that she had not sought safety in the UK, and instead had died in her home country. Having been moved to a smaller less connected place, Derya struggled to adjust. She was unable to find halal food shops easily, and felt disconnected from the community. Derya struggled to feel at home in the house she was given by the council as there were men from the housing company who had the key to this house and would sometimes enter uninvited. Derya had no choice but to adapt. She slowly started building links with the community and described people as good and welcoming. The links made at her son’s school were particularly valuable. Derya described the importance of the refugee drop-in centre and the relief this brought her from week to week. Derya continued to wait for the asylum decision, living minute by minute until the decision is made. She described the process as a torturing process and the wait continues.

**Zeinab**

Zeinab is a 40 year old rejected asylum seeker who arrived in the UK from Egypt with her two young children. Zeinab’s husband went out one day five years before she arrived in the UK and never came back. Zeinab was left to raise her children alone as a single woman in a rural village in Egypt. Zeinab’s family and community saw this as unacceptable and were determined to arrange a forced marriage for Zeinab. She suffered a range of abuse at the hands of her brothers including physical, emotional and threats of violence towards her children. Zeinab was forced to meet with a man 20 years her senior who would be her prospective husband and during this meeting she was sexually abused. Zeinab’s breaking point was when her brothers began to arrange for her five year old daughter to undergo Female Genital Mutilation (FGM). Zeinab underwent FGM when she was a child and continues to be traumatised by this harrowing experience. The thought of inflicting this level of pain on her own daughter forced her to flee. With a helping hand from a woman she worked for as a cleaner, Zeinab was able to make a fake passport to obtain a visa to the UK and make the journey.

This was the first time Zeinab ever travelled or boarded a plane. She was told to just follow the crowd at the airport and when arriving to the UK to just say the words “asylum” at the border. Apprehensive and scared, Zeinab and her children embarked on this journey. Zeinab arrived in the UK and claimed asylum, this was the beginning of a frustrating asylum process. Having had her profession initially misreported as a bank clerk to obtain a visa to the UK, Zeinab’s application for asylum came under suspicion. Zeinab felt unable to represent her story at the asylum interview due to exhaustion from the journey and high levels of anxiety. Due to this, Zeinab left out crucial parts of her experiences, including her daughters FGM threat. Zeinab received a rejection of her asylum application which was dismissed for being seen as unauthentic. Zeinab is currently appealing this rejection and lives in constant fear of being repatriated to Egypt. She continues to receive threats from her brothers. In the meantime, Zeinab is trying to adapt to life in [town in England]. She has made links with the community and feels her children are doing really well at school. However, she is struggling with the current uncertainty of her situation and seeing other refugee families move along while she and her family remain stagnant. Seeing her children suffer through the asylum process and feeling out of control is having a significant impact on her mental health. She didn’t know where her life would lead her, but continued to hold on to hope that God had a plan for her.

**Samar**

Samar is a rejected asylum seeker who arrived in the UK from Sudan with her infant daughter, being forced to leave her older children behind. The day of our interview she revealed she had just heard news that her asylum application has been rejected. Samar was distressed but determined to share some parts of her story and reflections on the asylum process. Samar described the difficulties she faced in the past 10 months waiting for a response about her asylum process, only to be told that her story was not believed. She felt immense guilt at leaving her other children behind while trying find safety for all of them in the UK. She expressed how she felt the asylum process should be faster for separated families and how unbearable the process of waiting felt. Samar yearned to feel validated and to be seen as telling the truth. The rejection of her application made her feel unworthy of protection and invalidated. She explained that she was never asked for proof of her experiences and that her torture was dismissed. Samar said that the proof of her torture was forever on her body, but this was never accepted as evidence. In our interview Samar pulled down her shirt to reveal a number of deep and protruding scars scattered all over her chest. The scars looked varied in stages of healing representing repeated experiences of torture. I explained to Samar again that I was not here to judge the authenticity of her story and that I believed everything she said. Samar described the hopelessness she felt at the rejection of her application and was not sure what to do next. She tried to keep in touch with her family to get her through the days, but felt lost and confused about her next steps.

**Amari**

Amari is a 29 year old asylum seeker who arrived in the UK from Ethiopia. Prior to seeking Asylum, Amari was a successful circus performer that toured the world with his performance troupe visiting the UK multiple times as a performer before seeking asylum. In 2015, Amari was captured by the Ethiopian government and imprisoned for eight days due to his involvement in political activity that was portrayed on a TV program. Amari described how this video ruined his life and put his life and his families at risk. With the fear of persecution in Ethiopia, Amari fled to the UK on a pre-existing visitor’s visa and sought asylum upon arrival in [city in England]. He was relocated to [city in England] and then [town in England]. Amari found the isolation of living away from his family and community really challenging. He felt alone and struggled to find a sense of connection with people around him. Amari particularly missed the church related activities that were central to his life at home. Not being able to work or make any plans for the future was difficult for Amari. He feels that he had his whole life, family, career and freedoms back in Ethiopia and currently feels like he has nothing. He felt that he lacked any control over his future and agency over his movement. Being apart from his family was also taking a toll on Amari and he felt he needs to keep himself busy and active during the day to stop himself becoming too depressed. Amari also found it difficult to access the health system for various injuries he sustained during his time in prison. Chronic pain further contributed to his distress. Amari found relief when he connected with members of the community drop in centre and described this as the only time where he forgets his problems and feels free. He expressed gratitude towards the home office for giving him a safe place to stay, but feels the wait for some sense of certainty is becoming increasingly difficult.

**Fekru**

Fekru is a 32 year old refugee who arrived in the UK originally from Eritrea. He was forced to leave his family behind. Fekru’s journey as a refugee began at the age of 12 when he and his family were forced to flee Eritrea and seek safety in Sudan. Life in Sudan came with a host of difficulties; the inability to work legally, no rights to education, threats of violence from Sudanese authorities and the stagnation to any life ambition. Fekru took the leap to leave the violence and injustice in Sudan and look for a better life for his family. His journey took him through Spain, Belgium and France. He endured endless months of sleeping in the cold, not finding food to eat and experiencing the harsh conditions of the Calais refugee camp. Fekru risked his life and crossed the sea by boat to arrive in Europe, hoping to find his human rights respected. However, he experienced violence at the hands of police in Belgium and France. Fekru eventually made his way to the UK by taking a lorry from Calais to [city in England]. He sought asylum in [city in England] and eventually transferred to [city in England] and then [town in England]. Fekru waited for 10 months before he was granted refugee status and described this as a very difficult time. Not being able to work or study and dealing with the constant fear of being rejected was very testing. During this 10 month wait, Fekru was unable to gain information about his family and was not able to communicate with his wife and children. The guilt of leaving them behind and not knowing how they were was distressing. Fekru described the relief of finally gaining refugee status and the rights that accompanied this. He is able to work, to seek an education and to move forward with his life. Fekru still experiences difficulties due to his traumatic experiences but has found that taking anti-depressant medication has helped. He has also reconnected with his family and is trying to facilitate the process of bringing them to the UK.

**Sarah**

Sarah is a 39 year old asylum seeker who recently arrived in the UK from Kuwait. Sarah is from the Bidoon community [social class in Kuwait, word translates into *without nationality*]. The Bidoon are a minority group who are persecuted in Kuwait and have no access to employment, education, health care or formal rights in the country. In recent years members of the Bidoon community began protesting these living conditions in the country. Sarah’s husband was captured and imprisoned during one of these protests and was away from the family for seven months. During his time in prison, Sarah and her children had multiple visits from the Kuwaiti authorities threatening to kill and rape them. They lived in constant fear and decided that it was time to find safety elsewhere. Sarah’s husband endured months of torture while in prison. Sarah and her husband were assisted to flee Kuwait and she was able to come to the UK with her youngest son, while her husband and five other children went to Greece. Sarah had never separated from her children before and found this experience terrifying. Sarah is really distressed by the separation from her young children and husband. She described the pain as intolerable and when she thinks of it too much she feel she can’t breathe. She described their living conditions and showed me a picture of them living in a tent in Greece. She felt guilt around leaving her family, but knows this is their only chance to apply for family reunification in the UK.

Sarah continuously expressed gratitude at being safe, being given a home and shelter. She initially lived in [city in England] before relocating to [town in England], but preferred life in [city in England]. Sarah was given only two days’ notice before her relocation. During her time in [city in England] she felt there was more of a community of Arabs that she could connect with and this made it easier to cope with her current situation. Her son had also began to settle into a school in [city in England] where she felt he was well supported and she saw improvements in his mood and behaviour. She also would regularly go to the mosque which isn’t available to her in [town in England]. She currently lives with a woman from Iran and they communicate through translating sentences on their phones. Not knowing the language felt isolating and Sarah hoped her son can begin school again soon. Sarah described the wait for asylum as unbearable and the only way she gets through the day is by praying. She will continue to pray until she is reunited with her family again.

**Laleh**

Laleh is a 19 year old rejected asylum seeker who arrived in the UK with her mother from Afghanistan. Laleh’s mother was being persecuted by the Taliban for teaching women’s rights in school. She fled with her mother leaving her father and four other siblings behind. Laleh and her mother were trafficked into the UK and she described a long and confusing journey. She did not know which country she was in upon arrival and remembered breaking down in relief when the police officer informed them they were in the UK. Laleh, only a child herself when arriving to the UK, had to navigate the drastic change in culture, language barrier, separation from her family and helping her mum with the asylum case.

Laleh and her mother’s asylum case has been rejected four times by the home office for not providing enough evidence. Laleh finds this claim distressing as she feels the evidence they are looking for is impossible to provide. Laleh explained that when they fled Afghanistan they were focused on keeping themselves safe and fleeing violence, not gathering pictures and evidence of this. Laleh described really struggling with her mental health and feeling depressed but having to hold it together as she did not want to affect her mother as she knew her mother was under a lot of stress. Laleh accessed therapy but did not find it really helpful. She found that the only thing that helped was keeping herself busy and distracted. She did not feel that therapy could change her current situation and the situation is what was causing her the most distress. Laleh has finished her GCSE’s and went to college. She was offered places in four universities to study law but cannot apply for financial aid due to her asylum status so is unable to accept any of these places. Laleh is ambitious and wants to become a lawyer in order to defend human rights, but her asylum status is making this dream impossible. Laleh described feeling like her life is wasting away, with each appeal taking a year. She and her mother are stagnant and apart from the family. The wait feels endless.

**Beyan**

Beyan is a 37 year old Kurdish refugee who fled Iraq with her two young sons. Beyan’s husband was murdered by the Daesh militant group due to being part of the Peshmerga military force. He was shot in the head in front of Beyan and her two sons at home. Concerned for the safety of herself and her children, Beyan left Iraq. Her journey took her from Iraq to Turkey. She described difficult living conditions in Turkey and discrimination against Kurdish people. She managed to board a boat from Turkey to take her to Greece. Beyan described a terrifying journey on a small boat filled with approximately 17 people. She tried to stay strong and reassure her children along the way, but couldn’t help but crying in fear herself. She described praying the whole journey just to get them through. From Greece Beyan travelled to Germany and from Germany to [city in England]. After a long car journey from Germany, Beyan and her children were cold, scared and hungry. She described the British police that met them as kind. They offered them hot drinks and food and were kind to her children. She felt safe.

Beyan had to complete the asylum interview straight away and found this really difficult as she was exhausted physically and mentally from the journey. She was relocated to a hostel in [city in England] for a few days before moving to [city in England] and then settled in a house in [town in England]. Beyan felt she was supported by the church volunteers and the community in [town in England]. They helped her get set up in her home and offer support for her sons appointments and needs. She is pleased her sons are now attending school but continued to worry about the effect the events in Iraq has had on them, particularly her eldest son. He experiences regular flashbacks of his father’s murder. She feels a lot of guilt around this and wishes she could have protected him. He was initially taking medication prescribed by a psychiatrist in Iraq to help with his anxiety, but this didn’t help. Beyan has slowly convinced him to start seeing a psychologist in the UK, and feels these sessions are helping. Beyan and her younger son are also seeing a psychologist. While Beyan begins to settle in the UK, she feels there is still a lot of healing to be done. She uses praying and engaging with the community to help her get though the difficult emotions she experiences every day.

**Sultan**

Sultan is a 42 year old who arrived in the UK after fleeing persecution in Kuwait. Sultan is from the Bidoon community [social class in Kuwait, word translates into *without nationality*]. The Bidoon are a minority group who are persecuted in Kuwait and have no access to employment, education, health care or formal rights in the country. In addition to his position in the Bidoon social group, Sultan was persecuted in Kuwait due to his dwarfism. In recent years members of the Bidoon community began protesting the living conditions in the country. Sultan was part of these protests and was detained and imprisoned by the police. Sultan was tortured and beaten during his imprisonment and sustained injuries to his head and both his arms. He described seeing a side of humanity and a level of cruelty he never knew existed during this time in prison. He was released from prison on the condition that he would be an informant to the police. Sultan’s family were concerned for his safety and paid a smuggler to help Sultan escape from Kuwait. Sultan was informed that he was going to the UK and boarded the plane thinking this was his destination, only to be surprised when he arrived in Finland. Sultan spent the next four years in Finland struggling with an asylum claim due to not having the right documentation. Sultan described the difficulties of living in the camp setting in Finland and the detrimental effect this had on his mental health. He received multiple rejections to his asylum case. His mental health continued to deteriorate and he contemplated ending his life. He felt oppressed, lost, isolated and alone.

Sultan was able to arrange for a smuggler to help him get to the UK. This involved initially going to France and then riding in the back of a lorry to the UK. Sultan described arriving to the UK as a new lease of life and another opportunity at finding protection. He initially arrived in [city in England] and was then moved to [city in England] before settling in [town in England]. Sultan described feeling safe for the first time in the UK and having his human rights respected. He says that living as an asylum seeker is still a struggle and he cannot afford to do much, but he is grateful for his safety. Sultan continues to suffer from his injuries and has metal plates in his arms due to the breaking of his bones. He would like to seek support for his physical health. He tries to manage these symptoms using pain killers. He also struggles with his memory and has said this has drastically changed since his imprisonment. Sultan converted to Christianity and found religion as a huge form of comfort. Sultan described coping through trying to stay in touch with his family, taking it day by day and keeping distracted. He also found a community in the church which really helped him feel connected. He is hopeful at the moment, but is finding the uncertainty difficult.

**Mohammed**

Mohammed is a 23 year old asylum seeker from Saudi Arabia who arrived to the UK 13 months ago after fleeing his home country for political reasons. Mohammed was involved in the protests and political activity surrounding the ‘Arab Spring’ in 2012 (popular movement in opposition of dictator governments). He was passionate about the events happening in Syria and planned to join the opposition forces there but was stopped from travelling by his family and the government and was placed under a five year travel ban. During this time, Mohammed was under close surveillance by the government who controlled any form of political expression and activism. Mohammed explained feeling trapped and simultaneously afraid of the prospect of becoming a political prisoner. During this period of time, Mohammed described experiencing periods of severe depression where he would be unable to take part in day to day activities or maintain his own self-care. He became completely isolated from friends, family and the larger society. After the initial period of the five year travel ban had passed, Mohammed appealed to be able to travel and this was rejected multiple times over the course of two more years.

Once the travel ban was finally lifted, Mohammed made the decision to flee to the UK under an existing visitor visa and seek asylum on arrival. Mohammed did not feel he had the freedom, protection or safety in Saudi Arabia. Mohammed explained that he was met with surprise when requesting asylum upon initially arriving in the airport in the UK, due to being from Saudi Arabia. Mohammed was resettled into housing provided by the home office while awaiting his asylum decision. He felt initially relieved to have made it to the UK, followed by the stark realisation of the isolation and uncertainty that was ahead of him. Mohammed had hoped to leave Saudi Arabia to gain freedom but instead felt trapped, controlled and powerless in the face of the asylum system. He sought mental health support in the UK and was prescribed anti-depressant medication which he did not find helpful, he did not feel able to take part in any other form of therapy offered. Mohammed eventually began to integrate in society and met his current girlfriend who has brought a sense of stability into his life. She is also an asylum seeker which means they are unable to live close to each other due to having to stay in the cities they were resettled in. Due to not being able to legally work, Mohammed struggles to pay for the travel expenses to see her on a regular basis. This is causing Mohammed a lot of stress and he continues to feel trapped. Mohammed has been awaiting the decision regarding his asylum status for 13 months, while he is relieved to have finally arrived in the UK, he experiences intense periods of fear, anxiety and depression at the uncertainty of his status and the prospect of being repatriated to Saudi Arabia.

**Bilal**

Bilal is a 32 year old refugee who fled Sudan to the UK due to political persecution and fearing for his life. Bilal embarked on a long and difficult journey before eventually reaching safety in the UK. He initially travelled seven days through the dessert to make it to Libya where he was imprisoned on arrival. Life in Libya was really difficult and unstable, there was no sense of safety and he felt the situation was worse than Sudan. Bilal decided he needed to seek safety elsewhere and managed to find a smuggler to take him to Italy. This journey was really difficult and Bilal feared for his life. He explained being at the complete mercy of the smugglers and having no idea where his final destination would actually be. They crossed to Italy via the sea and Bilal feared for his life throughout the turbulent journey. He also suffered from severe sea sickness making the journey unbearable.

When he arrived in Italy, the situation was not as expected, the refugee camp was overcrowded with not enough supplies and nowhere to sleep. Bilal decided to move to another camp where he found some support from volunteer organisations, but there was no consistency around this. He made the decision after a month of sleeping on the streets that he would continue his journey in search for a safer place. Bilal took a train and ended up in France. Unfortunately, the arrival in France proved the same situation. Bilal was forced to sleep outdoors in harsh weather conditions. From France he continued his journey to Belgium where he felt the situation was even worse. He spent five months there and felt that life was unbearable. Bilal was subjected to discrimination and violence at the hands of the police forces during this time and he once again feared for his safety. Bilal was finally able to arrange for a smuggler to take him to the UK.

Bilal arrived in the [city in England] before being resettled to [city in England]. After this long and testing journey he described finally finding a place to stay with some shelter and warmth, clean surrounding. He was able to provide for himself with the support and assistance provided from the government. Bilal waited for one year and three months before he received refugee status. He described this waiting period as really difficult but was able to pass this time by keeping himself busy with the community, seeing friends and keeping distracted. He couldn’t let himself think too much during this waiting period as the fear of being sent back to Sudan felt crippling. Bilal felt as though receiving refugee status made him feel like a valued human for the first time. Bilal still experiences nightmares and flashbacks of his previous experiences but feels as though he wants to move on, begin to build a life, finally set roots and begin to contribute to society.

**Omar**

Omar is a 19 year old refugee who arrived in the UK 14 months ago after fleeing political persecution. Omar was imprisoned and tortured in Sudan. Omar’s journey to the UK was very challenging and involved having to continually overcome multiple obstacles in the search for safety. Omar initially fled from Sudan when he was only 17 and arrived in Libya where he remained for nine months. Omar experienced a lot of difficulties in Libya including being subjected to racism, imprisoned multiple times, facing violence and not feeling any sense of safety or stability. Omar decided to attempt to flee to Europe and was warned about a potentially dangerous journey by sea. Omar explained that due to his experiences at the time he would rather die trying to find a dignified life than remain living under the oppression in Sudan or Libya. Omar boarded a small boat with 24 other people that was headed to Italy, the journey was a terrifying. Omar was forced to remain grounded in the current moment as he explained that if he let himself become scared he feared he would lose his mind. He kept praying throughout the journey. During their journey their boat was stopped by Libyan police forces who attempted to take them back to Libya, in this moment of despair Omar jumped from the boat to escape. He would not be taken back. He eventually got rescued by an Italian working ship and arrived in Italy a few days later.

The situation in Italy was not as Omar had expected, to his disappointment there was very little infrastructure for asylum seekers and he could not find food or warmth consistently. He moved from city to city in search for safety, to no avail. Omar decided to try to make it to France as he was told the situation might be better there. Accompanied by another asylum seeker they made the journey by foot and crossed the border into France. When they arrived, they were stopped by the police and sent back to Italy. This marked the first of multiple attempts Omar made to cross the border into France, each time being sent back. When he finally made it to France, Omar found equally difficult living conditions and continued his journey from France through to Belgium where the situation only got worse. Omar described feeling at breaking point, struggling to find the will to survive and yearning for safety and stability. Omar eventually embarked on the last part of his journey leading him to the UK. Upon seeking asylum, Omar was placed in a hostel with other asylum seekers. This was the first time in years Omar had a warm place to stay. He described sleeping for one week, only waking up to eat and drink. After recovering from his harrowing journey Omar began to realise how isolated and lonely it was being in the UK and the frustration that came with not knowing whether he would be granted refugee status. Omar was determined to do all it took to integrate into the community and develop independence, this led him to learn English in less than a year. After nine months of waiting, Omar was granted refugee status. This came as a huge relief and he began feeling like he could finally set down roots and build a life somewhere. Omar plans to apply to university to study engineering and begin to live a free and independent life. Although refugee status brought with it a sense of stability, Omar explained he still has trauma to face and experiences nightmares and flashbacks. He is awaiting psychological therapy.

**Khaled**

Khaled is a 26 year old asylum seeker who was forced to flee Sudan after being imprisoned and tortured for alleged political involvement. Khaled was subjected to inhumane treatment, deprivation of food and severe violence during his imprisonment in Sudan. Khaled managed to escape prison during his admission to a hospital due to a severe infection and was helped by a friend to flee Sudan. Khaled faced a long and turbulent journey before eventually arriving in the UK. Initially fleeing Sudan to Libya, Khaled was faced with a situation that he described as even worse than the torture in Sudan. Khaled was sold as a slave three times during his time in Libya, in addition to being imprisoned and beaten by Libyan police forces.

Khaled was separated from his family, his wife and felt completely isolated. He attempted to work in Libya in order to be able to support his family who were living in difficult circumstances, but could not find a consistent income. His experiences of inhumane treatment affected his sense of self-worth and he began to question what he had done to deserve this life. Khaled knew he had to leave Libya, no matter the cost. He eventually managed to make enough money to pay a trafficker to smuggle him to Italy, the first attempt of the journey they made it to Italian territorial waters and were sent back to Libya by a gang who robbed them on the journey. It took Khaled a month to eventually make it to Italy and from there he went directly to France.

The situation in France was described as hostile, there was no access to shelters or accommodation and Khaled had to find different places to sleep on the streets. Khaled eventually made it to Belgium where he spent four months on the streets and between various temporary accommodations organised by different charities. During this time Khaled became aware that many people were being captured and deported back to their home countries and he was terrified to be sent back to Sudan. Khaled eventually managed to organise travel to the UK where he remains now awaiting the processing of his asylum status. Khaled has been waiting for two years and has found this time really difficult. He is trying to support his family with the 35 pounds a week he receives from the government and is finding the inability to work and be self-dependant the hardest part. He feels stuck and stagnant. He is away from his family and years are passing him by without being able to progress with his life. Khaled struggles with his mental health and has often thought of ending his life, but feels he could not do this due to religious reasons and not wanting to hurt his family even more. He continues to await his asylum decision and uses the community centres and religion as a way to help him cope with the uncertainty.

**Appendix 2-D - Target journal submission guidelines**

PAPTRAP AUTHOR GUIDELINES

**Sections**

1. Submission
2. Aims and Scope
3. Manuscript Categories and Requirements
4. Preparing the Submission
5. Editorial Policies and Ethical Considerations
6. Author Licensing
7. Publication Process After Acceptance
8. Post Publication
9. Editorial Office Contact Details

1. SUBMISSION

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Click here for more details on how to use **Editorial Manager**.

All papers published in the Psychology and Psychotherapy: Theory Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

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All papers published in Psychology and Psychotherapy: Theory, Research and Practice are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

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For a limited time, the Psychology and Psychotherapy: Theory, Research and Practice are accepting brief-reports on the topic of Novel Coronavirus (COVID-19) in line with the journal’s main aims and scope (outlined above). Brief reports should not exceed 2000 words and should have no more than two tables or figures. Abstracts can be either structured (according to standard journal guidance) or unstructured but should not exceed 200 words. Any papers that are over the word limits will be returned to the authors. Appendices are included in the word limit; however online supporting information is not included.

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**Important: the journal operates a double-blind peer review policy. Please anonymise your manuscript and prepare a separate title page containing author details.**(Why is this important? We need to uphold rigorous ethical standards for the research we consider for publication.)

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Author Guidelines updated 28th August 2019

# Critical Appraisal

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Doctorate in Clinical Psychology

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**Word count: 4408**

Main text: 4000

Appendices: 408

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## Critical appraisal

### Summary of research

The current research consists of three papers, including this critical appraisal. The papers combined aim to gain an understanding of the way in which emotional distress is understood to guide the use of appropriate therapeutic intervention and mental health support for asylum seekers and refugees. The first paper is a metasynthesis of qualitative literature on refugee and asylum seekers’ experiences of individual psychological therapy. The metasynthesis resulted in the development of five themes; (i) the importance of recognition and validation within therapy, (ii) building safety, trust and a human connection within the therapeutic relationship, (iii) revisiting trauma, managing difficult emotions from therapy and regaining hope, (iv) the value of practical interventions, (v) “one should not wake up the djinns (demons)” – cultural stigma and accessing therapy. These themes highlighted the complexities of working therapeutically with forced migrants and highlighted important implications for clinical practice.

The second paper was an empirical paper which used narrative analysis to explore 13 participants’ experiences of forced migration and emotional distress. This research resulted in the development of five themes describing different stages of forced migration and the psychological experiences unique to each stage: (i) a search for safety: leaving everything behind, (ii) the journey: walking over mountains and crossing the sea, (iii) the arrival: unbearable uncertainty, living in limbo and the asylum process, (iv) accepted: realities of living as a refugee and (v) rejected: “where to now?”. These themes highlighted the importance of understanding the distinct factors affecting participants at each stage of the forced migrant journey and the implications this has on the provision of psychological support for this community. This current critical appraisal will be focusing on my experiences of conducting research for my empirical paper.

### Strengths and limitations

The study had a number of strengths. Participants came from a range of demographic backgrounds, which were representative of the forced migrant population in the local area. I aimed to provide greater flexibility in the recruitment process to gain trust among the community enabling participation in the research. I also tried to be as accommodating as possible in the location and setting of the interview, to encourage participants to feel as safe and comfortable as possible. Another strength was the participant sample represented various stages of the forced migrant process, with the study including asylum seekers, refugees and rejected asylum seekers. There were also a number of limitations. Participants who were not fluent in English or Arabic were not included in the research, as I had no access to translation services due to the research scope. Due to the nature of qualitative inquiry and analysis, it is likely my own personal biases were introduced into the research throughout the data collection and analysis phase. This was addressed throughout the research using supervision, peer supervision and keeping a reflective journal. While I was able to recruit 13 participants for this research, participants only came from three of the 16 charitable organisations contacted. While the sample still represented a culturally diverse group of asylum seekers and refugees from three geographic areas, the limited access to other recruitment locations could have limited hearing about experiences in other geographical areas.

### Areas for further research

This research contributes to the inclusion of refugee and asylum seeker voices and perspectives within the literature, research from the perspective of this community remains sparse. Further research into asylum seekers’ and refugees’ experiences of emotional distress can continue to strengthen our understanding of these experiences and improve the accessibility and appropriateness of mental health services for this community. The data for this research was collected prior to the COVID-19 pandemic, therefore research into the significant effects of the global pandemic on the mental health of asylum seekers and refugees is warranted.

### Personal journey throughout the research

The process of qualitative research, in particular a narrative approach, required me as a researcher to be aware of my own relationship with the research material and the influences this had on the research process. Due to the complexity of qualitative research and the subjectivity of qualitative analysis, reflection is seen as a vital cognitive practice when conducting a qualitative inquiry (Watt, 2015). This process facilitates engagement with our internal thoughts, allowing underlying cognitive processes to become conscious so they can be taken into consideration throughout the research (Guillemin & Gillam, 2004; Mortari, 2015). For these reasons, I chose to guide my reflective practice throughout this research by keeping a reflective journal. This journal was kept throughout the research from the project design phase to the analysis and write up stages. For an example of this reflective process, see an extract from this reflective journal in Appendix 3-A. This was used alongside formal supervision and peer supervision.

My motivations for engaging in this research stemmed from both a personal and professional interest in the subject area. I have worked therapeutically with refugees and asylum seekers for a number of years prior to commencing my doctorate in clinical psychology. However, my family’s origin was also a key motivator for my curiosity and passion for this topic. I was raised in Doha, Qatar by a Palestinian mother and an Egyptian father. My mother was an internally displaced refugee from Yafa whose family lived in Gaza before fleeing to Syria to seek safety. Her family eventually sought asylum in Qatar where they were granted temporary residential status (specific to the political situation around Palestinian refugees) meaning feelings of uncertainty and not belonging continue to be experienced within my family. Being a daughter of a refugee places me somewhere in between the ‘insider-outsider’ relationship with the research population (Dwyer & Buckle, 2009). While I cannot claim a lived experience of forced migration, intergenerational narratives of forced migration have significantly impacted my upbringing. It was important for me to be consciously aware of the interlinks between my family narrative and the narratives shared by participants during the research process.

I began the research by reflecting on my own family narrative of forced migration and re-visiting this story with my mother and grandmother before beginning data collection. The data analysis phase of the research coincided with my participation in a tree of life group as part of a leadership module on my Doctorate in Clinical Psychology. The tree of life (Ncube, 2006) is a collective narrative tool which uses a Zimbabwean folklore metaphor of a tree to encourage people to reflect on their life stories in a group setting. The aim of this is to promote connection, consider identity and support communities to overcome difficulties (Lock, 2016). Participation in this group throughout the data analysis stage of my research was a helpful way to continue to be in touch with these motivations at a later stage in the research process. This was complimented by the individual reflective process of keeping my reflective journal. For an example of my use of the tree of life tool see Appendix 3-B.

My reflective journal proved crucial for the research process as I took a 12 month break from the research while on maternity leave. Returning to the research material after having a baby and navigating this new life role in the context of the COVID-19 pandemic highlighted a new relationship I had formed with the research material. Re-listening to all my interview transcripts, I was aware I became more emotive and connected with the narratives around motherhood and participants wanting to protect their children. These points were poignant prior to this break from the research and noted in my reflective journal, however this felt qualitatively different upon returning to the study. It was important for me to be aware of this when entering the data analysis phase of the research and the reflection process and discussions in supervision allowed me to become more aware of this changed perspective.

### Considerations around the inclusion and exclusion criteria

I found the process of developing the inclusion/exclusion criteria required the consideration of multiple ethical implications and the use of supervision was imperative during this stage of the research. The main dilemma was deciding if the research should include either asylum seekers or refugees as opposed to a combination of both. It is recognised there are qualitative differences in the experiences of each of these stages of migration with asylum seekers having to navigate the prolonged experiences of uncertainty over legal status and the inability to legally seek paid employment during this period (Gartley & Due, 2017; Mayblin & James, 2019).

I had a strong preference to include both asylum seekers and refugees in my research sample, partly due to my view that this distinction can be problematic at times and I do not personally view one status to have legitimacy over the other, aside from the political recognition of legal status. Furthermore, the inclusion of both groups was in line with exploratory aims of the narrative research aimed to understand the experiences of forced migration at its different stages. Therefore, in my rationale to include both groups in the research sample, it was argued the inclusion of asylum seekers and refugees reflects the diversity of the experience at each stage of the journey to being recognised as a refugee. This was seen as crucial to understanding the complexity of the process and the impact this had on participants’ emotional wellbeing. However, ethical considerations around recruiting asylum seekers were considered due to their increasingly vulnerable and marginalised position in society (De Haene et al., 2010). This included thinking about clear consent procedures and making it explicit participation in research did not affect legal status, with the research being completely independent from any legal processes.

As the research progressed to the recruitment phase, I discovered many of my participants who initially approached me self-identifying as ‘refugees’, were in fact still awaiting refugee status and were technically still asylum seekers. For one of the participants this was only revealed as their narrative progressed and the interview was already in progress. I was grateful the research included both groups as if it had not I would have been left in the position of having to inform these participants they could no longer participate in this research due to their legal status, perhaps denoting a greater value/interest in the narratives of refugees over asylum seekers and further contributing to their experiences of marginalisation and lack of acceptance.

Another consideration for the inclusion/exclusion criteria was the length of time participants were in the United Kingdom (UK) at the time of interview. In order to ensure homogeneity between participant experiences, the inclusion criteria limited recruitment to participants who have been in the UK between three months and three years. This meant I was unable to include some of the informal narratives that were shared with me in encounters with refugees and asylum seekers who did not meet these criteria during the prolonged rapport building phase of the research. Although there was an understanding this would not be formally documented, I listened and allowed these individuals to share their stories of forced migration with me if they found this useful. Although these informal narratives felt in many ways similar to the other narratives collected, the stories of refugees who had been here for longer periods of time (most exceeding five years) added a qualitatively different layer to the experience and focused less on the experiences of seeking asylum/the journeys to the UK. I initially felt conflicted about not being able to formally include these narratives in the research but was able to resolve these feelings by re-visiting the rationale for my inclusion/exclusion criteria documented in both discussions with supervisors and my reflective journal.

### Narrative methodology with refugees and asylum seekers

The prospect of using narrative methodology with this research population was very intriguing due to the flexibility of this approach and its ability to capture coherent individual stories facilitating a deeper understanding of each participant’s unique experience of forced migration (Brown, 2017; Creswell, 2014). The narratives collected throughout this research were deep, detailed and comprehensive. I allowed myself to become fully immersed in the participants’ story telling without feeling a pressure to guide the interview in any given direction. I was able to dedicate a lot of time and space for the analysis of each interview transcript, the listening process, the transcription and the connection with each narrative. However, translating this to a written results section within the word count of my doctoral thesis proved challenging. While the narrative methodology and the inclusion of narrative summaries allowed me to maintain the individuality of each participant throughout the research, I felt there was more I wanted to include that inevitably had to be excluded from the research. This was an interesting process for me as a researcher and forced me to return to my analysis process with a more pragmatic lens of including the salient features of my participants’ narratives with the realistic outcome of producing a word limited results section.

Another aspect of this research methodology that needed to be considered when working with asylum seekers and refugees was the context in which narratives are usually shared within this population. Refugees and asylum seekers are required to tell their narratives of forced migration multiple times during the asylum process to authority figures who have control over the determination of their refugee status. For many of the participants navigating the asylum system, their narratives were required to “conform not only to the categories of refugee law but also to the ‘metanarratives of truth and credibility’ of the judicial system. The implicit assumption in the legal context is that there is a truth there (in the story) and that it can be apprehended” (Macklin, 1998 as cited in Eastmond, 2007, p. 260). This directly contradicts the view of story-telling within narrative research where a unique narrative arises through the social interaction between listener and story teller (Eastmond, 2007). It was important to remember this crucial context and the effect any perceived authority of my research role would have on the relationship during the interview. This was explicitly addressed at the beginning of each research interview where it was made clear this research was exploratory in nature, anonymous and independent from any governmental processes.

Despite this, I found some participants in my research continued to put emphasis on the authenticity of their narratives. This was most common for my three participants who had received rejections to their asylum claims. For these participants the experience of having their narratives questioned, scrutinised and eventually disbelieved left them feeling invalidated. These participants chose to show me pictures of their living conditions in the camps and of the over-crowding of the boats in the journey by sea. One participant showed me evidence of her torture through revealing multiple deep scars on her chest. This experience clearly shaped the way in which they related to their narratives of forced migration and had a clear impact on the way in which they shared their stories. As a researcher, I felt quite hopeless in this situation as it was clear my efforts to communicate my belief of their experiences could not overpower their feelings of invalidation in having their stories previously dismissed. I reflected on this and hoped that allowing these participants to share their narratives in a safe, non-judgmental and validating encounter could work towards countering their feeling of invalidation and disbelief.

Another important consideration was the content of the narratives shared within this research. It was important to consider the ethical implications of the potential re-activation of trauma during the research interview and my responsibility to balance this risk with the experience of sharing this narrative being empowering and important for research participants. There needed to be a balance between bearing witness and hearing participants’ experience of trauma and the potential re-traumatisation of this process (De Haene et al., 2010). For every participant in the study, trauma featured heavily in their journeys and participants’ preferences varied in the details they disclosed surrounding this trauma. I made it clear from the beginning of the interview there was no expectation to speak about traumatic experiences and they could share as much of their story as they felt comfortable. However, many participants chose to share details of their trauma during the interviews, which was an emotive experience for both the participant and myself. Participants were reminded they could stop at any time if they did not feel they wanted to continue with the interview and resources for further support were re-shared. I found myself yearning to help, give, support and ultimately contain these emotions. I fluctuated from feeling helpless to feeling angry which highlighted the strength of the stories shared during the interviews. I felt torn between my professional role as a trainee clinical psychologist and the limits of using this skill set while assuming a researcher role.

The research process reminded me that no matter how many times you hear the unimaginable events forced migrants are subjected to, the emotional experience of hearing a story first hand holds a lot of power. Reflecting on these emotional experiences in supervision and through use of my journal was imperative at this stage of the research. These feelings of sadness, hopelessness and frustration at the trauma of the participants were channelled through feeling a strong commitment and responsibility towards the participants to publish this research and share their experiences with a wider audience to contribute in improving services for this population.

### Experiences of recruitment - reaching a “hard to reach” group

In the development phase of this research multiple conversations were had about the potential obstacles when trying to recruit from the asylum seeking and refugee community, who are commonly referred to as a ‘hard to reach’ group. Research into this area has found multiple factors can affect this community’s willingness to engage in research including logistical factors, concern around safety, research team factors (perceived trust in the researcher), the offer of financial incentives and language barriers (Gabriel et al., 2017). I was conscious of these potential obstacles when approaching the recruitment phase of the research. Participants for this research were recruited through three third sector organisations in the North West of England. I made initial contact with 16 charitable organisations. Of these organisations, seven responded saying they could not assist with research, six did not respond and three organisations responded and invited me to community drop-in clinics to meet with potential participants.

I considered the seven organisations who responded saying they do not pass on research information to refugees and asylum seekers due to the number of requests they receive and their hesitancy for members of this population to engage in research that might be distressing. One organisation said they only pass research information onto potential participants if the researcher could directly benefit the service through volunteering for six months prior to recruitment. This was not an option for me due to the demands of the course. It appeared my first obstacle was gaining access to the research population through ‘gatekeepers’ of this community. While I understood the rationale behind wanting to protect this community from potential distress of recounting trauma and participating in emotive research, I began to consider potential power dynamics at play. I wondered whether gatekeepers’ well-meaning intentions to safeguard and protect this community may be inadvertently contributing to silencing and assuming vulnerability of this community whose voices are already excluded from so much of the research literature on mental health (Dona, 2007).

Having gained access to three out of 16 organisations that were approached, I considered the best way of engaging with this community to increase participation in the research. Previous research highlighted the importance of building trust with this community for engagement in research through investing time in developing trusting inter-personal relationships (Miller, 2004). Building trust with this community took time, effort and involved engaging with people at the walk in centres prior to any formal research taking place. I helped people translate communications from the home office, played games, held children, shared food and got to know potential participants. As my presence and familiarity increased at these walk-in centres, there was an influx of interest in participants engaging in the research. The research journey highlighted my dislike for the term ‘hard to reach’ group and I began to view it more as an issue of the approach used to reach this population for research recruitment. I found myself consistently wanting to step outside the domain of what I perceived as “researcher role” and offer human support to my participants, also yearning for this human connection. I constantly reflected on where these ideas of a research role came from. Were they consistent with my own cultural upbringing and the way I connected with people in a professional capacity prior to moving to the UK or was this the impact of being educated and trained in a Eurocentric educational system? I see the importance and value of clear boundaries of my professional role, but have also begun to think of the recruitment process as encompassing more than promoting my research, and also for investing time connecting with my participants on a human level.

I was able to recruit 13 participants for my research with an offer for more participation which I could not pursue due to reaching data saturation. I reflected on my experience of recruitment from this population and what factors contributed to this. Miller (2004) argues that examining our own personal characteristics as a researcher is imperative for the research process with this population as we should “regard the data we collect as reflecting, at least to some extent, the unique features of the relational context in which our research is conducted” and that it “then it becomes apparent that a discussion of these issues is not merely desirable, but essential for any critical evaluation of our findings” (Miller, 2004, p. 224). I began to examine my own characteristics as a researcher and how this related to the research population. I was visibly from an ethnic minority background and shared the common language of Arabic with many participants. I had also disclosed the refugee background of my family. I was left with the question of whether these factors had an impact on the level of engagement from potential participants or whether the extended rapport building phase of the research would have generated the same results for another researcher who was not viewed to share these common factors with the research population.

### COVID-19 pandemic

The data collection for this research was conducted prior to the COVID-19 pandemic. Therefore, the results of the data within this research does not reflect the additional stressors, increased social isolation, delayed asylum processes and lack of support experienced by this community due to the global pandemic (Endale et al., 2020). With the knowledge the research participants viewed the support of the community drop-in centres as a vital resource for their emotional wellbeing, I felt concerned about the impact social distancing measures may be having on them. With many participants experiencing a lack of access to consistent internet connection that could facilitate online social interaction, I wondered what impact this social isolation would have on their emotional wellbeing. Furthermore, with a main research finding being participants’ difficulties dealing with prolonged periods of uncertainty, I worried about the additional uncertainty the COVID-19 pandemic would introduce in terms of travel, security and asylum process waiting times. Future research investigating the impact of the COVID-19 pandemic on the mental health of refugees and asylum seekers is warranted.

### Conclusion

This critical appraisal highlighted the multiple areas considered while developing and carrying out this research. There was a focus on my personal reflections of working with this research population including my personal journey throughout the research, considerations around inclusion/exclusion criteria, the use of narrative methodology, experiences of recruitment, and the impact of the COVID-19 pandemic on this population. This research is an important contribution to the inclusion of the voices of asylum seekers and refugees in research aiming to improve the acceptability and accessibility of mental health services for this community.

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## Appendix 3-A - Extract from reflective journal

## Appendix 3-B- Tree of Life

# Ethics Documentation

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**Word count: 13506**

Main text: 5656

Appendices: 7850

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## Research Protocol

**Study Title:**  Refugee and asylum seekers experiences of forced migration and emotional distress: a narrative analysis

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**Background and rationale**

Refugees are a diverse group of people who have the common experience of being forced to flee their home countries for fear of persecution (Ehntholt & Yule, 2006). The term asylum seeker is used to define people who are not yet legally recognised as refugees in the host country where they have arrived (Dennis et al., 2017). While refugees and asylum seekers are an ethnically and culturally heterogeneous group of people, the forced migrant experience shares a number of common challenges. Pre-migration challenges may include the witnessing or experiencing of disaster, war, break down of communities and loss or separation from loved ones (Gartley & Due, 2017). Post migration challenges may include adjusting to linguistic barriers and unfamiliar surroundings (Kirmayer et al., 2011), experiencing a lack of support and loss of valued social roles in society (Miller et al., 2005). In addition to this, asylum seekers experience challenges around uncertainty of their legal status and limited rights (Gartley & Due, 2017).

It is well established that refugee communities have a high prevalence of mental health difficulties. This has been reported in a range of quantitative literature describing higher incidence of depression, anxiety and post-traumatic stress (PTS) within refugee communities as compared to general populations in host countries (Altunoz et al., 2016; Gülşen et al., 2010; Heeren et al., 2012; Morgan et al., 2017; Richter et al., 2018; Shawyer et al., 2014). Despite the reported prevalence of mental health difficulties, refugees are underrepresented in access to mental health provisions. This has been partly attributed to language and cultural barriers, stigma towards mental health issues and distrust of authority (Heidi et al., 2011; Langlois et al., 2016). However, the application of western psychiatric diagnosis to refugee communities has been criticised for lacking validity in cross cultural settings and imposing western understandings of mental health on communities with diverse world views (Kirmayer, 2006; Miller et al., 2006; Summerfield, 2012). It has been proposed that culturally appropriate mental health services can only be developed through gaining a meaningful understanding of how mental health is conceptualised within refugee communities and allowing this to inform service delivery (Wells et al., 2015).

The use of traditional western psychological approaches that are not adapted for the needs of refugee communities may lead to unsuccessful interventions (Murray et al., 2010). A qualitative study in the USA investigating resettled refugee experiences of traditional mental health interventions for depression and anxiety found that there was a preference for group interventions as opposed to more traditional individual therapy. Refugees also prioritised immediate social needs of securing housing, learning the language and financial stability before engaging in psychological intervention and that meeting these needs reduced psychological distress (Mitschke et al., 2017).

This calls for research that develops a greater understanding of individual experiences of mental health within the refugee community. Qualitative research exploring this has been limited but has found some important points for consideration. An Australian study of Somali refugees perceptions of mental health found that individuals attributed most importance to physical symptoms of psychological distress, religious explanations for mental health difficulties and experiences of the stigma of mental health (Bettmann et al., 2015). Another study conducted in the USA exploring Sudanese refugee beliefs around mental health found that there did not exist a cultural equivalent to the concept of depression and instead this emotional distress was conceptualised as part of everyday life which did not require professional support. When support was sought for mental health difficulties this was through Sudanese community resources and members of the extended family (Savic et al., 2016). The pronounced differences in which culturally diverse communities both understand and alleviate psychological suffering cannot be overlooked.

This research aims to further the understanding of refugee and asylum seekers experiences of forced migration, particularly regarding how they make sense of the impact this has on their psychological wellbeing. This research also aims to contribute to the limited qualitative research in this area using a narrative research methodology. The aims of this research are in line with the values of the profession of clinical psychology to gain an understanding of social and cultural factors that shape psychological distress and influence barriers to wellbeing (Division of Clinical Psychology, 2011). Research in this area can aid in guiding health care systems in the provision of culturally appropriate care for refugees and asylum seekers.

**Aims and objectives**

This research is concerned with refugee and asylum seekers’ experiences of forced migration, with a focus on how these experiences have impacted upon mental health. Therefore, the broad research aims are to explore refugee and asylum seekers experiences of forced migration through narrative accounts, with an aim to explore how these experiences are understood to affect participants mental health and how participants make sense of these experiences. The research objectives will be to identify commonalities and differences between participants experiences of forced migration and emotional distress to further our understanding of how refugees and asylum seekers from different cultures understand and make sense of these experiences.

**Research Design**

This is a qualitative research study utilising narrative methodology. Narrative theory proposes that people use stories and narratives as a way to make sense and bring meaning to their experiences. Therefore, it is through listening to these narratives and interpreting the meaning applied to them that people’s subjective experiences can be understood (Brown, 2017; Bruner, 1986). This research methodology was seen to be the most appropriate for this question due to the ability of narrative research to maintain individual’s stories and accounts as coherent narratives in addition to looking at shared accounts between participants experiences (Riessman, 1993). This fits with the aim of this research to understand individual refugee’s experiences of mental health in the context of the larger society and culture. Furthermore, narratives are seen as representations of the world through the experience of an individual and are therefore not examined for ‘authenticity’. This is seen as appropriate when conducting research with refugees who are commonly subjected to a culture of disbelief throughout the asylum process (Eastmond, 2007).

The philosophical framework that will be used to guide this research will be critical realism (Bhaskar, 1975). This epistemological position is compatible with narrative methodology as it does not negate the existence of a ‘real’ social world, but proposes that this world is layered into different domains of reality which are accessible through individual’s subjective experiences of it. There is also an emphasis on the role of the researchers presence on the development of a narrative within the context of an interview and how this affects the story that is told (Edwards & Holland, 2013; Fletcher, 2017).

**Participant identification**

**Inclusion criteria**

This research will aim to recruit 10-20 refugees or asylum seekers who meet the following inclusion criteria:

1. Refugees and asylum seekers currently living in the UK, who have been in the UK for a minimum of 3 months and a maximum of 3 years.
2. Refugees and asylum seekers from any country of origin
3. Refugees and asylum seekers who are over 18 years old
4. Refugees and asylum seekers who speak the same language as the interviewer at a conversational level (Arabic or English)
5. Refugees and asylum seekers who at the time of the research interview are able to consent to participate

The inclusion criteria for this research has been purposefully left as open as possible in order to account for the varied experiences of forced migration. It was felt that in order to include mental health concerns within the inclusion criteria, the meaning of mental health would need to be conceptualised – this contradicts the aim of this current research to understand how refugees and asylum seekers make sense of these experiences.

**Inclusion criteria rationale**

*Rationale for sample size*

The researcher aims to recruit between 10-20 participants. This range is consistent with previous published narrative studies (Honkasilta et al., 2016; Seelman et al., 2017). The recruitment of 10 participants would provide scope for comparisons across diverse pariticpant experiences, whilst also allowing for sufficient depth of analysis in the time frame of the DClinPsy thesis. With the time limitations for this doctoral thesis, it would not be possible to recruit more than 20 participants for this research. The researcher will continue to recruit until a sufficient number of participants are recruited. This will be determined throughout the analysis of data until the research has reached data sufficiency. This is defined as the stage at which the researcher determines that there is a sufficient depth of understanding of the emergent theoretical categories in the research (Dey, 2012; Saunders et al., 2018).

*Rationale for restricting based on length of stay in the UK*

The sample has been restricted to refugees and asylum seekers who have been in the UK for a minimum of 3 months and a maximum of 3 years. This is with an aim of capturing early experiences of forced migration, without being too restrictive for pragmatic reasons (due to this being a potentially difficult to recruit population). This will ensure that participants have a relatively recent migratory experience to recount, whilst allowing time for the asylum process (which can sometimes take years to complete).

*Rationale for not excluding based on legal status*

In keeping with an aim to be as inclusive as possible in representing experiences of forced migrant populations in the UK, the decision was made to not exclude participants based on refugee status. This decision was reached for the following reasons: Asylum seekers may sometimes self-identify as refugees. This has been an issue in previous research where despite attempting to recruit only refugees for the sample (due to the researcher feeling that asylum seekers had a vulnerable status in society), it was discovered during the research interviews that some participants were currently in the asylum process but had self-identified as refugees (Kelly et al., 2016). There are potential ethical issues around trying to prove someone has refugee status during the research process. Furthermore, excluding asylum seekers who may be interested in taking part in the research may contribute to their feelings of exclusion and marginalisation.

Previous research has not made this distinction in sample and there are a number of qualitative studies looking at the experiences of both refugees and asylum seekers together; a few examples include: Bhatia & Wallace, 2007 (experiences of general practice); Fleay, Hartley, & Kenny, 2013 (occupational experiences), Weaver & Burns, 2001 (experiences of trauma) and Spicer, 2008 (experiences of exclusion in the UK).

A potential concern was that looking at both asylum seekers and refuges would not constitute a homogenous sample due to asylum seekers current experiences of uncertainty/instability around being able to stay in the UK. However, it is argued that as part of the forced migrant journey most refugees have been asylum seekers at one stage and have experienced a period of uncertainty. Even refugees who have been granted refugee status in their countries of origin experience comparable instability, often moving through multiple countries or cities until resettled. Therefore, looking at both groups together can be seen as looking at the forced migrant journey at different stages, inevitably including instability or uncertainty at some stage of their journey.

*Rationale for excluding participants with whom the researcher does not share a common language*

For practical reasons and due to the limited funds for the scope of this research, using interpreters will not be possible. However, the use of interpreters may not be appropriate for this research for the following reasons:

Quality of data: Narrative analysis has a focus on the conversation that unfolds between researcher and participant. The process of repeated translation of the interview material may disrupt the coherence of the narrative being told, and thus significantly impact on the quality of the data. An example of previous research that has used interpreters in narrative research is provided by Ditton and Lehane (2010). This research reports that using interpreters was only possible through the recruitment and training of interpreters in the process and production of narrative research and supporting them to take the role of the researcher within interviews (Ditton & Lehane, 2010). The training of interpreters in narrative research to assure the quality of the data would not be possible given the constraints of this study.

Experiences of trauma: There is the potential for the re-experiencing of traumatic memories during the interview process. As the interview process is not a therapeutic intervention, care needs to be taken regarding the discussion of potentially traumatic information. Use of interpreters may limit the extent to which the researcher could use their clinical skills to determine participants levels of comfort and ask questions in a sensitive way. Potential secondary traumatisation is an ethical issue and by having a psychologically trained professional as interviewer, the risk of this can be reduced.

*Rationale for not excluding based on country of origin*

The question of increasing homogeneity through limiting recruitment based on country/region of origin was thoroughly considered. It was decided that for the purpose of this research inclusion will not be limited based on a specific country of origin for the following reasons: At the exploratory stage of this research it was felt that limiting to one specific refugee population would narrow the ability to generalise the results in a meaningful way for service provision. It was also considered that services for this population are not set up for specific countries of origin, therefore this research sample aims to reflect this. In addition to this, previous qualitative research has considered refugees and asylum seekers as a homogenous group on the basis of their experiences of forced migration regardless of country of origin (Bhatia & Wallace, 2007; O’Donnell et al., 2008). There is a similar rationale for this research. The experience of forced migration and context of life as a refugee in the UK will be focused on as the socio-cultural context.

**Study Activities**

**Participant recruitment**

Participants will be recruited using a purposive sampling strategy with the researcher aiming to identify potential participants who meet the above-mentioned inclusion criteria (Palinkas et al., 2015). This is an accepted sampling method within narrative inquiry and qualitative research more generally, as it allows the researcher to identify participants who are able to provide rich and in-depth information on their research questions (Wells, 2011). Participants will be recruited from a number of local charities and non-NHS organisations who support refugees and asylum seekers in the UK. Recruitment will not be limited to refugees and asylum seekers identified by NHS healthcare systems as needing mental health support as this may bias the sample to those who meet the criteria for mental health services as defined by a western understanding of psychological distress.

Charities that will initially be contacted include the following: Rethink Rebuilt Society, Manchester Refugee Support Network, Refugee Action, Refugee Council, The Boaz Trust, Rainbow Haven, The Arc Project Blackburn, Darwen Asylum & Refugee Enterprise, Lancaster & Morecambe Asylum and Refugee Support, British Red Cross Refugee Service and Caritas Rosendale. In the case that the researcher was unable to recruit enough participants from these recruitment sites, charities within a larger geographic region will be contacted.

**Recruitment strategy**

Recruitment of participants will take the following steps:

1. The lead researcher will initially contact the lead person in each of the above-mentioned organisations and arrange to discuss the research with members of the organisation. At this meeting, the researcher will attempt to gain permission to recruit participants from their organisations.
2. If permission to recruit from the organisation is gained, the researcher will visit the organisation in order to introduce themselves and start to make links to promote the research. The promotion of the research can be done through both formal and informal routes. This may include organised meetings, attending sessions run for refugees in each of these organisations, attending coffee mornings or team meetings. The researcher will be guided by organisation leads and staff members on what the best way to promote the research is for each individual organisation.
3. The researcher will attend agreed meetings/sessions and promote the research verbally and using written information (participant information sheet).
4. Interested participants will be invited to approach the researcher on the day to ask any additional questions or contact the researcher via the information provided on the participant information sheet.
5. Participants who have expressed interest and consented to being contacted will be contacted to arrange an interview time at their preferred location. All volunteering participants that meet the inclusion criteria will be included in the research and the researcher will continue to recruit until a sufficient number of participants are recruited.

**Research interview(s)**

The data will be collected through narrative interviews. Narrative interviews are unstructured, in-depth interviews that aim to allow participants to freely re-tell their story about a particular life event and the social context of this (Bhatia & Wallace, 2007). Narrative interviews aim to reconstruct an event from the perspective of the participant with a focus on minimising the influence of the interviewer in the re-telling of this narrative. However, the interaction between interviewer and participant is seen as a collaborative process since the unique retelling of this story is constructed through the interaction of the interview itself (Creswell, 2014). Through the narrative interviews the researcher aims to gain detailed narratives of the participants forced migration journey, experiences of emotional distress and how they make sense of these experiences.

Narrative interviews typically involve multiple phases as outlined by Fehér (2011) (2011). The first phase of the process involves familiarising the participant with the focus of the interview and asking an open-ended question that can prompt the re-telling of their narrative. The researcher will use this initial part of the interview process to ask the participants to share their story of forced migration starting before things were problematic in their home country through to their current experiences in the UK. Throughout this part of the interview the researcher will engage in active listening but try and influence the narrative as little as possible. The researcher will ask non-directive questions to prompt more information where necessary. The second phase of the interview has been described as the narrative follow up and involves asking the participants to expand or elaborate on parts of the story that have been mentioned and allow the narrative to develop from these questions. The researcher will use narrative follow up questions to elaborate on parts of the narrative relating to mental health experiences or how participants have been affected by experiences of forced migration (Fehér, 2011).

**Interview procedures**

Participants who have consented to be contacted by the main researcher, will be contacted in order to arrange a time and place for the research interview. Participants will be able to choose their preferred location to conduct the research interview, this could be in the participants home or another location in the community. Participants will be reimbursed for any expenses incurred through travelling for this research, this is capped at £20 per journey.Therefore, the researcher will ensure that when participants travel the commute costs to the interview venue is within this budget.

On the day of the interview participants will be reminded of the purpose and nature of the research interview and what this will involve. Participants who wish to continue at this stage will be asked to sign a consent form (see consent section for further details on consent procedures). Participants will be reminded at the beginning of the research interview that they are not required to share information they are not comfortable to share and are able to stop the interview at any time without giving a reason. Participants will also be reminded of the limits to confidentiality. All research interviews will be conducted by the main researcher and will be audio-recorded. Research interviews will be conducted in either English or Arabic (where Arabic is the person’s preferred language).

*Interview length*

There is no set time-limit on how long the research interviews must last and this will be guided by the participant’s narratives and will depend on each individual interview. For purposes of participant comfort, the researcher will aim for interviews to last no longer than 90 minutes. Although it is not anticipated that all interviews will reach this time limit.

*Multiple interviews*

If after the first research interview, participants feel as though there is more information they are willing to share about their narratives, an additional research interview will be arranged. Multiple research interviews are not uncommon within narrative research, as this research method involves gathering a rich and detailed account of participants life stories (Wells, 2011).

*Participant discomfort*

There is a potential risk that participants recounting their experiences of forced migration (and any potential trauma) may elicit strong emotional responses and potentially re-trigger traumatic experiences. In these cases, the researcher will use their clinical skills to help support participants and stop the interview. The researcher will make sure participants are aware of available sources of support prior to the interview and share an information sheet detailing sources of support on the day of the interview.

*Participant debrief*

At the end of the research interview the participant will be debriefed covering all points on the participant debrief form (see attached research material). This will include a conversation on how the participant found the research interview, how they are feeling afterwards and signposting to relevant sources if needed. Participants will also be reminded of the procedures involved in withdrawing their data from the research.

**Additional study considerations**

**Informed consent**

Participants will initially give verbal consent for the researcher to contact them about the research/arrange a research interview. During the promotion of their research the researcher will not approach any individual person and will only promote research in the group setting. This is to mitigate any perceived coercion and ensure the voluntary nature of participant involvement.

At the time of the interview the researcher will verbally confirm that the participant is still willing to take part in the research and provide the participant with a written or verbal version of the participant information sheet (see attached research materials). If the participant is willing to continue after reading/listening to this information they will be asked to read and sign the written consent form. For participants who are unable to read the consent forms/write their signatures, the researcher will read the consent form to the participant and obtain their verbal consent prior to the interview, this verbal consent will be audio recorded prior to their research interview. The original signed form will be retained by the researcher and will stored securely (see section on data management for further details).

**Screening and** **Screening and Eligibility Assessment**

All participants who meet the inclusion criteria and self-identify as either a refugee or an asylum seeker will be recruited for this research. The researcher will continue to recruit participants until a sufficient number of participants have been recruited. A decision was made not to assess the eligibility of participants through asking to provide evidence of their refugee/asylum status. The researcher felt as though this was a more ethical approach given the culture of disbelief that refugees and asylum seekers are commonly subjected to (Eastmond, 2007). Furthermore, due to the inherent power imbalances within the researcher-participant relationship, it was felt as though asking participants to produce identification proving their refugee/asylum status may affect the relationship negatively.

**Exclusion/Withdrawal of Participants from Study**

Participants are able to withdraw from the study at any time before the interview, including the day of the interview. Participants will be able to withdraw their data for a period of two weeks following completion of the interview. After this time frame has passed, the participants data may have already been anonymised and incorporated into themes within the research write up – on this occasion, every effort will be made to withdraw participants data but this cannot be guaranteed.

The researcher may also discontinue a participant from the research at any time if this is considered necessary for one of the following reasons:

* The participant does not meet the inclusion criteria and this arises either during the study or retrospectively having been initially overlooked.
* There is a withdrawal of consent from the participant (if reason is provided this will be recorded in study file)
* The researcher is unable to contact/follow-up with research participant if needed.

**Analysis**

The data collected from this research will be analysed using line-by-line narrative analysis. This involves the following phases as outlined by (Fraser, 2004) these phases roughly involve compiling stories through narrative interviews, familiarising oneself with these stories through several readings, reflecting on own responses to stories and documenting this, analysing the explicit content of each story, considering non-explicit content of stories, making comparisons between stories, considering the larger social and political context on the narratives obtained and finally producing themes, insights and understandings based on these narratives (Ezzy, 2002; Fraser, 2004).

**Transcribing interview material**

The main researcher will transcribe all audio-recordings in this research as it is seen as an important part of the methodology. For interviews conducted in Arabic, the researcher will translate these audios first and then transcribe them into English. It was decided that an external translator will not be used in this research due to the following reasons; previous research on translation in cross-cultural research has found that the introduction of translators posed a number of difficulties. These difficulties were mainly around finding a translator who understood the specific culture, language and experience of the participant within the context of the research interview (Choi et al., 2012). Other research has proposed that “socio-linguistically competent, bilingual native speakers” possess the necessary skills for translation in the qualitative research process (Squires, 2008, p. 4). It was therefore felt that the researcher possessed the necessary skills for the translation process.

**Reflective journal**

Throughout the research process the researcher will use a reflective journal to document their emotional reaction to the interview material. Feelings that emerge will be described and recorded and this will be referred to when further interpretation of the narratives are made (Fraser, 2004).

**Data Management**

**Consent forms**

All consent forms will be scanned into a computer (at the first possible opportunity following interview) and then shredded. The electronic documents will then be stored electronically in one of the following secure locations: Lancaster University secure drive or Lancaster University secure cloud storage (Box). As an added measure, all of the electronic documents with participant identifying information will be password protected and only members of the research team will have access to this password. All identifying details relating to the participants who have taken part in this research will be deleted within 6 months of the project completion date. This will be done by the lead researcher

**Audio-transcripts**

For the duration of the study audio-transcripts will be anonymised and given a participant number that will match participant details stored separately. The audio-transcripts be stored electronically in one of the following secure locations: Lancaster University secure drive or Lancaster University secure cloud storage (Box). As an added measure, all of the transcripts will be password protected and only members of the research team will have access to this password. Following completion of the study, the anonymised transcripts will be transferred securely (using Lancaster University Box cloud storage) to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a period of 10 years, before deleting them.

**Audio-recordings**

All audio recording will be recorded on an audio recording device obtained from the Clinical Psychology Doctorate programme. This device does not have the facility to be encrypted. Therefore, to ensure the protection of this sensitive material the following measures will be taken: All audio recordings will be transferred to a secure storage location (University secure drive, box cloud storage or encrypted USB) at the first possible opportunity following the interview. This will be done on the same day of the interview in all cases. As an added measure, all audio recording will be password protected (encrypted ZIP file) and only members of the research team will have access to this password. Until the audio recordings are transferred to a secure storage location the audio recording device will be kept with the lead researcher. All audio recordings will be deleted by the main researcher from the secure storage locations after the doctoral thesis has been examined. The reason these recordings will be retained until this time frame is in case the original recording need to be checked for examination or publication.

**Data Sharing**

All relevant files with documentation will be offered to the UK Data Archive as per the standard ESRC procedures. If the UK Data Archive will not accept the offered data, it will be stored in Lancaster University’s data repository (via Pure) where it will be preserved according to Lancaster University’s Data Policy for a minimum of 10 years. Due to the small sample size in this research, even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request with genuine researchers. Access will be granted on a case by case basis by the Faculty of Health and Medicine.

**Participant anonymity and confidentiality**

*Data collection:* All information will be kept confidential during data collection. Participants are able to choose a preferred location to conduct the research interview. As per the information sheet and consent form, the participant will be aware prior to the interview of thelimits of confidentiality. If during the data collection phase the researcher obtains information indicating the participant or someone else is at risk, this information will be disclosed to the research supervisors and appropriate action will be taken. When possible this will be discussed with the participant first.

*Data analysis:* Transcriptions will contain no identifying information and will be anonymous. This will include names of other people mentioned in research interviews and any local addresses/service names identified. As this research will involve the submission of direct quotes from participants, confidentiality cannot be maintained. However, all materials submitted for examination or publication will be anonymised. This will be through using pseudonyms in place of participants real names.

**Ethical considerations**

**Ethical considerations in research with forced migrant populations**

*Re-telling stories:* Refugees and asylum seekers are required to tell their stories of forced migration multiple times during their asylum process to figures of authority that may have control over their refugee status. There is a risk that participants may experience the research interview/questions in the same way as these previous experiences. Therefore, it is important that the researcher acknowledges this at the beginning of the research interview and explicitly addresses their independence from any legal authorities.

*Voluntary, informed consent:* gaining voluntary informed consent within this population sample may require some additional considerations. Refugee/asylum seeking communities may have had previous negative experiences with authorities or for cultural reasons be suspicious of written consent forms (Clark-Kazak, 2017), therefore the researcher must consider this and explain the reasons behind recording consent and when appropriate offer other forms of recording consent (verbal recorded consent). Furthermore, the compensation offered to participants for travel costs should be reasonable and cover only these costs as there may be a risk that participants who are in financial need may be motivated to participate for these reasons (Clark-Kazak, 2017).

*Re-experiences of trauma:*  There is a potential risk that participants recounting their experiences of forced migration (and any potential trauma) may elicit strong emotional responses and potentially re-trigger traumatic experiences. In these cases, I the researcher will use their clinical skills to help support participants and stop the interview. The researcher will make sure participants are aware of available sources of support prior to the interview and share an information sheet detailing sources of support on the day of the interview. During the interview, the researcher will also be sensitive to any signs that the participant is becoming increasingly distressed and when appropriate stop the interview to mitigate the risk of the participant re-experiencing trauma. Participants will also be reminded on the day of the interview that they are able to stop at any time and choose not to continue.

*Confidentiality and anonymity:* maintaining confidentiality for this community is particularly important due to their vulnerable position in society and potential background of fleeing persecution. It is also possible that people currently seeking asylum would fear that information shared may affect their asylum claims. To mitigate this the aims of the research will be clarified before each research interview and the researcher’s independence from any legal processes will be made clear. The participants will be informed about how their data and personal details will be stored securely. Confidentiality of personal information and anonymity of interview material will also be ensured.

The researcher is also aware that recruiting through identified organisations may limit confidentiality if members in the organisations are aware of who approached the researcher to express interest in the research. To mitigate this, the researcher will inform the group when they are promoting their research that interested participants are able to call the researcher at a later date as opposed to approaching the researcher on the day.

**Project timescale**

**April 2019 – June 2019**: Review any amendments to ethics application and begin study.

**July 2019 – September 2019:** Write up introduction and methods, submit drafts and review drafts.

**June 2019 – February 2020:** Participant recruitment, data collection and data analysis. Data analysis and transcription may be conducted alongside participant recruitment.

**February 2020 – March 2020:** Write up result and discussions, submit drafts and review drafts.

**April 2020:** Submit full draft and review for final submission.

**15th of May 2020:** Thesis submission deadline

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## Appendix 4-A - Faculty of Health and Medicine Research Ethics Committee (FHMREC) Lancaster University Ethics Form

**Faculty of Health and Medicine Research Ethics Committee (FHMREC)**

**Lancaster University**

**Application for Ethical Approval for Research**

***for additional advice on completing this form, hover cursor over ‘guidance’.***

**Guidance on completing this form is also available as a word document**

**Title of Project**: Refugee and asylum seekers experiences of forced migration and emotional distress: a narrative analysis

**Name of applicant/researcher**: Mariam Khairat

**ACP ID number (if applicable)\*:** N/A **Funding source (if applicable)** N/A

**Grant code (if applicable):**  N/A

**\*If your project has *not* been costed on ACP, you will also need to complete the Governance Checklist [**[link](http://www.lancaster.ac.uk/fhm/research/research-ethics/#documentation)**].**

**Type of study**

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. **Complete sections one, *two* and four of this form**

Includes *direct* involvement by human subjects. **Complete sections one, *three* and four of this form**

**SECTION ONE**

**1. Appointment/position held by applicant and Division within FHM**  Trainee Clinical Psychologist, Doctorate in Clinical Psychology.

**2. Contact information for applicant**:

**E-mail**: m.khairat@lancaster.ac.uk **Telephone**: 07572226093 (please give a number on which you can be contacted at short notice)

**Address**: Doctorate in Clinical Psychology, Furness College, Lancaster University, Lancaster, LA1 4YG.

3. **Names and appointments of all members of the research team (including degree where applicable)**

Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University.

Dr. Anna Duxbury, Clinical Tutor and Clinical Psychologist, C15, Furness Building, Lancaster University.

**3. If this is a student project, please indicate what type of project** by marking the relevant box/deleting as appropriate: (please note that UG and taught masters projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](http://www.lancs.ac.uk/shm/research/ethics)  
  
PG Diploma  Masters by research  PhD Thesis  PhD Pall. Care

PhD Pub. Health  PhD Org. Health & Well Being  PhD Mental Health  MD

DClinPsy SRP  [if SRP Service Evaluation, please also indicate here: ] DClinPsy Thesis

**4. Project supervisor(s), if different from applicant**: Dr. Pete Greasley and Dr. Anna Duxbury

5. **Appointment held by supervisor(s) and institution(s) where based (if applicable)**:

Dr. Pete Greasley, Teaching Fellow, Department of Health Research, Furness Building, Lancaster University.

Dr. Anna Duxbury, Clinical Tutor and Clinical Psychologist, C15, Furness Building, Lancaster University.

**SECTION TWO**

**Complete this section if your project involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants**

1. Anticipated project dates (month and year)

Start date:       End date:

2. Please state the aims and objectives of the project (no more than 150 words, in lay-person’s language):

**Data Management**

*For additional guidance on data management, please go to*[Research Data Management](http://www.lancaster.ac.uk/library/rdm/) *webpage, or email the RDM support email:* [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

3. Please describe briefly the data or records to be studied, or the evaluation to be undertaken.

4a. How will any data or records be obtained?

4b. Will you be gathering data from websites, discussion forums and on-line ‘chat-rooms’

4c. If yes, where relevant has permission / agreement been secured from the website moderator?

4d. If you are only using those sites that are open access and do not require registration, have you made your intentions clear to other site users?

4e. If no, please give your reasons

5. What plans are in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

6a. Is the secondary data you will be using in the public domain?

6b. If NO, please indicate the original purpose for which the data was collected, and comment on whether consent was gathered for additional later use of the data.

Please answer the following question *only* if you have not completed a Data Management Plan for an external funder

7a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

7b. Are there any restrictions on sharing your data?

**8. Confidentiality and Anonymity**

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. How will the confidentiality and anonymity of participants who provided the original data be maintained?

9. What are the plans for dissemination of findings from the research?

10. What other ethical considerations (if any), not previously noted on this application, do you think there are in the proposed study? How will these issues be addressed?

**SECTION THREE**

**Complete this section if your project** **includes *direct* involvement by human subjects**

1. Summary of research protocol in lay terms (indicative maximum length 150 words):

***Background:*** Refugees and asylum seekers are people who have had to leave their home countries due to a fear of persecution. Refugees and asylum seekers share common challenges relating to witnessing violence, war and loss, in addition to difficulties in adjusting to living in a new country where they might not speak the language or have access to important sources of social support. ***Problem:*** Due to these experiences, it is understandable that refugee communities experience a number of mental health difficulties. However, western perspectives of mental health may not be appropriate when attempting to understand mental health difficulties in other cultures. There is also evidence to show that while refugees are having these mental health difficulties, and they are less likely to access mental health services than the rest of the population. ***Aim:*** This research therefore aims to contribute to the understanding of refugee and asylum seekers experiences of forced migration and how this has affected their psychological wellbeing. This is with a goal of providing more culturally appropriate mental health services for refugees and asylum seekers from different cultural backgrounds.

2. **Anticipated project dates (month and year only**)

Start date: June 2019 End date: May 2020

**Data Collection and Management**

*For additional guidance on data management, please go to*[Research Data Management](http://www.lancaster.ac.uk/library/rdm/) *webpage, or email the RDM support email:* [rdm@lancaster.ac.uk](mailto:rdm@lancaster.ac.uk)

3. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

This researcher will aim to recruit between 10-20 participants for the research. This range is consistent with previous published narrative studies (Honkasilta et al., 2016; Seelman et al., 2017). The recruitment of 10 participants would provide scope for comparisons across diverse pariticpant experiences, whilst also allowing for sufficient depth of analysis in the time frame of the DClinPsy thesis. With the time limitations for this doctoral thesis, it would not be possible to recruit more than 20 participants for this research. The researcher will continue to recruit until a sufficient number of participants are recruited. This will be determined throughout the analysis of data until the research has reached data sufficiency. This is defined as the stage at which the researcher determines that there is a sufficient depth of understanding of the emergent theoretical categories in the research (Dey, 2012; Saunders et al., 2018).

Participants will meet the following inclusion criteria: (1) Refugees and asylum seekers currently living in the UK, who have been in the UK for a minimum of 3 months and a maximum of 3 years, (2) refugees and asylum seekers from any country of origin, (3) refugees and asylum seekers who are over 18 years old, (4) Refugees and asylum seekers who speak the same language as the interviewer at a conversational level (Arabic and English), (5) refugees and asylum seekers who at the time of the research interview are able to consent to participate.

The rationale for the above-mentioned inclusion criteria is as follows:

(1) Restricting based on length of stay in the UK (minimum 3 months - maximum of 3 years): The sample has been restricted based on the length of time that participants have been in the UK as the research aims to capture early experiences of forced migration without being too restrictive for pragmatic reasons (due to this being a potentially difficult to recruit population). While it recognised that there may be potential distress arising from participants who have been in the UK for a short period of time, the inclusion of these participants was important for the following reasons: to capture the asylum-seeking experience and this period of transition and to allow potential participants agency/choice regarding sharing their experiences at different points of the forced migration journey (see section 10 for supporting participants who may become distressed).

(2) Not restricting based on country of origin: It was decided that at the exploratory stage of this research it was felt that limiting to one specific refugee/asylum seeking population would narrow the ability to generalise the results in a meaningful way for service provision. It was also considered that mental health services for this population are not set up for specific countries of origin, therefore this research sample aims to reflect this.

(4) Excluding participants who don’t share a common language with the researcher: For practical reasons and due to the limited funds for the scope of this research, using interpreters will not be possible. However, the use of interpreters may not be appropriate for this research due to the following reasons: (a) Quality of data: This method of data collection (narrative enquiry) places a focus on the conversation that infolds between researcher and participant. The process of repeated translation of the interview material may disrupt the coherence of the narrative being told, and thus significantly impact on the quality of the data. (b) Experiences of trauma: Due to the potential nature of some of participants experiences, there is a risk that participants may re-experience traumatic memories during the interview process. The use of an interpreter may limit the extent to which the interviewer could use their clinical skills to determine participants levels of comfort and ask questions in a sensitive way. Therefore, due to this ethical risk, having a psychologically trained professional as interviewer (lead researcher), this risk can be reduced.

4. How will participants be recruited and from where? Be as specific as possible. Ensure that you provide the *full versions* of all recruitment materials you intend to use with this application (eg adverts, flyers, posters).

Participants will be recruited using a purposive approach. Participants will be recruited from a number of local charities and non-NHS organisations who support refugees and asylum seekers in the UK.

Charities that will initially be contacted will include: Rethink Rebuilt Society, Manchester Refugee Support Network, Refugee Action, Refugee Council, The Boaz Trust, Rainbow Haven, The Arc Project Blackburn, Darwen Asylum & Refugee Enterprise, Lancaster & Morecambe Asylum and Refugee Support, British Red Cross Refugee Service and Caritas Rosendale.

***Recruitment of participants will take the following steps:***

i. The lead researcher will initially contact the lead person in each of the above-mentioned organisations and arrange to discuss the research with them.

ii. At this meeting, the researcher will attempt to gain permission to recruit participants from their organisations.

iii. If permission to recruit from the organisation is gained, the researcher will visit the organisation in order to introduce themselves and start to make links to promote the research. The promotion of the research can be done through both formal and informal routes. This may include organised meetings, attending sessions run for refugees in each of these organisations, attending coffee mornings or team meetings. The researcher will be guided by organisation leads and staff members on what the best way to promote the research is for each individual organisation.

iv. The researcher will attend agreed meetings/sessions and promote the research verbally and using written information (participant information sheet).

v. Interested participants will be invited to approach the research on the day to ask any additional questions or contact the researcher via the information provided on the participant information sheet.

VI. Participants who have expressed interest and consented to being contacted will be contacted via a telephone call to arrange an interview time at their preferred location. All volunteering participants who meet the inclusion criteria will be included in the research and the researcher will continue to recruit until a sufficient number of participants are recruited (see section 3).

5. Briefly describe your data collection and analysis methods, and the rationale for their use.

This will be a qualitative research study using narrative methodology. Narrative theory suggests that people make sense of their experiences though stories, and that thorough listening to these narratives and interpreting the meaning applied to them people’s subject experiences can be understood (Brown, 2017; Bruner, 1986).

This was seen to be the most appropriate research methodology for this question due to the ability of narrative research to maintain individual’s stories and accounts as coherent narratives in addition to looking at shared accounts between participants experiences (Riessman, 1993). This fits with the aim of this research to understand individual refugee’s experiences of mental health in the context of the larger society and culture.

The data will be collected thorough face to face narrative interviews. When possible, the interviews will take place in the participant’s preferred location, which will be agreed prior to the interview. This location could include the participants home, a community centre or the university. Potential interview venues will have to have access to a private room where the interview can be carried out confidentially. When the location is in the participant’s home the researcher will carry out a risk assessment regarding the location and accessibility of the building and if deemed necessary the research may request to carry out the interview in a community location. The interviews are expected to last between 45-90 minutes. Narrative interviews involve unstructured, in-depth interviews that will aim to allow participants to freely re-tell their stories of their journeys to the UK and how this has affected their emotional wellbeing. The interviewer will invite the participant to re-tell their story of their journey to the UK and how this has affected their emotional wellbeing. Throughout this the interviewer will engage in active listening but try and influence the narrative as little as possible. The researcher will ask non-directive questions to prompt more information where necessary (Fehér, 2011).

All research interviews will be conducted by the main researcher in either Arabic or English. The audio recordings will then be translated and transcribed into English by the main research. The data will this be analysed using a narrative analysis method. I researcher will use the frameworks outlined by texts and worked examples to guide the data analysis (Emerson & Frosh, 2009; Ezzy, 2002). These frameworks roughly involve the following steps: compiling stories through narrative interviews, familiarising oneself with these stories through several readings, reflecting on own responses to stories and documenting this, analysing the explicit content of each story, considering non-explicit content of stories, making comparisons between stories, considering the larger social and political context on the narratives obtained and finally producing themes, insights and understandings based on these narratives (Ezzy, 2002).

6. What plan is in place for the storage, back-up, security and documentation of data (electronic, digital, paper, etc.)? Note who will be responsible for deleting the data at the end of the storage period. Please ensure that your plans comply with General Data Protection Regulation (GDPR) and the (UK) Data Protection Act 2018.

***Consent forms:*** All consent forms will be scanned into a computer (at the first possible opportunity following interview) and then shredded. The electronic documents will then be stored electronically in one of the following secure locations: Lancaster University secure drive or Lancaster University secure cloud storage (Box). As an added measure, all of the electronic documents with participant identifying information will be password protected, and stored in a separate file location from the other data. Only members of the research team will have access to this password. All identifying details relating to the participants who have taken part in this research will be deleted once the research is complete. This will be done by the lead researcher.

***Audio-transcripts:***

For the duration of the study audio-transcripts will be anonymised and given a participant number that will match participant details stored separately. The audio-transcripts be stored electronically in one of the following secure locations: Lancaster University secure drive or Lancaster University secure cloud storage (Box). As an added measure, all of the transcripts will be password protected and only members of the research team will have access to this password. Following completion of the study, the anonymised transcripts will be transferred securely (using Lancaster University Box cloud storage) to the Doctorate in Clinical Psychology Research Coordinator. They will be responsible for storing these anonymised transcripts and personal/identifying details (stored in a separate secure file) for a minimum period of 10 years, before deleting them.

7. Will audio or video recording take place?  no  audio  video

a. Please confirm that portable devices (laptop, USB drive etc) will be encrypted where they are used for identifiable data. If it is not possible to encrypt your portable devices, please comment on the steps you will take to protect the data.

All audio recording will be recorded on an audio recording device obtained from the Clinical Psychology Doctorate programme. This device does not have the facility to be encrypted. Therefore, to ensure the protection of this sensitive material the following measures will be taken: All audio recordings will be transferred to a secure storage location (University secure drive, box cloud storage or encrypted USB) at the first possible opportunity following the interview. This will be done on the same day of the interview in all cases. As an added measure, all audio recording will be password protected (encrypted ZIP file) and only members of the research team will have access to this password. Until the audio recordings are transferred to a secure storage location the audio recording device will be kept with the lead researcher. Once transferred, the audio recording will be immediately deleted from the device.

What arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

As the researcher aims to publish this study in an academic journal, all audio recordings will be retained beyond thesis examination to allow the researcher to review original audio-recordings if necessary for publication. The data will remain securely stored for this time frame. All audio recordings will be deleted by the main researcher from the secure storage locations after the research has been published.

Please answer the following questions *only* if you have not completed a Data Management Plan for an external funder

8a. How will you share and preserve the data underpinning your publications for at least 10 years e.g. PURE?

All relevant files with documentation will be offered to the UK Data Archive as per the standard ESRC procedures. If the UK Data Archive will not accept the offered data, it will be stored in Lancaster University’s data repository (via Pure) where it will be preserved according to Lancaster University’s Data Policy for a minimum of 10 years.

8b. Are there any restrictions on sharing your data ?

Due to the small sample size in this research, even after full anonymization there is a small risk that participants can be identified. Therefore, supporting data will only be shared on request with genuine researchers. Access will be granted on a case by case basis by the Faculty of Health and Medicine.

9. Consent

a. Will you take all necessary steps to obtain the voluntary and informed consent of the prospective participant(s) or, in the case of individual(s) not capable of giving informed consent, the permission of a legally authorised representative in accordance with applicable law?

b. Detail the procedure you will use for obtaining consent?

All consent to take part in the research will be obtained by the main researcher. The researcher will attend organised meeting/sessions at identified charities and promote the research. Interested participants will be invited to speak to the researcher or contact the researcher at a later date on the contact details provided in the information sheet.

Verbal consent will initially be sought to contact interested participants to arrange an interview time or to discuss the research further.

At the time of the interview the researcher will verbally confirm that the participant is still willing to take part in the research and if so ask them to read and sign the written consent form. For participants who are unable to read the consent forms/write their signatures, the researcher will read the consent form to the participant and obtain their verbal consent prior to the interview, this verbal consent will be audio recorded prior to their research interview. Furthermore, some participants may not feel comfortable signing written consent forms (for personal or cultural reasons – see section 17). In these cases, the researcher will consider this and explain the reasons recording consent and when appropriate offer the option of verbal recorded consent which will be audio-recorded prior to their research interview.

Participants will be reminded after the research interview that they have the right to request for their data to be withdrawn from the research study for a period of two weeks following completion of the interview. After this time frame has passed, the participants data may have already been anonymised and incorporated into themes within the research write up – on this occasion, every effort will be made to withdraw participants data but this cannot be guaranteed.

10. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

There is a potential risk that participants recounting their experiences of forced migration (and any potential trauma) may elicit strong emotional responses and potentially re-trigger traumatic experiences. In these cases, the researcher will use their clinical skills to help support participants and pause the interview. If the participant wishes to continue with the interview after this point, the researcher will support them to do so. The researcher will make sure participants are aware of available sources of support prior to the interview and share an information sheet detailing sources of support on the day of the interview. During the interview, the researcher will also be sensitive to any signs that the participant is becoming increasingly distressed and when appropriate stop the interview to mitigate the risk of the participant re-experiencing of trauma. Participants will also be reminded on the day of the interview that they are able to stop at any time and choose not to continue.

Participants are able to withdraw from the study at any time before the interview, including the day of the interview. Participants will be able to withdraw their data for a period of two weeks following completion of the interview. After this time frame has passed, the participants data may have already been anonymised and incorporated into themes within the research write up – on this occasion, every effort will be made to withdraw participants data but this cannot be guaranteed.

11. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

There is a potential risk that the researcher may be affected by the content of the interview material and may require some support around this. In this occasion, the researcher will seek supervision and support from their research supervisor and field supervisor. The researcher will also be able to utilise the support of their clinical tutor from the doctorate program.

The researcher will be lone working while collecting data and potentially conducting interviews within participants homes. The researcher will follow Lancaster University lone working policy.

The researcher will have access to the Skyguard security system during the interviews. This security system is a personal safety device with an emergency call button. This device is GPS enabled, meaning that If the researcher is in need of help, they can press the emergency button which will notify the incident management centre who will be able to listen and talk to researcher (if appropriate) and contact the appropriate authorities if necessary.

If for any reason access to the Skyguard system is unavailable the researcher will use the following procedure: (i) another member of the research team will be aware of the interview schedule with the addresses that the research will be attending (this will be stored on the secure cloud storage and password protected), (ii) the researcher will be responsible for informing this member of the research team once they have concluded their interview and are safe, this can be done via email or telephone, (iii) if this does not happen, attempts will be made to contact the research on their research phone and personal phone, (iv) If contact cannot be made, the appropriate authorities will be notified.

In the case that another member of the research team is not available to act as a buddy, the researcher will enclose the details of their location in a sealed envelope and give this to their emergency contact (husband). He will be instructed to only open the envelope if he has followed the above-mentioned steps and needs to inform the appropriate authorities.

12. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

Although there is no direct benefit from participating in this research, participants may find it interesting and may have a positive experience of the research process. Participants may also feel that they are contributing to our understanding of refugee and asylum seekers experiences which may help us support this population more effectively in the future.

13. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentive payments for taking part in this research. Participants will be reimbursed for any expenses incurred through travelling for this research, this is capped at £20 per journey.Therefore, the researcher will ensure that when participants travel the commute costs to the interview venue is within this budget.

14. Confidentiality and Anonymity

a. Will you take the necessary steps to assure the anonymity of subjects, including in subsequent publications?

b. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

**Data collection**

All information will be kept confidential during data collection. Participants are able to choose a preferred location to conduct the research interview. As per the information sheet and consent form, the participant will be aware prior to the interview of the limits of confidentiality. If during the data collection phase the researcher obtains information indicating the participant or someone else is at risk, this information will be disclosed to the research supervisors and appropriate action will be taken. This may include sharing this information with appropriate professionals (such as health of social care worker) or advising the person to seek support. When possible, this will be discussed with the participant first.

**Data Analysis**

Transcriptions will contain no identifying information and will be anonymous. This will include names of other people mentioned in research interviews and any local addresses/service names identified. As this research will involve the submission of direct quotes from participants, confidentiality cannot be maintained. However, all materials submitted for examination or publication will be anonymised. This will be through using pseudonyms in place of participants real names.

15. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

Members of the refugee and asylum-seeking community were consulted about the design and content of the research material (participant information sheet and consent form). Amendments to the research material were made accordingly.

Once recruitment for the research begins and the cultural backgrounds of interested participants are identified, the researcher will consult with members of this community for guidance on; (i) the best locations to carry out interviews and (ii) cultural norms around gender interactions and the appropriateness of conducting 1:1 interviews with male/female participants.

16. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

This research will be submitted as part of the main researcher’s doctoral thesis requirement for the Doctorate in Clinical Psychology.

Results of this research may be submitted for publication in an academic/professional journal. Potential journals that could be targeted are; Psychology and psychotherapy: Theory, research and practice, Journal of refugee studies and Journal of transcultural psychiatry.

The researcher will also aim to disseminate this research in the form of a presentation or poster in conferences that target professionals working with refugee and asylum-seeking populations.

The research may also present these findings at a reflective practice group in Lancashire Care NHS Foundation Trust for mental health practitioners working with asylum seekers and refugees.

17. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

*Re-telling stories:* Refugees and asylum seekers are required to tell their stories of forced migration multiple times during their asylum process to figures of authority that may have control over their refugee status. There is a risk that participants may experience the research interview/questions in the same way as these previous experiences. Therefore, it is important that the researcher acknowledges this at the beginning of the research interview and explicitly addresses their independence from any legal authorities.

*Voluntary, informed consent:* gaining voluntary informed consent within this population sample may require some additional considerations. Refugee/asylum seeking communities may have had previous negative experiences with authorities or for cultural reasons be suspicious of written consent forms (Clark-Kazak, 2017), therefore the researcher must consider this and explain the reasons behind recording consent and when appropriate offer other forms of recording consent (verbal recorded consent). The compensation offered to participants for travel costs should be reasonable and cover only these costs as there may be a risk that participants who are in financial need may be motivated to participate for these reasons (Clark-Kazak, 2017).

*Confidentiality and anonymity:* maintaining confidentiality for this community is particularly important due to their vulnerable position in society and potential background of fleeing persecution. It is also possible that people currently seeking asylum would fear that information shared may affect their asylum claims. To mitigate this the aims of the research will be clarified before each research interview and the researcher’s independence from any legal processes will be made clear. The participants will be informed about how their data and personal details will be stored securely. Confidentiality of personal information and anonymity of interview material will also be ensured.

The researcher is also aware that recruiting through identified organisations may limit confidentiality if members in the organisations are aware of who approached the researcher to express interest. To mitigate this, the researcher will inform the group when they are promoting their research that interested participants are able to call the researcher at a later date as well as to approaching the researcher on the day.

**SECTION FOUR: signature**

**Applicant electronic signature**: Mariam Khairat Date 23/04/2019

Student applicants: please tick to confirm that your supervisor has reviewed your application, and that they are happy for the application to proceed to ethical review

**Project Supervisor name** (if applicable): Dr. Pete Greasley and Dr. Anna Duxbury

Date application discussed 16/04/2019 and 17/04/2019

**Submission Guidance**

1. **Submit your FHMREC application by email to Diane Hopkins (**[fhmresearchsupport@lancaster.ac.uk](mailto:fhmresearchsupport@lancaster.ac.uk)) as two separate documents:
   1. **FHMREC application form.**Before submitting, ensure all guidance comments are hidden by going into ‘Review’ in the menu above then choosing *show markup>balloons>show all revisions in line.*
   2. **Supporting materials.**Collate the **following materials for your study, if relevant, into a single word document:**
      1. **Your full research proposal (background, literature review, methodology/methods, ethical considerations).**
      2. Advertising materials (posters, e-mails)
      3. Letters/emails of invitation to participate
      4. Participant information sheets
      5. Consent forms
      6. Questionnaires, surveys, demographic sheets
      7. Interview schedules, interview question guides, focus group scripts
      8. Debriefing sheets, resource lists

**Please note that you DO NOT need to submit pre-existing measures or handbooks which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.**

1. Submission deadlines:
   1. Projects including direct involvement of human subjects **[section 3 of the form was completed]**. The *electronic* version of your application should be submitted to [Becky Case](mailto:fhmresearchsupport@lancaster.ac.uk) **by the committee deadline date.** Committee meeting dates and application submission dates are listed on the [FHMREC website](http://www.lancs.ac.uk/shm/research/ethics). Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application. Please ensure you are available to attend the committee meeting (either in person or via telephone) on the day that your application is considered, if required to do so.
   2. The following projects will normally be dealt with via chair’s action, and may be submitted at any time. **[Section 3 of the form has *not* been completed, and is not required].** Those involving:
      1. existing documents/data only;
      2. the evaluation of an existing project with no direct contact with human participants;
      3. service evaluations.
2. **You must submit this application from your Lancaster University email address, and copy your supervisor in to the email in which you submit this application**

## 

## Appendix 4-B - Participant Information Sheet

*\**All participant study materials were provided in either Arabic or English. Only examples of the English material are provided in this appendix section due to word constraints of the doctoral thesis.

**Participant Information Sheet**

***Refugee and Asylum Seekers experiences of their journeys to the UK and emotional distress***

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: [www.lancaster.ac.uk/research/data-protection](http://www.lancaster.ac.uk/research/data-protection)

My name is Mariam Khairat and I am conducting this research as a trainee clinical psychologistat Lancaster University, Lancaster, United Kingdom.

**What is the study about?**

The purpose of this study is to understand refugees and asylum seekers experiences during their journeys to the UK and to understand how this has affected their emotional wellbeing. The aim of this research is to try and understand how refugees and asylum seekers from different cultures understand their experiences of emotional distress and how this might be different from the ways in which emotional distress is understood here in the UK. The information from this study will aim to contribute to our understanding of refugee and asylum seekers experiences and help us to support refugees more effectively in the future.

**Why have I been approached?**

You have been approached because you are a refugee or an asylum seeker who is currently living in the UK and has been in the UK for more than 3 months and less than 3 years.

**Do I have to take part?**

No. It’s completely up to you to decide whether or not you take part in the research. If you do decide to take part in the study, you are still free to withdraw at any time without giving a reason.

**Can I take part if I don’t speak English?**

I will only able to interview people who can speak English or Arabic as I will not have access to an interpreter for this study. If you have any concerns about this, please get in contact with me.

**What will I be asked to do if I take part?**

If you decide you would like to take part in this research, you would be asked to take part in an interview. In the interview, you will be asked to speak about your journey from your home country to the UK. You will be asked to say as much as you are comfortable with about how these experiences affected you or how they continue to affect you. You do not have to answer questions that you do not feel comfortable with.

The interviews can take place at any location that is convenient for you, this could be your home or another location in the community. There is no set time for how long the interview will last but these interviews usually last between 45 minutes – 90 minutes. You can stop the interview at any time or choose to do the interview over more than one day. The interview will be audio recorded and then turned into a written transcript.

**Will my data be Identifiable?**

All identifying information you provide is confidential (this includes your name/name(s) of others, address and date of interview). This means I will not share this with anyone else. All of your personal information will be stored securely (on a password protected computer) and only the researchers conducting this study will have access to this data. All of your personal data will be kept separately from your interview responses.

Your audio recording will be stored securely until it is turned into a written transcript. Audio recordings will be deleted once this research has been completed. Your transcript will be stored securely and made anonymous. This means your name and other personal information will not be linked to what you say in the interview. Anonymised quotations from your interview may be used in the reports or publications from the study, so your name will not be attached to them.

You have the right to request to withdraw your data from this research after the interview is completed. You do not have to give a reason for this. However, once your data has been written up for the thesis of publication it might not be possible for it to be withdrawn. Every attempt will be made to extract your data, up to the point of publication.

**Are there any exceptions to confidentiality?**

There are some limits to this confidentiality: if during the interview, I have serious concerns that you, or someone else is at significant risk of harm, I will have to share this with an appropriate professional where possible (such as a health or social care worker) or advise you to seek support. I will usually try to talk to you about this first.

**What will happen to the results?**

All results are anonymised. The results will be summarised in a doctoral thesis may be submitted for publication in an academic or professional journal and presented at academic or professional conferences.

**Are there any risks?**

You may find that speaking about your experiences may be upsetting. If you experience distress during the interview you can choose to stop the interview at any time. You do not have to continue with the interview if you do not feel like you want to. If you are upset, you will be supported by the researcher who is trained in working with people who have gone through difficult experiences.

If you experience any distress following participation in the interview you are encouraged to inform the researcher and contact the resources provided at the end of this sheet.

**Will participating in this research affect my legal status or access to services?**

Participating in this research will not affect your legal status or access to services in any way. Choosing not to participate in this research will also not affect your legal status or access to services in any way. Your data will be anonymous meaning that people will not be able to identify you.

**Are there any benefits to taking part?**

Although you may find participating interesting, there are no direct benefits in taking part. However, the information from this study will aim to contribute to our understanding of refugee and asylum seekers experiences and help us to support refugees more effectively in the future.

**Who has reviewed the project?**

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

**Where can I obtain further information about the study if I need it?**

If you have any questions about the study, please contact the main researcher:

Mariam Khairat, Trainee Clinical Psychologist.

Email: m.khairat@lancaster.ac.uk

Tel: 07508375655.

**Complaints**

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Ian Smith

Research Director for Doctorate in Clinical Psychology

Division of Health Research

Furness Building

Lancaster University

Lancaster

LA1 4YG

Email: i.smith@lancaster.ac.uk

Tel: (01524) 592282

If you wish to speak to someone outside of the Clinical Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup

Associate Dean for Research

Faculty of Health and Medicine

(Division of Biomedical and Life Sciences)

Lancaster University

Lancaster

LA1 4YG

Email: r.pickup@lancaster.ac.uk

Tel: +44 (0)1524 593746

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

**Resources in the event of distress**

Should you feel distressed either as a result of taking part, or in the future, you can contact:

You can contact your registered doctor (GP) and make an appointment to see them.

You can also contact the Samaritans if you feel you need to talk to someone using their local helpline:

01524 61666 or website www.samaritans.org

The following resources may be of assistance. These are organisations for supporting for refugees and asylum seekers across Lancashire:

**Blackburn: The ARC Project**

Wesley Hall Feilden Street Blackburn, BB21LQ

<https://www.facebook.com/arcprojectblackburn>

Email: [arcprojectblackburn@gmail.com](mailto:arcprojectblackburn@gmail.com)

Telephone: 01254 690282, 01254692674

**Burnley: NEW Neighbours**

St John's Church Hall, Ivy Street Burnley BB10 1TB

Asylum Seekers support group, Mondays, 1pm-3pm

**Darwen: DARE (Darwen Asylum & Refugee Enterprise)**

Central United Reformed Church, Duckworth St, Darwen, BB3 1AT email:eastiseast2004@yahoo.co.uk, c.lewissmith@gmail.com

Telephone: 01254 952558

**Lancaster: Lancaster & Morecambe Asylum and Refugee Support**

Marsh Community Centre, Willow Lane Lancaster Lancashire, LA1 5PP

http://marshcommunitycentre.org.uk/city.php

Email: coshousecoord@gmail.com

Telephone: 07731 552259, 01524 843300

**Preston: British Red Cross Refugee Service**

St Cuthbert Church Centre (Douglas Hall) Lytham Road Fulwood Preston PR2 3AR

**British Red Cross Refugee Service Pittman Court**

Pittman Way Fulwood PR2 9ZG

Website: redcross.org.uk

Email:wphiri@redcross.org.uk

Telephne: 01772707308, 07753976711, 0775 3976711

**Rossendale: Caritas Rossendale Refugee Drop-In**

Community Link, Bury Road, Haslingden, Rossendale, BB4 5PG (Tuesdays 12.30-2.30)

Email: info@caritassalford.org.uk

Telephone: 01706 230116

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## Appendix 4-C - Consent Form

**Consent Form**

**Study Title: *Refugee and Asylum Seekers experiences of their journeys to the UK and emotional distress***

We are asking if you would like to take part in a research project that aims to understand refugees and asylum seekers experiences during their journeys to the UK and to understand how this has affected their emotional wellbeing.

Before you consent to participating in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Mariam Khairat.

Please initial each statement

1. I confirm that I have read the information sheet and fully understand

what is expected of me within this study.

1. I confirm that I have had the opportunity to ask any questions and to

have them answered.

1. I understand that my participation is voluntary and that I am free to

withdraw at any time without giving any reason, without my access to services or legal rights being affected.

1. I understand that interviews undertaken as part of the study will be

recorded. I understand that this recorded information will then be

made into anonymised written transcripts.

1. I understand that once my data has been anonymised and

incorporated into themes it might not be possible for it to be

withdrawn, though every attempt will be made to extract my data,

up to the point of publication.

1. I understand that the information from my interview will be pooled

with other participants’ responses, anonymised and will be written up

for Mariam Khairat’s doctoral thesis. I understand that this may be

published.

1. I consent to information and anonymised quotations from my interview being used in reports, conferences and training events.
2. I understand that any information I give will remain confidential

and anonymous unless it is thought that there is a risk of harm to

myself or others, in which case the principal investigator will

need to share this information with their research supervisor.

1. I consent to Lancaster University keeping written transcriptions

of the interview for 10 years after the study has finished.

1. I consent to take part in the above study.

**Name of Participant\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_**

**Name of Researcher \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_**

## Appendix 4-D - Participant Debrief Sheet

**Participant Debrief Sheet**

**Study Title: *Refugee and Asylum Seekers experiences of their journeys to the UK and emotional distress***

Firstly, I would like to thank you for participating in this research and sharing your experiences.

**Purpose of the project**

The purpose of this study is to understand refugees and asylum seekers experiences during their journeys to the UK and to understand how this has affected their emotional wellbeing. The aim of this research is to try and understand how refugees from different cultures understand their experiences of emotional distress and how this might be different from the ways in which emotional distress is understood here in the UK.

**Sources of support**

If you require any support as a result of taking part in this research, or in the future, you can contact:

You can contact your registered doctor (GP) and make an appointment to see them.

You can also contact the Samaritans if you feel you need to talk to someone using their local helpline:

01524 61666 or website www.samaritans.org

The following resources may be of assistance. These are organisations for supporting for refugees and asylum seekers across Lancashire:

**Blackburn: The ARC Project**

Wesley Hall Feilden Street Blackburn, BB21LQ

<https://www.facebook.com/arcprojectblackburn>

Email: [arcprojectblackburn@gmail.com](mailto:arcprojectblackburn@gmail.com)

Telephone: 01254 690282, 01254692674

**Burnley: NEW Neighbours**

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Asylum Seekers support group, Mondays, 1pm-3pm

**Darwen: DARE (Darwen Asylum & Refugee Enterprise)**

Central United Reformed Church, Duckworth St, Darwen, BB3 1AT email:eastiseast2004@yahoo.co.uk, c.lewissmith@gmail.com

Telephone: 01254 952558

**Lancaster: Lancaster & Morecambe Asylum and Refugee Support**

Marsh Community Centre, Willow Lane Lancaster Lancashire, LA1 5PP

http://marshcommunitycentre.org.uk/city.php

Email: coshousecoord@gmail.com

Telephone: 07731 552259, 01524 843300

**Preston: British Red Cross Refugee Service**

St Cuthbert Church Centre (Douglas Hall) Lytham Road Fulwood Preston PR2 3AR

**British Red Cross Refugee Service Pittman Court**

Pittman Way Fulwood PR2 9ZG

Website: redcross.org.uk

Email:wphiri@redcross.org.uk

Telephone: 01772707308, 07753976711, 0775 3976711

**Rossendale: Caritas Rossendale Refugee Drop-In**

Community Link, Bury Road, Haslingden, RossendaleBB4 5PG (Tuesdays 12.30-2.30)

Email: info@caritassalford.org.uk

Telephone: 01706 230116

**What will happen next?**

You do not need to do anything else and you will not be contacted for further participation in this project.

## Appendix 4-E - Debrief Sheet for researcher

**Debrief Sheet for researcher**

**Study Title: *Refugee and Asylum Seekers experiences of their journeys to the UK and emotional distress***

The debrief is to be conducted at the end of the interview, in person.

Debrief guidance (try to ensure that all these points are covered within the debrief):

* Thank the participant for participant in the interview
* Explore participants feeling around the process of being interviewed; are they feeling ok to leave and continue with their day?
* Does the participant feel ok to end the interview or would they like to add any more information?
* Is there anything that the researcher could do that would be helpful?
* Reiterate sources of support that are on information sheet and share them again if necessary (have an extra copy).
* Reiterate the contact details of the researcher and supervisors.
* Reiterate the purpose of the study, how the data will be stored and used.
* Confirm consent to participant and reiterate right of withdrawal prior to write-up.
* Ask if there are any questions or comments

## Appendix 4-F - Ethics approval letter



Applicant: Mariam Khairat  
Supervisor: Pete Greasley and Anna Duxbury Department: Health Research  
FHMREC Reference: FHMREC18

13 June 2019 Dear Mariam

**Re: Refugee and asylum seekers experiences of forced migration and emotional distress: a narrative analysis**

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

* -  ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
* -  reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
* -  submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information. Tel:- 01542 593987

Email:- fhmresearchsupport@lancaster.ac.uk Yours sincerely,

Becky Case  
Research Ethics Officer, Secretary to FHMREC.

ualitative metasynthesis is a method of systematic review aimed to

deepen our understanding of a particular topic area by carefully inte-

grating, synthesizing and interpreting the findings of a number of qual-

itative studies

1. Throughout this research the terms ‘asylum seeker’ and ‘refugee’ will be used to differentiate between the two stages of the forced migrant journey to reflect the unique challenges that accompany each of these stages. [↑](#footnote-ref-1)
2. An example of this feedback was suggestions regarding reducing the amount of text on the information sheets to make them more accessible to potential participants. [↑](#footnote-ref-2)
3. A persecuted minority social class in Kuwait, who experience no rights to education, healthcare, employment and social security. The word translates into *without nationality*  (Minority Rights, 2021). [↑](#footnote-ref-3)
4. FGM refers to the partial or total removal of female genitailia for cultural or non-therapeutic reasons. Type 3 FGM refers to “Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening” (Whitehorn et al., 2002, p. 164) [↑](#footnote-ref-4)
5. Kurdish people [Kurds] are the largest non-Arab ethnic minority living in Iraq, Iran, Syria and Turkey. Iraqi Kurds have been systematically targeted by ISIS (Minority Rights, 2021). [↑](#footnote-ref-5)