Developing our Knowledge of Resilience:

The Experiences of Adults Seeking Asylum

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A thesis submitted in fulfilment of the requirements for the Degree of Doctor of Clinical Psychology at Cardiff University and the South Wales Doctoral Programme in Clinical Psychology

DECLARATION

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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Thesis Summary

Asylum seekers undergo immense hardship involving a unique set of circumstances during the asylum application process, but we know very little about their experiences and how asylum seekers cope. There are few studies which have explored the experiences of asylum seekers during the asylum application process, and fewer which have investigated resilience in asylum seekers. A systematic review and meta-analysis investigated the efficacy of psychological interventions for treating post-traumatic stress disorder in asylum seekers and refugees. This qualitative study used a Constructivist Grounded Theory method to explore asylum seekers' experiences during the asylum application process with a focus on factors affecting resilience. In-depth, semi-structured interviews were conducted with 10 adult asylum seekers in the UK. Participants' length of time in the UK ranged from 1 month to over 10 years. The interviews were recorded and transcribed, and data analysed using inductive analysis and constant comparison strategies. A constructivist grounded theory was presented diagrammatically and narratively to describe findings. The main constructed categories were 'systemic hardship', 'factors that inhibit coping' and 'factors that enhance coping'. Experiences of 'not being believed' and 'uncertainty for the future and safety' were linked with the asylum process and an insecure asylum status. Individual resources identified included understanding of trauma, its impact on wellbeing, and of coping strategies. Trauma and hardship could lead to fear, distrust of others, social isolation, and personal shrinkage whereas, access to community resources seemed to increase individual resources and lead to personal growth. The theory outlined understandings of how individual factors, environmental factors, and community resources may affect the resilience and wellbeing of participants. Theory has important implications for policy, services, clinical practice, and research.

Contents

Paper 1:

Psychological Interventions for post-traumatic stress disorder of asylum seekers and refugees: A systematic review and meta-analysis

This systematic review was prepared with the journal 'Clinical Psychology Review' in mind. The guidelines of which can be found in Appendix 4.1.

Word count: 7,227 words excluding figures and tables.

1 Psychological Interventions for post-traumatic stress disorder of asylum seekers and refugees: A systematic review and meta-analysis

1.1 Abstract

There is a high prevalence of post traumatic stress disorder (PTSD) in asylum seeker and refugee populations which can pose distinct challenges for mental health professionals. This review included 14 randomised controlled trials (RCTs) with 1,034 participants investigating the effect of psychological interventions on PTSD in these populations. We searched PsychInfo, ProQuest (including selected databases ASSIA, IBSS, PILOTS), Web of Science, the Cochrane Central Database of Controlled Studies (CENTRAL) and Cochrane Database for Systematic Reviews (CDSR) to identify peer-reviewed, primary research articles up to January 2017. 381 trials were reviewed, 14 were included with 13 contributed to meta-analyses. We found evidence for trauma-focused psychological interventions for treating PTSD at post-intervention compared with inactive controls, based on very low quality of evidence. We found no difference between interventions and active controls on PTSD severity. We used rigorous methods to assess the quality of included trials and evidence using Cochrane, SURE and GRADE systems. Following sub-group analyses, we found some evidence to support the use of EMDR and NET for PTSD symptoms. We reported on depressive symptoms, PTSD diagnosis and participant drop-out as secondary outcomes. Findings from this review have important implications for clinical practice and future research.

1.2 Highlights

- Increasing numbers of asylum seekers and refugees with complex needs.
- PTSD most-researched mental health condition.
- Evidence to support use of trauma-focused psychological interventions.
- Lack of evidence for group-based or non-trauma-focused approaches at present.
- The quality of current evidence is very low.

1.3 Keywords

Asylum seekers, refugees, post-traumatic stress disorder, psychological intervention, meta-analysis

1.4 Introduction

The number of forcibly displaced people around the world has increased by 75% over the last two decades with more individuals, families and communities affected by armed conflict, general violence and human rights violations (United Nations High Commission for Refugees UNHCR, 2016). The United Nations defines a refugee as someone who 'owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country' (UN General Assembly, 1951). An asylum seeker has asked a Government to provide them with refugee status and is awaiting a decision. Globally, in 2016 the UNHCR reported over 21 million refugees and close to 3.2 million asylum seekers.

Asylum seekers and refugees are much more likely to have experienced traumatic events than members of the general population in high income countries (Kalt, Hossain, Kiss, & Zimmerman, 2013). Individuals who have experienced multiple traumatic events in their home country, in transition to, and within the hosting country, undergo elevated levels of stress linked with unmet basic needs and uncertainty about their own future and the safety of loved ones. Asylum seekers and refugees have higher rates of mental health conditions, particularly post-traumatic stress disorder (PTSD), anxiety, depression (Bogic et al., 2015; Burnett & Peel, 2001) and psychoses (Hollander et al., 2016). Of these mental health conditions, PTSD is the most widely researched in asylum seeker and refugee populations. PTSD is a major global health problem for asylum seekers and refugees worldwide. Fazel, Wheeler and Danesh (2005) estimated that refugees are ten times more likely to experience PTSD than the general population in a systematic review of the prevalence of serious mental health disorders for individuals living in high income countries.

Psychological therapies have been used in the treatment of PTSD in the general population since PTSD was first included in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) (American Psychiatric Association, 1980). Efficacious psychological interventions for the treatment of PTSD include trauma-focused cognitive behavioural therapy (TF-CBT) and eye-movement desensitisation and reprocessing (EMDR). Both therapies are currently the treatments recommended within the United Kingdom's National Institute of Health and Clinical Excellence (NICE) guidelines. TF-CBT is a variant of cognitive behavioural therapy (CBT) and includes different therapies including Prolonged Exposure (Foa, Hembree, & Rothbaum, 2007), Cognitive Processing Therapy (Resick & Schnicke, 1993), Narrative Exposure Therapy (NET) (Schauer, Elbert, & Neuner, 2011) and Cognitive Therapy (Ehlers & Clark, 2000). These therapies aim to support individuals to manage difficulties following

traumatic events by combining cognitive therapy and behavioural therapy to change the way they think and act. The therapy involves exposing the individual to the distressing memory. EMDR aims to support individuals to reprocess their traumatic memories and involves supporting the individual to focus on distressing components of the memories including the image, thoughts, feelings and physical sensations, whilst guiding them through sets of eye-movements in a process of bilateral stimulation.

For the treatment of PTSD in asylum seeker and refugee populations, a qualitative review (Crumlish & O'Rourke, 2010) of 10 randomised controlled trials (RCTs) found evidence for CBT and NET, describing the latter as probably the best-supported modality. NET is a short-term psychological therapy for individuals with PTSD symptoms following multiple traumatic experiences over extended periods. Like EMDR and other forms of TF-CBT, treatment involves exposure to traumatic memories but involves the reorganisation of these memories into a coherent chronological narrative. The authors concluded that no treatment for PTSD in asylum seekers and refugees had a solid evidence base. Another quantitative review (Robjant & Fazel, 2010) of NET involving studies with asylum seekers and refugees summarised that studies had demonstrated efficacy in treating PTSD in a variety of low- and middle- income settings and for treating PTSD in asylum seekers and refugees in high-income settings. A meta-analysis (Lambert & Alhassoon, 2015) of 12 RCTs examined the results of psychotherapeutic intervention for traumatised adult refugees. Comparisons of 13 trauma-focused therapies found evidence for the benefit of psychological interventions for PTSD.

Refugees and asylum seekers often report being victims of torture (Burnett & Peel, 2001). A Cochrane review (Patel, Kellezi, & Williams, 2014) compared nine RCTs of interventions for psychological health and well-being of torture survivors, a population with similarities to asylum seekers and refugees. The authors reported no immediate benefits of psychological therapy in comparison with controls for PTSD symptoms and PTSD caseness. However, they found evidence to support a moderate effect of CBT and NET at six months post-treatment. Evidence was described as being of very low quality with authors citing non-standardised assessment methods using interpreters and very small sample sizes. A recent review and meta-analysis (Nosè et al., 2017) of 14 controlled and uncontrolled trials compared psychosocial interventions with waitlist or treatment as usual in adult refugees and asylum seekers in high-income countries. The authors found significant benefits of psychological therapies in reducing PTSD symptoms and concluded that their findings provide further empirical evidence that psychosocial interventions that are effective for PTSD in the general population may not completely overlap with those that are appropriate for

PTSD in asylum seekers and refugees. Nosè and colleagues emphasise the limited quality of evidence in their review citing a small number of studies and low methodological quality.

Within the last few years, the evidence base for psychological interventions in the treatment of PTSD in asylum seeker and refugee populations has grown, with implications for clinical practice and research. Previously, no meta-analysis has assessed the efficacy of EMDR when considering the effect of psychological interventions. Recently, several trials (Acarturk et al., 2015, 2016; Ter Heide, Mooren, Van De Schoot, De Jongh, & Kleber, 2016) not included in previous reviews (Lambert & Alhassoon, 2015; Nosè et al., 2017) have investigated the effect of EMDR. We aimed to build on the review of Robjant & Fazel (2010) by including a number of new trials (Hensel-Dittmann et al., 2011; Hijazi et al., 2014; Stenmark, Catani, Neuner, Elbert, & Holen, 2013) investigating NET which were published subsequently. We conducted this systematic review and meta-analysis considering a growing need to review emergent data with an aim to contribute important findings affecting clinical practice and future directions for research. To build on the existing body of literature we aimed to overcome limitations of the review conducted by Nosè et al. (2017). We tightened our inclusion criteria by limiting studies to RCTs, thus drawing conclusions from more robust studies. We set limits on the proportion of participants who were not either an asylum seeker or refugee and made it necessary for four-fifths of participants to have a probable PTSD diagnosis on the basis of validated standardised assessment measures. Finally, we included studies from low-, middle- and high- income settings.

1.4.1 Objectives

To determine the clinical efficacy of psychological therapies for the treatment of PTSD in adults who are seeking asylum or have refugee status. This review aimed to present an up-to-date analysis of randomised controlled trials (RCTs).

1.5 Methods

1.5.1 Criteria for considering studies for this review

Randomised, controlled trials with a primary focus to investigate the clinical efficacy of psychological interventions for treating PTSD in adults were considered for inclusion in this review. The RCT is generally considered to be the gold standard in treatment outcome research (Ehring et al., 2014), providing a reduced risk of bias and the most robust means of furthering evidence of the effectiveness of clinical interventions (Higgins & Green, 2011). We specified that studies must include a control condition, (e.g. treatment as usual, waitlist

control, monitoring group) or an alternative psychological intervention condition and must be a primary research paper. Included psychological interventions were those which had been reviewed by the Cochrane review of psychological therapies for PTSD in adults (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013). These included individual and group therapies, with or without trauma-focused techniques. Studies were limited to peer-reviewed, English-language only. Study sample size was not used to limit selection. This review defined adults as 18 years or over and required 80% of study participants to be either an asylum seeker or a refugee at point of recruitment. In line with prior PTSD treatment outcome reviews (Roberts, Roberts, Jones, & Bisson, 2015) 80% of study participants were required to have a probable PTSD diagnosis at point of recruitment according to DSM-III (APA 1980), DSM-IIIR (APA 1987), DSMIV (APA 2000), DSMV (APA 2013), ICD-9 (WHO 1979) or ICD-10 (WHO 1992) criteria. Accepted methods of PTSD diagnosis required either a clinician-led structured interview (e.g. the Clinician Administered PTSD Symptom Scale CAPS, (Blake et al., 1995) or a self-report measure validated for PTSD diagnosis (e.g. the Posttraumatic Diagnostic Scale PDS, (Foa, Cashman, Jaycox, & Perry, 1997). There was no restriction on type of traumatic event, other co-morbidity, substance use or study setting.

To identify studies, systematic computerised searches of PsychInfo, ProQuest (including selected databases ASSIA, IBSS, PILOTS), Web of Science and the Cochrane Central Database of Controlled Studies (CENTRAL) from 1 January 1992 to 7 January 2017 were carried out. The following search terms and Boolean operators were used TI=(asylum seeker* OR refugee*) AND TI=(intervention* OR treatment* OR therap* OR RCT OR “randomised control* trial” OR “randomized control* trial”) NOT TI=(child* OR adolescent* OR school). Additionally, the Cochrane Database for Systematic Reviews (CDSR) was searched for relevant reviews. We checked reference lists of reviews identified and those of included studies.

1.5.2 Outcomes

The primary outcome identified was PTSD symptom severity using standardised and validated assessment measures. The three secondary outcomes were: depressive symptom severity, PTSD diagnostic status and participant drop-out as measured by the number of participants who had retained in treatment. Primacy was given to standardised clinician-administered assessments. Following from Bisson *et al.*, (2015), outcome time points were grouped into four month periods of 0 to 4 months for post-intervention, and between 5 to 8 months, 9 to 12 months and 13 months or more for follow up.

1.5.3 Data extraction

The titles and abstracts of all potential trials were read. If an abstract appeared to represent a randomised, controlled trial with a primary focus to investigate the clinical efficacy of a psychological intervention for PTSD, two reviewers independently conducted a whole article review to determine if the study met the inclusion criteria. The Specialist Unit for Review Evidence (SURE) checklist for experimental studies (Specialist Unit for Review Evidence (SURE), 2013) was used to capture study characteristics and study data. Any differences regarding study inclusion were discussed and presented to a third reviewer when agreement could not be obtained.

1.5.4 Assessment of methodological quality

We used the Cochrane Collaboration's handbook for assessing risk of bias which provides an established framework for evaluating the quality of evidence of findings from systematic reviews (Higgins & Green, 2011). The approach focuses assessment on seven key areas of methodological quality: sequence generation, allocation sequence concealment, blinding of participants and investigators, blinding of outcome assessment, incomplete outcome data, selective outcome reporting and other biases. We used the SURE checklist for experimental studies (Specialist Unit for Review Evidence (SURE), 2013) to support the quality assessment process. The checklist comprises 14 broad categories with specific questions regarding internal validity, such as clearly defined hypotheses, methodology and validity of results. The checklist also supports analysis of key quality areas not included within the Cochrane approach, such as sample size, power analysis and the granting of ethical approval. We decided to provide a risk of bias table including the seven key areas, as well as additional areas covered by the checklist, to improve transparency and reliability of the review process. The risk of bias for each criterion was rated as of high, low or unclear risk of bias in accordance with Cochrane guidelines (Higgins & Green, 2011).

1.5.5 Main and subgroup analyses

We conducted an initial analysis of any psychological intervention versus waitlist or treatment as usual. Due to interventions possibly being conducted with an individual or with a group focus, we decided to analyse separately on this basis. We also decided to undertake subgroup analyses according to the type of psychological intervention i) EMDR ii) NET iii) CBT, and type of control condition i) inactive (e.g. waitlist/treatment as usual) ii) active (e.g. alternative psychological intervention). The timepoint for the main analyses was post intervention (0-4 months) with follow-up time points investigated for main outcomes as a subgroup analysis.

1.5.6 Statistical analyses and quality of evidence

We used the standardised mean difference (SMD) to analyse continuous outcomes as trials measured outcomes on different scales. SMD was based on Hedges' g (Hedges, 1981) calculated by dividing the difference in mean outcome between groups by the standard deviation of outcome among participants. We used the risk ratio (RR) to measure categorical outcomes. Heterogeneity was examined using the I^2 statistic. A random-effects model was used to summarise results as we anticipated a large degree of clinical heterogeneity between studies. Review Manager Version 5.3.5 (The Cochrane Collaboration, 2011) was used to analyse data. All *p* values are 2-tailed. We assessed the quality of evidence using the "Grades of Recommendation, Assessment, Development, and Evaluation" (GRADE) approach (Guyatt et al., 2013; Guyatt, Oxman, Schünemann, Tugwell, & Knottnerus, 2011) which provides an established framework for evaluating the quality of evidence of findings from systematic reviews (Higgins & Green, 2011). The quality of evidence was assessed using five factors: limitations in study design and implementations of included studies, unexplained heterogeneity or inconsistency of results, potential publication bias, imprecision of effect estimates. We pooled data to provide an overview classification of the quality of evidence according to the following criteria:

- High quality: further research is very unlikely to change our confidence in the estimate of effect.
- Moderate quality: further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
- Low quality: further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
- Very low quality: we are very uncertain about the estimate

From a starting point of high quality, the rating of quality was downgraded by one level for each serious study limitation (risk of bias), or two levels for very serious limitations, relating to indirectness of evidence, serious inconsistency, imprecision of effect estimates or potential publication bias.

1.6 Results

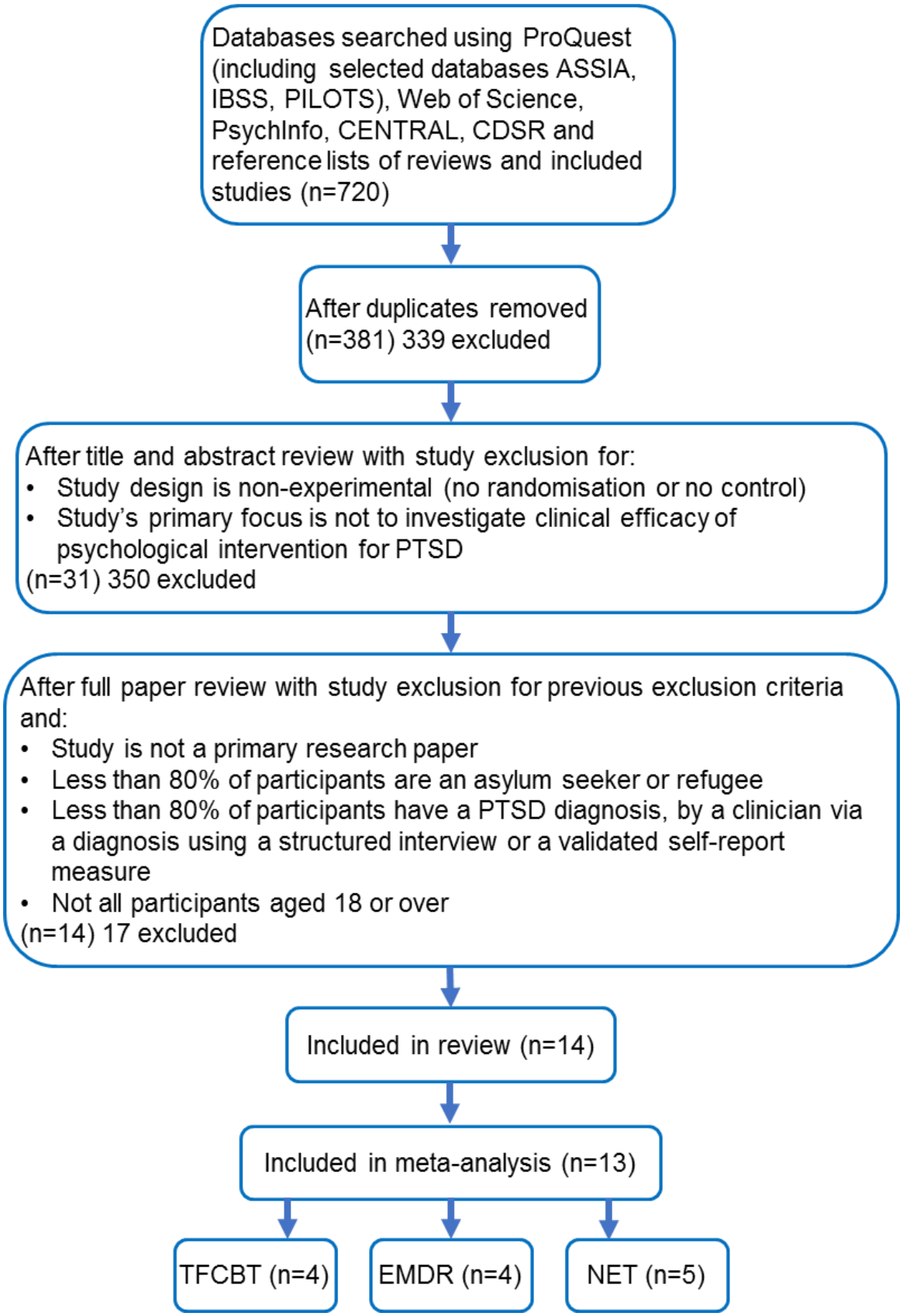

Figure 1.1. PRISMA flow diagram of search methodology

A final search was conducted on 7 January 2017 and identified 381 unique citations 350 were removed after reading the title and abstract. A further 17 studies were excluded following a full paper review. The reasons for exclusion are provided in Appendix 4.2. Fourteen studies with 1034 participants met inclusion criteria and were included with twelve of these providing data which contributed to meta-analysis. The mean average study sample size was 74 participants (range 10 to 280). The mean average length of follow-up was four months (range 1 to 12). Figure 1.1 provides a PRISMA flow chart of the selection criteria.

1.6.1 Study characteristics

Study characteristics of included studies are provided in Table 1.1. One study involved asylum seekers only (Neuner, Kurreck, Ruf, Odenwald, & Schauer, 2010), six studies involved refugees only (Buhmann, Nordentoft, Ekstroem, Carlsson, & Mortensen, 2016; Hijazi et al., 2014; Hinton et al., 2004, 2005; Otto et al., 2003; Paunovic & Ost, 2001), four studies involved both asylum seekers and refugees and analysed their outcomes either together (Hensel-Dittmann et al., 2011; Ter Heide, Mooren, Kleijn, de Jongh, & Kleber, 2011; Ter Heide et al., 2016) or separately (Stenmark et al., 2013) and three studies involved forcibly displaced migrants currently residing in refugee camps, with two studies in Turkey and one in Uganda (Acarturk et al., 2015, 2016; Neuner et al., 2008). Seven studies were conducted in Europe (Norway, Sweden, Denmark, two in Germany, two in The Netherlands) and four in the USA. Interpreters were used in ten of the studies.

1.6.2 Interventions and control conditions

All main psychological interventions investigated by included trials were identified as trauma-focused as they involved a substantive exposure component.

Table 1.1. Characteristics of included randomised controlled trials

Authors, Year, Country of study	Comparison	Sample size, Gender & Age	Participants' Country of Origin	PTSD diagnostic instrument	PTS Measures	Other Outcome Measures
Acarturk, Konuk, Cetinkaya, Senay, Sijbrandij, Cuijpers, Aker (2015) Turkey	EMDR, WL	N = 29, 7 male, 22 female, Mean age = 36	Syria	Cut-off score (≥ 33) used on Impact of Event Scale - Revised (IES-R) (Creamer & Falilla, 2002)	IES-R (Weiss & Marmar, 1997)	Beck Depression Inventory (Beck, Steer & Brown, 1996) Arabic version (Ghareeb, 2000)
Acarturk, Konuk, Cetinkaya, Senay, Sijbrandij, Gulen, Cuijpers (2016) Turkey	EMDR, WL	N=70, 25 males, 45 females, Mean age = 33	Syria	Diagnosis (DSM-IV) using the Mini-International Neuropsychiatric Interview Plus (M.I.N.I. PLUS) (Sheehan *et al.* 1998)	Harvard Trauma Questionnaire (HTQ) (Mollica *et al.,* 1992) Arabic version (Shoeb *et al.,* 2007), Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997)	Beck Depression Inventory-II (BDI-II) (Beck *et al*, (1996) Arabic version (Ghareeb, 2000), Hopkins Symptoms Checklist-25 (HSC-25) (Mollica *et al.,*2004) Arabic version (Kobeissi *et al.,* 2011)
Buhmann, Nordentoft, Ekstrom, Carlsson & Mortensen (2016)[a] Denmark	TF-CBT, Antidepressants, TF-CBT +Antidepressants, WL	N = 217, 128 males, 89 females, Mean age = 45	Iraq, Iran, Lebanon, Ex-Yugoslavia, Angola	Diagnosis using ICD-10 (WHO, 1993) using the Harvard Trauma Questionnaire (HTQ) using cut-off score of 2.5	Harvard Trauma Questionnaire (HTQ) (Mollica *et al*., 1992, 1996a) (language versions by Kleijn *et al*., 2001)	Hopkins Symptom Checklist (HSCL-25) (Mollica *et al*., 1987, 1996b), Symptom Checklist-90 (SCL-90), Hamilton Rating Scale for Depression (HRSD) (Hamilton, 1960) and for Anxiety (HSRA) (Hamilton, 1959), Visual Analogue Pain Scales (VAS) (Olsen et al., 2007), Sheehan Disability Scale (SDS) (Sheehan & Sheehan, 2008), WHO-Five Well-being Index (WHO-5).
Hensel-Dittmann, Schauer, Ruf, Catani, Odenwald, Elbert, Neuner (2011) Germany	NET, SIT	N = 28, gender and age not specified	Not specified	Diagnosis using DSM-IV (*APA*, 1994) criteria with Clinician Administered PTSD Scale (CAPS) (*Blake et al*., 1995)	Clinician Administered PTSD Scale (CAPS) (*Blake et al.*, 1995)	Vivo checklist of war, detentions and violent events, Mini-International Neuropsychiatric Interview Plus (M.I.N.I. PLUS) (*Sheehan et al*. 1998), Hamilton Depression Scale (HAM-D) (*Hamilton*, 1960,1967)
Hijazi, Lumley, Ziadni, Haddad, Rapport & Arnetz (2014) USA	NET, WL	N = 63, 28 males, 35 females, Mean age = 48	Iraq	Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1992, 1996a)	Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1992, 1996a)	Posttraumatic Growth Inventory (PTGI) (Tedeschi & Calhoun, 1996), WHO Well-being and Index (WHO-5) Arabic translation (Bech, 1998), Beck Depression Inventory-II (BDI-II) (Beck et al., 1996), Patient Health Questionnaire (PHQ-15) (Kroenke et al., 2002), A satisfaction measure
Hinton, Chhean, Pich, Safren, Hoffman & Pollack (2005) USA	TF-CBT, WL	N = 40, 16 males, 24 females, Mean age = 51	Cambodia	Diagnosis using Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) Module PTSD (First *et al.,* 1995)	Clinician-Administered PTSD Scale (CAPS) (Weathers *et al*., 2001)	Anxiety Sensitivity Index (ASI) (Taylor et al., 1992), Neck Panic Attack Severity Scale (N-PASS) and Orthostatic Panic Attack Severity Scale (O-PASS), Neck-Panic Flashback Severity Scale (N-FSS) and Orthostatic-Panic Flashback Severity Scale (O-FSS), Symptom Checklist-90-R Scales (SCL) (Derogatis, 1994)

Hinton, Pham, Tran, Safren, Otto & Pollack (2004) USA	TF-CBT, WL	N = 12, gender and age not specified	Vietnam	Diagnosis using Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) Module PTSD (First et al., 1995)	Harvard Trauma Questionnaire (HTQ) (Mollica *et al*., 1992)	Hopkins Symptom Checklist-25 (HSCL-25) (Mollica *et al*., 1990), Anxiety Sensitivity Index (ASI) Vietnamese version (Reiss & McNally, 1985), Headache Panic Attack Severity Scale (HPASS), Orthostatic Panic Attack Severity Scale (OPASS)
Neuner, Onyut, Ertl, Odenwald, Schauer & Elbert (2008) Uganda	NET, TC, MG	N = 277, 135 males, 142 females, Mean age = 35	Rwanda, Somalia	Diagnosis using the Composite International Diagnostic Interview (CIDI) (WHO, 1997) and DSM-IV (APA, 1994) criteria	Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995)	A physical health checklist
Neuner, Kurreck, Ruf, Odenwald, Elbert, Schauer (2010) Germany	NET, TAU	N = 32, 22 males, 10 females, Mean age = 31	Turkey, Balkans, Africa	Diagnosis using the clinician administered PDS with a combination of DSM-IV (APA, 1994) cut off score of 17	Posttraumatic Stress Diagnostic Scale (PDS) (Foa, 1995)	Vivo-Checklist of Organised Violence (VCOV), Composite International Diagnostic Interview (CIDI-C) (WHO, 1997), Hopkins Symptom Checklist-25 (HSCL-25) (Derogatis et al., 1974)
Otto, Hinton, Korbly, Chea, Phalnarith, Gershuny & Pollack (2003) USA	TF-CBT (group format) Antidepressant	N = 10, 0 males, 10 females, Mean age = 47	Cambodia	Diagnosis using Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) Module PTSD	Clinician-Administered PTSD Scale (CAPS) (Blake *et al.*, 1990)	Hopkins Symptom Checklist-25 (HSC-25) (Mollica *et al*., 1987), Symptom Checklist-90-R (SCL-90-R), Anxiety Sensitivity Index (ASI) (Taylor *et al*., 1992)
Paunovic & Ost (2001) Sweden	TF-CBT, Exposure therapy	N = 20, 17 males, 3 females, Mean age 38	Not specified	Diagnosis using DSM-IV (APA, 1994) criteria with Clinician Administered PTSD Scale (CAPS) (Blake *et al.*, 1997)	Clinician-Administered PTSD Scale-IV (CAPS) (Blake *et al.*, 1997), PTSD Symptomm Scale (PSS-SR) (Foa *et al.*, 1993), Impact of Event Scale-Revised (IES-R) (Weiss & Marmar, 1997)	Anxiety Disorders Interview Schedule-IV (ADIS-IV) (Brown *et al*., 1994) including the Hamilton Anxiety Scale (HAS, 1959) and the Hamilton Depression Scale (HDS, 1959). Beck Anxiety Inventory (BAI) (Beck *et al.,* 1988*),* State Trait Anxiety Inventory (STAI-S+T) (Speilberger *et al.,* 1970), Beck Depression Inventory (BDI) (Beck *et al.,* 1961, 1988), World Assumptions Scale (WAS) (Janoff-Bulman, 1989, 1992), Quality of Life Inventory (QOLI) (Frisch, 1992)
Stenmark, Catani, Neuner, Elbert, Holen (2013) Norway	NET, TAU	N = 81, 56 males, 25 females, Mean age = 35	Not specified	Diagnosis (DSM-IV) using the Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995)	Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995)	M.I.N.I International Neuropsychiatric Interview (Sheehan et al., 1998), the Hamilton Rating Scale for Depression (HAM-D) (Hamilton, 1960)
ter Heide, Mooren, Kleijn, de Jongh, Kleber (2011) The Netherlands	EMDR, Stabilisation	N = 20, 12 males, 8 females, Mean age = 41	Afghanistan, Algeria, Angola, Bosnia, Iran, Iraq,Lebanon Turkey	Diagnosis using Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) Module PTSD.	Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-I) Module PTSD (Dutch version by Van Groenestijn et al., 1998), Harvard Trauma Questionnaire (HTQ) (Mollica et al., 1996a)	Mini International Neuropsychiatric Interview (MINI) (Sheehan *et al.*, 1998) (Dutch version by Overbeek *et al.*, 1999), Hopkins Symptom Checklist (HSCL-25) (Mollica *et al,* 1996b), WHO Quality of Life questionnaire (WHOQOL-BREF) (WHOQOL Group, 1998)
ter Heide, Mooren, van de Schoot, de Jong, Kleber (2016) The Netherlands	EMDR, Stabilisation	N=72, 52 male, 20 female,Mean age = 41	Not specified	Diagnosis using DSM-IV-R (APA, 2000) criteria with Clinician Administered PTSD Scale (CAPS) (Blake et al., 1995)	Clinician-Administered PTSD Scale (CAPS) (Blake *et al*., 1995), Harvard Trauma Questionnaire (HTQ) (Mollica *et al*., 1996a)	Hopkins Symptom Checklist-25 (HSCL-25) (Derogatis *et al*., 1974), World Health Organisation Quality of Life Assessment (WHOQOL-BREF) (WHO, 1998)

Abbreviations: NET, Narrative Exposure Therapy; EMDR, Eye Movement Desensitisation and Reprocessing; CBT, Cognitive Behaviour Therapy; TC, Trauma Counselling; WL, waitlist; TAU, treatment as usual, SIT, Stress Inoculation Training, MG, monitoring group. [a] Study used a 2 x 2 design. Participants received experimental and control psychological interventions in combination with antidepressant medications.

1.6.3 Individual trauma-focused approaches

Four studies (Hijazi et al., 2014; Neuner et al., 2008, 2010; Stenmark et al., 2013) compared Narrative Exposure Therapy (NET) with an inactive control. The number of treatment sessions ranged from three to 10 with a mean average of seven sessions. Two studies (Hensel-Dittmann et al., 2011; Neuner et al., 2008) compared NET with an inactive control. Hensel-Dittmann et al. (2011) compared 10 sessions of NET with 10 sessions of stress inoculation therapy. Neuner et al. (2008) compared six sessions of NET with six sessions of trauma counselling and aimed to investigate whether trained counsellors recruited from a population of refugees, could carry out effective treatment for PTSD in a refugee camp. Stenmark et al. (2013) compared 10 sessions of NET delivered by a range of healthcare professionals including nurses, occupational therapists, and social workers, with a treatment as usual control condition. We were unable to obtain outcome data needed to include in our meta-analyses.

Four studies (Acarturk et al., 2015, 2016, Ter Heide et al., 2011, 2016) investigated Eye Movement Desensitisation and Reprocessing (EMDR) with two studies (Acarturk et al., 2015, 2016) comparing seven sessions of EMDR with a waitlist control. Two studies (Ter Heide et al., 2011, 2016) compared EMDR with stabilisation with Ter Heide et al. (2016) comparing 9 sessions of EMDR with 12 sessions of stabilisation and Ter Heide et al. (2011) comparing 11 EMDR sessions with 11 stabilisation sessions. Participants were divided evenly between groups in all studies. Studies by Acarturk and colleagues were conducted in a refugee camp with culturally sensitive treatment carried out in a kindergarten to avoid stigma associated with mental illness.

Five studies investigated Cognitive Behavioural Therapy (CBT) adapted for trauma. Four studies involved individual treatment (Buhmann et al., 2016; Hinton et al., 2004, 2005; Paunovic & Ost, 2001) and one study involved a group format (Otto et al., 2003). Three studies (Buhmann et al., 2016; Hinton et al., 2004, 2005) compared CBT with an inactive control. The number of treatment sessions ranged from 12 to 16 with a mean average of 13.3 sessions. Three studies (Buhmann et al., 2016; Otto et al., 2003; Paunovic & Ost, 2001) compared CBT with an active control with Buhmann et al. (2016) and Otto et al. (2003) comparing 16 or 10 sessions of CBT with a sertraline condition, and Paunovic & Ost (2001) comparing 16 to 20 sessions of CBT with 16 to 20 sessions of exposure therapy. Two studies (Buhmann et al., 2016; Otto et al., 2003) compared a combined treatment condition of CBT (12 or 10 sessions) and sertraline with sertraline only. Buhmann et al. (2016) also compared CBT (12 sessions) and sertraline with an inactive waitlist control.

Table 1.2. Study characteristics related to SURE and Cochrane's risk of bias criteria. (Cochrane criteria within border)

First author, year, intervention	Sequence generation	Allocation sequence concealment	Blinding of participants and investigators	Blinding of outcome assessment	Incomplete outcome data	Selective outcome reporting	Other biases	Hypothesis clearly described?	Interventions well described?	Ethical approval sought?	Trial protocol published?	Groups similar at start?	Sample size sufficient?	Participants accounted for?	Data analysis comprehensive?	Results seeming reliable?	Sponsorship/conflict of interest reported?	Limitations identified?
Acartuk 2016, EMDR	Low	Low	High	Low	Low	Low	Unclear	Low	Low	Low	Low	Low	Unclear	Unclear	Low	Low	Low	Low
ter Heide 2016, EMDR	Unclear	Low	High	Low	Low	Unclear	Unclear	Low	Low	Low	Low	Low	Low	Unclear	Low	Low	Low	Low
Neuner 2008, NET	Low	Unclear	High	Low	Low	Unclear	Unclear	Low	Unclear	Low	High	Low	Low	Unclear	Low	Low	High	Low
Acartuk 2015, EMDR	Low	Low	High	Low	Low	Unclear	Unclear	Low	Unclear	Low	High	Low	High	Unclear	Unclear	Unclear	Low	Low
Neuner 2010, NET	Low	Low	High	Unclear	Low	Unclear	Unclear	Low	High	Low	High	Unclear	High	Low	Low	Low	Low	Low
Hensel-Dittmann 2011, NET	Unclear	Unclear	High	Unclear	Low	Unclear	Unclear	Low	Low	Low	High	Unclear	High	Unclear	Unclear	Low	Low	Low
Stenmark 2013, NET	Low	Unclear	High	High	Low	Low	Unclear	Low	Low	Low	Low	Low	Low	Unclear	Low	Low	Low	Low
Hinton 2005, CBT	Unclear	Unclear	High	High	Low	Unclear	High	Low	Unclear	Unclear	High	Low	Unclear	Unclear	Low	Low	High	Low
Hijazi 2014, NET	Low	Low	High	Unclear	Low	Unclear	High	Low	Unclear	Low	High	High	Low	Unclear	Low	Unclear	High	Low
Hinton 2004, CBT	Unclear	Unclear	High	Unclear	High	Unclear	Unclear	Low	Unclear	High	High	Unclear	High	High	Unclear	Unclear	High	Low
Otto 2003, CBT	Unclear	Unclear	High	Unclear	High	Unclear	Unclear	Low	Unclear	Low	High	High	High	High	Unclear	Unclear	High	Unclear
Buhmann 2016, CBT	Low	Low	High	High	Low	Low	High	Low	Low	High	Low	Low	Unclear	Low	Low	Unclear	Low	Low
ter Heide 2011, EMDR	Unclear	Low	High	High	High	Unclear	Unclear	Low	High	High	High	High	High	Unclear	Unclear	Unclear	High	Unclear
Paunovic 2001, CBT	Unclear	Unclear	High	Unclear	High	Unclear	High	Unclear	Unclear	High	High	Low	High	Unclear	Unclear	Unclear	High	Low

1.6.4 Group-based approaches

One study (Otto et al., 2003) involved psychological treatment in a group format compared with an active control. Five participants underwent 10 sessions of trauma-focused CBT for adults in a treatment group whilst taking sertraline compared to a control condition with five participants undertaking a course of antidepressant medication (sertraline). No studies compared a group-format psychological intervention with an inactive control.

1.6.5 Quality of methodology

The methodological quality of studies is shown in Table 1.2. A detailed table on Cochrane risk of bias criteria is provided in Appendix 4.3. All studies were at high risk for blinding of participants and investigators, a criterion that is recognised as very difficult to achieve low risk for in psychological research. Reporting of sequence generation and adequate allocation concealment was often not clearly described or not undertaken. Blinding of outcome assessment was unclear in six studies and not carried out by three studies including two larger trials (Buhmann et al., 2016; Stenmark et al., 2013). Ten studies provided complete outcome data with four studies omitting outcome data. It was largely unclear as to whether studies selectively reported outcomes although three studies did detail their outcomes in a trial protocol. Other biases included potential researcher allegiance to intervention with four studies including researchers who have co-authored intervention protocols (Hensel-Dittmann et al., 2011; Neuner et al., 2008, 2010; Stenmark et al., 2013). Several therapist effects were reported in four trials (Hijazi et al., 2014; Hinton et al., 2004, 2005; Paunovic & Ost, 2001) with either one or two therapists carrying out all treatment, and in one trial where one therapist was thought not to agree with the treatment (Ter Heide et al., 2011). In a small number of studies, authors reported that participants could have an incentive to underreport progress if believing doing so could benefit their asylum claim. Therapist and assessor training, level of experience and professional backgrounds varied considerably between studies. Ten studies reported using interpreters.

Thirteen studies included a clearly defined hypothesis. Two studies did not clearly define their interventions or did not clearly distinguish treatment components between interventions. Nine studies reported obtaining ethical approval. Whilst it was assumed that most studies would have obtained ethical approval, four studies did not report doing so and one did not confirm approval being granted. Only four studies registered a trial protocol prior to trial commencement. Six studies were rated at high or unclear risk of bias from groups potentially being dissimilar at the start of the trial due to factors including baseline characteristics, degree of or types of trauma, length of time living in country. The sample size was small in seven studies (Acarturk et al., 2015; Hensel-Dittmann et al., 2011; Hinton et al., 2004;

Neuner et al., 2010; Otto et al., 2003; Paunovic & Ost, 2001; Ter Heide et al., 2011) and only six studies undertook a power analysis. Participants were properly accounted for in 11 trials with unclear accounting in three trials. An intention-to-treat analysis was carried out in eight trials with no need in two trials due to all participants remaining until follow-up. Three trials did not attempt an intention-to-treat analysis and one trial carried out an insufficient analysis. Eight studies reported sufficient data analysis including statistical and analytical methods, providing estimates of effect size, and meaningful confident intervals. Information provided was unclear in six studies. Results provided were seemingly reliable based on outcome measures used, outcomes assessed and authors' conclusions being adequately supported by the results. This was unclear in seven studies. Seven studies did not report on sponsorship or potential conflicts of interest. Twelve studies adequately identified limitations.

Table 1.3: Efficacy of experimental intervention versus inactive and active controls for PTSD severity with GRADE judgments of evidence quality.

Active intervention	Inactive control		Active control	
	Post-treatment	5-8 months follow-up	Post-treatment	5-8 months follow-up
Individual TFP	6 studies, n = 380 SMD = -1.14 (-1.99 to -0.30) [a] I^2 = 92% ⊕⊖⊖⊖ very low [b-d]	2 NET studies, see NET	6 studies, n = 494 SMD = -0.03 (-0.21 to 0.14) I^2 = 0% ⊕⊖⊖⊖ very low [b,d]	3 studies, n = 264 SMD = 0.11 (-0.13 to 0.35) I^2 = 0% ⊕⊖⊖⊖ very low [b,d]
Group TFP	No data available	No data available	No data available	No data available
EMDR	2 studies, n = 127 SMD = -1.48 (-1.88 to -1.09) [a] I^2 = 0% ⊕⊖⊖⊖ very low [b]	No data available	2 studies, n = 92 SMD = -0.29 (-0.94 to 0.37) I^2 = 45% ⊕⊖⊖⊖ very low [b,c]	No data available
NET	1 study, n = 63 MD = -0.10 (-0.40 to 0.20) I^2 = N/A ⊕⊖⊖⊖ very low [b,e]	2 studies, n = 198 SMD = -0.62 (-0.93 to -0.32) [a] I^2 = 20% ⊕⊖⊖⊖ very low [b,d]	2 studies, n = 243 SMD = 0.06 (-1.56 to 1.68) I^2 = 0% ⊕⊖⊖⊖ very low [b,d]	2 studies, n = 243 SMD = -0.01 (-0.54 to 0.53) I^2 = 45% ⊕⊖⊖⊖ very low [b-d]
TF-CBT	3 studies, n= 190 SMD = -1.32 (-3.17 to 0.53) I^2 = 94% ⊕⊖⊖⊖ very low [b-d]	No data available	2 studies, n = 161 SMD = 0.00 (-0.20 to 0.20) I^2 = 0% ⊕⊖⊖⊖ very low [b,d]	1 study, n = 20 MD = 2.40 (-20.30 to 25.11) N/A ⊕⊖⊖⊖ very low [b,e]
TF-CBT + sertraline	1 study, n = 139 MD = 0.00 (-0.33 to 0.33) N/A ⊕⊖⊖⊖ very low [b,e]	No data available	1 study, n = 142 MD = 0.00 (-0.33 to 0.33) N/A ⊕⊖⊖⊖ very low [b,e]	No data available

GRADE Working Group grades of evidence:

- ⊕⊕⊕⊕ High quality: Further research is very unlikely to change our confidence in the estimate of effect.
- ⊕⊕⊕⊖ Moderate quality: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
- ⊕⊕⊖⊖ Low quality: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
- ⊕⊖⊖⊖ Very low quality: We are very uncertain about the estimate.

[a] Statistically significant P<0.05.
[b] Risk of bias unclear or high in several domains.
[c] Unexplained statistical heterogeneity.
[d] Significant clinical heterogeneity.
[e] Findings based on outcomes from one study with a small sample size.

1.6.6 Assessed outcomes and evidence synthesis

Outcomes were grouped and analysed in line with intervention characteristics identified above and decided *a priori* as recommended by Cochrane guidelines (Higgins & Green, 2011). The results of meta-analyses for the main outcome PTSD severity are shown in Table 1.3.

1.6.7 Main Analysis

1.6.7.1 Individual trauma-focused psychotherapy (TFP)

Nine trials included in this review evaluated an individual psychological intervention versus waitlist control/treatment as usual or minimal intervention (Acarturk et al., 2015, 2016; Buhmann et al., 2016; Hijazi et al., 2014; Hinton et al., 2004, 2005, Neuner et al., 2008, 2010; Stenmark et al., 2013). Six trials (Acarturk et al., 2015, 2016; Buhmann et al., 2016; Hijazi et al., 2014; Hinton et al., 2004, 2005) with 380 participants were involved in an analysis of individual TFP on PTSD severity at post-intervention. We found a large effect in favour of individual psychological intervention at post-intervention (SMD -1.14; 95% CI -1.99 to -0.30) as shown in Figure 1.2. Using GRADE, we rated the quality of evidence for these findings as very low.

Two trials investigating NET conducted follow-up analysis as described in the NET section below. Six trials (Buhmann et al., 2016; Hensel-Dittmann et al., 2011; Neuner et al., 2008; Paunovic & Ost, 2001; Ter Heide et al., 2011, 2016) with 496 participants were involved in an analysis of individual TFP compared with an active control. No difference was found (SMD -0.03; 95% CI -0.21 to 0.14) as shown in Figure 1.3. Following an analysis of three studies (Hensel-Dittmann et al., 2011; Neuner et al., 2008; Paunovic & Ost, 2001), we found no difference at follow-up (SMD 0.14; 95% CI -0.13 to 0.35). We assessed the quality of evidence for all of these findings as very low.

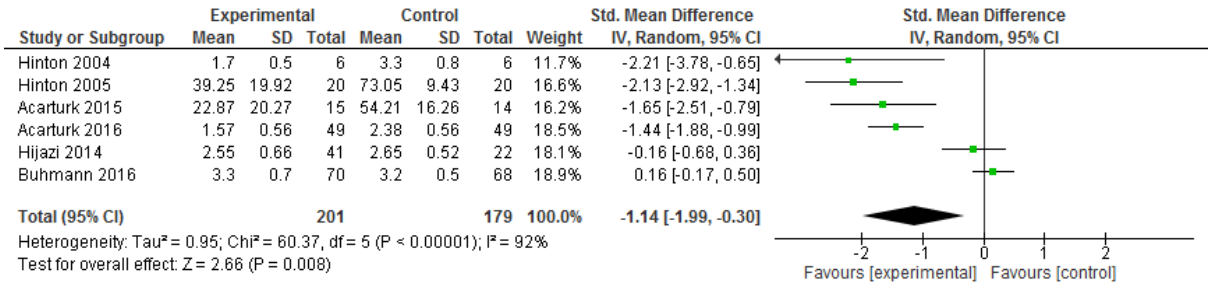

Figure 1.2. Forest plot of comparison: trauma-focused psychotherapy vs inactive control, main outcome: PTSD severity at 0 to 4 months

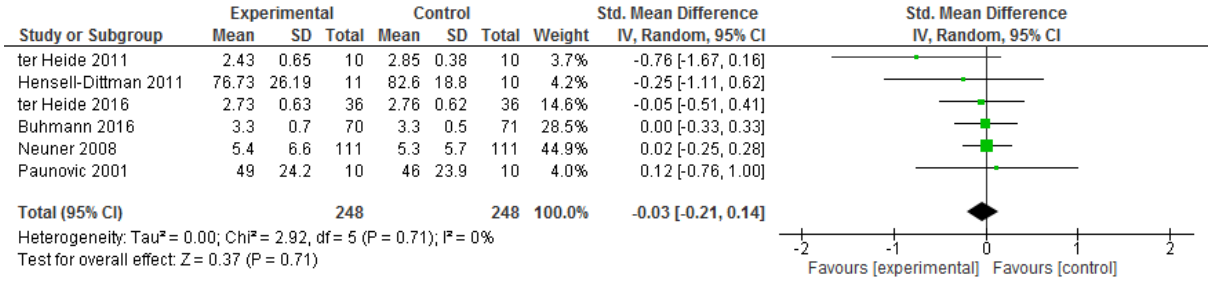

Figure 1.3. Forest plot of comparison: trauma-focused psychotherapy vs active control, main outcome: PTSD symptoms at 0 to 4 months

For secondary outcomes, six studies compared TFP with inactive control on depressive symptoms (Acarturk et al., 2015, 2016; Buhmann et al., 2016; Hijazi et al., 2014; Hinton et al., 2004; Stenmark et al., 2013) at post-intervention and were involved in an analysis. We found a small effect (SMD -0.48; 95% CI -0.85 to -0.11) in favour of psychological interventions. Four studies (Acarturk et al., 2015, 2016; Stenmark et al., 2013; Ter Heide et al., 2016) compared TFP with inactive control on PTSD diagnosis and were involved in an analysis. No difference was found (RR 0.67; 95% CI 0.41 to 1.11). An analysis of eight studies (Acarturk et al., 2015, 2016; Buhmann et al., 2016; Hijazi et al., 2014; Hinton et al., 2005; Neuner et al., 2008, 2010; Stenmark et al., 2013) found no difference between groups for participant drop-out (RR 0.81; 95% CI 0.65 to 1.02). Five studies (Buhmann et al., 2016; Hensel-Dittmann et al., 2011; Paunovic & Ost, 2001; Ter Heide et al., 2011, 2016) compared TFP with active controls on depressive symptoms. Data from Ter Heide et al. (2016) was reported in a manner that could not be used. The remaining four trials were involved in an analysis on depressive symptoms at post-intervention. We found no difference between conditions (SMD -0.21; 95% CI -0.59 to 0.16). Two trials (Hensel-Dittmann et al., 2011; Ter Heide et al., 2016) investigated effect of intervention on PTSD diagnosis and were involved in an analysis. We found no difference (RR0.98; 95% CI 0.84 to 1.15) between conditions. Six trials (Buhmann et al., 2016; Hensel-Dittmann et al., 2011; Neuner et al., 2008; Paunovic

& Ost, 2001; Ter Heide et al., 2011, 2016) investigated participant dropout and were involved in an analysis. We found no difference (RR 0.89; 95% CI 0.42 to 1.89) between conditions.

1.6.7.2 Group-based psychotherapy

Only one study included in this review investigated the effect of group-based psychotherapy. Otto and colleagues (2003) compared combined treatment consisting of a trauma-focused CBT intervention and sertraline, with a condition involving sertraline only in a group of pharmacotherapy-refractory Cambodian refugees. Small to large effects in favour of combined treatment for PTSD severity were reported. No difference in effect for depressive symptoms was found. Due to how the data was reported we were unable to carry out an analysis.

1.6.8 Sub-group analyses

1.6.8.1 Eye Movement Desensitisation and Reprocessing (EMDR)

Four studies investigated EMDR with two comparing the psychological intervention to a waitlist control (Acarturk et al., 2015, 2016) and two comparing EMDR versus a stabilisation condition (Ter Heide et al., 2011, 2016). In an analysis of EMDR versus inactive control for PTSD symptoms at post-intervention, we found a large effect (SMD -1.48; 95% CI -1.88 to -1.09) in favour of the psychological intervention. No additional follow-up data was available. The quality of evidence for these findings was graded as very low. In an analysis of EMDR versus active control for PTSD symptoms at post-intervention, we found no difference (SMD -0.29; 95% CI -0.94 to 0.37) between conditions. No data was available at follow-up. We assessed the quality of evidence for these findings as very low.

1.6.8.2 Narrative Exposure Therapy (NET)

Three studies (Neuner et al., 2008, 2010; Stenmark et al., 2013) which compared NET with an inactive control were not involved in the meta-analysis of PTSD severity at post-intervention due to either having no data for a condition at post-intervention, or data being reported in an unusable manner. Stenmark and colleagues (2013) compared NET versus treatment as usual in a multicentre study involving a variety of health professionals as therapists. Authors reported a significant effect in favour of NET for PTSD severity and depressive symptoms at post-intervention, and a reduction of PTSD diagnosis at six-month follow-up. Authors reviewed the effects on asylum seekers and refugees separately and found no difference in outcomes between these groups. An analysis of one study (Hijazi et

al., 2014) comparing NET with a waitlist control found no difference between groups (MD -0.10; 95% CI -0.40 to 0.20) for PTSD severity at post-intervention. Two studies (Neuner et al., 2008, 2010) which compared NET with a monitoring group or treatment as usual for PTSD symptoms at follow-up were involved in an analysis. We found a moderate effect in favour of treatment (SMD -0.62; 95% CI -0.93 to -0.32). Two studies (Hensel-Dittmann et al., 2011; Neuner et al., 2008) compared NET with an active control, either stress inoculation therapy or trauma counselling. These studies were involved in an analysis of NET on PTSD symptoms at post-intervention and follow-up. We found no difference between conditions at post-intervention (SMD 0.06; 95% CI -1.56 to 1.68) or follow-up (SMD -0.01; 95% CI -0.54 to 0.53). We assessed the quality of evidence for these findings as very low.

1.6.8.3 Cognitive Behavioural Therapy (CBT)

Three studies (Buhmann et al., 2016; Hinton et al., 2004, 2005) compared CBT with a waitlist control. We found no difference (SMD -1.32; 95% CI -3.17 to 0.53) between conditions. No follow-up data was available. Two studies (Buhmann et al., 2016; Paunovic & Ost, 2001) compared CBT with an active condition. Buhmann et al., (2016) compared CBT only with a sertraline condition and Paunovic & Ost, (2001) compared CBT with exposure therapy. These studies were included in an analysis of CBT on PTSD severity at post-intervention. We found no difference between conditions (SMD 0.00; 95% CI -0.20 to 0.20). In an analysis of one study (Paunovic & Ost, 2001) at follow-up, we found no difference (MD 2.40; 95% CI -20.30 to 25.11) between conditions. One study (Buhmann et al., 2016) compared CBT as part of a combined treatment of CBT and sertraline versus a waitlist control. In an analysis of CBT with sertraline on PTSD severity at post-intervention, we found no difference (MD 0.00; 95% CI -0.33 to 0.33) between conditions. No data was available at follow-up. Two studies (Buhmann et al., 2016; Otto et al., 2003) compared CBT as part of a combined treatment of CBT and sertraline versus sertraline only. We were unable to analyse data from Otto et al (2003) due to the manner in which data was reported. The authors reported medium to large effect sizes in favour of combination treatment. In an analysis of one study (Buhmann et al., 2016) comparing CBT + sertraline with an active control on PTSD severity at post-intervention, we found no difference (MD 0.00; 95% CI -0.33 to 0.33) between conditions. No data was available at follow-up. We assessed the quality of evidence for these findings as very low.

1.7 Discussion

We included 14 randomised controlled trials (RCTs) with 1,034 participants in this review. We analysed the evidence base of psychological interventions aiming to reduce PTSD severity in adult asylum seeker and refugee populations. Secondary outcomes were depressive symptoms, PTSD diagnosis and participant drop-out.

In accordance with previous systematic reviews and meta-analyses conducted with asylum seeker and refugee populations (Lambert & Alhassoon, 2015; Nosè et al., 2017) this study found empirical evidence for the effectiveness of trauma-focused psychological interventions in reducing PTSD symptoms. The data suggests a large effect for trauma-focused psychotherapy (TFP) for PTSD symptoms when compared with inactive controls. For secondary outcomes, the data suggests a small effect of TFP for depressive symptoms when compared with inactive controls at post intervention. No difference was found for PTSD diagnosis or for participant drop-out. Following an analysis comparing TFP with active controls (stabilisation, exposure therapy, sertraline, stress inoculation therapy), we found no difference for PTSD severity or secondary outcomes. We used robust methods for analysing the methodological quality of included studies and the quality of evidence of pooled data, in line with Cochrane (Higgins & Green, 2011), SURE (Specialist Unit for Review Evidence (SURE), 2013) and GRADE systems (Guyatt et al., 2013; Guyatt et al., 2011). We rated the quality of all evidence obtained as of very low quality in all analyses, therefore, the findings reported in this review need to be interpreted with caution and may be liable to change as further evidence accumulates.

For treating PTSD in the general population, a Cochrane review (Bisson et al., 2013) found strongest evidence to support the use of TF-CBT, EMDR and Stress Management (SM). This review is the first to include meta-analyses investigating the effect of EMDR for PTSD in asylum seeker and refugee populations. We found some evidence for EMDR to be used with asylum seeker and refugee populations via sub-group analyses of four studies with very low quality of evidence. The data suggested a large effect for EMDR compared with a waitlist inactive control at post-intervention. However, we did not find a difference of effect in an analysis comparing EMDR with stabilisation as an active control. Both analyses need to be interpreted cautiously given the small number of trials. Both trials that compared EMDR to inactive controls were carried out in a refugee camp setting by the same study group. It can be hypothesised that where studies are conducted in settings where interventions for common mental health disorders are practically non-existent, even minimal interventions can have some effect (Rahman et al., 2016). This point may also hold significance for

participants included in other studies in this review and might help explain why we did not find an effect between TFP and active controls. For individuals who may not have been able to access interventions very easily within their host country, they may benefit from even minimal forms of intervention.

Following sub-group analyses, we did not find evidence to support the use of TF-CBT for treating PTSD in asylum seeker and refugee populations. We rated the quality of evidence as very low. We did not find evidence in a comparison of CBT with waitlist inactive controls or active controls (exposure therapy, sertraline). We also did not find evidence for CBT as part of a combination treatment with sertraline compared with sertraline only. These findings need to be interpreted cautiously due to the very low quality of evidence. Comparisons were limited by a small number of trials with mainly small samples and limitations in methodological quality. Limitations involved trials with two or more high risk of bias judgements for Cochrane and SURE criteria including blinding of outcome assessment, incomplete outcome data and other biases such as participants not ending treatment in the groups they started in. We noted that no trials investigated more established forms of TF-CBT such as Prolonged Exposure, CPT or CT. Also, descriptions of interventions were often lacking in detail or did not adequately explain differences between treatment arms.

Similarly to Nosè and colleagues (2017), we found some evidence to support the use of NET following a sub-group analysis of evidence of very low quality. However, the data suggested a moderate effect for NET at 5-8 months follow-up rather than at post-intervention where no difference versus inactive control was found. These findings also need to be interpreted with caution due to the very low quality of evidence. Only one trial was involved in an analysis at of NET versus inactive controls at post-intervention. Both trials that found an effect at a 5-8 month follow-up were conducted by the same group of researchers who acknowledged therapist allegiance to the active intervention, and with therapists likely using the same treatment manual between trials. In one trial, lay counsellors trained in NET were involved in delivering both treatment arms. Neither trial included a comparison of NET with an inactive control at 0 to 4 month post-intervention preventing any comparison between time-points or investigation into possible changes of outcome scores between time-points.

There was a high degree of heterogeneity amongst studies included in this review. Interventions varied between and within intervention sub-type in the number of sessions and time for exposure to traumatic memories, with therapists and assessors from differing professional and lay backgrounds with varying levels of expertise/training/supervision in the psychological model. Clinical populations were diverse in terms of types of trauma

experienced and trauma severity. Participants from differing cultures and backgrounds will have had varying understanding of mental health difficulties and expectations of mental health services. Individuals worked through a translator in the majority of trials and were at varying stages of their asylum journey. Trials varied in terms of their exclusion criteria, inclusion of comorbid disorders and methods for controlling for medication. Outcome measures used to diagnose and assess PTSD and depressive symptoms varied in terms of their validity and reliability. By including RCTs only in this review, we sought to strengthen the evidence base from which we have made conclusions by reducing risk of bias from unobserved heterogeneity. By conducting a quantitative analysis of pooled data, we aimed to increase the power of findings and conducted subgroup comparisons to investigate the effect of individual psychological interventions. Due to comparisons consisting of a small number of trials and pooled sample sizes, caution is required when interpreting findings due to the risks of over or under-estimating effect sizes and underestimating heterogeneity.

Our review used stringent methodology to analyse the evidence base but has some limitations. Our search strategy only identified studies published in English and as such we may have missed robust studies published in other languages. We made efforts to obtain missing data deemed important for inclusion in meta-analyses, but we did not receive responses from some authors. Meta-analysis only rarely involves synthesis of data from identical studies (Borenstein, Hedges, Higgins, & Rothstein, 2011). We attempted to group studies together in a way that was logical and clinically meaningful. It is, however, important for us to acknowledge that there is significant clinical heterogeneity within comparisons. We therefore decided to use random effects analyses throughout. The small pool of studies limited the number of analyses that could be undertaken. For instance, we were unable to compare the effects of intervention between asylum seeker and refugee samples or between high-income and low-income countries. We were not able to investigate for publication bias.

Findings from this review have important implications for clinical practice and research which can be used to support the creation of policy and guidelines. This review builds on the existing evidence base for psychological interventions with asylum seeker and refugee populations. This review provides evidence which can be used to underpin a case for providing trauma-focused therapy for asylum seekers and refugees with PTSD. However, we did not find robust evidence to recommend any mode of psychological intervention.

We found the current evidence base to be limited by a small number of RCTs of limited methodical quality. Few trials compared the main intervention to an established, alternative psychological intervention. Only one trial investigated a group-format intervention. Larger,

more robust trials are needed to replicate findings and strengthen the evidence base. Direct comparisons between psychological interventions will help to determine efficacy. We found trials investigating a narrow range of interventions: EMDR, CBT and NET. In light of the lack of difference between TFP and active controls, there is also a need for trials to investigate non-trauma-focused interventions. Trials should be conducted by researchers independent from the mode of therapy to reduce possible researcher bias due to therapy-allegiance.

Few studies investigated follow-up effects. Longitudinal trials are needed to enhance our understanding of the sustainability of psychological interventions. We found that individual trauma-focused interventions currently dominate research trials. Considering the complexity of contextual factors affecting outcomes, it seems important that trials should not limit their attention to individual trauma focused interventions but should consider the evaluation of social, familial and welfare interventions as well (Patel, Williams, & Kellez, 2016). We found measures of PTSD and depression to be the most common outcome measures used to determine treatment effect.

Researchers of interventions for asylum seekers and refugees need to be cautious when interpreting findings on the basis of outcome measures that have been designed for, standardised with, and validated for use with English-speaking, Western populations. Outcome measures used within trials in this review were often subjective and relied on participant responses being interpreted on the spot, without a back-translation check for reliability of translation. Until measures have been standardised and validated for use with diverse populations, uncertainties relating to existing outcomes measures' construct validity will remain. Five trials within this review used a quality of life measure, one used a measure of post-traumatic growth, and one assessed participants' satisfaction with treatment. Patel et al. (2014) stress that people who are applying for asylum or have refugee status will have psychological and social difficulties that go beyond scoring highly on PTSD instruments. There is a need for clinicians to evaluate outcomes not only based on symptoms, but taking into account participants' views on the cultural meaningfulness and appropriateness of the intervention, and on their overall satisfaction with therapy.

Only two included trials reviewed the effects of intervention on asylum seekers. There is a need to distinguish asylum seekers and refugees as distinct groups. Due to the different stressors experienced by asylum seekers and by refugees it will be helpful for trials to investigate for differential effects of intervention with these groups to guide clinical practice.

The majority of individuals who have experienced traumatic events do not go onto develop PTSD and resilience factors have been associated with better mental health in displaced populations (Siriwardhana, Abas, Siribaddana, Sumathipala, & Stewart, 2015). Research with a focus on understanding factors affecting individuals' resilience will enhance our understanding of why individuals develop mental health conditions and how people can be supported at different levels within health, social and community systems. To this end, the evidence base will be enriched by studies of various designs which can effectively explore the impact of interventions on family and community systems affecting resilience, as well as for the individual.

This review can be used to underpin the use of psychological interventions for PTSD in asylum seeker and refugee populations. However, this review highlights substantial gaps in our understanding of how best to support asylum seekers and refugees with complex difficulties. Future studies should aim to robustly evaluate the efficacies of treatment approaches which will be essential for informing clinical practice guidelines and enhancing psychological well-being.

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Paper 2:

Developing our Knowledge of Resilience: The Experiences of Adults Seeking Asylum

This empirical study was prepared with the 'Journal of Ethnic and Migration Studies' in mind. The guidelines of which can be found in Appendix 4.4.

2 Developing our Knowledge of Resilience: The Experiences of Adults Seeking Asylum

2.1 Abstract

Asylum seekers undergo immense hardship involving a unique set of circumstances during the asylum application process, but we know very little about their experiences and how asylum seekers cope. This qualitative study used a Constructivist Grounded Theory method to explore asylum seekers' experiences during the asylum application process with a focus on factors affecting resilience. In-depth, semi-structured interviews were conducted with 10 adult asylum seekers accessing community services in the UK. Participants' length of time in the UK ranged from 1 month to over 10 years. The interviews were recorded and transcribed, and data analysed using inductive analysis and constant comparison strategies. The main categories were 'systemic harship', 'factors that inhibit coping', and 'factors that enhance coping'. Experiences of 'not being believed' and 'uncertainty for the future and safety' were linked with the asylum process and an insecure asylum status. Individual resources identified included understanding of trauma, its impact on wellbeing, and of coping strategies. Trauma and hardship could lead to fear, distrust of others, social isolation, and personal shrinkage whereas, access to community resources seemed to increase individual resources and lead to personal growth. Theory has important implications for policy, services, clinical practice, and research.

2.2 Keywords

Asylum seekers, resilience, coping, wellbeing, constructivist grounded theory

2.3 Introduction

The international community has recognised forced migration as a major issue affecting public health (World Health Organisation, 2017). Over the last two decades, the number of forcibly displaced people around the world has increased by 75% (UNHCR, 2016). The United Kingdom, as a member state of the United Nations, is one of 193 countries to have signed the Universal Declaration of Human Rights. Article 14 proclaims that "Everyone has the right to seek and to enjoy in other countries asylum from persecution" (United Nations General Assembly UNGA, 1948). Within the UK, an asylum seeker is defined as "someone who has formally applied for asylum and is waiting for a decision on their claim". According to the UNGA, anyone seeking protection is legally entitled to stay in that country whilst awaiting a decision.

2.3.1 Experiences of the asylum application system

There are very few peer-reviewed research studies investigating individuals' experiences of applying for asylum within host countries. The limited evidence base suggests that asylum seekers experience long-lasting periods of hardship (Mann & Fazil, 2006; Masocha & Simpson, 2011). These appear linked with their insecure asylum status, and a unique set of circumstances, which have been associated with experiences of exclusion and marginalisation (Hynes & Sales, 2009) and a lack of rights (Bloch, 2014). Within the UK, asylum seekers do not enjoy equal rights to citizens (Edwards, 2005). They are entitled to free emergency, primary and secondary healthcare but are not permitted to work, apart from in rare circumstances (Asylum Aid, 2017). Asylum seekers can apply for housing and receive an allowance which equates to around half that afforded to unemployed nationals. One study (Liebling, Burke, Goodman, & Zasada, 2014) reported that asylum seekers had negative experiences of the Home Office and another (Souter, 2011) criticised an asylum system for a perceived desire to refuse access within a 'culture of disbelief'.

2.3.2 Effects of asylum system on mental health

Although asylum seekers are very likely to have experienced multiple traumas within their home country and migration journey, it is often their experiences in the host nation that have a greater impact on their mental wellbeing (Mann & Fazil, 2006; Masocha & Simpson, 2011;

Siriwardhana, Ali, Roberts, & Stewart, 2014; Spicer, 2008). The uncertainty that the asylum system creates, including the threat of detention or rapid deportation back to the country from which individuals were forced to flee, can negatively affect mental health (Lawrence, 2004). This effect is thought to be worsened by governmental restrictions, including those on work, which enforce poverty (Burnett & Peel, 2001; Gerritsen et al., 2006). Mental health problems, linked with feelings of social isolation, make integration more difficult (Strijk, van Meijel, & Gamel, 2011). Asylum seekers often experience societal attitudes of racism and discrimination within host countries, putting them at increased risk of anxiety, depression and psychosis (Berg et al., 2011; Krieger, 2014).

Fazel, Wheeler, & Danesh (2005) suggested that refugees living in Western countries were around 10 times more likely to have PTSD than age-matched general populations within those countries. Despite often having complex mental health needs, asylum seekers frequently experience difficulties accessing healthcare in host countries (Schneider, Joos, & Bozorgmehr, 2015). However, although many asylum seekers experience mental health difficulties, many do not develop severe mental illness (Gerritsen et al., 2006). Mann & Fazil (2006) describe how some asylum seekers and refugees experience atrocities such as torture without developing any serious psychological difficulties, whereas others develop anxiety, depression, and feelings of shame and guilt. Asylum seekers' responses to trauma are varied and many individuals who have experienced multiple traumas do not develop symptoms of PTSD, anxiety and depression (Gerritsen et al., 2006).

2.3.3 Definition of resilience

The current study, with its focus on exploring resilience and the experiences of asylum seekers from diverse cultures and backgrounds, used a definition of resilience which emphasised its multidimensional nature. In a study of 1500 youths in 14 communities across 5 continents, which aimed to explore cross-cultural factors important to resilience, Ungar, (2006) defined resilience as:

> *'In the context of exposure to significant adversity, whether psychological, environmental, or both, resilience is both the capacity of individuals to navigate their way to health-sustaining resources, including opportunities to experience feelings of well-being, and a condition of the individual's family, community and culture to provide these health resources and experiences in culturally meaningful ways.'* p225

Ungar (2006) emphasised how, even when faced with similar adversities, there was great variation across cultures in how individuals coped. Resilience is described as a

multidimensional construct, the definition of which is *negotiated* between individuals and their communities. The focus on the role of community, cultural and contextual factors, goes beyond the typified understanding of resilience founded on Western-based research studies, which have focused on individual psychological factors. For instance, a systematic review (Siriwardhana et al., 2014) of resilience and mental health outcomes of conflict-driven adult forced migrants in 23 quantitative and qualitative studies, found only two studies which explored community resilience. The authors emphasised the need for further exploration of the construct of resilience with regards to displaced populations, especially affected by prolonged displacement.

2.3.4 Resilience in asylum seekers

Although there is a growing evidence base on resilience in forced migrant populations, including refugees and internally displaced persons, very few studies have investigated resilience in asylum seekers, who cope with a unique set of circumstances associated with their insecure asylum status. Understanding of resilience factors within this population is consequently limited.

Most research conducted with asylum seekers, has investigated mental illness, such as PTSD, anxiety and depression (Carlsson, Mortensen, & Kastrup, 2006; Kirmayer et al., 2011) in a minority of individuals with PTSD. The research base may therefore be limited as, by not exploring factors which help protect most individuals from developing severe mental illness, we potentially have a skewed understanding of factors affecting individuals' wellbeing. Furthermore, by focusing on mental health illness, the literature risks not acknowledging asylum seekers' resilience factors which have helped individuals to manage immense hardships. Such knowledge can be useful in supporting others who are experiencing hardship, to maintain their wellbeing. Most studies investigating resilience have used quantitative methodologies to test *a priori* assumptions. This can be problematic in under-researched areas such as the experiences of asylum seekers, since testing a limited range of relevant variables risks oversimplifying experiences of complex phenomena.

A systematic review (Siriwardhana et al., 2014) of resilience in forcibly displaced adult migrants, including but not limited to asylum seekers, reported that high quality social and family support was shown to be associated with increased resilience and lower psychological problems. Other factors affecting resilience which were reported included individual qualities, available social support, coping strategies, religious belief systems, and culture. These findings, in line with Ungar's (2006) construct of resilience, include community, individual, contextual and cultural factors. Other studies which investigated

resilience in refugees and asylum seekers emphasised the importance of context and community factors. Rees (2003), who conducted a qualitative study with East Timorese women living in Australia, described insecurity of tenure and living with the fear of forced removal, as dangerously compromising wellbeing. English language skills, social isolation, physical illness, access to health services, and post-secondary education were also reported as affecting well-being.

A qualitative study (Sherwood & Liebling-Kalifani, 2012) also emphasised the importance of community, cultural and contextual factors as authors emphasised the importance of community, support and treatment, in assisting African women refugees living in the UK, to utilise their resilience and reconstruct their identities. The role of individual psychological factors and cultural factors was also described, with positive thinking, positive self talk, hope and problem solving, as well as spiritual beliefs, positively affecting resilience and wellbeing. The role of individual factors, as well as contextual factors such as the ability to work and study, were emphasised by Lavie-Ajayi & Slonim-Nevo (2016) who interviewed asylum seekers from Darfur, living in Israel. They identified cognitive and behavioural coping strategies as important individual factors but also emphasised the importance of community factors such as the support of family and friends. The authors also described values-based action as important, such as social and political activism.

The present study aimed to contribute to the knowledge base on resilience by exploring the experiences of asylum seekers with a focus on resilience. To the author's knowledge, this was the first study to explore asylum seeker experiences with a focus on resilience during the asylum application process. The study aimed to provide insight into how asylum seekers manage hardship during periods of uncertainty, which may be used to inform the support of individuals. Implications for policy and research were also discussed.

2.3.5 Study aims

By investigating asylum seekers' experiences with a focus on resilience, the current study aimed to build on the existing evidence of resilience and factors affecting wellbeing.

2.4 Methodology

2.4.1 Constructivist grounded theory

Qualitative methodologies allow for investigation of experience through inductive processes which explore meaning. Grounded theory as a methodology allows for the investigation of

experience through systematic processes that are immersive and iterative. Constructivist grounded theory emphasises the subjective inter-relationship between the researcher and participant and the construction of meaning (Mills, Bonner, & Francis, 2006). The researcher, as author and co-constructer, questions and searches for tacit meanings about values, beliefs, and ideologies. The researcher is considered to have an ethical obligation to describe the experiences of participants in the most faithful way possible (Mills et al., 2006). By investigating multiple participant perspectives, it is possible to gain a deeper understanding of the asylum seeker experience and resilience factors affecting coping. The theory that emerges from using a constructivist grounded theory methodology offers the researcher's interpretation of experiences, rather than a complete theory (Charmaz, 2006).

2.4.2 Position of the Researcher

The researcher positions himself as a 30 year old, white, British, male who is undertaking doctoral training in clinical psychology. He was brought up in secure circumstances by liberal parents. He attended Christian-faith schools and although he does not believe in a God, recognises the value of religion and faith. He formed interests in cross-cultural learning through voluntary experiences within the UK and overseas. Professionally, he has worked in the third sector in roles involving engaging young people with global issues. Following academic study (BSc Psychology), he has worked within mental health services. Whilst conducting this study, he has worked within a community mental health team which supports adults with mental health difficulties, often consequential of traumatic experiences. He is politically left-wing and values human rights, equality, and social justice. Epistemologically, he identifies with the 'social constructionist' viewpoint on truth and reality and assumes a relativist ontological position, whilst recognising the value of pragmatic approaches within mental health research and clinical contexts. These factors will have influenced the researcher's interpretation of data and construction of theory within this study. As theory has been constructed through the lens of the researcher, and developed with the support of others involved in the study, readers should consider constructed theory in relation to the researcher's background, views, and values. For instance, the researcher believes that asylum systems must prioritise treating individuals with dignity and respect, and provide services which enhance wellbeing, support the rebuilding of lives, and avoid further traumatisation.

2.4.3 Ensuring quality

This study followed Elliott and colleagues' (1999) guidelines for reviewing qualitative research studies in psychology. Seven criteria for qualitative studies are detailed with descriptions of how this study addressed each action in Table 2.1.

Table 2.1. Guidelines for reviewing qualitative studies (Elliott et al., 1999) and description detailing how this study has addressed them

1. Owning one's perspective	By providing a summary of the author's own position, background, and views (Position of the researcher, Methodology section)
2. Situating the sample	By providing details of anonymous demographic information and considering the context, circumstances, background, and views of participants in data analysis (Design, Methodology section)
3. Grounding in examples	In the results section, categories developed from the data are illustrated by quotations from the interviews with participants
4. Providing credibility checks	By checking the understandings with participants, discussing constructed categories with the research supervisor, placement supervisor and other trainee (Triangulation, Methodology section)
5. Coherence	Findings were conceptualised narratively and diagrammatically in the results section
6. Accomplishing general vs specific research tasks	The findings from this study are not considered to be generalisable to any other group as findings are specific to this study's group of participants.
7. Resonating with readers	Material is presented with the aim of being representative of participants' experiences. Drafts were scrutinised by the research supervisor and feedback on readability was provided. Ideas were checked with staff at the third sector organisations.

2.4.4 Design

This qualitative study was guided by the principles of Constructivist Grounded Theory (Charmaz, 2014). Semi-structured interviews were conducted with ten adults seeking asylum in south Wales. Participants were recruited from two third sector organisations supporting asylum seekers to integrate within their communities. Participants were invited to interview by the researcher or representative of these organisations. To be involved in the study, participants were required to meet inclusion criteria:

- To be an adult defined as 18 years or older;
- To be seeking asylum in the UK at point of interview;
- To be receiving support from third sector organisation at time of recruitment;

- To have capacity to understand information provided about the study and
- Consent to taking part.

Organisation representatives were aware of the inclusion criteria and had a copy of the English and Arabic information sheets (Appendix 4.5). Potential participants were given a copy of the information sheet and were given time to consider before agreeing to involvement.

At interview, participants were read the information sheet and given opportunities to ask questions in line with British Psychological Society (BPS) guidelines for obtaining informed consent (British Psychological Society, 2014). If still willing and eligible to take part, participants initialled and signed a consent form (Appendix 4.6) and provided basic demographic information (Demographics Datasheet – Appendix 4.7). The demographic information is presented in Table 2.2. Using the interview schedule (Appendix 4.8) participants were encouraged to discuss their experiences since arriving in the UK and respond to questions relating to resilience and coping. The interview schedule evolved to include more focused questions on experiences, resilience and coping following data analysis of prior interviews, allowing for the development of ideas around categories. Interviews were recorded using an MP3 recording device, and then transcribed. All interviews were conducted in English. No interpreters were used.

Table 2.2. Characteristics of Sample

Interview	Age range	Gender	Time in UK	Area of origin	Reason for asylum
1	18-30	Female	1-5 years	Eastern Europe	Family
2	18-30	Male	6-10 years	Central Asia	Political
3	41-65	Male	10+ years	Southern Africa	Political
4	18-30	Male	1-5 years	Eastern Africa	Political
5	31-40	Male	1-5 years	Eastern Africa	Political
6	18-30	Male	1-5 years	Western Asia	Political
7	31-40	Male	6-10 years	Western Africa	Sexuality
8	18-30	Male	0-1 year	Central Asia	Religion
9	41-65	Female	10+ years	Eastern Africa	Family
10	31-40	Male	1-5 years	Northern Africa	Religion

2.4.5 Data analysis

Immediately following interviews, the researcher collected written reflections on his impressions of the interview. Transcriptions were then analysed within a week of the

interview using systematic analytical processes outlined in constructivist grounded theory (Charmaz, 2006, 2014). Processes involved initial coding of data on a line-by-line basis, focused coding, and categorisation (example in Appendix 4.9). Memo-writing followed each interview to develop ideas around initial codes and categories. Initial categories that emerged were illustrated by quotations from the data, in accordance with the guidelines (Elliott et al., 1999). Constant comparison involved comparisons of data with data, and categories with categories, was used to develop deeper understandings of experiences. Initial and focused coding of the first three interviews were re-coded.

2.4.6 Triangulation

Through a process of triangulation, constructed a theory was developed and amended. Diagrammatic versions of the emerging theory were shown to people involved in the research process (four participants, three organisation representatives, research and placement supervisors and another trainee) and discussed along with key ideas. When asking for feedback, questions focused on how well the theory seemed to fit with personal experiences, the relevance of categories, and coherence. Changes were made to the diagram in consideration of feedback received (see Appendix 4.14 for development of the diagrammatic constructed theory). Versions 4 to 7 were independently discussed with four research participants. The penultimate version was discussed with the research supervisor and used to form ideas which led to the final diagrammatic version and narrative account of theory as presented in the results section. The narrative account was developed using feedback from the research supervisor.

2.4.7 Clinical Governance

Cardiff University's Research and Development department sponsored this study. Ethical approval was granted by Cardiff University School of Psychology Ethics Committee (Appendices 4.10 & 4.11).

2.4.8 Confidentiality

Procedures were implemented to ensure the confidentiality of all participants throughout the process including use of anonymisation and confidentiality agreements (Appendix 4.12). This was an extremely important area for participants and care was taken to ensure participants understood confidentiality procedures, including limitations. The researcher followed practices in accordance with principles of BPS Human Research Ethics (British Psychological Society, 2014), BPS Code of Ethics and Conduct (British Psychological Society, 2009) and the Data Protection Act (Great Britain, 1998).

2.4.9 Ensuring participant welfare

The researcher and research supervisor met with third sector organisation representatives early in the study process to discuss the sensitive nature of the study focus and potential for harm of participants. A risk management strategy was developed to safeguard people involved in the study. Participants were informed that they could decline to answer any question or stop the interview at any point to take a break or cease involvement. Following the interview, participants were given a debrief sheet (Appendix 4.13) with information on how to contact the researcher, supervisor, or Research Ethics Committee regarding distress, concerns, complaints or requests for further information.

2.5 Results

The analysis in this study yielded four key categories and ten core categories. The constructivist grounded theory is presented diagrammatically (Figure 2.1) and narratively. Within the diagram and narrative, key categories are underlined, ***core categories*** are in bold and italic lettering. Subcategories are included within the diagram in normal lettering, and are discussed in the narrative.

2.5.1 Summary of the constructivist grounded theory

The theory relates to the experiences and perspectives of participants within this study, as interpreted by the author and co-constructed with participants and others involved in the study. The constructivist theory is applicable to asylum seekers within this study who were receiving support from within the community through a third sector organisation. The grounded theory relates to experiences and factors affecting resilience and wellbeing. The first category sets the context for participants as experiences of ‘not being believed’, ‘uncertainty for the future and safety’ and environmental factors permeate through the asylum journey. The second and third categories describe factors that affect coping and wellbeing with factors that inhibit coping grouped separately from those that enhance coping.

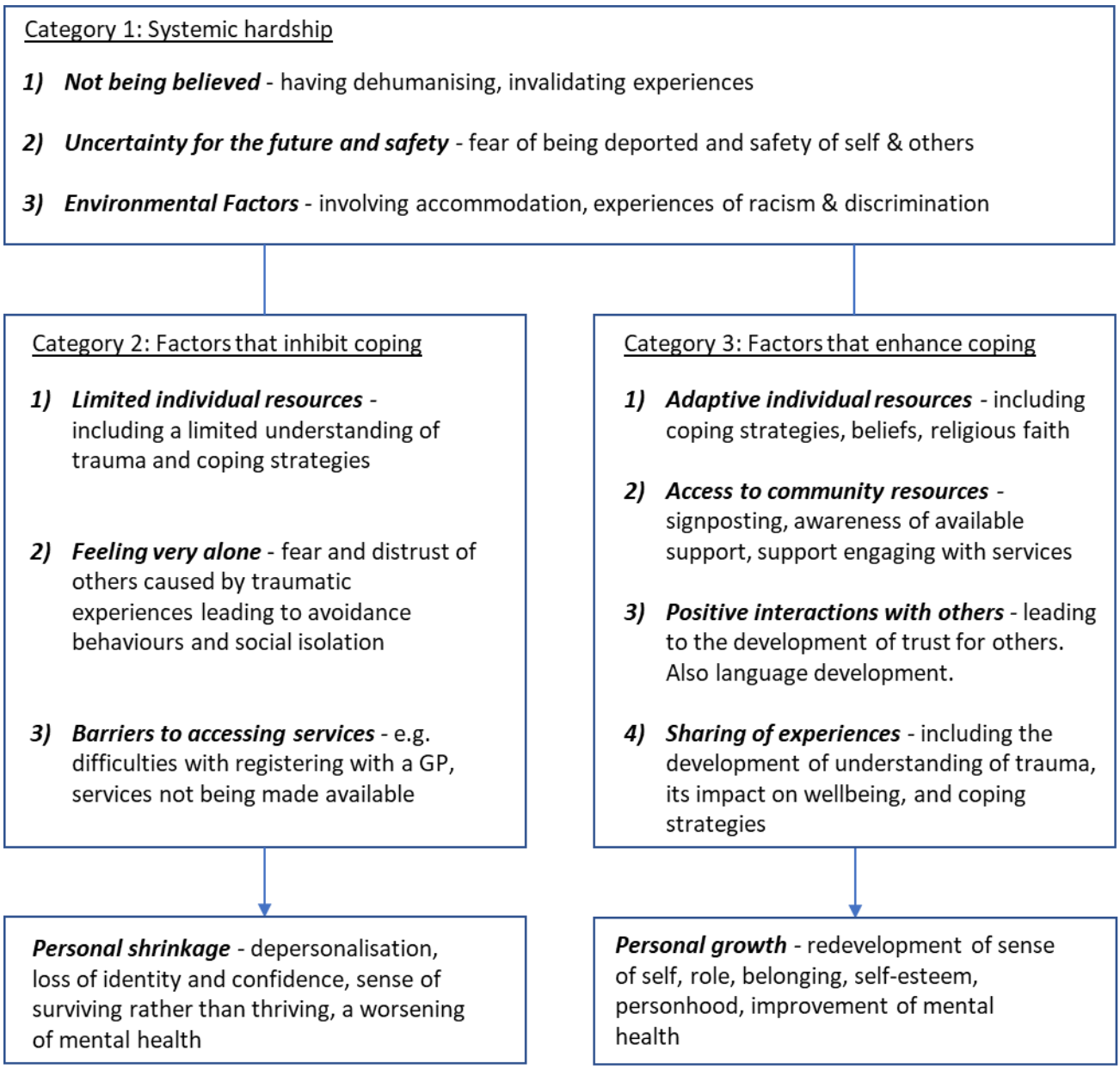

Figure 2.1. Diagram of the Constructivist Grounded Theory.

Key Category 1: 'Systemic hardship'

Participants described the asylum application process as a very difficult journey involving hardship and suffering. Feelings of fear and anxiety were linked with uncertainty about their future and their safety. Participants explained that these feelings persisted throughout the asylum journey because the uncertainties around their future and safety are linked with their insecure asylum status. Throughout the interviews, participants shared adverse experiences which emphasised the difficult and relentless nature of the asylum journey. As well as the ongoing circumstantial pressures, participants described single and multiple distressing

systemic events including incidents of racism and discrimination, episodes of destitution, and periods of time spent within detention centres.

> "*It has been a journey of suffering, suffering, suffering, suffering. So I have this hope that it will end and I will be OK*." (Participant 1)

Here, the participant emphasises the suffering they felt. This quotation formed part of the first interview I heard, in response to my opening question asking participants to describe their experience since arriving in the UK. Their hope for the future strikes me as undramatic and low key, it is simply for the suffering to end, and to be OK.

Core category: 'Not being believed'

Participants explicitly labelled the most difficult part of applying for asylum as the experience of not being believed. They reported that incidents occurred within the asylum application process during asylum interviews and afterwards, when they were denied refugee status. Whilst some participants did describe positive experiences of asylum interviews, others found it very difficult and talked about being forced to share their experiences. My impression was that people were describing not being ready to share details of previous traumatic events which they had endured in their home country and migration, and that the process of having to talk about them was retraumatising. This notion was confirmed by participants who were visibly upset when recounting their memories of the interviews. For some participants, the most difficult part was not the asylum interview itself, but the refusal of their claim which often came after extensive periods of waiting:

> "*I don't believe this. I lost everything. I lost my country. But one thing, I'm not safe because of this one thing and he's done everything for me apart from this one thing of believing me. Why doesn't he believe me?*" (Participant 4)

> *"I wasn't sure if I was going to be able to live because I was refused. I leave my country because the government will get all of my family and group together and kill them so I don't care for my life. If I live here no problem. But the UK government says to me refuses me and I am confused. I am scared because I am refused and I'm not safe…I think too much after that. Maybe I'm crazy?...if you think too much it's bad for your mental health. I'm not safe*." (Participant 4)

The above extracts come from one interview and illustrate why not being believed is experienced as being so difficult by the participant. The participant's current state of affairs is situated within the context of their history and the sense of loss which was felt from having to leave their home. It seemed to me, that the participant had been through so much to attain safety for his loved ones and yet because he was possibly not believed by the authorities, who have the power to grant refugee status, then he cannot feel safe because his status remains insecure.

Previous literature has emphasised how insecure asylum status and the perceived threat of deportation can negatively affect mental health. Deportation, or the threat of deportation, may be perceived by participants as posing a severe threat to their safety and to the safety of loved ones, as described by participant four. He explained that he would be returned to the country from which he had had to leave. With regards to his situation, I perceived him to experience a sense of desperation but also hopelessness, as well as underlying feelings of disbelief and confusion. The last part of the quotation illustrates the potential detrimental effect of being refused refugee status on his wellbeing, as he makes a link between "thinking too much" and his state of mind, and he considers, "*Maybe I'm crazy?".*

The first core category is linked with the second core category as not being believed increases feelings of uncertainty for the future, and of not feeling safe.

Core category: 'Uncertainty for the future and safety'

The second category describes a prevailing feeling of uncertainty which appeared to affect all participants, regardless of their stage in their asylum journey. One individual described dehumanising experiences of being arrested and detained in a detention centre. Whilst sharing their experiences they became visibly upset and angry with the way that they had been treated. During this period, they described how uncertainty about the future affected them:

> *"…all you are thinking about is what is going to come next? Where am I heading? Because I knew they're not going to take me back. And I thought I'm going to die before they take me. Because I didn't expect anything good. Me myself I was just so scared. I didn't see any way out." (Participant 9)*

This description emphasises their feelings of fear and concern for their safety and life, and provides an example of a traumatic experience caused by not being in control of their situation. Where the participant mentions dying before being taken back, this refers to the suicidal ideation which they experienced at the time, linked with very low mood and a desperation not to be deported. This individual explained how prior to applying for asylum, they had never been involved with the police. They perceived being detained as being imprisoned. For them, this experience was immensely humiliating, and led to a deterioration in mood that could have had catastrophic implications. Linking back to the first category of not being believed, they also described how their treatment within the detention centre affected them:

> "*They treat us like mad people. Anything you are telling them, they don't believe you. They are saying "You are lying, you are lying". They don't look at what you are going through. They don't recognise what is happening to you. They don't believe that your mind is gone. They take it for granted that you are lying, but internally you are bleeding. You are bleeding, you are bleeding. Your mind is gone, is gone, is going, is going. It is the same thing today. Nothing has ever changed.*" (Participant 9)

Through this powerful description of their experience, they portray a part of the asylum system which appears non-compassionate, unempathetic and sceptical of asylum seekers. I was drawn to the detrimental impact of the invalidating experience on their mental wellbeing. Although the description is of a past event, the lack of change they describe appears to emphasise how the suffering persisted over time. The extent of suffering which participants described seem to be influenced by contextual and cultural factors, as well individual and community factors. The next category explores some of these factors, which appeared to affect how participants coped with the asylum journey.

Core Category: 'Environmental factors'

Environmental factors affecting resilience, as described by participants and borne from data analysis, were accommodation and societal experiences involving racism and discrimination. One participant who did not have accommodation and was currently destitute described how being homeless had affected his wellbeing:

> *"I don't know where to sleep, except churches and where I used to sleep, there are many junkies, people smoking heroin, smoking cocaine. Your life is not safe in the*

night…you are always scared of what's going to happen next…Some of them accused me of snoring so they put me somewhere else to sleep. They called me names. Nigger, monkey. It's been very rough. Very hard." (Participant 7)

His description succinctly summarises the threatening nature of experiences and emphasises social isolation and rejection by others. The participant had sought asylum in the UK following persecution because of his sexual orientation. He had experienced difficulties with not being accepted within communities in his home country. The abuse he experiences, when understood within the context of his asylum journey, has the potential to be especially damaging. He described how the racism and discrimination he experienced negatively affected his wellbeing, and talked about feeling bad about himself, indicating how feelings of shame and humiliation preceded a process of depersonalisation.

Another participant who was currently living in a house with three other asylum seekers, described his experiences of being destitute on two separate occasions, each lasting of between three to five months. He described how, during these periods, he experienced incidents of racist abuse, physical assault, and possessions being stolen. The participant described how having accommodation helped him, such as by increasing his confidence:

"I like to have a place to stay. I don't like to look bad or nasty. I don't want people to think of me like crazy person. When I take a shower and have nice clothes I get confidence." (Participant 2)

During the interview, the participant described mental health difficulties which had affected his asylum journey. He described common difficulties which people experience following adverse events, including flashbacks, panic attacks, difficulties sleeping, and difficulties regulating their emotions. This description demonstrates his concern that other people would perceive him as "a crazy person". Accommodation, as well as providing a sense of safety, also provided him with the means to maintain his hygiene/appearance and to present himself favourably to others. This was described as positively affecting his confidence and his interactions with others.

<u>Key Category 2: 'Factors that inhibit coping'</u>

The interview schedule in this study focused on factors affecting resilience and evolved to include more focused questions to explore how individuals coped. Participants described

how they felt they were coping and discussed their views on factors which they thought had affected their coping. The data analysis yielded 'factors that inhibit coping' as a key category involving three core categories, 'limited individual resources', 'feeling very alone' and 'barriers to accessing services' which appeared to lead to 'personal shrinkage'. The categories incorporate participants' experiences following and during times of trauma and hardship including fear and distrust of others, social isolation, difficulties forming interpersonal relationships and the effects of these difficulties on their sense of identity, self-esteem and wellbeing. Other factors unique to asylum seekers are also incorporated, such as restrictions on work and movement which inhibit having a role and reduce participants' sense of purpose.

Core Category: 'Limited individual resources'

When individuals appeared to have less insight into trauma and impact on mental health, and of coping strategies that could be used to manage difficulties, they seemed less likely to cope. Use of drugs and alcohol was described when distress was particularly pronounced, such as to control anxiety and depression.

> *"Sometimes I smoke weed usually to kill depression sometimes, but he just fights around and will just come back another day."* (Participant 7)

> *"I started drinking to cope with that problem and with my feelings at the time. That wasn't helpful. I was just damaging myself."* (Participant 3)

Whilst some participants recounted experiences of coping with hardship before applying for asylum, which seemed to help with self-belief in their own abilities, this was less apparent in others. One participant described,

> *"I didn't have the chance to be strong, that's the problem I think. People who are going through the same things as me, I tend to worry too much about things…Some people were independent but I'm not like this. I was always kept at home and looked after by my parents."* (Participant 2)

This participant described experiencing severe difficulties with his mental health. During the interview he compared himself to others whom he perceived as stronger because they were coping where he felt he was not. However, although he highlights factors that may have

affected his ability to cope, it seemed to me that a limited understanding about trauma, common mental health difficulties that follow traumatic experiences and coping strategies that could help manage these difficulties was limiting his resilience.

Core Category 2: 'Feeling very alone'

Participants described long periods of time when they felt very alone during their asylum journey. Feelings of loneliness seemed to be linked with a sense of loss and social isolation, having been dispersed to a new community without knowing anyone.

> *"The first time I was just crying the first three four months. I was crying. I just felt lost. I don't know where I am... I didn't have a family."* (Participant 1)

Mental health difficulties which were often described included depression, anxiety, and suicidal ideation as well as descriptions of common difficulties following trauma. These trauma effects, as the author understood them, included interpersonal difficulties with experiences of being fearful of others and the consequences of interacting, and finding it difficult to trust others, which appeared to lead to avoidance behaviours and may have reinforced social isolation. Fear of others seemed to be linked with uncertainty about their own future and safety, and difficulties knowing whom they could trust.

> *"If you go out on the street, and see someone which you don't know, they ask you a personal question, you feel panic because you never know what can happen"* (Participant 1)

> *"I would meet new people and then I would talk with them. But I hated for people to ask about my life, and I never opened up to people because I don't trust. Because I don't know where my life is going to head, who am I talking to?...So it is so bad that you don't even trust anybody. Not until you are free…that's when you can trust. That's when you can talk to other people."* (Participant 9)

The last sentence of this quotation helps us to understand their difficulties within the context of applying for asylum. As the first category illustrated, uncertainty for the future is linked with the real possibility of deportation and fear about safety for the self and loved ones. Difficulties trusting others therefore appear to serve as a useful adaptive strategy which can help participants to keep themselves safe. However, avoidance of others also presented a

challenge to maintaining wellbeing. Not trusting others also created difficulties for participants with their asylum claims. One participant described their experience of not trusting Home Office staff during their asylum interview. He explained that he did not disclose all of the information that he was asked for, but subsequently did in a later interview. He explained that this inconsistency of information was later used by the Home Office as a reason to deny him refugee status.

> *"Before, my life is dangerous and Home Office tells me that I don't tell them everything but I don't tell them everything because I don't know who they are…In my country I am not safe so I don't believe anyone. I can't trust people because of the government."* (Participant 4)

He helps us to understand his decision to hold back information by describing the situation in his home country. He explained that authority figures cannot be trusted, having previously explained about the threat posed to himself and his family by the government. Within the context of participants' past circumstances, it is understandable why sharing information with others might be experienced as very threatening.

Core Category: 'Barriers to accessing services'

Participants described barriers to accessing community resources. Difficulties included a lack of knowledge about available support, support being limited or hard to access, not speaking English, difficulties with wellbeing, and being afraid of others. Four participants described difficulties with accessing support for mental health difficulties with one individual reporting that he was informed that there was no service that could support them:

> *"I talk to a doctor and say me I need help because of what I feel, I tell him how do you change this? I need it. Because I'm hurt because I've seen many things. I need someone to say you do like this. He said there's nobody like that."* (Participant 4)

This participant recognised their need for support but described being misinformed and told that there was no one who could support them. It is possible that the individual could have been denied services to which he was entitled, as another participant described a similar experience:

> *"So, I was mentally disturbed, it's affected my life so much because I spent so many hours without getting access to medical services. When I tried to register myself they refuse me. They wanted my passport which I didn't have that time with me."*
> (Participant 9)

These descriptions, suggest to me that participants found it difficult to access support for mental health difficulties. In the second description, the participant focuses on being refused, and perhaps an associated feeling of rejection. These interactions seem to reflect the larger picture and may be symbolic of participants' ongoing struggle to seek refugee status, involving being refused and needing to reapply. Or, at a more focused level, these experiences could demonstrate examples of misinformed staff or even institutional discrimination, examples of which have been emphasised within the literature (Krieger, 2014) as affecting marginalised communities. Difficulties with accessing support when participants described their perception that they needed it, fits within the wider context of hardship which participants described.

Core Category: 'Personal shrinkage'

Personal shrinkage is a term that has been coined in this study to describe a collection of experiences of participants that includes a loss of self-identity and confidence, depersonalisation, a sense of surviving rather than thriving, and a worsening of mental health. Asylum seekers described a sense of loss having been separated from their friends and family.

When considering the variation in values between societies, with independent cultures favouring values linked with autonomy and independence, and interdependent cultures promoting loyalty and a sense of belonging, it is easier to understand consequences of social isolation on participants' possible loss of identity. Losing the group, may translate into losing a part of the participant's personal identity. Difficulties with trusting others appeared to limit their interactions as participants described avoiding others, infringing upon their ability to form relationships, and seeming to reduce their confidence and sense of identity. Interviewees described losing respect for themselves as they became reliant on others to survive:

> *"I had to flee my country. You see? from a qualified teacher to nothing…I don't want to be in this situation forever. I want to give to the community. I want to do something*

positive, to help people. I want to be in a position where I could help as well, not getting help from people…These things as an asylum seeker makes you think who are you?" (Participant 3)

Restrictions placed upon participants, such as not having the right to work, not being able to travel freely, and living in poverty, seemed to affect individuals' sense of purpose and self-worth, and also seemed to make it more difficult for individuals to live in accordance with their values, or to fulfil their goals. Some interviewees described having to play the system. Descriptions of experiences involving interactions with asylum systems, gave a sense of participants having to take action to survive rather than to thrive:

"*But they force you to lie, they give me no option and I hate it…what was I meant to do? And this makes me more upset. You don't want to do something but you have no choice*." (Participant 2)

Behaving out of line with one's values, as this snippet illustrates, appeared to further reduce participants' sense of self-worth, as they described feelings linked with losing respect for themselves. To me, it felt like these types of interactions, which were described by many participants, emphasised the power imbalances which participants seemed regularly to encounter. It felt, where individuals were not given any choice but had to abide by the rules of a system, policy, or procedure, like the equivalence of forcing someone into a box, or a corner, perhaps because of a potential power imbalance and lack of choice. It seemed as though the context of applying for asylum served to further reduce participants' sense of identity. Difficulties experienced by participants, including social isolation and personal shrinkage, appeared to detrimentally affect interviewees' coping and wellbeing:

"*I won't say I'm coping, I'm going through it*." (Participant 10)

"I'm struggling with life right now, I'm struggling with life. I'm not happy and I'm not feeling well...I am just managing with life" (Participant 7)

Whilst participants described experiencing hardship throughout their asylum journey, participants also described contrary experiences through which they developed and grew.

<u>Key Category 3: Factors that enhance coping</u>

The third key category describes factors that enhance coping with a focus on individual resources, community resources and the associated benefits.

Core Category: '*Adaptive individual resources'*

Overall, it seemed that individuals who had some understanding of how their experiences affected their wellbeing, were more likely to use more adaptive forms of coping strategies to manage. Individuals' resources which emerged as important were wide-ranging and included coping strategies, previous experiences, personal beliefs, and religious faith. Coping strategies which appeared to be most relied upon by participants were methods to avoid thinking worrying thoughts linked with uncertainty for their future and safety, loss and adverse events.

> "*If I think worrying thoughts then I can distract myself with other activities because I want to keep myself busy so that I can keep from thinking about bad things."* (Participant 4)

Strategies included keeping oneself busy, giving self-reassurance, and use of prayer. Although some participants described having difficult feelings towards religion, religious faith emerged as a particularly powerful strategy for several participants and was described as giving them strength during difficult times.

> *"I said I want to know why you are arresting me. I said you know what, I don't care, I don't fear you, the only person I think that is God. Because he is the one who is holding my life."* (Participant 9)

The last example demonstrates how having a belief system helped the individual to take control of a situation in which they appeared to be powerless and helped them to feel less isolated in a threatening situation.

Another individual who had described himself as not having any psychological difficulties, other than thinking about deportation, explained how his prior reading had helped him to cope:

> *"I read some psychological books. If you face any problem, if you share with people, if you talk with people, it reduces, if you don't speak to any people you put it in your*

brain as harm. Even if you don't talk with other people, but keep yourself entertained, it's better. If you are entertained, you do speak again and it's good." (Participant 5)

This participant demonstrates his understanding of how to maintain wellbeing and describes coping strategies which he uses. He appears to prioritise talking with others and sharing experiences, but recognises that not everybody finds this easy. Although he himself described difficulties trusting others, he recognised the value of engaging in activities, and trying to engage with others.

Core Category: 'Access to community resources'

Experiences described by participants suggests that access to community resources grew over time, but varied between individuals. As participants' access to support systems increased, their interactions with others appeared to help them to overcome their fear of others as they learned who, to some extent, could be trusted. Through sharing their experiences with others, they achieved a sense of belonging which appeared to reduce some of the effects of personal shrinkage, with positive effects for their wellbeing.

Core Categories: 'Positive interactions with others' and 'sharing of experiences'

Interviewees described positive experiences through engaging with third sector organisations, faith groups and support groups, which helped them to build their trust for others:

"*Just even to come out of your house and find someone giving you a hug, just loving you, it is really important because you are on your own*." (Participant 9)

"*These groups help in a way because you meet different people, different cases. A few of them you might access to share your life with them…You get that togetherness. You get that hope to say we are many, we are receiving help, we are learning, it's all about that. You are not alone*." (Participant 9)

These descriptions help to demonstrate how positive interactions with others can lead to a sharing of experiences and a sense of belonging being developed. For individuals who have lost contact with their own family and friends, staff at organisations can play an important

role in providing a sense of belonging. Positive interactions appeared to help people to cope with the uncertainty of their situation, and the stress that comes with the asylum application process as one participant described:

> "*People like [staff member] they help a lot. They are just like my family around here. When they see me they are happy, they start laughing. Alright, if I am angry then I end up smiling just like*." (Participant 3)

Increasing access to community resources through the development of relationships with others appeared to increase participants' opportunities for developing understanding about their wellbeing, trauma effects, and of coping strategies to help manage difficulties.

Some participants described how community resources helped them to develop new and existing methods for coping with problems. Through sharing their experiences with others and learning about others' stories, including those of other asylum seekers, participants reported learning about common difficulties that other people were facing. This sharing of experiences appeared to help normalise their problems within the context of their current situation, and past and ongoing adverse events. This learning and development of resilience had a positive impact on participants' wellbeing:

> "*They teach us how to cope with our problems, they teach us how to cope and how to be so free, they teach us how to be strong, to be free with others*." (Participant 9)

> "*I have been learning that I shouldn't be negative all the time. Because the more I take things to be negative, the more it will be negative. So I have been learning to make myself think positive. To treat myself positive, so it has helped me…It is a journey. I have learned a lot."* (Participant 9)

Opportunities to learn English also seemed important for three of the participants, and may have affected coping. Participants described how learning English made it easier to interact with others and appeared to me that this may have opened doors to community resources, potentially with positive effects for wellbeing. One participant described how an English course helped her:

> "*the course makes me better, to feel better, and makes me do things, and I am starting to live*." (Participant 1)

Experiences such as these, may provide opportunities for positive interactions with others as well as the benefits of being able to communicate with others. Perhaps the course provided a sense of togetherness which might not have been gained if the course had not been available. To me it seemed that opportunities to access community resources opened doors to having positive interactions with others and potentially helped to develop participants' confidence and identity. Such experiences might therefore help people to grow, reducing some of the effects of personal shrinkage.

Core Category: 'Personal growth'

Participants described how these relationships helped them to rebuild their confidence and self-esteem as they learned about common difficulties experienced by others and their experiences were listened to and understood by others. This may have helped participants to feel better about themselves, such as by reducing possible feelings of shame and humiliation linked to traumatic experiences, and experiences of struggling to manage mental health problems.

These relationships, which also appeared to stimulate a sense of belonging, may have helped participants to regain their identity. Participants described changes in their self-esteem and behaviours which appeared to lead them to take action in line with their personal values. Such actions may have helped participants to develop a sense of purpose, even though for many, restrictions placed upon them might have made it more difficult to achieve their goals. Actions included volunteering, political action and supporting others. The following quotation provides an example of how one participant's learning helped them to grow:

> *"…because of what I have gone through I am very strong, I am becoming stronger, I have learnt a lot. Now I know how to deal with people, I have learnt how to deal with situations. It's not easy like people think and that's why I want to help. I want to give back…I want to put on the table what I have learnt."* (Participant 9)

This participant, who in her description shows how she had developed and grown, shared many difficult experiences during the interview, involving immense suffering and hardship. She provides a positive reframing of her struggles with hardship during her asylum journey, by focusing on how her experiences helped her to learn and become "strong". This example demonstrates how personal growth can occur during the asylum seeker experience.

However, this did not come across as a quick process, but instead took a long time to develop. It appeared that personal growth was dependent upon the community resources which were available to participants. The same participant explained her experience of accessing community resources, and building resilience through others:

> *"It hasn't been all that easy because I did not know straight away that if you go there you get help, it took years, to have access to some organisations. I did not know that you can go and receive counselling. Like it has been a journey, through other people."* (Participant 9)

2.5.2 Summary of results

Participants described experiencing the asylum application process as a very difficult journey. Difficult experiences which shaped their journey involved not being believed and uncertainty for their future and safety. Environmental factors which appeared to negatively affect coping included destitution and experiences of racism and discrimination. Individual resources which seemed to enhance coping included having some understanding of trauma and mental health difficulties, and coping strategies to help manage difficulties.

Experiences of hardship described by participants involved feeling very alone which may contribute to personal shrinkage. Social isolation, a fear of others, and difficulty trusting others may be linked with past experiences and with current circumstances relating to an insecure asylum status. Participants described perceiving being denied refugee status, and deportation, as threatening. This appeared to make it more difficult to form relationships with others. This may contribute to a sense of depersonalisation through a loss of confidence and identity, which seemed likely to reduce wellbeing. These effects could be reduced by having access to community resources.

Through positive interactions and sharing experiences with others, participants described developing trust and a sense of belonging. These experiences seemed to help participants to develop their understanding of wellbeing and to develop their coping strategies for managing difficulties. Over time, some participants described personal growth through the development of their confidence and identity which appeared to lead to taking action in line with their values. Developments in resilience and personal growth seemed to positively affect their wellbeing.

2.6 Discussion

This study explored the experiences of asylum seekers with a focus on resilience and factors affecting wellbeing. This qualitative study used a Constructivist Grounded Theory approach (Charmaz, 2006, 2014) to analyse data from semi-structured interviews with 10 adult asylum seekers in the UK.

2.6.1 Experiences of the asylum journey

The first category focused on the systemic hardship of asylum seekers' experiences during the application process and supported previous literature detailing this as an extremely stressful period (Masocha & Simpson, 2011; Spicer, 2008). The core categories 'not being believed', 'uncertainty for the future and safety' and 'environmental factors' set the context for participants' experiences. These findings resonate with previous research which emphasised the importance of safety (Goodman, Burke, Liebling, & Zasada, 2015; Liebling et al., 2014) and fear and trauma linked with uncertainty of asylum status (Rees, 2003). Participants described experiences of hardship including social isolation and feelings of loneliness. These were perceived by the researcher as being affected by a fear of others, difficulty with trusting others, and avoidance of others. Previous literature also emphasised psychological difficulties caused by social isolation (Rees, 2003). Participants linked their difficulty with trusting others with past experiences and their asylum circumstances involving the perceived threat of deportation and associated uncertainty about their future and safety.

2.6.2 Personal shrinkage

Personal shrinkage was a term which was coined within this study to describe participants' experiences of depersonalisation, with theory linking a loss of confidence and identity, and a sense of surviving rather than thriving, with an associated negative impact on their wellbeing. Personal shrinkage appeared to follow social isolation. The effects of personal shrinkage seemed to be reduced with improved access to community resources.

2.6.3 Factors affecting resilience

The theory appears to support Ungar's (2006) definition of resilience which includes the notion of resilience as a multidimensional construct. The definition, which includes "individuals' capacity to navigate their way to health-sustaining resources", emphasises context and individuals' environment with its role in providing "health sustaining", or community resources.

Contextual factors which appeared to affect resilience seemed to be related to participants' insecure asylum status with uncertainty for their future, and safety. These factors are similar to those reported by Rees (2003) which linked living in fear of forced removal and insecure asylum status as negatively affecting wellbeing. Access to community resources seemed to positively affect resilience in participants of this study. Participants described how positive interactions with others helped them to build their trust for others. Community resources such as support groups and third sector organisations seemed to provide an important function in providing space for positive interactions.

This proposed finding was consistent with the literature which emphasises positive effects of social support (Lavie-Ajayi & Slonim-Nevo, 2016; Rees, 2003; Sherwood & Liebling-Kalifani, 2012). Mental health services were described by participants as being hard to access. Access to services was also reported as a difficulty experienced by asylum seekers in Rees' (2003) qualitative study.

Individual factors which seemed to affect coping and resilience included participants' understanding of trauma and mental health difficulties. Participants who demonstrated some understanding of these and also of how coping strategies can help to manage psychological problems, appeared to experience fewer psychological difficulties. This theory does not appear to have been reported within the literature on resilience in asylum seekers.

Other individual factors which were described as important by participants included keeping busy, which appeared to help participants to avoid worrying thoughts linked with uncertainty for the future and safety, and past adverse experiences. Religious faith was also described by some participants as important, a finding which supports previous literature (Sherwood & Liebling-Kalifani, 2012; Siriwardhana et al., 2014). Findings developed within the current study suggest that individual factors associated with trauma and hardship including a fear and distrust of others and social isolation might reduce resilience. This aspect of refugee experience does not appear to feature in other studies investigating resilience in asylum seekers.

2.6.4 Personal growth

Within the current study, the researcher theorised how positive interactions may have helped participants to grow through improved confidence and sense of identity. Services, organisations, and groups, by providing opportunities for sharing experiences, may positively affect resilience by providing opportunities for sharing experiences. These experiences of

positive interactions appeared to help participants by normalising problems and supporting the development of understanding of mental health difficulties and coping strategies. Similarly, Sherwood & Liebling-Kalifani, (2012) suggest how community and social support positively affect identity. The current study suggests how experiences described by participants and conceptualised as personal growth, appeared to involve the development of their confidence and identity. These appeared to lead participants to take action that was in line with their values, such as volunteering or political activism. The importance of values-based action was similarly emphasised by Lavie-Ajayi & Slonim-Nevo (2016).

2.6.5 Limitations of the study

This study has some limitations. Due to its exploratory nature and methodology, it cannot make causal links between coping factors and mental health or draw any conclusions regarding underlying coping mechanisms. Findings should not be considered as representative of asylum seeking populations as they reflect experiences of participants of this study and may not be generalisable to other asylum seekers. The sample of asylum seekers in this study was diverse with participants from a wide variety of nations, cultures, and backgrounds. Being an adult seeking asylum were the only demographic criteria required for this study. However, within the context of the research methodology, the diversity of participants helped to ensure that multiple perspectives of the asylum seeker experience were considered. There was a gender imbalance with females being under-represented. No interpreters were used in this study reducing the risk of data being misrepresented. However, English was not the first spoken language of all participants, increasing the risk of participants not being able to fully understand or describe concepts.

The same researcher conducted all of the interviews. The researcher acknowledges his subjectivity in theorising and has provided information on his background, values and epistemological position, in accordance with the methodology, to enable the reader to judge the interpretation of findings. Theory was triangulated with study participants, third sector organisation representatives, and others involved with the research process to check the credibility of the grounded theory. Feedback from triangulation was used to develop the constructivist grounded theory. Data analysis and triangulation was used to ensure theoretical saturation had been reached.

2.6.6 Implications for policy

Within the UK, Home Office asylum interviews are important for determining refugee status (Bloch, 2014). Proposed theory from this study appear consistent with previous literature (Bögner, Brewin, & Herlihy, 2010) that suggests that asylum seekers may withhold important

information that could affect their claim. The experiences recounted by participants in this study study suggest that within the context of applying for asylum and the associated uncertainty for their future and safety, participants' past traumatic experiences (which often include events involving threatening authoritative systems), may make it difficult to disclose important information during asylum interviews. This raises concerns in relation to existing policy which uses *sufficiency of detail and specificity*, and *internal consistency* as means to assess an applicant's credibility (Home Office, 2015). Contrary to this assumption, withholding of information, can be viewed as an understandable action linked with survival within the context of a threatening situation. Where an individual may see it as necessary to withhold information to protect themselves or others, until trust for the asylum system has been established, this should not be used to undermine their credibility or to deny them refugee status. The author therefore urges a review of existing policy.

2.6.7 Implications for services

Theory from this study suggest that participants experienced difficulties accessing mental health services, with potentially negative consequences for resilience and wellbeing. Within the UK, asylum seekers are entitled to free healthcare at all levels of care (UK Government, 2014) and services have a legal duty to ensure that all individuals who are entitled to services are not prevented from accessing them (Department of Health, 2017; Great Britain, 2010). Clinicians should be aware of obstacles that may present barriers to accessing services, such as misinformed staff or institutional discrimination, and take action improve the accessibility of services, such as the provision of training, or making adaptations to engage marginalised or hard to reach communities.

2.6.8 Implications for clinical practice

Participants in this study described experiencing uncertainty for the future and their safety, racism and discrimination, social isolation, and difficulties trusting others during their asylum seeker experience. Clinicians should consider how contextual factors, including ongoing adverse, traumatic experiences, as well as effects of past traumatic experiences, affect coping. Clinicians should consider what community resources are available to individuals.

Theory from this study suggest that third sector organisations, faith groups and support groups have an important role in supporting individuals. Clinicians can support individuals by signposting asylum seekers to community resources. Mental health professionals are well-placed to offer consultation and training to third sector organisations. Clinicians may consider joint-working to deliver training, run groups, or provide reflective spaces or supervision to staff, who may be at risk of being vicariously traumatised.

Theory from the current study suggest that an understanding of trauma, mental health difficulties, and coping strategies that can be used to manage psychological difficulties, can positively affect resilience and wellbeing. Mental health professionals may be able to support individuals by developing understanding of trauma, mental health difficulties and coping strategies.

Within the literature, clinicians have raised issues around the appropriateness of individuals receiving trauma-focused psychological interventions as an asylum seeker (Ter Heide, Mooren, & Kleber, 2016). Arguments have been made that individuals should not receive trauma-focused psychological interventions until being safe from further persecution (National Institute for Clinical Excellence, 2005). However, theory from the current study suggest that asylum seekers may not feel safe until they have had gained refugee status, and this process can take years. Clinicians must consider the evidence base (Lambert & Alhassoon, 2015; Nosè et al., 2017), as well as ethical implications linked with withholding trauma-focused psychological interventions from individuals who stand to benefit from them. Practitioners must also consider the legality of withholding treatment from individuals who are entitled to equal services as those of citizens.

2.6.9 Implications for research

This study explored the experiences of adults seeking asylum with a focus on developing our knowledge about resilience. Theory from the current study suggest how individual, community, environmental and contextual factors may influence resilience and wellbeing. Further research is needed to understand psychological mechanisms that underpin factors affecting resilience and wellbeing in asylum seeking populations. This includes a need for more qualitative studies to explore asylum seeker experiences to develop psychological theory and concepts. Further quantitative or mixed-methods studies, using measures of resilience and wellbeing, will also help to develop our understanding of psychological theory.

Researchers need to be wary regarding the use of Western-based psychological theory when working with culturally diverse populations. Outcome measures of resilience that have been developed and standardised with Western populations, may not be validated for use with non-Western populations. Future studies could investigate the model of resilience as a multidimensional construct encompassing individual, environmental, community, cultural and contextual factors (Ungar, 2006), and its applicability for working with asylum seeking populations.

2.6.10 Conclusion

Very few studies have previously explored resilience in asylum seeker populations and to the knowledge of the author, this was the first study to explore resilience during the asylum application process. This study used a Constructivist Grounded Theory approach to explore asylum seekers' experiences and to develop knowledge on resilience. A constructivist grounded theory was presented diagrammatically and narratively to describe findings and to outline how individual factors, environmental factors, and community resources may affect the resilience and wellbeing of participants. Theory has important implications for policy, services, clinical practice, and research.

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Paper 3:

Critical and Reflective Evaluation

Word count: 9,522 (excluding references)

3 Critical and Reflective evaluation

This section provides a consideration of the work undertaken for this thesis, including the systematic review and empirical research study, and how both pieces contribute to the overall evidence base of which they are a part. Implications for clinical practice will be discussed, as well as the wider context of research work with reflection on issues of research governance, service user involvement and the relationship to local and national policies, priorities and services.

3.1 Research Process

3.1.1 My background and experiences

Prior to commencing clinical training, I gained experiences of working with diverse communities through voluntary and professional work experience. Through the non-governmental organisation Voluntary Service Overseas (VSO) I spent 6 months on a cultural exchange with a team of volunteers from the UK and Zambia. We undertook work experiences in towns in Wales and Zambia, organised events for our local communities and learning days for our colleagues, whilst creating a portfolio of learning on global issues. This led to certification with the British Council as an 'Active Global Citizen'. These experiences shaped my sociological outlook and understanding of cultures as I learnt about the similarities between different ethnic groups and our interconnectedness.

During my time in Swansea, I volunteered at the Swansea Bay Asylum Seeker Support Group (SBASSG) where I first met individuals who were applying for asylum. I knew very little about the circumstances experienced by asylum seekers but I developed some understanding through listening to people's stories. I remember feeling a sense of injustice when I learned about the hardships people experienced within the UK. This sense of injustice stimulated feelings of frustrations and disappointment with people and systems at various levels of British society from Government to members of the general public. These feelings were perhaps most strongly felt when I perceived inequality or unfairness, whether that be through governmental restrictions which limited freedoms or prejudicial attitudes communicated through the media or on the street.

I went on to work for a charity where my role involved visiting schools and colleges around Wales to deliver workshops on global issues including forced migration. I became involved in

the City of Sanctuary Project, a movement committed to building a culture of hospitality and welcome within the UK for asylum seekers and refugees.

3.1.2 Decision to undertake a research study on the experiences of asylum seekers

My experiences prior to training sparked an interest in researching how psychological theory can support asylum seekers and refugees. I developed my research idea in my first year of training and was directed to the work of a former South Wales trainee who had undertaken a research project on the experiences of asylum seekers. I arranged to meet to discuss the research project which helped me to form my own ideas around appropriate research questions. The meeting was useful for considering some of the obstacles which I might encounter and discussing the merits of various methodologies. I attended a British Psychological Society conference on working with asylum seekers and refugees to further my understanding of the research field and consider issues around clinical practice.

I decided to focus on the asylum application process. An investigation of the literature base suggested limited research into asylum seeker experiences during the application process. I read about current debates in the literature involving our limited understanding of resilience with marginalised communities such as asylum seekers. The debate focused on how our current understanding of psychological theory with asylum seekers and refugees is limited by a research focus on mental health disorders. I was interested in how researchers felt about this, as they pointed out that we risk undermining asylum seekers' ability to cope with hardship. The literature also indicated that current approaches to treatment which focus on mental disorders caused from previous traumatic events, risks failing to acknowledge current difficulties as a consequence of current circumstances. I decided that contributing to the evidence base in this area would be valuable and decided to explore asylum seekers' experiences for my own research study.

3.2 Systematic Review and meta-analyses

3.2.1 Decision to investigate psychological interventions

The decision of topic for the systematic review followed a discussion with my research supervisor about the field. Having undertaken an initial investigation, I suggested several areas which might be suitable. One area which we considered was the experiences of asylum seekers, an area which was closely related to my own research study. However, having recently explored the evidence base, I considered the low number of studies to be a

significant drawback and indicated that a review would be unlikely to advance the evidence base. We considered expanding the search to include studies of refugees which would have increased the number of studies. A previous trainee had recently conducted a systematic review of this topic and I did not think that there had been enough change in the field to warrant another review.

Rather than focus on experiences, another option we considered was on the efficacy of psychological interventions for asylum seekers and refugees. A brief search of the literature indicated that there had been previous reviews had been conducted but not for a couple of years. I was not sure whether there was a need for another review until I had completed a more comprehensive search of the evidence base since this review. This indicated that a number of studies investigating psychological interventions had been published during this time, including several on EMDR, an intervention which had not been included in previous reviews. I decided to focus on this area for the systematic review.

3.2.2 Outcomes, inclusion and exclusion criteria

Following a discussion with my supervisor, I decided to include randomised controls trials only. I hoped that this would improve the quality of the evidence on which conclusions from findings would be made, as previous reviews had highlighted the limited quality of evidence. I decided that PTSD should be the primary outcome as almost all studies had used PTSD as their primary outcome, often with depression or anxiety as secondary outcomes. I decided that the study's primary focus should be to investigate the effectiveness of psychological interventions for PTSD and to focus on adults of 18 years and older.

It occurred to me later that I would need to define what counts as a psychological intervention, something that was not clear-cut due to the wide variety of interventions including medication, arts, music, drama, and social interventions. Following a discussion with my supervisor about how best to define a psychological intervention I used a recent Cochrane review of psychological interventions for PTSD in adults (not limited to asylum seekers and refugees) to exclude studies.

When conducting the literature search, several issues arose which challenged existing inclusion/exclusion criteria. I was keen to maintain the quality of included studies but found a large variety of outcome measures being used by studies with varying credibility for diagnosing PTSD and secondary outcomes. It was not easy to make decisions about how best to proceed.

Following a discussion with my research supervisor, we decided that it would be useful to contact an expert in the field to ask for their advice. My supervisor put me in contact with a colleague and I arranged a meeting to discuss the project. It was very useful to discuss the review and gain feedback on common approaches adopted within the field of PTSD research. For inclusion criteria of participants, I decided that 80% of participants should have a PTSD diagnosis, ruling out studies which had investigated post traumatic stress symptoms but without requiring participants to have a diagnosis. Outcome measures were determined to be acceptable if they had been validated for PTSD diagnosis. Originally, this point had also included a requirement that the standardised assessment should be clinician-led, but this point added extra complications, given that not all studies reported who had administered assessment measures, while some studies used validated self-report measures. Method sections of previous reviews were considered in deciding that the change in criterion was acceptable and in line with previous reviews.

The 80% figure of participants with a PTSD diagnosis was considered more appropriate than the original 100% I had used, as it meant that useful studies that might have included a small number of participants who did not meet inclusion criteria could be included. As this approach had been used in Cochrane reviews, widely regarded as the 'gold standard' of reviews of quantitative studies, I was satisfied that this would not drastically reduce the quality of my own review. I also applied the 80% rule to the proportion of participants in studies who were either an asylum seeker or refugee. Research had often taken place in trauma clinics where other participants had been included in the trial.

I found that the balancing act between ensuring methodological rigour of the research study versus the need to include potentially useful studies required careful consideration. Referring to previous literature was particularly useful as was seeking advice from an expert in the field. Following a discussion with my research supervisor, we asked Dr Neil Roberts to act as my clinical supervisor for the research project. His decision to accept was important for me and helped guide my understanding and learning of methods for conducting the systematic review and meta-analysis.

3.2.3 Assessing quality of studies

As this area of research involved quantitative studies, I needed to find an appropriate method for rating the quality of trials. I decided against using a scale which provides a summary score of the quality. Such scales have been criticised within the literature for oversimplifying quality assessment and are at risk of scoring a trial highly despite having a significant flaw. I referred to Cardiff University's Specialist Unit for Review Evidence (SURE)

and found two critical appraisal checklists: Critical appraisal skills programme (CASP) checklist, and SURE's own checklist for systematic reviews.

I chose the SURE checklist because it included a more detailed and comprehensive spread of questions to investigate the quality of evidence. As well as considering factors important for internal validity, the checklist also considered areas not considered by Cochrane Collaboration's handbook for assessing risk of bias. I also considered it advantageous that the designers of the checklist were based locally and could therefore be easily approached concerning queries that might arise.

I decided to use the SURE criteria along with the seven key areas of methodological quality described in the Cochrane handbook to improve the transparency and reliability of the review process. I felt that one of the difficulties with the seven criteria used within the Cochrane handbook is that the criteria were designed originally for use in assessing the risk of bias in medical rather than psychological trials. As psychological trials are more likely to struggle with certain areas of methodological quality such as blinding of participants and investigators, I felt it would be useful to consider other areas which affect study quality. The risk of bias for each area was assessed using the ratings 'low risk', 'high risk' or 'unclear risk' as recommended by the Cochrane handbook.

3.2.4 Decision to undertake meta-analysis

I decided to undertake a meta-analysis of the data following a discussion of the arguments in favour and against undertaking one. Through a discussion with my supervisor I learned how undertaking an analysis would increase the power and precision by combining the data.. There were sufficient trauma-focused studies with sufficient similarities between their comparisons to undertake an analysis. We discussed the small but adequate homogeneity between studies investigating the three main active interventions of CBT, NET and EMDR to allow tentative sub-analyses. We considered the small number of studies to be a weakness that would reduce our confidence in findings. However, we decided that an analysis would contribute useful information to advance the evidence base, even if findings could not be used to make conclusions other than drawing attention to the need for further research.

A random-effects model was used to analyse data due to the anticipated large heterogeneity between studies. I decided to use the "Grades of Recommendation, Assessment, Development, and Evaluation" (GRADE) approach to assess the quality of data as the method was a well-established method recommended by the Cochrane handbook. I enjoyed

learning about the five factors used to assess evidence quality including how the framework incorporated the risk of bias of studies.

3.2.5 Reflections on undertaking a systematic review and meta-analysis

I found the whole process of undertaking a systematic review and meta-analyses greatly improved my confidence in critiquing the evidence base having developed my understanding of factors affecting risk of bias and quality of evidence. This process has seemed closely aligned with the 'scientist-practitioner' role and will be useful within my role as a Clinical Psychologist within the health service. Understanding strengths and limitations of the evidence base will help to advance my own clinical practice with service users, as well as supporting the development of working practices within teams in which I work. The process has helped me to understand the unique role Clinical Psychologists provide in this regard.

3.3 Conducting a research study on the experiences of asylum seekers

3.3.1 Decision to use a Constructivist Grounded Theory Methodology

Through discussions with my research supervisor we discussed some ideas about how best to undertake a research project that would contribute to the existing literature. Given the limited evidence base in this area and in particular, a paucity of studies linking psychological theory on resilience with asylum seekers, we discussed how an exploratory rather than a hypothesis-driven approach would be most appropriate.

The different methodology options which we considered included mixed-methods and qualitative approaches. I also briefly considered using a standardised assessment of resilience which could be used to compare differences between people at different stages of the asylum application process. However, this felt like jumping too far ahead given our limited understanding of the area. Using a resilience assessment would also introduce complications such as finding a suitable measure, standardised for use with a sample of asylum seekers. It was not clear at this stage whether it would be possible to involve a homogenous sample of participants, within the context of similar nationalities/region, raising concerns about the validity of use of a measure with a heterogeneous sample. Even with a more homogenous group, concerns around the suitability of using a measure with Western psychological terminology would exist, particularly with the risk of losing meaning through the interpretation of questions and answers with non-English speaking participants.

I decided that the study should focus itself on exploring individuals' experiences having identified this as a gap in the literature base. To meet the study aims, qualitative methods would be most appropriate. With my supervisor, we discussed various methods including Interpretative phenomenological analysis (IPA), discourse analysis, and grounded theory. IPA was considered a possible suitable method given its focus on exploring a phenomenon through close examination of experiences and meaning-making. The phenomenon would be the asylum application process but this felt to be possibly too broad a subject area, encompassing multiple components and processes.

Alternatively, we considered Grounded Theory. The method allows for the construction of a theory which is grounded in the data. I considered how inductive analysis through a process of constant comparison, would enable a theory to emerge which would help close the gap between psychological theory and empirical research. I decided that I preferred the hermeneutic stance of Charmaz's (2006) Constructivist Grounded Theory. Given my background and interest in the area, I did not feel comfortable with previous stances in Grounded Theory methodology in which the researcher attempts to acknowledge and suppress their own ideas and understanding of the subject. Instead I preferred Charmaz's stance in which the researcher acknowledges their position on the subject and recognises that the emergent theory has been shaped by their perception of reality. To me, this approach seemed more honest as it doesn't assume that the researcher has been successful in acknowledging but putting their perceptions to one side so as to provide a neutral stance, something which I considered might be impossible to do. I also consider my decision to use this version of grounded theory to be rooted in my generational stance towards qualitative research within the context of my training.

As a trainee of the South Wales Doctoral training programme, I am aware that as a relative newcomer to the field of qualitative inquiry, I will have been influenced by the leanings of my lecturers and positions of those around me. This generational methodology, defined as the generational character of a methodological translation of grounded theory (Ralph, Birks, & Chapman, 2015) will likely have permeated through the training programme and influenced my perception of the method, and its suitability for meeting my research aims.

3.3.2 Recruitment of participants

The decision to recruit participants through organisations which support asylum seekers was straightforward. My supervisor had advised me that recruiting participants may be difficult because of their stage in the asylum process and potential concerns about affecting their

asylum claim. Also, due to the nature of the research project with its use of interviews to gather information, this could unsettle individuals who may have had difficult experiences with the Home Office or in their home country.

It therefore seemed sensible to approach an organisation who through supporting individuals already had established a good relationship with potential participants, where trust had already been established. Diverse Cymru is a third sector organisation based in Cardiff supporting asylum seekers through a Black and Ethnic Minority (BME) mental health project. They had played a key role in the recruitment of participants in the prior research project and were willing to meet to discuss this research project. We met several times to discuss the project and share ideas around study aims, recruitment, logistics of interviews, translators, ethical considerations, translation of material, potential study participants. The meetings also served an important function in relationship building between myself and Diverse Cymru colleagues. It seemed important to developing a friendly working relationship and that I was trusted by staff who would be asking individuals they were supporting to similarly trust me to engage with the study. We shared opinions on current affairs and discussed our own background and interests as we spent time discussing non-related topics to the study.

Unfortunately, during the research project Diverse Cymru experienced threats to their sources of funding which created uncertainty around the longevity of the mental health project and staff roles. During this period, which happened just after the initial recruitment of the first study participant, Diverse Cymru was unable to take on new clients due to the uncertainties around being able to support individuals. However, Diverse Cymru put me in contact with another organisation that supports asylum seekers.

Oasis Cymru are a third sector organisation which support individuals to integrate within the community. They provide a space for asylum seekers to go to during the day where they can have hot drinks and lunch and receive donated clothing. They can also engage in activities such as sports and music and access English classes, as well as receiving practical support.

I arranged to meet Oasis Cymru who agreed to take part in the study, allowing me to recruit participants within the building. Through my supervisor, I made amendments to the ethics proforma and re-applied for study approval.

One difficulty at this stage of the study was that I had not factored in the time needed to build a working relationship with staff at a new organisation. Diverse Cymru were kindly recruiting participants for me in that they were communicating about the study with their clients and

arranging the date of interview. I had originally hoped to set up something similar with Oasis Cymru staff but this proved difficult to achieve, partly because I was not well known to them but also because the organisation was providing support to a large number of asylum seekers with only two permanent staff. Consequently they simply didn't have much time to consider my research project and to have the conversations with individuals that I was hoping they would have. I had regular contact with Oasis Cymru to discuss the project and to encourage discussion in team meetings to identify prospective participants and we had enthusiastic conversations to move things forwards. However, time was moving on and I was struggling to recruit additional participants.

My supervisor helped me to consider the systems at play and my role within them. We discussed different ways of working and decided that I would need to spend more time at Oasis Cymru to have the physical presence that would help me become more familiar to staff and potential participants, which would help build trust. I needed to be the one creating the links with potential participants, rather than relying on staff and their working relationships. By spending three to four days per week at Oasis Cymru I was slowly able to build trust with staff and asylum seekers.

As an organisation, Oasis Cymru receives many people who are looking to engage asylum seekers in their own project and staff later told me that they don't always consider the wellbeing of the individuals. This helped me to understand why it had taken time to build trust with staff about how I worked and how the wellbeing of participants had been considered, with ethical procedures in place to help safeguard against potential harms.

I was grateful that the first person I attempted to interview at Oasis Cymru had requested for a staff member to be present. This provided the opportunity, to follow interview procedures and lead the interviewee through the information sheet and consent form. It allowed staff to see how the process helped ensure that individuals are properly informed about the nature of the study, the process, and the ethics/participants' rights. The individual declined to take part in the study when they understood that the interview was going to be recorded.

Although I emphasised how the interview would not affect their asylum claim and how the material would be confidential with recordings deleted following transcription, the individual maintained their decision. This was useful for demonstrating to staff that participants were able to choose not to take part, helping to build trust in the process. I remember feeling drained at this point in time. I was spending a considerable amount of time on building trust but still hadn't actually interviewed anyone there.

I considered the interview process. It felt like an incredibly complex process involving abstract terminology to try to explain to someone who has only recently developed conversational English. To help with this I wrote a separate script which I learned so that I could avoid reading the information sheet verbatim, helping to reduce the formality of procedures which I felt had raised the individual's anxiety. In writing the script and considering my use of language, I became aware of how unsuitable some of the terminology within the information sheet was. I broke words down, finding their simple forms.

Once I had developed trust with staff it become easier to recruit participants. Once I was known as a regular face by staff and asylum seekers it was much easier to engage people in friendly conversations, helping me to appear more trustworthy to those who didn't know me.

One difficulty I encountered which I don't feel I managed to resolve, was recruiting female participants. Within my sample of participants, I only had two females. I was concerned that this would affect the internal validity of the grounded theory as it seemed likely that I would have missed out on data from alternative perspectives which would change the replicability of the study if the gender split were more neutral. Also, my perception of experiences as a male will have affected how I interpreted experiences. Through triangulating the theory with the female participants within the study, I was able to receive their feedback and make any necessary amendments. I considered cultural differences and the systems at play in Oasis Cardiff that might affect how I recruit female participants. My own gender was likely acting as a barrier. I reflected on trauma effects including fear of others and difficulty with trusting others and considered how traumatic events are more likely caused by men, potentially making me more threatening by a learned associative link.

I discussed my difficulty and need to recruit more female participants with staff at Oasis. Staff were very helpful and introduced me to individuals, explaining my role and giving me the opportunity to explain the research. On separate occasions, we arranged a date for interviews to happen with a staff member who would be present throughout the interview, but each time individuals did not attend.

3.3.3 Reflections on ethical considerations

One concern about interviewing asylum seekers was the possibility of retraumatising individuals through interviewing them about their experiences. I believed that the focus of the study on experiences during the asylum application process, would reduce the risk as it

would lead participants away from discussing past traumatic experiences in their home country or migration to the UK. Also, by focusing on coping and resilience I felt that the research had a more positive angle than if the focus was solely on mental health difficulties.

However, I feel that I should have considered how experiences within the UK could be more traumatic than previous events, particularly in light of the context of experiences being an ongoing phenomenon rather than events which had an ending to them. I am, however, pleased that prior consideration of the difficulty participants might have in discussing their experiences led to processes being put in place that did safeguard participants. It was important that interviewees understood that they did not have to talk about anything which they did not want to, and also that they could stop the interview at any point, or take a break.

This choice of options was contextually important for distinguishing the research interviews from Home Office interviews where participants would have had to have answered questions without choice. The decision to interview asylum seekers within the building of the supporting organisation and for asylum seekers to be able to have a staff member present, also helped to ensure that asylum seekers felt safe within the interview environment.

We did not use any interpreters as all participants spoke English but I wrote a confidentiality agreement to ensure that interpreters would be bound to the same level of confidentiality as the organisation staff and myself. Confidentiality was often difficult to explain, along with the process of anonymisation. Before being interviewed, interviewees were required to initial each point of the consent form to demonstrate that they had understood the purpose, process, and their rights. Enough time had to be allowed for everything to be explained and understood before starting the interview and this could take up to thirty minutes, along with collecting demographic information.

Following the interview, participants were provided with a debrief form including my own, my supervisor's, and the Ethics Committee's email addresses so that we could be contacted regarding any mental health difficulties which occurred following the interview, or issues which arose because of it.

3.3.4 Interviewees' experiences of taking part in the study

Interviewees were often very thankful towards the end of the interview and spoke positively of their experience of being interviewed. I think it took a lot of strength to overcome considerable, understandable doubts about whether they should take part in the study or

not. I reflected whether the process had had a therapeutic element to it and decided that it likely had. I think the interview format allowed itself to offer something useful, perhaps which some participants had not experienced, or at least not experienced often within the UK, or at all.

The process gave an opportunity to participants to share their experiences and to be listened to without judgement and without scepticism. Rather than questions which challenged the accuracy of interviewees' experiences, a tone of curiosity appeared to help interviewees to communicate their thoughts and feelings. For one interviewee, the interview lasted a particularly long time. They had recently arrived in the UK and had only applied for asylum just over a month previously. It seemed that he had a greater to need than other interviewees to share his experiences of life prior to coming to the UK and of the journey of migration. I felt that the interview needed to last longer to allow enough time for him to process some of the events which had happened. So despite early reminders of the focus on life since arriving in the UK, his focus remained on life previously for the first hour.

More than one interviewee commented on how they had been happy to have helped and hoped that the study would be useful for other asylum seekers in the future. This fitted with one of the categories to emerge, 'action in line with values'. Personally, I was happy to hear this and was glad that the study was helping people to feel like they were contributing something, thereby helping to reduce the disempowerment that accompanies the asylum seeker role through being a recipient of support. One interviewee took it upon himself to help me recruit other participants. This was a very kind gesture but led to difficult conversations with people who had been instructed to find me for questioning, contrary to the gentle introduction to the study I had developed.

I do not know for certain that participants did not experience any adverse reactions to being interviewed, despite not receiving an email or being notified by anyone afterwards. Although I checked in with people when I next saw them, I wondered whether people might hesitate to let me know if they had experienced difficulties afterwards, perhaps due to not wishing to offend me. It did not seem useful to use an adverse effects assessment measure, given the stand-alone interview format of the research rather than an investigation of a psychological intervention. I remain confident that appropriate opportunities to disclose difficulties were given.

I found that the process of triangulation served as a useful method for furthering experience of being listened to and validated. It provided another opportunity for interviewees to

contribute their thoughts about their experiences to critique the grounded theory. It was an opportunity to demonstrate that they had been heard, their experiences understood, and to be thanked for sharing their experiences and for trusting in the research process.

3.3.5 Reflections on data analysis

The experience of conducting a qualitative research study data analysis using a Constructivist Grounded Theory methodology was new for me. Although I had previously undertaken service user evaluations using thematic analysis, the process of constant comparison and inductive analysis whilst reflecting on my own position and perspective in relation to the data and emerging categories was much more involving than anything I had used before.

One of the challenges I found at the outset was trying not to do any prior reading around the subject which could influence my thinking. I resisted the temptation to read prior studies results sections in for fear of learning about key categories which could affect how I interpret data from my own study. It seems more like a leap of faith than with other methods, particularly not starting with a hypothesis, but instead allowing for the hypotheses to come through the process of memo-writing and then incorporating a deductive analysis with the re-working of the interview schedule to explore ideas about emerging categories. The whole process actually generated a strange mix of feelings, including a feeling of isolation since during the analysis phase I did not seek feedback on my categories until I had analysed the data and constructed a grounded theory.

This was a decision which was taken prior to starting analysis, as was the decision not to share memos with my supervisor. This approach was based on Glaser's (1998) ideas around not discussing categories so as to avoid praise or criticisms which could affect the creative flow of ideas.

Interviews were recorded and transcribed in line with Charmaz's (2014) adaptations to grounded theory in which transcribing, coding and re-coding are considered integral to the construction of theory. The open coding stage involved line-by-line coding of the transcription. The data collected was very rich and so conceptualising all incidents contained within it was a time consuming process.

To begin with, when getting used to coding transcriptions I found it frustrating that I wasn't capturing thoughts about concepts and so I evolved my practices to use memos as I was coding. I also developed the habit of recording my impressions, thoughts and feelings on

interviews immediately afterwards. I found that this helped me when considering ambiguities around people's communications. I found selective coding to be a lot faster process than open coding, particularly as I completed more interviews and begun to get more of a feeling for the data. I recoded my first three interviews keeping the core codes in mind as I went through. Sections of the transcript, open coding and selective coding around core categories were compared with each other to shape core categories. Ideas around core categories were captured using memos and used to shape the interview schedule.

One of the difficulties I experienced at this stage was definitively deciding upon which categories were more important, especially for such a diverse group of participants. It was useful to be able to explore ideas such as these through later interviewees and this helped to determine significance. However, sometimes I felt the need to suspend my uncertainty and trust in my instinct to determine one category as more important than another. This reliance on a feeling, even though the feeling is tied to a learning process through the systematic processing of data, could feel quite unsettling. This might be because of how contrary the method seemed to the deductive methods of inquiry with which I am more familiar. Nevertheless, I was aware of the richness of the categories that were being constructed and I was excited by the transition with the development of ideas. I was becoming more aware and confident in my core categories.

3.3.6 Construction of a grounded theory

The process of constructing a grounded theory was a consuming one. Originally the process was fast and felt similar to creating a mind-map, using core categories and memos to develop the theory. Multiple versions of the theory showing the development of its construction can be found in the appendix 4.14. As the theory was developed through a process of triangulation, more time was spent thinking about the intricacies of the theory with a focus on the nuances and suitability of language.

One difficulty I experienced with choice of language was whether to use the words of interviewees, or to use my own understanding around concepts which would introduce words not often used by asylum seekers, such as psychological concepts like trauma, validation, de-humanising, and resilience. I had been expecting for there to be differences in understanding of psychological concepts which could affect how individuals interpret their experiences and how I interpret their interpretations. However, I found that the use of words largely depended on the individual's competency speaking English. Often, when the individual had been living in the UK longer, or was from an English-speaking nation, they did use psychological terminology within their answers. For individuals who did not understand

terminology like resilience, I found that they understood the concept when broken down using simpler terminology. With resilience for example, inner strength seemed to be an appropriate substitute. I therefore decided that as long as the concepts were understood and used by participants, psychological terminology could be used within the grounded theory. However, this was balanced with a need to not overcomplicate ideas so where a simpler terminology could be used, it was.

Throughout the process of constructing the grounded theory, I needed to be aware of my point of view so as to try and disentangle this from those of interviewees. I experienced this as an ongoing challenge. Throughout the process, I had been working at my elective placement, a community mental health service for adults. The service uses a trauma recovery model to support individuals who are experiencing psychological and related difficulties having experienced traumatic events. My learning and experiences of using psychological theory and models in my clinical practice during phases of assessment, formulation, and interventions, shaped how I interpreted the experiences of interviewees. Memo-writing helped me to reflect on these influences, helping me to develop awareness of my own lens and to consider how models might be suitable for working clinically with asylum seekers.

3.3.7 Deciding about point of saturation

An important decision involved deciding when I was going to stop gathering data, i.e. when did I think I had reached saturation? I used triangulation as a method to check whether the grounded theory fitted with the experiences of participants by showing them the grounded theory and asking for feedback. I also shared it with staff at Oasis Cymru and Diverse Cymru. I used the feedback to develop the theory through a process of comparison of the new data with core categories and memos. This led to changes in the theory involving changes in terminology with the development of hardship and growth as key categories and also a refinement of core and subcategories, including within the experiences of the asylum application process. I continued triangulating the theory until no new ideas for categories were emerging. I used this as the basis to stop interviewing participants.

Although I felt concerned that 10 participants was on the smaller side of the target I had set within my ethics proforma, I was also aware of the richness of data the interviews had produced. Furthermore, I did not feel that it was particularly useful to determine the point of saturation on the basis of number of participants alone, given that study designs vary and will need different numbers of participants to reach saturation, thus making quantity insufficient as an indicator (Fusch & Ness, 2015). As Charmaz (2006) points out, ‘a very

small sample size can produce an in-depth interview study of lasting significance'. I placed more emphasis on the richness of the data and reflected on how multi-layered, intricate, detailed and nuanced the data appeared.

Charmaz recommends increasing the number of interviews, under certain conditions, if a controversial topic is pursued or if surprising or provocative information is found. Within this study, I felt that this consideration related to two categories which had been experienced by a minority of participants: destitution and detention centres. They did not emerge as core data within this study and did not feature as categories within the grounded theory but not because they were not important areas. I suspect the reason was because they were experiences which were not shared by enough participants and therefore did not feel as central as other areas. However, I felt that core categories from the grounded theory expanded into experiences of destitution and detention centres, such as 'uncertainty of future and safety of self', and 'having an invalidating, dehumanising experience'. I therefore decided against pursuing questioning into these areas.

3.3.8 Reflections on using Constructivist Grounded Theory

Throughout the process of learning to use Constructivist Grounded Theory within my empirical study, I found myself learning about the basic tenants that differentiate the epistemological and ontological position of various research methodologies and the selected method. This included developing my understanding about how grounded theory differs from other forms of qualitative methodologies and how Constructivist Grounded Theory differs from other variants of grounded theory. I found it interesting to consider how researchers' own preferences and choice of methodology affects how they define theory and perceive its purpose.

Charmaz (2014) describes how grounded theorists rarely define their conceptualisation of theory, but suggests that their definitions vary depending on how positivist or interpretivist they are. Positivists are described as seeing their theoretical concepts as variables and focus on observable facts. Interpretative definitions on the other hand, are described as emphasising interpretation and giving abstract understanding greater priority than explanation. Interpretive researchers view theory as being gained through the theorist's interpretation of the studied phenomenon. Within Constructivist Grounded Theory, researchers adopt an interpretive stance as they consider their own subjectivity and the subjectivity of others in constructing theory. There are multiple perspectives rather than facts.

I was interested to develop my understanding about how the method assesses its validity and reliability, concepts which are not used within grounded theory as when reality is constructed by individuals, there is no constant reality on which to base assumptions. Instead, Charmaz (2014) describes how theory aims to:

- Conceptualise the studied phenomenon to understand it in abstract terms
- Articulate theoretical claims pertaining to scope, depth, power and relevance of a given analysis
- Acknowledge subjectivity in theorising and hence recognise the role of experience, standpoints, and interactions, including one's own
- Offer an imaginative theoretical interpretation that makes sense of the studied phenomenon

These guidelines to constructing grounded theory were useful, but do not however provide a method for measuring methodological quality. Following a discussion with my supervisor, we decided that I could use guidelines for reviewing qualitive studies (Elliott, Fischer, & Rennie, 1999). Although the guidelines were not specifically designed for constructivist grounded theory, they seemed very relevant to the model, and could be combined with considerations from *Constructing Grounding Theory* (Charmaz, 2006, 2014) such as above.

As a researcher, I have been used to conducting research from a positivist standpoint by testing hypothesis in a deductive process. Through this study, I found that I was learning not only about different methods' positions and preferences in practice, but also about my own position and preferences for working. Being inexperienced in the use of inductive processes, I enjoyed conducting research in an interpretive stance and I found that the method fitted well with my own beliefs about reality. However, I found certain aspects challenging, such as attempting to continuously consider my own subjectivity and the subjectivity of interviewees whilst theorising and constructing a theory. I feel that I moved along an objectivist-constructivist continuum, away from Objectivist Grounded Theory towards Constructivist Grounded Theory, as I grew in confidence with using constructivist analytic processes.

One uncertainty I worked with was whether the emerging theory was becoming too neat, i.e. was it becoming more like a model which attempted to explain a reality rather than a genuine constructivist grounded theory? I used Charmaz's (2014) description of the aims of a theory (as described above) to consider whether the final version acted as a theory. I used a

process of triangulation to develop the theory in line with this description and make sure that it made sense to study participants.

3.3.9 Extended consideration of resilience literature

This section provides an extended consideration of the research that underpins psychological theory on resilience. As previously discussed, research in asylum seeker and refugees populations has predominantly focused on mental health disorders with quantitative investigation of PTSD. There is limited existing research investigating the experiences of asylum seekers and very few studies have investigated resilience and coping within this population. Quantitative research test a priori assumptions about the range of relevant variables to be assessed and risks simplifying individuals' experiences. This can be problematic in under-researched areas such as the experiences of asylum seekers.

By solely focusing on mental health illnesses, the literature risks not acknowledging asylum seekers' resilience factors which have helped individuals to manage immense hardships. Asylum seekers are more likely to have experienced multiple traumatic experiences than citizens of the country where they have applied for asylum (Kalt, Hossain, Kiss, & Zimmerman, 2013). Positive psychology approaches have recognised that individuals who have endured traumatic experiences often cope remarkably well (Bonanno, 2004). Mann & Fazil (2006) describe how some asylum seekers and refugees experience atrocities such as torture without developing any serious psychological difficulties, whereas others develop anxiety, depression, and feelings of shame and guilt. By understanding resilience and factors affecting coping in asylum seeking populations, clinicians will be better-equipped to support individuals to maintain their well-being.

Research into resilience initially investigated resilience factors in young children (Garmezy, 1976) before being broadened to adult models. Bonanno (2004) describes resilience as:

"The ability of adults in otherwise normal circumstances who are exposed to isolated and potentially highly disruptive event such as a life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning…as well as the capacity for generative experiences and positive emotions' Pg 20

Bonanno & Mancini, (2012) describe both traumatic experiences and resilience as common. They cite studies focusing on loss and trauma to describe how some individuals develop severe difficulties with their mental health following traumatic events, whereas others, and sometimes the majority of individuals, cope well, or at least do not exhibit the symptom

profiles of PTSD. They focus on the need to understand the variability in post-traumatic reactions and describe how the dominant focus on PTSD in the literature has led to a simplistic understanding of trauma responses. It is suggested that focusing on “trauma symptoms” has limited clinical utility because they do not provide information about the range of normative responses to traumatic events.

Bonanno’s (2004) model of resilience focuses on *multiple and sometimes unexpected pathways to resilience*. Factors that promoted resilience include the personality trait of hardiness which helps individuals to cope with extreme stress (Kobasa, Maddi, & Kahn, 1982). Hardiness is described as consisting of three dimensions: being committed to finding meaningful purpose in life, the belief that one can influence their surroundings and the outcome of evens, and the belief that one can learn and grow from both positive and negative life experiences. Self-enhancement was another factor, described as positive bias in favour of the self which can benefit self-esteem (Bonanno, Field, Kovacevic, & Kaltman, 2002). Repressive coping, described as the avoidance of unpleasant thoughts, emotions, and memories (Weinberger, 1990) was another factor. Also, positive emotion and laughter which were reported to reduce distress following aversive events by undoing negative emotion (L. Fredrickson & Levenson, 1998) and by increasing continued contact with important people from their social environment (Keltner & Bonanno, 1997). On the basis of these theories, Bonanno (2004) recommends for future investigations of loss and trauma to develop a deeper understanding of health and resilience.

Bonanno’s resilience model provides helpful considerations about the role of resilience in well-being. A criticism can be made that the model emphasises the role of the individual’s personal resilience factors without fully considering the role of community and environment in resilience. Seccombe (2002) for example, argues that resilience is as much about the individual’s environment as it is about the individual. Perhaps Bonanno’s focus on the individual is unsurprising, given that the model incorporates western-based research which has traditionally focused on individuals’ psychological factors. Another criticism therefore, considering the model is based on research with western samples of participants, is the model is lacking in sensitivity to cultural factors that contextualise how resilience is defined by different populations (Ungar, 2006) and may not be generalisable to non-western populations.

More recently, research on resilience has focused on community and contextual factors as in addition to individuals’ psychological factors. As referenced within the empirical paper, Ungar (2006) describes a model of resilience based on a cross-cultural investigation of resilience in

adolescents. Four factors are described as underlying a more culturally and contextually embedded understanding of resilience:

1. There are global, as well as culturally and contextually specific aspects to young people's lives that contribute to their resilience
2. Aspects of resilience exert differing amounts of influence on a child's life depending on the specific culture and context in which resilience is realised
3. Aspects of children's lives that contribute to resilience are related to one another in patterns that reflect a child's culture and context
4. Tensions between individuals and their cultures and contexts are resolved in ways that reflect highly specific relationships between aspects of resilience

Ungar (2006) emphasised how even when faced with similar adversities, there was great variation across cultures in how the young people coped. This point was used to pronounce resilience as a multidimensional construct, the definition of which is *negotiated* between individuals and their communities. Whilst this model is based on research with young people, it provides a useful basis from which to consider resilience in adult populations. Ungar (2006) points out that there has been little investigation into the applicability of the construct of resilience to non-western cultures where the resources available for survival may differ to those accessible to western populations. This consideration applies to asylum seekers during the application process who have unique contextual and environmental circumstances than other populations.

Very few studies have investigated resilience within asylum seeker populations. A qualitative study (Rees, 2003) investigated the impact of asylum seeker status on the wellbeing of East Timorese women living in Australia. Insecurity of tenure and living with the fear of forced removal was described as dangerously compromising wellbeing. English language skills, social isolation, physical illness, access to health services, post-secondary education were also found to affect well-being.

A qualitative study (Sherwood & Liebling-Kalifani, 2012) investigated the experiences of African women refugees living in the UK with a focus on resilience and identity. Authors emphasised the importance of support and treatment in assisting women to utilise their resilience and reconstruct their identities. Five factors affecting resilience were described: religion/faith, positive thinking, positive self talk, hope, and problem solving. Authors explained that difficulties during the asylum application process decreased resilience and

coping and were linked with difficulties accessing services, loss of self-identity, and feelings of fear and uncertainty about the future.

Lavie-Ajayi & Slonim-Nevo (2016) conducted a qualitative study of resilience among asylum seekers from Darfur living in Israel. The study identified six factors as important to resilience: cognitive coping strategies, behavioural coping strategies, the ability to work, the ability to study and educate oneself, the support of family and friends, and social and political activism. The authors emphasised the role of both personal strategies and social support as important to resilience.

3.3.10 Implications of findings on theory and clinical practice

Implications from my research study are considered in detail within the empirical paper. In brief, asylum seekers described factors which affected their resilience. Feelings of uncertainty and fear about the future and safety, insecurity of accommodation, experiences of racism/discrimination, social isolation, difficulty accessing services, trauma effects and personal shrinkage negatively affected asylum seekers' resilience.

Recommendations for improving clinical practice emphasised the need to consider personal and community resilience factors during the clinical cycle, and to consider different ways of working involving systems of support available to asylum seekers.

Findings from previous research on psychological theory of resilience have important implications for clinical practice. Mental health professionals increasingly work with diverse communities with a broad spectrum of ethnic, racial, and religious identities including asylum seekers. They face challenges to develop treatment models and services which will build components of service users' resilience.

Ungar (2006) describes several factors which clinicians should consider. Clinicians are recommended to privilege service users' knowledge about resilience, involve them in defining meaningful positive health or wellbeing indicators, and to design interventions that are sensitive to the aspects of resilience which will have the greatest impact, within a specific context. Clinicians are challenged to consider resilience as something that is far more complex than has generally been theorised. Also, to consider how an understanding of culture and diversity can lead to a more in-depth understanding of the processes of risk and resilience.

3.3.11 Dissemination of findings

I intend to publish the findings of my research study, systematic review and meta-analysis and have written up my empirical paper and systematic review to meet journal specifications. I feel that it is important for trainees to consider how their research will be disseminated, particularly in consideration of the limited funding available for psychological research, with the research component of training courses representing a significant proportion of research grants.

I am targeting the journals *Clinical Psychology Review* for my systematic review, and the *Journal of Ethnic and Migration Studies*. The former publishes reviews of topics relevant to clinical psychology, and the latter publishes research on all forms of migration and its consequences, with an interest in publishing the results of theoretical work. I intend to disseminate findings of the study by presentations to staff and volunteers of both third sector organisations.

When published, the grounded theory will be provided to organisations. It is envisioned that the grounded theory could be used for the training of staff and volunteers, and for supporting asylum seekers.

Finally, when applications open, I intend to submit an abstract to apply to present orally or with a poster at the UK Psychological Trauma Society's annual conference later this year. The conference aims to provide a forum for multi-disciplinary professionals working in the field of psychological trauma to share ideas and knowledge relevant to work in their field.

3.4 Reflections on professional and personal development

The research journey has not been a straightforward one and I have encountered hurdles which were necessary to overcome. At times, I have felt very stressed, and I have questioned whether I would make it to the finishing line. However, now that I am approaching the end of this journey, I can reflect on how I feel the process has affected my professional and personal development.

Resilience is a categorythat has permeated through my research study. I have learned about how people manage experiences of extreme hardships. Although hearing about such stories of hardship has not been easy, I have felt privileged to have been in a position where I could listen to and validate people's experiences. The more I developed my understanding of

asylum seekers' experiences, the more I appreciated how hard it must be to share stories which have previously been met with suspicion, scepticism, and disbelief.

I am fortunate to be training with a programme which has allowed me to choose my area of research and that I was able to find a supervisor who was willing to supervise me in this study. I believe that my passion and level of interest in this area has helped to motivate me to keep struggling and to develop the competencies I have needed to complete the process. I now feel that I have developed a range of competencies through this process which have greatly improved my understanding of and confidence in using research methods. I feel more confident in my roles as a 'scientist-practitioner' and 'reflective-practitioner'. I hope to carry these skills forward into my role as a qualified practitioner. I intend to continue contributing towards the evidence base on resilience and asylum seekers as well as applying my skills to other areas of interest. I have developed an appreciation for the value of qualitative methods in exploring individuals' experiences to develop psychological theory and enhance clinical practice. The research process has helped me to understand the research skills Clinical Psychologists offer and the importance of promoting these in their role.

The research has affected my own clinical practice as I have found it useful to consider how interviewees' experiences relate to service users I work with on my placement. Although the sample of participants in my study were heterogeneous with large variances in their nationality, background and cultures, there were many similarities which struck me about how individuals demonstrate resilience in response to hardships. I felt that the grounded theory constructed in this study for asylum seekers also had clinical utility within the context of my service setting for working with service users who have experienced traumatic events.

The research furthered my understanding of psychological models including trauma recovery models such as the three stage approach by Judith Herman (Herman, 1992) and those within Compassion Focused Therapy (CFT) (Gilbert, 2009). I feel pleased to have developed working ties with the two third sector organisations through this study and have considered ways that I might be able to take this work forward. I have discussed ways that I might be able to support staff at Oasis Cymru with staff and my placement supervisor. Methods we have discussed have included delivering training for staff and volunteers on supporting asylum seekers with mental health difficulties. This discussion evolved to considering how staff could benefit from having a reflective space to consider some of their experiences of working with asylum seekers, their own wellbeing and coping strategies, and the systems within which they work.

Regarding my own professional development, I feel more confident in managing large projects involving multiple demands. I also feel more confident with juggling competing demands and have developed my own working practices. These have involved developing planning and organisational skills, and networking skills needed to engage others in the study and to keep stakeholders informed of developments. In terms of personal development, I have become more aware of my own resilience, and limitations to resilience, which have helped me to recognise when I am becoming overwhelmed by mounting pressures. The ability to step back from the situation, access support such as through supervision, and consider the systems at play and my role within them, is an important learning point which will help me to manage future roles.

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4 Appendix

4.1 Relevant author guidelines for 'Clinical Psychology Review'

CLINICAL PSYCHOLOGY REVIEW

AUTHOR

INFORMATION PACK

DESCRIPTION

Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.
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4.2 Excluded studies and reasons for exclusion

Authors	Reason for exclusion
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Bolton, Lee, Haroz, Murray, Dorsey, Robinson, Ugueto & Bass (2014)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Mitschke, Aguirre & Sharma (2013)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Snodgrass, Yamamoto, Frederick, Ton-That, Foy, Chan, Wu, Hahn, Shinh, Nguyen, de Jonge & Fairbanks (1993)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Renner, Banninger-Huber, Peltzer (2011)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Hinton Kredlow, Bui, Pollack, Hofmann (2012)	Study's primary focus is not to investigate clinical efficacy of psychological intervention
Meffert, Abdo, Alla, Elmakki, Metzler, Marmar (2014)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Small, Kim, Praetorius, Mitschke (2016)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Drozdek & Bolwerk (2010)	Study design is non-experimental (no randomisation or no control)
Weine, Kulauzovic, Klebic, Besic, Mujagic, Muzurovic, Spahovic, Sclove, Pavkovic (2008)	Study's primary focus is not to investigate clinical efficacy of psychological intervention
Ince, Cuijpers, Riper (2013)	Less than 80% of participants are an asylum seeker or refugee
Arntz, Sofi & Breukelen (2013)	Study design is non-experimental (no randomisation or no control)
Drozdek, Kamperman, Bolwerk, Wietse, Kleber (2012)	Study design is non-experimental (no randomisation or no control)
Sonne, Carlsson, Bech, Elkit, Mortensen (2016)	Study's primary focus is not to investigate clinical efficacy of psychological intervention
Adenauer, Catani, Gola, Keil, Ruf, Schauer, Neuner (2011)	Study's primary focus is not to investigate clinical efficacy of psychological intervention
Morath, Gola, Sommershof, Hamuni, Kolassa, Catani, Adenauer, Ruf-Leuschner, Schauer, Elbert, Groettrup, Kolassa (2014)	Less than 80% of participants have a PTSD diagnosis, by a clinician via a diagnosis using a structured interview or a self-report measure, validated for diagnosing PTSD.
Liedl, Muller, Morina, Karl, Denke, Knaevelsrud (2011)	Study has been retracted

4.3 Cochrane risk of bias table

Study	Sequence generation	Allocation sequence concealment	Blinding of participants and personnel	Blinding of outcome assessment	Incomplete outcome data	Selective outcome reporting	Other biases
Stenmark *et al.*, 2013	Balls drawn from a bag. Unclear risk	No information. Unclear risk	Not possible. High risk	Yes. "Assessors had no access to information about what therapy patients had been assigned to." "In 11 out of 54 post-tests (20%) the patients had revealed information about their treatment to assessors." High risk	High rates of attrition: 26% at post-test. 'Natural' attrition reasons 'moved insided Norway' and 'sent out of country' accounted for 52% of droupout. Reason unkown for 43% of droupout. 1 particpant in treatment group 'quit due to treatment stress'. Rates and reasons even across groups. Mixed-effect models used to account for missing data. Low risk	Trial protocol published. All outcomes in protocol reported in trial. Low risk.	Interpreters used for half of assessments and treatments. Possible researcher bias as study undertaken by authors of NET manual. Unclear risk.
Acartuk *et al.*, 2016	Computer generated number list. Low risk	Yes. Low risk	Not possible. High risk	Yes. "The outcome assessors were kept blind to the allocation". Low risk	High rates of attrition with a higher rate in wait-list (33%) than treatment (25%) at post-test. Reasons for dropouts not identified but "high movability" of regugees suggested within the refugee camp study setting. Mixed-effect model models used for missing data. Low risk	Trial protocol published. All outcomes in protocol reported in trial. Low risk.	Interpreters used in all assessments and treatments; EMDR followed psychoeducation related to trauma, PTSD and EMDR; considerable community engagement with Syrian opinion leaders including imams, village leaders, women with strong social networks. Researcher bias towards intervention. Unclear risk.
ter Heide *et al.*, 2016	Coin toss. Low risk.	Yes. Carried out by independent research associate. Low risk.	Not possible. High risk	Yes. "Interviews were administered by trained Master's students in psychology who were kept masked to treatment condition by having limited access to participant data and by asking participants not to reveal treatment content." Low risk	Attrition was 19% for treatment and 24% for TAU groups at post-test. In each group '4 refused to complete assessment, 1 was not approcahed for assessment, 1 excluded from analysis because of not receiving any treatment'. Reasons not specified. Missing data was imputed using Bayesian analysis. Low risk	Trial protocol published. 4 of 5 outcomes in protocol were reported in the trial. 'Coping styles as measured by the Cope Easy' was not reported in the trial. Unclear risk	Interpreters used (number of participants needing interpreters unclear). Unclear risk.
Buhmann *et al.*, 2016	Yes. Computer generated by independent department. Low risk	Yes. Used sequentially numbered sealed envelopes. Carried out by secretaries not involved in the research project. Low risk	Not possible. High risk	No for PTSD. Masked ratings for anxiety and depression undertaken by medical students. High risk	Attrition varied between groups with high rates in medicine and therapy (23%), therapy (26%) and WL (29%) groups and lowest rate in medicine group (13%). Reasons more indicative of risk of bias included 'unknown, withdrawn consent, adverse reaction, inconvenience, too demanding or hospitalised' and accounted for 15% in the medicine and therpy group, 6% in the medicine group, 17% in the therapy group and 22% in the WL group. All treatment groups rate and reasons lower than WL group. Missing data was accounted for using a full information maximum likelihood analysis. Low risk	Trial protocol published. All outcomes in protocol reported in trial. Low risk.	Interpreters were used for assessment and treatment for 54% of participants. "adverse reactions (to medication), high cancellation rates of sessions by the patients. This resulted in low total number of sessions, low maximum dose of sessions and crossover between groups." "Only 25% of psychotherapy patients received exposure treatment and the majority were only exposed to trauma once or twice." More complex participants with severe trauma, treatment-resistent and relatively few exclusion criteria. "The majority of patients had been unsucecessfully treated with antidepressants or other psychiatric treatment previously." High risk.

Neuner *et al.*, 2008	No information. Unclear risk	No information. Unclear risk	Not possible. High risk	Yes. "participants were assessed by a group of five expert interviewers who were not involved in the trial and were blind to treatment". Low risk	High attrition rate with 23% in treatment group, 23% in comparison treatment group and no data on monitoring group at post-test. At 6 month follow up attrition rates for treatment (50%) and comparison treatment (52%) were lower than monitoring group (65%). Reasons not included. Authors compare combined totals for the reasons 'dropout' and 'refusers' between treatment (4%) and comparison treatment (20%) groups finding a significant difference. Missing data accounted for using mixed-effects models. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Possible researcher bias as study undertaken by authors of NET manual. Unclear risk
Neuner *et al.*, 2010	A block permutation procedure. Low risk	Yes. Low risk	Not possible. High risk	Yes. "We aimed at keeping interviewers blind…occasionally the participants revealed their condition despite instructions not to". Unclear risk	Low attrition rates, treatment group (12.5%) and none in TAU (0%) with with 2 discontinues in treatment group at post-test. No significant difference between groups. Missing data accounted for with mixed-effects models. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Interpreters used (unclear how often). Bibliography produced could be used by participatns to support their asylum application. Possible researcher bias as study undertaken by authors of NET manual. Unclear risk.
Acartuk *et al.*, 2015	Computer generated number list. Low risk	Yes. Low risk	Not possible. High risk	Yes. "The outcome assessors were kept blind to the allocation" Low risk	No attrition and no missing outcome data. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Possible researcher bias towards intervention. Interpreters were used in all cases. Psychoeducation and community liaison was carried out prior to treatment to reduce mental health stigma. Unclear risk.
Hinton *et al.*, 2005	Coin toss. Unclear risk	No information. Unclear risk	Not possible. High risk	Yes. All assessments were made by an assessor who was blind to treatment condition. Low risk	No attrition and no missing outcome data. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	All participants continued supportive psychotherapy, which consisted of a meeting with a social worker every two weeks. Therapist effect - all treatment conducted by the first author. All assessments conducted by one assessor. High risk.
Hensel-Dittmann *et al.*, 2011	Coin toss. Unclear risk	No information. Unclear risk	Not possible. High risk	Yes. "We aimed to keep the assessors blind to the treatment condition…occasionally the treatment condition was revealed by the patient". Unclear risk	Low attrition rate with 1 participant (7%) in treatment group and 1 in comparison group (8%) at post-test. Missing data accounted for with mixed-effects analysis. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Interpreters were used (frequency unknown) with equal distribution between groups. Possible researcher bias as study undertaken by authors of NET manual. Unclear risk.
Hijazi et al., 2014	Computer generated. Low risk	Yes. Assistants informing participants received a sealed envelope. Low risk	Not possible. High risk	No. Self-report measures. "All participants were mailed follow-up assessment measures". Unclear risk	Low attrition rates, treatment group (7%) and WL (5%). Missing data accounted for with a multiple imputation procedure. Low risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Relied on self-report measures. 2 therapists carried out intervention. Small number of sessions (3) likely to affect outcome. High risk.
Paunovic & Ost 2001	No information. Unclear risk	No information. Unclear risk	Not possible. High risk	No. Self-report measures. "An independent assessor was not used". Unclear risk	High attrition rate in the treatment group with 3 participants (30%) excluded at post-test: 2 for missing sessions and 1 for hostile behaviour. This compared with 1 (10%) in the comparison group. No indication that excluded participants' outcomes were included in the analyses. High risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Therapist effect - one therapist for intervention and evaluation. Differences between interventions are unclear. High risk.
Otto *et al.*, 2003	No information. Unclear risk	No information. Unclear risk	Not possible. High risk	No information. Unclear risk	No information provided on attrition or whether missing outcome data was accounted for. High risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Change in medication immediately before trial. Interpreter used in all cases. Unclear risk.

Hinton *et al.*, 2004	No information. Unclear risk	No information. Unclear risk	Not possible. High risk	No information. Unclear risk	No information provided on attrition or whether missing outcome data was accounted for. High risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Therapist effect - one therapist. Interpreters used (Vietnamese staff and social workers) but frequency unclear. Unclear risk.
ter Heide *et al.*, 2011	Coin toss. Low risk	Yes. "an independent research associate performed randomisation" Low risk	Not possible. High risk	Yes. "Blindness was maintained only in 70% of SCID-interviews". High risk	High attrition rates in both groups with 5 participants (50%) at post-test. In treatment condition, authors state reasons for drop-out: one was satisfied with symptom reduction, one did not want to speak about the past, one therapist consedered treatment unsuitable for all three assigned participants because of current stress and cultural factors. Analysis inludes outcome data of completers only. High risk	No trial protocol. All outcomes in trial methods reported. Unclear risk.	Interpreters were used for 8 partipants (out of 20). Therapist effect reported "one therapist thought EMDR unfit for all three assigned patients". Unclear risk.

4.4 Guidelines for the Journal of Ethnic and Migration Studies

About the journal

Journal of Ethnic and Migration Studies is an international, peer reviewed journal, publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.
Please note that this journal only publishes manuscripts in English.

Peer review

Taylor & Francis is committed to peer-review integrity and upholding the highest standards of review. Once your paper has been assessed for suitability by the editor, it will then be double blind peer-reviewed by independent, anonymous expert referees. Find out more about what to expect during peer review and read our guidance on publishing ethics.

Preparing your paper

Word limits

Please include a word count for your paper.
A typical paper for this journal should be no more than 9000 words; this limit does not include tables; figure captions; this limit includes references; endnotes; abstract.

Style guidelines

Please refer to these style guidelines when preparing your paper, rather than any published articles or a sample copy.
Please use British -ise spelling consistently throughout your manuscript.
Please use single quotation marks, except where 'a quotation is "within" a quotation'.
Please note that long quotations should be indented without quotation marks.

Formatting and templates

Papers may be submitted in any standard format, including Word and LaTeX. Figures should be saved separately from the text. To assist you in preparing your paper, we provide formatting templates.
Word templates are available for this journal. Please save the template to your hard drive, ready for use.
A LaTeX template is available for this journal. Please save the template to your hard drive, ready for use.
If you are not able to use the templates via the links (or if you have any other template queries) please contact authortemplate@tandf.co.uk

References

Please use this reference guide when preparing your paper. An EndNote output style is also available to assist you.
Author details. Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on

the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted. Read more on authorship.

A non-structured **abstract** of of no more than 200 words. Read tips on writing your abstract.
Graphical abstract (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .gif. Please do not embed it in the manuscript file but save it as a separate file, labelled GaphicalAbstract1.

You can opt to include a **video abstract** with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

Up to 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:
For single agency grants: This work was supported by the[Funding Agency] under Grant [number xxxx].
For multiple agency grants: This work was supported by the [funding Agency 1]; under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx].

Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.

Biographical note. Please supply a short biographical note for each author. This could be adapted from your departmental website or academic networking profile and should be relatively brief.

Geolocation information. Submitting a geolocation information section, as a separate paragraph before your acknowledgements, means we can index your paper's study area accurately in JournalMap's geographic literature database and make your article more discoverable to others.

Supplemental online material. Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

Figures. Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be saved as TIFF, PostScript or EPS files. More information on how to prepare artwork.

Tables. Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

Equations. If you are submitting your manuscript as a Word document, please ensure that equations are editable. More information about mathematical symbols and equations.

Units. Please use SI units (non-italicized).

4.5 English and Arabic Participant Information sheets

PARTICIPANT INFORMATION SHEET

Title of study:	**Developing Knowledge of Coping and Resilience: The experiences of adults seeking asylum**
Project lead:	Chris Thompson, Trainee Clinical Psychologist
Supervisor:	Dr Andrew Vidgen, Consultant Clinical Psychologist
Contact details:	Clinical Psychology Training, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. e-mail: thompsonc11@cardiff.ac.uk telephone: 02920 874007 (school of psychology – ask to be put through to the clinical psychology programme and leave a message if necessary)

We would like to invite you to take part in this research study to find out about the experiences of adults seeking asylum in the UK. The study is a research study and will have no bearing or influence on any asylum claim you may be involved in.

The interview will take about an hour. Chris Thompson (project lead) will go through the information sheet with you and answer questions you have before the interview begins. Before deciding whether or not you would like to take part, please read the following information about why the research is being done and what it will involve.

Thank you for reading the information and your interest in the study.

The purpose of this study

The study aims to find out how individuals are able to cope with the uncertainty of the asylum application process. When all of the information has been put together, Chris Thompson will submit this study as part of his training in Clinical Psychology.

Why have I been invited to take part?

You have been invited to take part because you are currently seeking asylum in the UK and have accessed charity services in Wales. We would like to find out more about the ways you have managed stress and coped with uncertainty since applying for asylum within the UK. We are aiming to speak with 10 other people about their experiences also. **This study will have no bearing on your asylum status.**

What will happen?

If you agree to take part in this study, you will be invited to Diverse Cymru's or Oasis Cardiff's offices where the interview will take place. Chris Thompson, the project lead, will welcome you and take you to a quiet room. Chris will go through the information sheet with you and answer any questions you may have. Chris will also explain about confidentiality.

You will be asked whether you would still like to be interviewed. If you agree, Chris will ask you some questions about your experience of applying for asylum. The discussion will last about an hour. The interview will be audio-recorded. Following the interview, Chris will make transcripts of the discussion. Transcriptions and recordings will be kept on a password protected memory stick. You are welcome to have a copy of the interview. Recordings and transcriptions will be destroyed when the project is finished.

Confidentiality

The interview will be confidential, and any information that we use in the completed study will be anonymous, so you will not be able to be identified. Anyone else present during the interview, such as an interpreter or staff member from Diverse Cymru or Oasis Cardiff, will be bound by a confidentiality agreement, so will not be able to talk about you or your case.

Do I have to take part?

No! If you agree to take part you can change your mind at any point until the interviews have been transcribed when false names will be used. If you agree to take part you will be asked to sign a consent form. You are welcome to take a break at any point during the interview, if you decide to take part.

What will happen to the results of the study?

Chris will analyse the interviews and search for similarities and differences between what people have said about their experiences. The results will be submitted as part of Chris' training in Clinical Psychology. They may also be written up and published in an article. It is hoped that this will help services/people who work with individuals who are seeking asylum to understand about their experiences to better support them.

What are the risks of taking part in this study?

It is important to be aware that during the interview we may talk about situations that have been difficult for you. However, we do not have to talk about anything which you do not wish to talk about. This study has a particular focus on how you coped with the uncertainty that comes with applying for asylum in the UK.

Who has said that the study is OK to go ahead?

The research study has been reviewed and approved by the School of Psychology Research Ethics Committee at Cardiff University.

If you would be willing to take part in the study, please complete the response slip below and return in the envelope provided. The project lead will then make contact with you in regard to making an appointment.

Many thanks,

Chris Thompson (Trainee Clinical Psychologist) – project lead.

Email: thompsonc11@cardiff.ac.uk

Address: South Wales Doctoral Programme in Clinical Psychology, 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT.

Telephone: 02920 874007 (school of psychology – ask to be put through to the clinical psychology programme and leave a message if necessary)

صفحة المعلومات الخاصة بالمشارك

عنوان الدراسة:

الخبرة الخاصة البالغين بالباحثين عن اللجوء,المعرفة المتنامية من التكيف والمرونة

منفذ البحث:

Chris Thompson

كريس تومسون متدرب علم نفس سريري

مشرف الدراسة:

Andrew vidgen

استشاري في علم النفس

معلومات الاتصال :

Clinical Psychology training, Tower building,70 park place, Cardiff,CF10 3AT

thompsonc11@cardiff.ac.uk

الهاتف:02920874007

(مدرسة علم النفس اطلب ان يتم توصيل ببرنامج تدريب علم النفس أو اترك رسالة في حال الضرورة).

نود دعوتك لتكون جزءً من هذا البحث عن الخبرة الخاصة بطالبي اللجوء في المملكة المتحدة، لن يكون لهذه الدراسة البحثية أيا تأثير على طلبك للجوء
هذه المقابلة سوف تأخذ حوالي الساعة. كريس(منفذ البحث) سوف يناقش معك صفحة المعلومات ويجيب على اسئلتك قبل الشروع في المقابلة. قبل ان تقرر فيما اذا كنت تريد ان تكون جزءا من هذه الدراسة نود منك ان تقرأ معلومات عن هذه الدراسة وماذا الذي تتضمنه.

شكرا لقراءة المعلومات الدراسة واهتمامك ان تكون جزءا منها .

هدف هذه الدراسة:

تهدف هذه الدراسة إلى إيجاد كيفية تعامل الأفراد مع تعقيدات عملية طلب اللجوء، عندما يتم جمع كل المعلومات مع بعضها، كريس سوف يقدم الدراسة كجزء من تدريبه في علم النفس السريري.

لماذا انا مدعو لأكون جزءا من هذه الدراسة:

انت مدعو لهذه الدراسة لأنك حاليا طالب للجوء في المملكة المتحدة، ولأنه متاح لك الاستفادة من الخدمات الخيرية في ويلز. نود ان نعرف اكثر عن الطرق التي تعاملت بها مع الغموض في طلبك للجوء في المملكة المتحدة والضغط النفسي الناجم عنها . كما اننا نهدف للتحدث إلى

عشرة اشخاص اخرين عن تجاربهم أيضا . **لن يكون لهذه الدراسة اية تأثير على طلبك للجوء.**

ماذا سيحدث:

اذا قررت ان تكون جزءا من هذه الدراسة سوف يتم دعوتك لإجراء المقابلة في احد هذين المكانين :

Diverse Cymru's offices

Oasis Cardiff

كريس منفذ الدراسة سوف يرحب بك وسوف يصطحب إلى غرفة هادئة .

كريس سوف يناقش معك المعلومات الخاصة بالدراسة ويشرح لك الأمور المتعلقة بسرية المعلومات الخاصة بك.

سوف يتم سؤالك في حال مازالت تريد ان تكون جزءا من هذه الدراسة وفي حال الموافقة ، كريس سوف يسأل عن تجربتك في التقدم لطلب اللجوء. هذه المناقشة سوف تأخذ تقريبا ساعة.

المقابلة سوف تكون مسجلة. بعد المقابلة كريس سوف يضع بكتابتها .التسجيل الصوتي والنسخة الكتابية سوف توضع في خزانة محمية بكلمة مرور. سوف يتم منحك نسخة عن المقابلة اذا اردت وسوف يتم إزالة ومسح المقابلات كاملة عندما ينتهي الدراسة.

سرية المعلومات :

سوف تكون المقابلات سرية .وأية معلومات واردة في الدراسة سوف تكون بأسماء وهمية، بحيث لن يكون هناك أيا وسيلة للتعرف عليك. واية شخص سوف يحضر المقابلة سواء كان مترجما او موظف سوف يتم الزامه باتفاق سرية المعلومات وعدم الإفصاح عن هويتك.

هل يجب عليان أكون جزءا من هذه هذين الدراسة ؟

لا، يمكنك لانسحاب في أي وقت قبل كتابة المقابلة عندما سيوضع أسماء وهمية.

في حال قررت ان تكون جزءا من الدراسة سوف يطلب منك التوقيع على طلب معين، سوف يكون لديك الحق في طلب استراحة في اية وقت خلال المقابلة.

كيف سيتم التعامل مع نتائج هذه الدراسة:

كريس سوف يقوم بتحليل المقابلات للبحث عن اختلافات أو تشابهات في ما قاله الأفراد عن تجاربهم وسوف تقدم النتائج كجزء من تدريب كريس في علم النفس. ومن الممكن ان يتم كتابتها كنص للنشر. نأمل ان يتم توظيف هذه النتائج لمساعدة المؤسسات والأفراد المعنيين في التعامل مع الأفراد الطالبين للجوء لتفهم ما يواجهون بغية تقديم دعم افضل.

ماهي المخاطر من ان تكون جزءا من الدراسة؟

من الضروري ان تعلم اننا ربما نتكلم عن مواقف صعبة مررت بها خلال المقابلة ولكن لن نتكلم عن أي شيء لا ترغب في التحدث عنه. هذه الدراسة لديها تركيز واضح الا وهو كيفية تعامل مع غموض القرار عند التقدم لطلب اللجوء في المملكة المتحدة.

من الذي اقر إمكانية اجراء هذه الدراسة؟

تم المراجعة والمصادقة على هذه الدراسة من لجنة الأبحاث الخاصة بمدرسة طب النفس في جامعة كارديف.

شكرا جزيلا ،

كريس تومسون (متدرب في علم النفس السريري) - منفذ الدراسة

Email: thompsonc11@cardiff.ac.uk

Address: south Wales doctoral programme in clinical psychology, 11th floor, school of psychology, Tower Building, 70 park place, Cardiff, CF10 3AT

Telephone: 02920874007

(school of psychology)

اطلب ان يتم ايصالك ببرنامج تدريب علم النفس السريري أو اترك رسالة.

بيان المعلومات:

عنوان الدراسة :

المعرفة المتنامية في التكيف والمرونة: خبرة الأفراد الطالبين للجوء

شكرا لك لانضمامك للدراسة، سوف يتم تحليل المعلومات التي أخذت منك خلال المقابلة بالتوازي مع المعلومات التي أخذت من الآخرين في هذه الدراسة . نامل ان تساعد نتائج هذه الدراسة الأشخاص المعنيين في التعامل مع الأفراد الطالبين للجوء بغية تقديم خدمة ودعم افضل لهم.

اذا سببت المقابلة لك اية تشويش الرجاء الاتصال بنا لاستعراض كيفية حصولك على مزيد من الدعم .

ان بيان الموافقة الذي سيتم التوقيع عليه سوف يوضع في خزانة ملفات محمية وسوف يكون متاحا فقط للباحثين. والسجلات الصوتية سوف يتم نسخها وكتابتها والتخلص منها فيما بعد. يمكنك الانسحاب من المشاركة إلى ان يتم طباعة المقابلة ، المقابلات سوف توضع بأسماء وهمية.

اذا كنت تود الحصول على نسخة من النتائج الرجاء اعلام كريس بذلك وهو بدوره سوف يرسل نسخة ملخصة عن النتائج بمجرد أصبحت جاهزة.

اذا كانت لديك اية أسئلة أخرى الرجاء الاتصال :

منفذ الدراسة:

Chris Thompson
Trainee clinical psychologist
thompsonc11@cardiff.ac.uk

المشرف:

Andrew Vidgen
Consultant clinical psychologist
andrewvidgen@wales.nhs.uk
South Wales doctoral programme in clinical psychology, 11th floor, school of psychology, tower building, 70 park place, Cardiff CF10 3AT

اذا كانت لديك اية شكوى عن البحث يمكنك الاتصال أو الكتابة ل:

school of psychology research ethics committee
Secretory to the research ethics committee, shook of psychology, tower building, 70 park place, Cardiff, CF10 1AT

4.6 Consent form

Please put your initials in the following boxes only if you agree with the following statements:

1. I confirm that I have understood the information sheet for the above study.	
2. I have had the opportunity to consider the information, ask any questions and have had these answered satisfactorily.	
3. I understand that taking part in the project will have no impact, either positive or negative on my asylum application process.	
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without my medical care, legal rights or asylum status being affected.	
5. I understand that information I give will be published as part of the project (in the form of quotations), but I will not be able to be identified by this information (they will be made anonymous). I give consent for anonymous quotations of mine to be published in the study write-up.	
6. I consent to the interview being recorded and transcribed, but I understand that once the project is complete, this information will be destroyed.	
7. I understand that translators will be used at the interview in order to translate information from my language into English for the benefit of the project lead (Chris Thompson). I understand that the translators also have to abide by confidentiality so will not be able to discuss the answers that you give to anyone.	
8. If I request, I give my consent for you to contact my GP to let them know that I have taken part in the project, but that no information discussed in the study will be shared.	
9. I agree to take part in the above study	

Signature of Participant:_____ Date _____

Signature of Researcher:_____ Date _____

4.7 Demographics data sheet

Participant ID……..... Date of interview…….....

First language/ language at interview……..

Country of origin……..Age…….Gender……

Length of time in the UK…….....years……..months

Immigration status (refugee / asylum seeking?)……

Reason for seeking asylum……...

4.8 Interview schedule

(The main questions are in **bold**, with supplemental questions following.)

Experience since arriving in the UK

1. **What has been your experience since arriving in the UK?**
    - How did all of this feel?
    - What did you expect to find in the UK?
    - Has the reality been different to what you hoped for?

2. **Can you tell me what it was like to apply for asylum in the UK?**
    - What would make the asylum process easier?

Coping and Resilience

3. **How do you feel now that you are in the UK? (Can you describe why that is?)**

4. **How do you feel you are coping at the moment?**
    - How have you coped (on a daily basis?) (with the uncertainty of waiting for residency status?)

5. **Has your previous experience helped you to cope? (If so how?)**

6. **How easy has it been to get help from others?**
    - What help do you receive from others?
    - What agencies or groups do you engage with? (e.g. health, social, charities, faith groups, drop-in centres)
    - Do you find it easy to ask others for support? (Why is that?)

7. **What are your hopes for the future?**
    - How important is it to have hope?
    - How does it affect how you cope?

8. **Is there anything you would like me to ask that I haven't?**

9. **Is there anything you would like to ask me?**

End of interview

4.9 Example of coding from transcription

Participant 7		
Focused coding	Initial coding - line by line coding	Transcription
UK as place of safety before applying for asylum **Life getting smaller** **Avoidance of others** Being arrested Being made to talk about traumatic experiences **Fear about the future and the unknown** **Not being believed** **Invalidating experience of asylum interviews** **Homelessness** **Worries about basic needs (shelter)** **Lack of trust for others**	Comparing early life in the UK prior to applying for asylum with situation in home country – UK as more peaceful due to not having anyone trying to hurt him. (For memo: asylum sought for human rights on grounds of risk of harm because of sexuality). Explaining that he took the decision to live life in a small way by avoiding everyone (Describing a common symptom of complex trauma following abuse from others – avoiding others). Being forced to talk about his problems Describing experience since being arrested and applying for asylum – emotion of fear linked with thoughts about future and the unknown with refusal of asylum claim. Also, the invalidating experience of not being believed by interviewers. Then, released and experienced homelessness – worrying thoughts regarding the basic need, shelter, for sleep. Describing a lack of trust for others (probably on the basis of learning from prior experiences and psychological harm experienced when others betrayed his trust when in need).	**What has life been like since arriving in the United Kingdom?** My life has been so peaceful because there was no one chasing me around and there is no fear of someone coming to hurt me, when I came here. I decided to stay back and live my life as small as possible to keep away from everyone since then until I was arrested by immigration and I had to tell them my problems and why I needed asylum. It has been terrible because there is this fear of what is going to happen next when I declare the asylum. All I told them was my story but they did not believe me. Since then, I was released on the streets so there is this fear of what is going to happen next and is this the place I stay tonight? It has been very difficult since then. Because of the fear of the unknown and what is going to happen next? **And what do you fear?** Why do you run away from somebody? And you run to somewhere else and you find out that the person you run to is the one who is going to do you more harm. Do more damage than what you expect. Psychologically.

4.10 Ethics Form

School of Psychology Research Ethics Committee Summary

This project will be conducted as part of Chris Thompson's doctorate in Clinical Psychology. As this project will not involve recruitment of NHS patients and the participants will only be recruited if they have the capacity to consent, NHS Research ethical approval is not required (for more information see APPENDIX I). Therefore, ethical approval from the University Research Ethics Committee is sought.

i. Title of study:

Developing Knowledge of Coping and Resilience: The experiences of adults seeking asylum

Study contacts:

Principle Investigator:
Name: Chris Thompson
Position: Trainee Clinical Psychologist, Postgraduate student
Responsibilities: Data collection, gaining informed consent, data analysis, and writing-up of the project.
Contact information: Doctoral Programme in Clinical Psychology, Cardiff University, 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT.
Telephone: 02920 874007
Email: thompsonc11@cardiff.ac.uk

Academic Supervisor:

Name: Dr Andrew Vidgen
Position: Consultant Clinical Psychologist and Principal Lead of year 1 of South Wales Doctoral Programme in Clinical Psychology.
Responsibilities: Ensuring academic quality of the research and assisting in accessing clinical settings where the research will be conducted**.** Providing supervision for the researcher time within the ward settings.
Contact information: Doctoral Programme in Clinical Psychology, Cardiff University, 11th Floor, Tower Building, 70 Park Place, Cardiff, CF10 3AT.
Telephone: 02920870587
Email: Andrew.vidgen@wales.nhs.uk

Study Sponsor: Cardiff University.

ii. Aims and objectives:

This study aims to explore the experiences of adults seeking asylum in the United Kingdom with a particular focus on coping and resilience. By focusing on coping and resilience rather than negative reactions to trauma this study aims to redress an imbalance within the literature. By developing our understanding of individuals' experiences with a focus on coping and resilience, this study aims to support high service provision in relation to meeting the mental health needs of individuals who are seeking asylum. For instance, an enhanced understanding of coping and resilience will support clinicians in assessing individuals for psychological distress and carrying out interventions.

This study will meet these aims through the following objectives:

- Semi-structured interviews (See APPEDNIX II) will be conducted by the Principle Investigator, Chris Thompson.
- Using a constructivist grounded theory methodology, interview data will be analysed.
- The Principle Investigator will search for key categories after each interview and will compare and contrast new categorieswith existing ones through a method of constant comparison.
- Interviews will be conducted until saturation of categories has been achieved.
- A theory will be constructed to account for individuals' experiences whilst seeking asylum.
- This will be compared with existing theories within the literature to identify improvements or alterations required to support high service provision in relation to meeting the mental health needs of individuals seeking asylum.

iii. Academic rationale for study

Impact of seeking asylum on mental health

Individuals experience many challenges with the potential to compromise their mental health needs (Murali & Oyebode, 2004; Bhugra *et al.,* 2014). Asylum seekers tend to experience discrimination, dislocation and powerlessness (Pierson, 2002). This is compounded by the public's negative attitude to asylum seekers, reproduced by hostile media coverage (Mollard, 2001; Refugee Council 2002; Robinson *et al.* 2003). Individuals often face long delays while waiting for decisions on their asylum applications (Tribe, 2002). The asylum application process represents a highly stressful period of uncertainty for applicants (Tribe, 2002). A survey conducted by the National Institute for Mental Health in England (2006) found that individuals seeking asylum generally felt that their mental health had deteriorated since arriving in the United Kingdom. Recently, global events including wars and natural disasters have led to rapidly increasing numbers of displaced individuals and a hardening of attitudes towards those seeking asylum (Sen, 2016).

Whilst people seeking asylum are at particular risk of developing mental illness including PTSD, they are also more at risk of developing depression and anxiety compared to the general population (Fazel *et al,* 2005; Sen, 2016) and to refugees (Gerritsen *et al.,* 2006). That risk is greater due to their immigration status, time in detention, unemployment (Spicer, 2008), absence of family support (Bhugra *et al*, 2014), loneliness and boredom (Tribe, 2002), racial discrimination, impact of negative media coverage on prejudices (Schemer, 2014), destitution, and complex asylum processes (Masocha & Simpson, 2011). Asylum seekers are not readily considered for specialist therapeutic interventions like cognitive behavioural therapy and psychotherapy which refugees can access (Maocha & Simpson, 2011). Studies which focus on pre-migration stressors arguably underestimate the impact of post-migration factors such as these.

Coping and resilience

Research suggests that there are significant individual differences in response to exposure to extreme stressors (Hoare, 2013). Resilience plays an important part in how individuals adapt to stressful life events. Resilience, as a psychological concept, emerged from the work with children by Rutter (1971) and Garmezy (1971) and has been developed to apply to adult models. Few studies have investigated resilience and coping in asylum seeking populations.

Traditional trauma research has focused on negative symptoms related to PTSD such as psychopathology, physical illness and disability (Breslau *et al.,* 1991; Cherry & Galea, 2015). Research with asylum-seeking populations is dominated by quantitative research investigating the negative psychological impact resulting from exposure to traumatic events (Hoare, 2013). Within the literature there exists a dearth of high quality research exploring the experiences of asylum seekers who are waiting for a decision regarding their residency status (Masocha & Simpson, 2011; Hoare, 2013).

There is a need to broaden our focus in research towards adaptive responses to traumatic experiences to develop a more complete understanding of stress-related psychopathology, its interventions and prevention Wald *et al.* (2006). Although an estimated 40-60% of adults have been exposed to traumatic events (Yehuda & Wong, 2001), only round 8% have developed PTSD (American Psychiatric Association (APA), 2000). The overemphasis in the research on negative reactions to trauma has impacted our understanding of coping with stressful events, limiting our knowledge of individuals' resilience (Bonanno *et al. (2004)*.
This study aims to develop our understanding of coping and resilience by using a qualitative methodology to investigate how people experience the asylum application process.

iv. Study design

This study will use a qualitative methodology approach to elucidate the common categories of experiences of adults seeking asylum. Constructivist grounded theory will be employed to analyse data collected from semi-structured interviews conducted by Chris Thompson (Main Researcher) (See APPENDIX II for interview schedule). The grounded theory method was developed to allow new, contextualised theories to emerge directly from data. It was designed to minimise the imposition of the

researcher's own categories of meaning upon the data during the research process. Constructivist grounded theory is a development of grounded theory which views theories as being constructed by the researcher through interaction with the data, rather than theories 'emerging' from the data (Charmaz, 2006). This version of grounded theory acknowledges that the researcher's decisions, selection of questions, use of method, as well as their background and beliefs, shape the research process and, ultimately, the findings. As a result, the theory produced constitutes one particular reading of the data rather than the only truth about the data (Willig, 2013).

Semi-structured interviews allow for flexible data collection, allowing the researcher to tailor questions between interviews following analysis of data for key categories. As such, the current semi-structured interview contains 7-9 major questions for each interview with supplemental questioning being responsive to the conversation developing with the participant. The main questions will explore two main areas:

1. experience since arriving in the UK
2. coping and resilience

At the end of the interview, the interviewee will have an opportunity to ask questions and to say if there is anything else that they would like to be asked.
In addition to the interview some contextual and demographic information will be obtained including: the participant's name, first language, country of origin, age, gender, length of time in the UK, immigration status and reason for seeking asylum. (See APPENDIX IV).

v. Selection and enrolment of participants

Sponsorship will be sought from Cardiff University R&D (contact: Helen Falconer – FalconerHE@cardiff.ac.uk). Ethical permission will be granted from the School of Psychology, Cardiff University Ethics Committee 'Psychethics'.

The participant pool will be drawn from a community sample of asylum seekers via the local collaborators Diverse Cymru and Oasis Cardiff not through any health settings. Diverse Cymru is a third sector organisation with a black, minority and ethnic (BME) mental health project. Oasis Cardiff supports refugees and asylum seekers to integrate into their local community in Cardiff.
All relevant staff members of Diverse Cymru and Oasis Cardiff will be provided with written information about the study. Participant information and consent sheets will be translated into the first language of participants. Due to budget limitations, materials will be translated into one other language only. Participants will therefore all either be able to speak English or all be able to converse in the alternative language (e.g. Farsi. Language to be decided). Potential participants will be contacted by a member of staff at Diverse Cymru or Oasis Cardiff and provided with written information (see APPENDIX III). Staff will make clear to potential participants that taking part is voluntarily and will not affect support that they receive, nor will it have any impact, positive or negative, on their asylum application process. Contact details will also be provided so further questions about the study can be answered. Potential participants will be given time to consider taking part. If they are interested in participating, an appointment to conduct the interview will be arranged at a mutually convenient time

at Diverse Cymru or Oasis Cardiff. An interpreter will be used during interviews with individuals who cannot speak English.

Once arrived at the interview, the participant will be read the information sheet and consent form in English or the alternative language. Participants will be given the opportunity to ask any questions. If they are still happy to take part they will be asked to give their informed consent (APPENDIX V). Formal written or verbal consent will be sought. Prior to the interview starting, the interviewer will ask participants for some contextual and demographic information on: first language, country of origin, age, gender, length of time in the UK, immigration status and reason for seeking asylum (Appendix IV).

Inclusion Criteria

In order to participate in the study, individuals will need to meet the following criteria:

- Be an adult (defined as being over the age of 18)
- Currently seeking asylum in the UK
- Be a person who has accessed the recruiting service (Diverse Cymru or Oasis Cardiff)
- Be a person with the capacity to understand the information provided and consent to
  take part in the study.

Exclusion Criteria

- An inability to provide informed consent.
- Capacity issues such as intoxication or inadequate levels of understanding required to understand the purpose of the study, what is required for participation or possible adverse consequences.

Issues regarding informed consent and capacity are explained under 'ethical considerations'.

vi. Data collection and analysis

Interviews will be recorded, transcribed and analysed. Analysis of data in grounded theory is an iterative, inductive process of decontextualisation and recontextualisation (Ayres, Kavanaugh, & Knafl, 2003).
During decontextualisation data will be separated from the original context of individual cases and codes will be signed to units of meaning in the texts.
During recontextualisation, the data will be examined for patterns before being reintegrated, organised, and reduced around key categories. A constant comparison method of coding will be used to analyse the data (Willig, 2013). This will involve three stages: open coding (examining, comparing, conceptualising and categorising data), axial coding (reassembling data into groups) and selective coding (identifying and describing the central phenomenon) (Willig, 2013; Charmaz, 2014). The main researcher will move back and forth between data collection and analysis, checking that categories are grounded in the data. Each interview will be coded before the next is conducted so that new categories can be explored in the following interview.

Throughout the data collection and analysis process, the researcher will maintain a written record of theory development. During this 'memo-writing' process, the researcher will write definitions of categories and justify labels chosen for them, tracing their emergent relationships with one another, and keeping a record of the progressive integration of higher and lower-level categories (Willig, 2013). Memo-wiring will provide the researcher with the opportunity to reflect on a priori knowledge and assumptions. Also, to note development and changes of key categories. All memos will be dated, contain a heading and state which section of the data they refer to.

In addition to information from the interview, minimal demographic information will be obtained: the participant's first language, country of origin, age, gender, length of time in the UK, immigration status and reason for seeking asylum (APPENDIX IV).

vii. Study procedures

The interview will take place at Diverse Cymru or Oasis Cardiff's offices, depending on which organisation the participant is recruited from. The site and setting will be familiar to potential participants who will already have accessed services through the recruiting organisation. This is intended to reduce any pre-interview anxieties.

At the interview the potential participant will be taken through the information sheet and consent form by the researcher. If they still wish to take part in the study and are deemed to have capacity (see ethical considerations section), they will be asked to give their informed consent (in writing). Participants will be informed that they can stop the interview at any point, either for a break or to exit the study. The interview and contextual/demographic information collection is anticipated to last approximately one hour and a half, including time for the 'interpreter effect'. Following the interview the participant will be debriefed and given a debriefing sheet (Appendix V). The debriefing form will outline how they can receive a summary sheet of the findings of the study and will contain contact details for the researcher if they have any queries. It will also explain what to do if they experience any distress through their participation in the study and who to contact to discuss accessing support.

viii. Sample size

It has been estimated that 10 to 12 participants have been estimated as being a sufficient number considered suitable to complete a doctoral level research project (Turpin *et al.,* 1997). However, there is some debate within Grounded Theory circles regarding the most suitable sample size. However, Charmaz (2006) points out that 'a very small sample size can produce an in-depth interview study of lasting significance'. Also, Charmaz recommends increasing the number of interviews, under certain conditions, if; a controversial topic is pursued, surprising or provocative information is found, the researcher constructs complex conceptual analyses, interviews are the only source of information or where professional credibility is sought. She adds that the number of interviews will depend on the initial research and emergent research questions and how the researcher conducted the study and constructed the analysis. On the basis of this guidance, the researcher will aim to interview 10-12 individuals but anticipates that the number of interviews may increase to meet requirements.

ix. Ethical considerations

Informed consent

Potential participant's ability to consent to participation in the study will be determined through informal assessment of their capacity, in line with the Mental Capacity Act (2005). As part of their training, the interviewer has received training in capacity and informed consent and their application in clinical practice. The interviewer will remain alert to the potential participant's ability to provide informed consent. If complex factors regarding an individual's capacity emerge, the Academic Supervisor will be consulted in the first instance. If the issue of capacity is not easily solved, then the potential participant will be thanked for their time and their participation in the study will end.

Confidentiality

To ensure the confidentiality of all participants throughout the process, procedures will be implemented in accordance with the Data Protection Act (1998), the British Psychological Society Code of Human Research Ethics (BPS, 2011) and the British Psychological Society Code of Ethics and Conduct (BPS, 2009).

Confidentiality will be emphasised to potential participants by recruiting organisations' staff and the interviewer before and after the interview. Staff involved in the study at the organisations and interpreters will be required to sign up to confidentiality agreements. It will be emphasised that other people present during the interview (interpreter and potentially project worker) are also bound by confidentiality agreements. Limits to confidentiality will be explained (concerns about the participant's or anyone's well-being will be disclosed to an appropriate member of staff such as research supervisor or staff at Diverse Cymru or Oasis Cardiff).

It is anticipated that given the sensitive nature of asylum applications, and perhaps previous negative experiences of persecution and interviews, participants will be nervous about sharing information. It will be emphasised that any identifiable information will be removed and pseudonyms will be used to ensure anonymity.

Interviews will be recorded using an MP3 audio recording device. Following each interview the recording will be uploaded onto a password-protected laptop and deleted from the recording device. The laptop will be stored in a locked cabinet at the school of psychology. Each interview will be transcribed. Any details related to the individual's identity will be removed through the process of transcription. Transcriptions will be kept on the password-protected laptop. Transcripts will be analysed solely by the researcher, with anonymised excerpts shared for credibility checking and triangulation.

Potential adverse consequences

Given that participants will likely have previously experienced events which may have had a lasting impact on their mental wellbeing, such as effects of trauma, the researcher and recruiting organisation will want to ensure that participant engagement in the research process does not cause any adverse distress. It will be emphasised to potential participants that the focus of the research is on how they are currently coping

with the current situation, not on past events that they may have found traumatic. However, as has occurred in previous studies on coping and resilience (Hoare, 2013), participants may describe traumatic narratives about their lives and life in the UK. At the start of the study and before the interview begins, participants will be informed that the interviews can be stopped (for a break or altogether) if they find the conversation distressing or do not wish to continue. The main researcher, Chris Thompson, as a Trainee Clinical Psychologist, has training and clinical experience of interactions with clients in emotional distress and is confident about providing emotional support. Participants may be directed to other sources of support offered by the recruiting organisation or other services (e.g. a NHS Community Mental Health Team, drop-ins run by Oasis Cardiff, Cardiff Refugee and Asylum Seeker Welcome and Space 4 U). At the end of the interview, participants will be provided with a debriefing sheet (Appendix V) detailing how to seek support if they have experienced any distress from participating in the study. A protocol will be put in place for scenarios in which the interviewer feels uncertain about the safety of participants. This will ensure that either clinical or academic supervisors will be available. Participants will be directed to Andrew Vidgen (academic supervisor), regarding any concerns or complaints.

The welfare of the researcher, project worker and interpreter will be considered. Given the nature of the interview process, there is a risk of vicarious traumatisation. The researcher, interpreter and project worker will meet regularly to de-brief and reflect on topics that arose during the interviews. The researcher will receive supervision from the academic supervisor regarding the interview topics.

x. Estimated start date and duration of project

It is anticipated that the project will commence in July 2016, upon receipt of ethical approval and will be completed by June 2017.

4.11 Confirmation of ethical approval

psychethics <psychethics@cardiff.ac.uk> Aug 1

to Christopher, Andrew

Dear Christopher

The Ethics Committee has considered your revised project proposal: *Developing Knowledge and Understanding of Coping and Resilience: The experiences of adults seeking asylum (EC.16.06.14.4540R).*

The project has now been approved.

Please note that if any changes are made to the above project then you must notify the Ethics Committee.

Best wishes,

Mark Jones

4.12 Consent form for interpreters

You are being asked to participate in a research study. The study aims to find out how individuals are able to cope with the uncertainty of the asylum application process. When all of the information has been put together, Chris Thompson will submit this study as part of his training in Clinical Psychology.

What will happen?

Study participants will be invited to take part in the study by Diverse Cymru or Oasis Cardiff. They will be invited to either Diverse Cymru or Oasis Cardiff's offices where the interview will take place. Chris Thompson, the Project Lead, will welcome the participant and introduce the Interpreter to them. The Interpreter will translate this and further communication between the Project Lead and participant. The Project Lead will lead the participant to a quiet room with the Interpreter. The Project Lead will go through the information sheet with the participant and answer any questions they may have.

They will be asked if they would still like to be interviewed. If they agree, the Project Lead will ask questions about their experience whilst applying for asylum. The interview will last about an hour. The interview will be audio-recorded. Following the interview, the Project Lead will make transcripts of the discussion. Transcriptions and recordings will be kept on a password protected memory stick. Recordings and transcriptions will be destroyed when the project is finished.

Your role

As the interpreter your role will be to ensure that study participants understand the following:

- the purpose of the study
- the study will have no effect on their asylum application
- they are free to withdraw from the study at any point without giving any reason, and without my medical care, legal rights or asylum status being affected
- information provided will be published in the form of quotations as part of the project, but that they will not be able to be identified from it (information will be anonymized).
- the interviews will be recorded and transcribed but once the project is complete all information will be destroyed.
- if they request for their GP to be contacted to inform of their participation in the study, they give their consent for their GP to be contacted. No information discussed in the study will be shared.

- translators will be used at the interview in order to translate information from your language into English for the benefit of the project lead (Chris Thompson).
- translators have to abide by confidentiality so will not be able to discuss the answers that you give to anyone.
- Following the interview, if the interview has caused distress, they can contact the project lead (Chris Thompson) to explore how to gain extra support.
- if they would like to receive information about the results of the study Chris Thompson will send a summary of the results as soon as they are available.

By signing below you confirm that the study has been fully explained to the potential subject in a language they understand and all their questions have been answered. You are also signing to confirm that you will abide by confidentiality and will not discuss or pass on information provided in the interview to anyone other than the project lead (Chris Thompson).

Signature of Interpreter:_____ Date _____

Signature of Researcher:_____ Date _____

4.13 Debrief Sheet

Title of Study: **Developing Knowledge of Coping and Resilience: The experiences of adults seeking asylum**

Thank you for taking part in this study. The information that you have provided in your interview will analysed along with information from other interviews for this study. We hope that the findings will help people and services who are working with individuals who are seeking asylum to better understand and support those individuals. If the interview has caused you distress, please contact us so that we can explore how you can gain extra support.

The consent form that you signed will be locked in a filing cabinet, only accessible by the researchers. The audio recording will be transcribed and then destroyed. You can withdraw from participation up until the interview is typed up, as it will then contain made up names.

If you would like to receive information about the results of the study please let Chris Thompson know and he will send you a summary of the results as soon as they are available.

If you have any further questions please contact us:

Project Lead:	**Academic Supervisor:**
Chris Thompson	Andrew Vidgen
Trainee Clinical Psychologist / Principal Lead	Consultant Clinical Psychologist
Email: thompsonc11@cardiff.ac.uk	Andrew.vidgen@wales.nhs.uk
Telephone: 02920 874007	02920870587

South Wales Doctoral Programme in Clinical Psychology,
11th Floor, School of Psychology, Tower Building,
70 Park Place, Cardiff, CF10 3AT

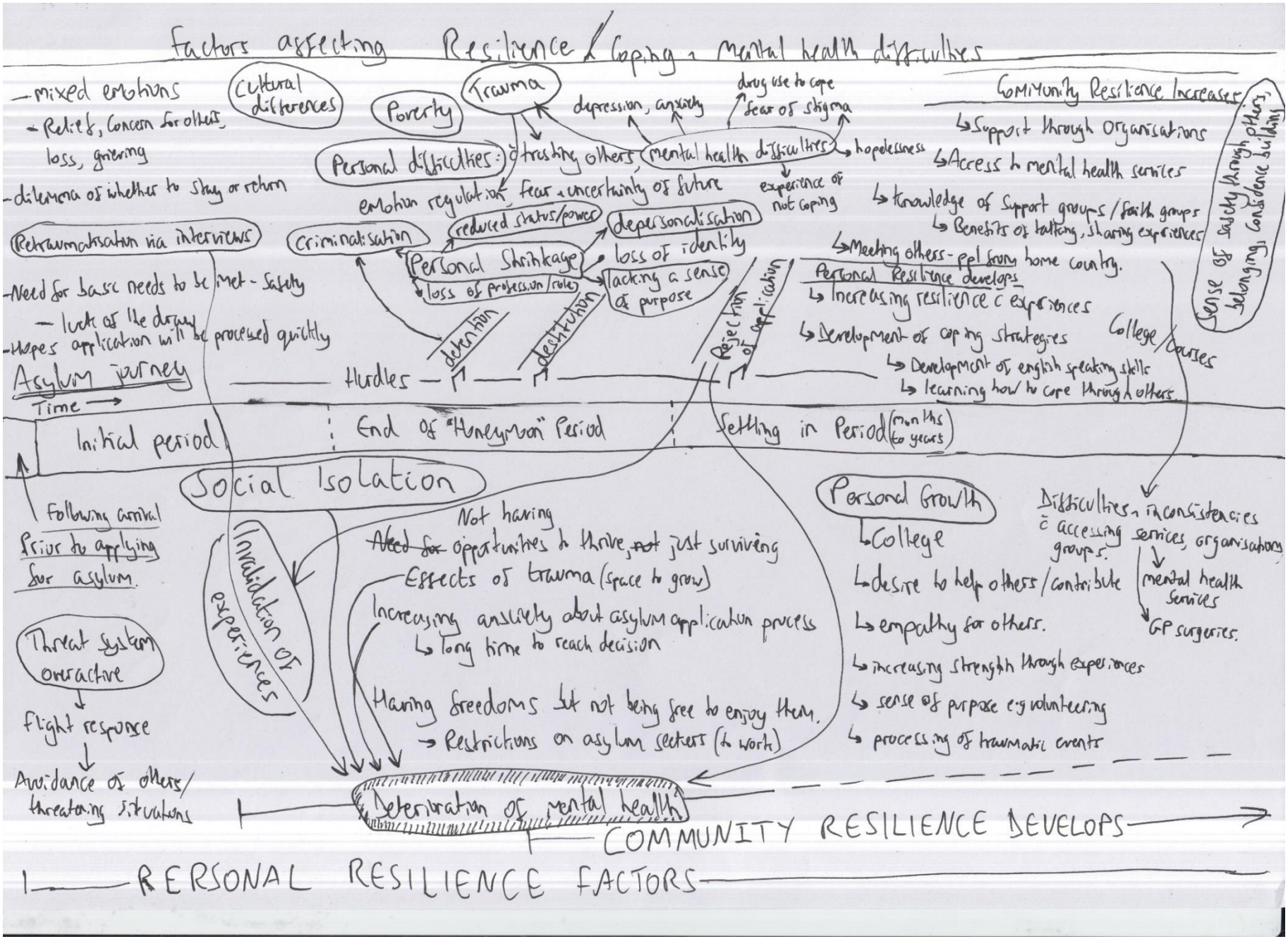
If you have any concerns or complaints about the research you can contact the School of Psychology Research Ethics Committee in writing at:

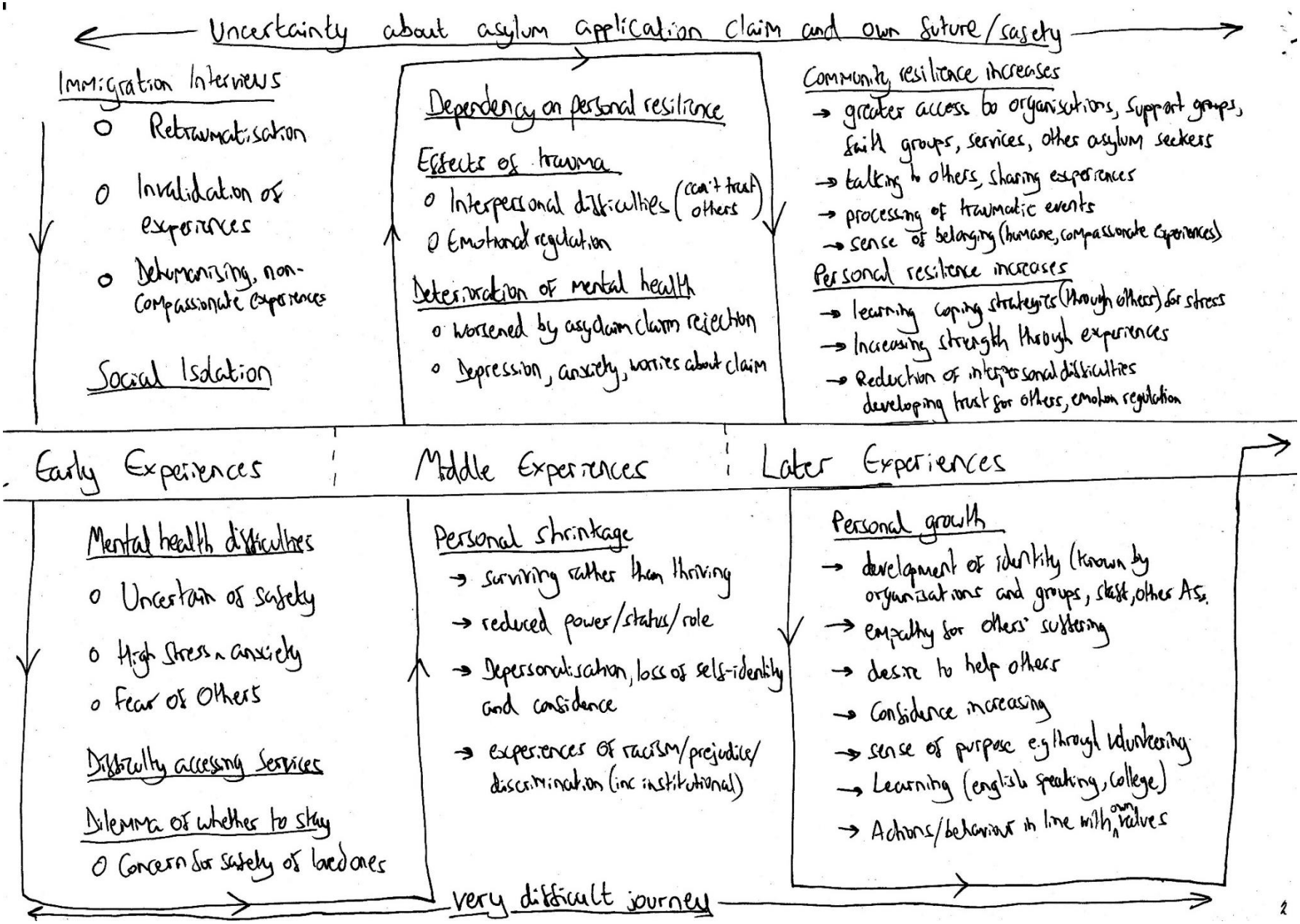
Secretary to the Research Ethics Committee
School of Psychology, Tower Building
70 Park Place, Cardiff, CF10 3AT

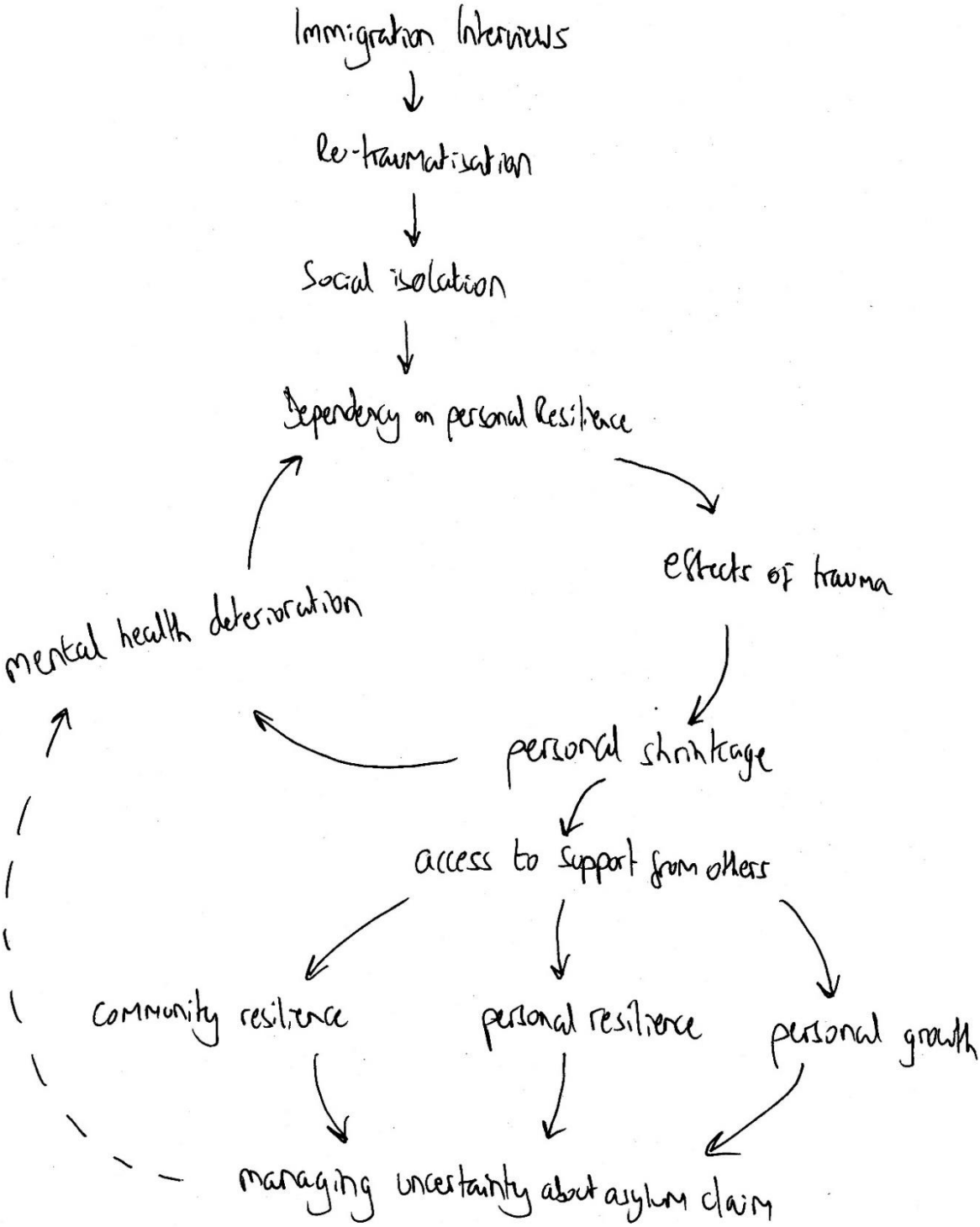
psychethics@cardiff.ac.uk

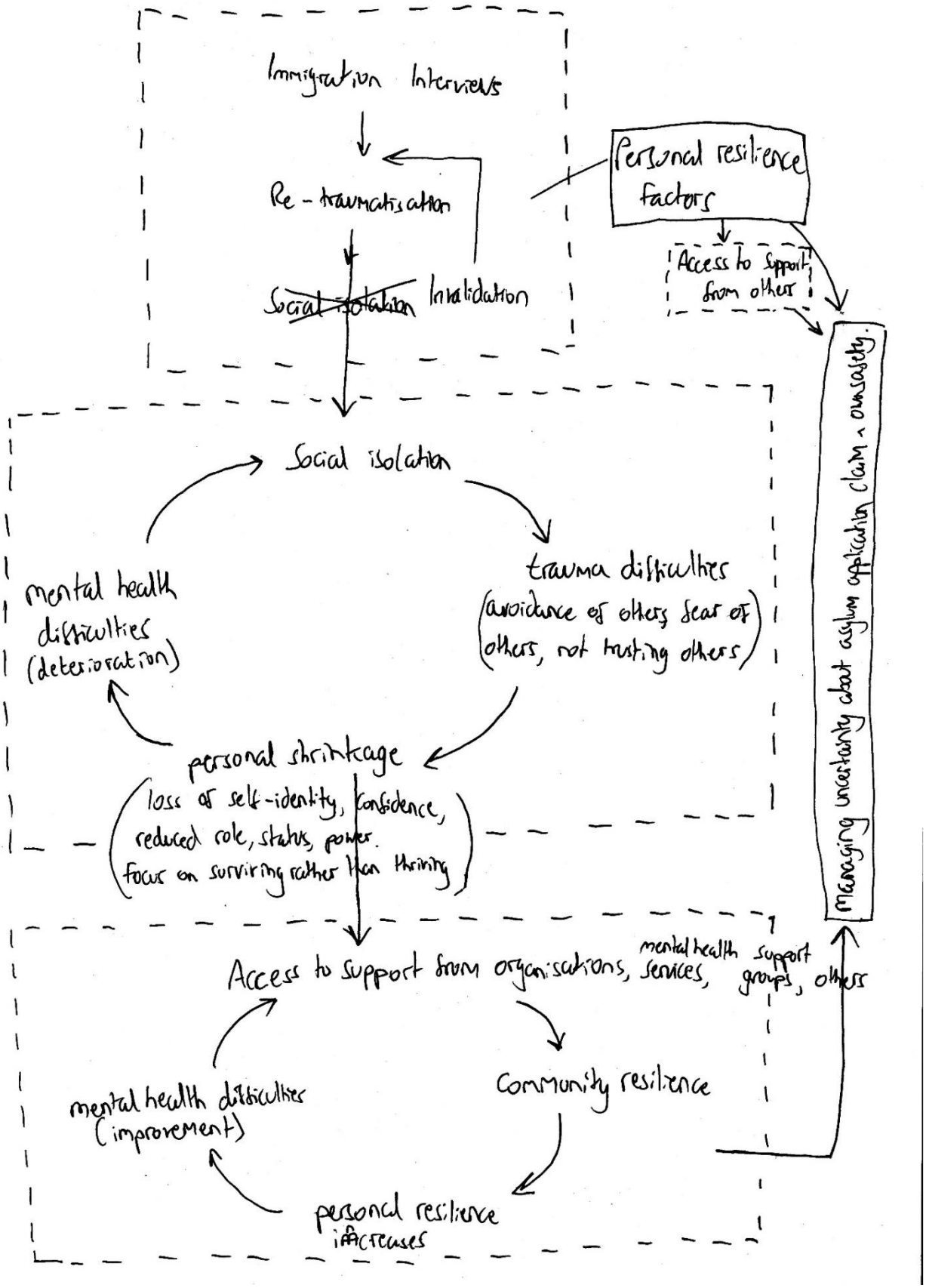
4.14 Development of Constructivist Grounded Theory

Versions 1 – 7 of diagram


Factors affecting Resilience / Coping + mental health difficulties
- mixed emotions
- Relief, Concern for others, loss, grieving
- dilemma of whether to stay or return
Cultural differences
Poverty
Trauma
depression, anxiety
drug use to cope
fear of stigma
Personal difficulties:
trusting others
mental health difficulties
hopelessness
emotion regulation
fear + uncertainty of future
experience of not coping
Community Resilience Increases
↳ Support through organisations
↳ Access to mental health services
↳ Knowledge of support groups / faith groups
↳ Benefits of talking, sharing experiences
↳ Meeting others - ppl from home country.
Sense of safety through others, belonging, confidence building
Retraumatisation via interviews
criminalisation
reduced status/power
depersonalisation
Personal Shrinkage
loss of identity
loss of profession/role
lacking a sense of purpose
detention
destitution
Rejection of application
Personal Resilience develops
↳ Increasing resilience & experiences
↳ Development of coping strategies
↳ Development of english speaking skills
↳ learning how to care through others
College / courses
Need for basic needs to be met - Safety
- lack of the drugs
Hopes application will be processed quickly
Asylum journey
Time →
Hurdles
Initial period
End of "Honeymoon" Period
Settling in Period (months to years)
Following arrival prior to applying for asylum.
Social Isolation
Not having
~~Need for~~ opportunities to thrive, ~~not~~ just surviving
Effects of trauma (space to grow)
Increasing anxiety about asylum application process
↳ long time to reach decision
Having freedoms but not being free to enjoy them.
→ Restrictions on asylum seekers (to work)
Invalidation of experiences
Personal Growth
↳ College
↳ desire to help others / contribute
↳ empathy for others.
↳ increasing strength through experiences
↳ sense of purpose e.g. volunteering
↳ processing of traumatic events
Difficulties + inconsistencies in accessing services, organisations, groups.
mental health services
GP surgeries.
Threat system overactive
flight response
Avoidance of others/ threatening situations
Deterioration of mental health
COMMUNITY RESILIENCE DEVELOPS
PERSONAL RESILIENCE FACTORS


Uncertainty about asylum application claim and own future/safety
Immigration Interviews
Retraumatisation
Invalidation of experiences
Dehumanising, non-compassionate experiences
Social Isolation
Dependency on personal resilience
Effects of trauma
Interpersonal difficulties (can't trust others)
Emotional regulation
Deterioration of mental health
worsened by asylum claim rejection
Depression, anxiety, worries about claim
Community resilience increases
→ greater access to organisations, support groups, faith groups, services, other asylum seekers
→ talking to others, sharing experiences
→ processing of traumatic events
→ sense of belonging (humane, compassionate experiences)
Personal resilience increases
→ learning coping strategies (through others) for stress
→ increasing strength through experiences
→ Reduction of interpersonal difficulties developing trust for others, emotion regulation
Early Experiences
Middle Experiences
Later Experiences
Mental health difficulties
Uncertain of safety
High stress + anxiety
Fear of Others
Difficulty accessing services
Dilemma of whether to stay
Concern for safety of loved ones
Personal shrinkage
→ surviving rather than thriving
→ reduced power/status/role
→ Depersonalisation, loss of self-identity and confidence
→ experiences of racism/prejudice/discrimination (inc institutional)
Personal growth
→ development of identity (known by organisations and groups, staff, other AS)
→ empathy for others' suffering
→ desire to help others
→ Confidence increasing
→ sense of purpose e.g through volunteering
→ Learning (english speaking, college)
→ Actions/behaviour in line with own values
very difficult journey


Immigration Interviews
Re-traumatisation
Social isolation
Dependency on personal Resilience
effects of trauma
personal shrinkage
access to support from others
community resilience
personal resilience
personal growth
managing uncertainty about asylum claim
mental health deterioration


Immigration Interviews
Re-traumatisation
Social isolation
Invalidation
Personal resilience factors
Access to support from others
Managing uncertainty about asylum application claim + ongoing.
Social isolation
mental health difficulties (deterioration)
trauma difficulties (avoidance of others, fear of others, not trusting others)
personal shrinkage
loss of self-identity, confidence, reduced role, status, power. focus on surviving rather than thriving
Access to support from organisations, services, mental health support groups, others
mental health difficulties (improvement)
Community resilience
personal resilience increases

Experience of the Asylum Application Process

Immigration interviews

Having a dehumanising, non-compassionate experience

Invalidation of traumatic experiences

Negative impact on mental health

Application process

Very difficult experience

Uncertainty for future and own safety

Negative impact of process and rejection of asylum claim on mental health

Environmental Factors: Accommodation; Societal experiences: racism/discrimination

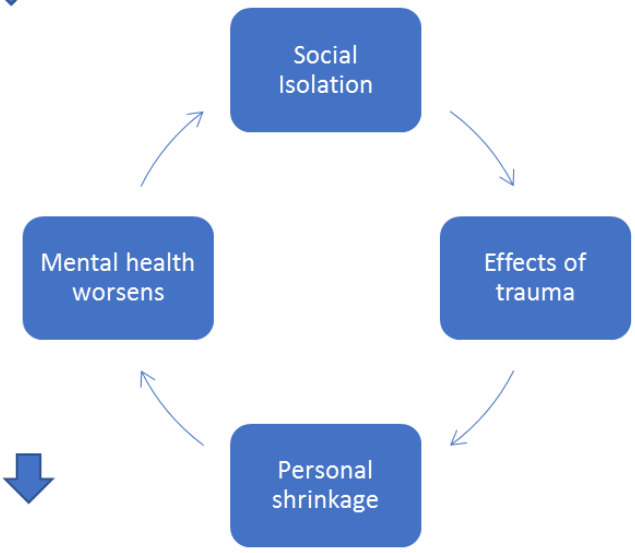
Personal Resilience: Coping strategies, Beliefs, Faith, Upbringing, Previous experiences

Community Resilience: Access to health services, organisations, faith groups, support groups

Effects of trauma: Interpersonal difficulties: (not trusting others; fear of others); Emotion regulation difficulties, Avoidance behaviours.

Personal shrinkage: Depersonalisation; Loss of self-identity and confidence; Surviving rather than thriving;

Mental health worsens: Uncertainty of safety; high stress and anxiety levels; Mood worsens



Community resilience increases: Not easy to access support; Support from others: asylum seekers. organisations, services, support groups, faith groups; Sharing of experiences; Sense of belonging

Personal resilience increases: Learning coping strategies (through others); Struggle makes self stronger; Effects of trauma decrease

Personal growth: Development of self-identity and confidence; Learning; Action in line with values

Experience of the Asylum Application Process

Theme 1: Experience of the asylum application process

1. A very difficult journey
1) Having a dehumanising, invalidating experience
2) Uncertainty for the future and for the safety of self and others

Theme 2: Factors affecting coping

1. Environmental Factors 1) Accommodation 2) Societal experiences: racism/discrimination

2. Personal Resilience 1) Coping strategies 2) Previous experiences 3) Beliefs/religious faith

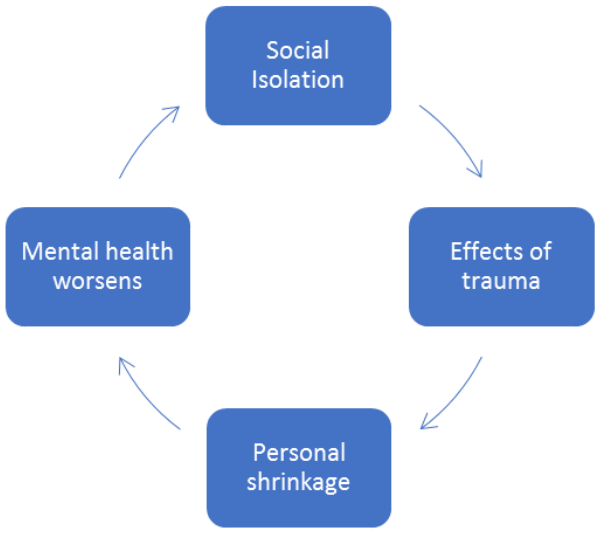
3. Community Resilience 1) Not easy to access support 2) Types of support: health services, non-governmental organisations, faith groups, support groups, other asylum seekers, legal support

Theme 3: Hardship

1.Social isolation

2. Effects of trauma
1) Interpersonal difficulties, not trusting others, fear of others, emotion regulation difficulties, avoidance behaviours, high anxiety levels

3. Personal shrinkage
1) Depersonalisation (loss of self-identity and confidence)
2) Surviving rather than thriving
3) Mental health worsens



Theme 4: Growth

1. Community resilience increases:
1) Building trust for others
2) Sharing of experiences
3) Sense of belonging

2. Personal resilience increases:
1) Learning coping strategies through others
2) Language development
3) Struggle makes self stronger

3. Personal growth:
1) Development of self-identity/confidence
2) Action in line with values
3) Improvement of mental health

Experience of the Asylum Application Process

Theme 1: A very difficult journey

1) ***Not being believed*** - Having dehumanising, invalidating experiences

2) ***Uncertainty for the future and safety*** - fear of being deported and safety of self & others

Theme 2: Factors affecting coping and resilience

1) Environmental Factors - Involving accommodation, and experiences of racism & discrimination

2) Individual Factors - Involving coping strategies, previous experiences, beliefs & religious faith

3) Community Resources - Not easy to access health services, non-governmental organisations, faith groups, support groups, other asylum seekers & legal support

Theme 3: Hardship

1) Feeling very alone - social isolation

2) Fear and suspicion of others - Involving being afraid of others, not trusting others, and avoiding others

3) Personal shrinkage
Involving depersonalisation, loss of identity and confidence, sense of surviving rather than thriving, a worsening of mental health

Theme 4: Resilience can increase

1) Access to community resources improves By sharing of experiences which can reduce fear of others and develop trust and a sense of belonging

2) Individual resilience factors can increase By Learning coping strategies through others, and language development

3) Personal growth may occur By development of identity/confidence, taking action in line with values which lead to potential improvements in mental health