The experiences of professionals and service providers working with Arab Asylum seekers and refugees in the UK

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Title of degree programme	**Professional Doctorate in Clinical Psychology**
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Declaration and signature of candidate

I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed: Hannane Hamlaoui Date: 21.03.25

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Dedication

To the Martyrs, to the millions of displaced refugees, families and individuals, may your voices never be silenced, may your struggles be acknowledged and may you always be remembered.

To my father, Dr M. N. Hamlaoui, who continued to be my inspiration, strength, and role model throughout training, who would always encourage me to strive for knowledge, humility and determination. I hope I have made you proud. May Allah rest your soul.

Acknowledgments

بِسْمِ اللَّهِ الرَّحْمَٰنِ الرَّحِيمِ

"In the name of Allah, the Most Gracious and the Most Merciful"

I would like to praise Allah the Almighty, the Most Gracious, and the Most Merciful for giving me the strength to undertake and complete this research. It is through his guidance and wisdom that I have been able to navigate and manage the many challenges and hurdles encountered during this process.

I am also profoundly grateful for my husband and family for their continued support and blessings throughout my doctorate. I would like to extend my sincere gratitude towards my mother for her prayers, sacrifices, strength and endless patience, without her love and hard work I would not be the person I am today.

I want to thank my clinical supervisor Dr Kim Gordon for her invaluable expertise, guidance and continued support throughout my research journey. Finally, I would like to offer my sincere gratitude to all research participants who dedicated their time to participate in this study and share their valuable experiences and perspectives.

Table of Contents

Thesis Abstract

This thesis focuses on exploring what is known about how mental health professionals experience working therapeutically with Arab communities globally, and synthesising findings from available research on this subject. The thesis also presents new research on this topic with a focus on Arab refugees and asylum seekers in the UK from the perspectives of professionals and service providers.

The first paper is a systematic literature review about mental health professionals' experiences of working therapeutically with Arab communities around the world. Globally, Arab populations experience mental health difficulties, however, despite mental health difficulties being common, Arabs are less likely to seek professional support. The aim was to understand whether any facilitators, challenges or barriers exist, and what considerations are needed to optimise the mental health support for this group. Searches were conducted during April and May 2024 and 10 studies were identified and selected for the review. The Critical Appraisal Skills Programme Qualitative Studies Checklist (CASP, 2018) was used to evaluate the quality of the included studies. A 10-criteria rating system developed by Kmet, Cooke and Lee (2004) to appraise the quality of papers using various research designs was also used as it provided percentage ratings of the overall quality of the studies. Using a narrative synthesis (Popay et al, 2006), four key areas were highlighted: 1) why Arabs are hesitant to seek mental health support, 2) cultural experiences and competence, 3) systemic and service-level issues, 4) personal impact of working with Arab refugees.

The second paper is an empirical study on the experiences of professionals and service-providers working with Arab asylum seekers and refugees (ASRs) in the UK. This qualitative study utilised interview data from seven participants who had direct experiences of working with Arab ASRs with various roles such as psychology-focused roles and community roles. Reflexive thematic analysis was used to analyse the data. Five themes were identified: (1) the therapeutic relationship; (2) cultural awareness: the Arab culture; (3) power and negative perceptions of ASRs; (4) tailoring support services and improving access; (5) navigating the rewards and challenges of the role.

The third paper is an executive summary which is an overview summarising key points, findings and recommendations from the empirical research in paper 2. The executive summary is aimed at professionals and service-providers who work directly with Arab ASRs in any type of role or setting with the aim to present information that is accessible to better facilitate decision making.

Paper 1: **Literature Review**

The experiences of Mental Health Practitioners working therapeutically with Arab communities

Word count: 8000

(Excluding title page, references, and appendices)

Although this literature review is not intended for publication, it will broadly follow the structure in accordance with the author guidelines for Culture, Medicine and Psychiatry, provided in Appendix 1.

Abstract

Introduction and Aims: Mental health difficulties are common among Arab populations globally, however, most Arabs are less likely to seek professional support (Khatib, Alyafei & Shaikh, 2023). The current research has predominantly focused on client perspectives, and whilst these views are crucial, there is also a need to investigate the views of Mental Health Professionals (MHPs).

The systematic literature review explored MHPs' experiences of working therapeutically with Arab communities around the world. The aim was to explore and understand whether any barriers, facilitators or challenges exist, and what considerations are needed to optimise the mental health support for Arab communities.

Methods: Four electronic databases and the grey literature were searched yielding 451 records. Following further manual searching and screening against the eligibility criteria, 10 qualitative studied were selected. The studies were published between 2000 and 2023, spanning eight countries including Western and non-Western countries.

Results: Four key areas were highlighted: 1) why Arabs are hesitant to seek mental health support, 2) cultural experiences and competence, 3) systemic and service-level issues, 4) personal impact of working with Arab refugees.

Conclusions: MHPs reported facilitators, barriers and considerations when working with Arab communities across different settings, countries, and contexts. Several clinical implications include tailoring interventions, increased training resources and cultural competence for staff, and mental health awareness for Arab communities in host countries.

Key words: mental health professionals, Arab communities, mental health, therapy, barriers, access.

Introduction

Mental difficulties are understood to be experienced as a significant individual, family and as a societal problem in countries and cultures throughout the world (World Health Organisation; WHO, 2001). Anxiety and depression are the most common mental health problems affecting approximately 16% of the population at any one time (Moller et al, 2019). The Arab population consists of a diverse group of Arabic speaking individuals who share common cultural and religious values from 22 Arab countries across the Middle East to North Africa (Maalouf et al, 2019; Zeinoun et al, 2020). In 2019, the overall rates of mental illness were the highest in Palestine, with rates of depression being 1,168 per 100,000, and the lowest in the UAE with 628.63 per 100,000 (Effatpanah et al, 2024).

Arab immigrants are increasingly becoming one of the largest groups of displaced migrants around the world. The United States of America (US) accepted approximately 85,000 refugees between 2016-2017, and roughly 10,000 immigrated from Syria (United Nations High Commissioner for Refugees; UNHCR, 2020). A significant proportion of Arab immigrants have been exposed to violence, war, and torture, and many of which are likely to experience trauma-induced mental illnesses such as post-traumatic stress disorder (PTSD) and resettlement-related anxiety (Fazel, Wheeler, & Danesh, 2005).

Within Arab communities, regardless of refugee status, there is a discrepancy in the use of and access to mental health services (Arday, 2018). Findings in the Arab mental health literature including studies in the US, the United Kingdom (UK) and in Australia show that individuals usually underutilise mental health services, presenting negative attitudes towards mental health and psychological services (Erikson & Al-Timimi, 2001; Hamid & Furnham, 2013; Youssef & Deane, 2006). Instead, this population usually seeks help through religious and social networks or through medical doctors, often avoiding therapeutic services due to the stigma placed on seeking such services (Aloud, 2004).

Within psychotherapy, stigma is conceptualised as the rejection by society towards an individual's distress as well as one's own internal struggles to accept their mental health difficulties (Corrigan, 2004; Vogel, Wade & Haake, 2006). A recent systematic review by Khatib et al (2023) found that

fear of societal and cultural stigma stemmed from individuals being treated differently and marginalised because of labels that they were ‘mentally ill’.

Other areas of research have focused on barriers relating to the lack of adaptation of evidence-based therapeutic interventions to non-Western cultures. Psychotherapies such as Cognitive Behavioural Therapy (CBT) has been criticised for being less effective for non-Western communities (David, Cristea & Hofmann, 2018). Standard CBT is based on Western models of illness and places less attention on modifying the framework and practise to integrate an understanding of diverse ethnic, religious and cultural contexts (Rathod, Phiri & Naeem, 2019). In contrast, a recent review of the public health budget for ethnic minority communities in the UK proposes that ethnic minorities personally favour culturally appropriate mental health services (Ayoola & Butt, 2021). Cultural competence has been defined as providing culturally appropriate services by paying attention to language differences and cultural impacts on beliefs that shape the experience of mental difficulties and help-seeking behaviour, therefore culturally-tailored services can facilitate access for individuals from different backgrounds (Bhui et al, 2007).

Rationale and Aims

Whilst there has been some research into the experiences of Arab communities accessing mental health support, there has been limited research into the perspectives of mental health professionals (MHP) who interact with this population (Khatib et al, 2023). It is important to explore MHPs’ experiences of working therapeutically with Arab communities in order to understand what their experiences are, and whether they are aware of what Arab clients find helpful or unhelpful during therapy. One study reported that the relationship between practitioner-patient impacted the likelihood of seeking and continuing treatment, though this study was conducted with General Practitioners (GPs) who have a different role to MHPs and are therefore unlikely to apply psychotherapeutic interventions (Al-Busaidi, 2010).

Therefore, the aim of this systematic literature review is to explore the experiences of MHPs working therapeutically with Arab communities worldwide. The findings will help to understand how MHPs perceive working with this population, and aim to shed light on any facilitators and barriers to highlight future meaningful changes and practises that may be necessary to best support both Arab service-users and MHPs who work with this population.

Materials and Methods

Search Strategy

The search aimed to identify qualitative evidence from the literature on MHP's experiences of working therapeutically with Arab communities. A conceptual tool 'The SPIDER tool' (Sample, Phenomenon of Interest, Design, Evaluation, Research type; Cooke, Smith & Booth, 2012) was used to categorise key elements of the research topic and guide the systematic search process of the literature (Table 1).

Table 1. Key elements of research question (Cooke et al, 2012).

SPIDER terms	**Justification**
S – Sample	Any type of Mental Health Care Professional that has worked therapeutically in some capacity with Arab clients
PI – Phenomena of interest	Experience of working therapeutically or psychologically with Arab communities
D – Design	Qualitative research methodology e.g. semi-structured, unstructured interview, focus groups etc.
E – Evaluation	Exploring MHPs experiences, perceptions, feelings, challenges, barriers, facilitators when working therapeutically with Arab communities.
R – Research Type	Qualitative research or mixed methods research where the qualitative aspect is separate to the quantitative aspect of the research.

A systematic search of the literature began on 20th April 2024 and was completed on 3rd May 2024 using four electronic databases: SCOPUS, APA PsycArticles, CINAHL and PubMed Central. The grey literature was also searched using Google Scholar and reference lists of suitable papers were

hand searched to identify any further studies. Search terms were chosen by reviewing the relevant literature and having multiple discussions with an academic librarian and academic supervisor. To identify studies, relevant terms for the research question and the Boolean operators 'AND' and 'OR' were entered collectively in one search with the following phrase:

> ("mental health practitioner" OR couns* OR "mental health nurse" OR psychologist* OR "mental health professional" OR mental healthcare assistant OR art therapist OR psychotherapist OR "psychological intervention") AND (Arab OR Arab-Australians OR Arab-Americans OR British-Arabs OR French-Arabs OR German-Arabs OR Arab-refugees OR Middle East OR Eastern Mediterranean OR Palestine OR Palestinian OR Egypt OR Egyptian OR Lebanon OR Lebanese OR Saudi Arabia OR Saudi OR Jordan OR Jordanian OR Syria OR Syrian OR Iraq OR Iraqi OR Oman OR Omani OR United Arab Emirates OR UAE OR Algeria OR Algerian OR Morocco OR Moroccan OR Qatar OR Qatari OR Kuwait OR Kuwaiti OR Comoros OR Comorian OR Djibouti OR Djiboutian OR Libya OR Libyans OR Mauritania OR Mauritanians OR Somali OR Somalians OR Sudan OR Sudanese OR Tunisia OR Tunisians OR Yemen OR Yemeni OR Muslim OR Islamic OR Bahrain OR Bahrainis) AND (experienc* OR percept* OR attitudes OR engagement OR barriers OR views OR challenges OR accounts)

Publication Bias

Publication bias may occur in the literature, which may involve the lack of transparency in the reporting of results, making it difficult to independently review the data and infer similar findings or replicate the study due to lack of rigour in the methodology (Smith & Noble, 2014). To address publication bias, Google Scholar was used to search the grey literature to consider unpublished research or research that has not been peer-reviewed.

Selection Criteria

Scoping Review

The systematic review covered international studies in order to explore MHPs' experiences of working therapeutically with Arab communities. The rationale for this is that an initial scoping

exercise found most studies were conducted outside of the UK. Additionally, as there are no existing literature reviews within this area it would be valuable to include global studies that represent a wide range of perspectives of MHPs working with a wider range of Arab communities.

Inclusion Criteria

- Peer-reviewed and non-peer-reviewed studies in the selected databases and grey literature where the full texts were available.
- Studies written in English due to lack of translation services.
- Qualitative studies were chosen as this type of methodology enables a rich and in-depth understanding of subjective experiences.
- Studies including experiences from the perspectives of any type of MHP that have worked therapeutically or applied psychological theory with Arab individuals in any type of context or mental health setting. Mixed sample studies looking at experiences from other stakeholders were included only if findings from MHPs were separate and distinguishable from other participants.

Exclusion criteria

- Quantitative studies.
- Reviews, editorial pieces or essays.
- Studied where the intervention is purely medical (e.g. physical health-related or purely medication).
- Studies that only reported on personal experiences of MHPs.

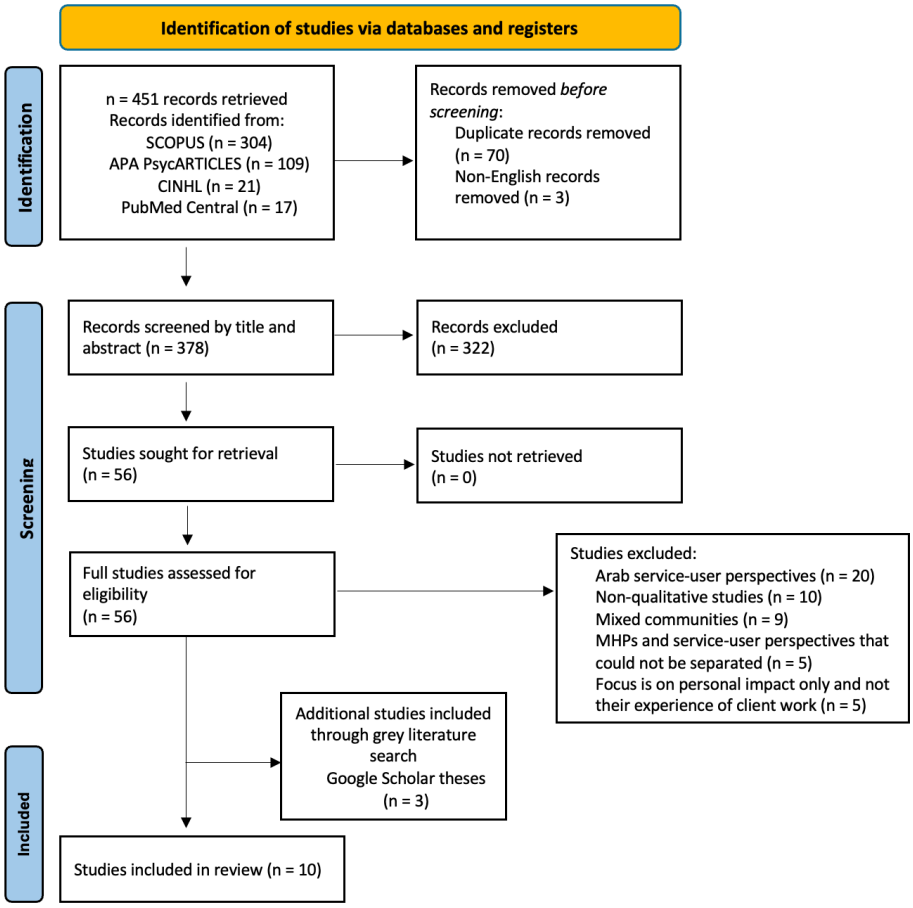
Synthesis Method

Due to the variety of studies, interventions, and settings, a narrative synthesis methodology was chosen. This approach is suitable for synthesising findings from diverse studies that are not similar enough for methods such as Thematic or Qualitative Synthesis (Thomas & Harden, 2008). This review followed Popay et al's (2006) guidance for conducting narrative synthesis in systematic reviews.

After removing duplicates and screening titles and abstracts, the full texts of the remaining articles were examined against the selection criteria, yielding seven relevant papers. Three doctoral theses were identified using Google Scholar. In total, there were 10 identified papers included for review. Figure 1 shows the systematic search process.

Figure 1

PRISMA Flow Diagram detailing search terms and sources (Page et al, 2021)



Quality assessment

The Critical Appraisal Skills Programme Qualitative Studies Checklist (CASP, 2018) was used to evaluate the quality of the included studies, which provides key criteria for appraising qualitative studies including appropriateness of research design, rigour of analysis of data, ethical issues etc. Studies were appraised in line with the CASP checklist wording of 'Y – Yes, C – Can't tell, N – No' based on whether they met each of the ten questions in the checklist. A 10-criteria rating system developed by Kmet, Cooke and Lee (2004) to appraise the quality of papers using various research designs was also used as it provides an overall quality rating for papers in percentages that the CASP tool does not (Kmet et al, 2004). Results were compiled in tables found in the Appendices 1 and 2.

Results

Papers included in the search were published between 2000 and 2023. A summary of the study characteristics is presented in Table 2.

Table 2

Study Characteristics Table

Study No., Author, Year & Country	Aims	Sample	Any additional Context	Methodology/Analysis	Key Findings
1. Algahtani et al (2019) Saudi Arabia & Bahrain	To understand the perspectives of patients with depression and anxiety, caregivers and MHPs about CBT	42 Patients 11 Carers 16 Psychologists and Psychiatrists	-	Semi-structured interviews Thematic Analysis	Three themes 1) Awareness and preparation for therapy -Culture and related issues -Individual and system level factors -Cognitions and beliefs about health and illness 2) Assessment and engagement -Assessment issues -Engagement issues 3) Adjustment in therapy techniques -Barriers to therapy
2. Anastasiou et al (2022) England	To explore the perceptions of service providers on the current mental-health and well-being services for Syrian refugees	8 MHPs	MHPs reflecting on service delivery for Syrian refugees in Coventry, Warwickshire	Semi-structured interviews Thematic Analysis	Three themes 1) Positive aspects of service delivery 2) Service challenges 3) Recommendations for service improvements and quality

3. Al-Mahrouqi et al (2022) Oman	Exploring healthcare providers' and clients' experience of tele-mental health during the COVID pandemic	6 Clinical psychologists 13 Clients	Clients had a 6-week trial of therapist-guided online therapy for COVID-induced anxiety and depression	Semi-structured interviews Thematic Analysis	Three themes 1) Benefits and advantages -Perform risk assessments safely -Reduces stigma of receiving mental health care 2) Challenges and limitations -Not accessible to rural areas -Confidentiality issues -Shortage of trained Clinical Psychologists in Oman 3) Recommendations and way forward -Increasing clinical psychology training -Offering choice of virtual vs face-to-face therapy
4. Bin-Hasan (2022) [Thesis] England	-To understand the views of Middle Eastern clients about accessing counselling and psychotherapy in England	4 clients 6 counsellors and psychotherapists	-	3 phases Phase 1 – quantitative survey to explore client views	Phase 1 survey findings: 1) Openness to accessing counselling and psychotherapy 2) Value in the counselling and psychotherapy profession

	-To explore the helpful and hindering aspects of counselling and psychotherapy for Middle Eastern clients in England			Phase 2 – qualitative semi-structured interviews to explore client and MHPs' views analysed using Interpretive Phenomenological Analysis (IPA)	3) Preference to cope on own Phase 2 client findings: 1) Therapy access experience 2) Cultural stigma 3) Confidentiality concerns 4) Preference and expectations Phase 3 therapist findings: 1) Cultural stigma 2) Confidentiality concerns 3) Cultural identity 4) Therapeutic approaches
5) Habhab (2018) [Thesis] USA	To explore the perceived barriers and facilitators of providing mental health services to Arab clients	11 Arab psychotherapists	-	Semi-structured interviews Grounded theory	Four themes Barriers of treatment -Acculturation -Gender -Family support -Stigma in the community

					Facilitators of treatment -Family support -The therapist -Community support Therapeutic interventions -Psychoeducation -Therapeutic consultation Recovery beliefs Arab-American recovery beliefs Defining recovery Therapists' role in recovery
6) Hamid, Scior & De C Williams (2000) Turkey	To explore Syrian MHPs' experiences of providing therapy within a shared Syrian culture and displacement context Reflecting on their own feelings and how it is for them personally	16 MHPs	Syrian MHPs who have been forcibly displaced to provide care to Syrian refugees in Turkey.	Semi-structured interviews Thematic Analysis	Two Themes 1) Shared characteristics -Empathising with experiences -Understanding language and culture -Self-disclosure 2) Personal Impact -Fulfilment -Distress

				-Ways of coping
7. Ibrahim et al (2021) Egypt	To explore Egyptian MHPs perspectives about mental health recovery, the enablers and barriers which influence its implementation	15 registered and - MHPs (psychiatrists, psychologists, and mental health nurses)	Semi-structured interviews Content Analysis	Three Themes 1) Definition of recovery -Being able to sustain personal relationships and effectively carry out work. -The conscious ability to be aware of and manage stressful experiences and emotions. -MHPs enable and support service-users to make choices and develop goals by highlighting their strengths. 2) Enablers of recovery -Therapeutic relationship and communication -Client and family engagement in treatment -Cultural sensitivity

					-Supervision and feedback on use of mental health services 3) Barriers to recovery -Barriers in Egyptian culture that hinder recovery processes -MHP-related qualities and attitudes that hinder recovery.
8. Nassar-McMillan & Hakim-Larson (2003) USA	To understand counsellors' views on working with Arab American communities within family services	10 Arab therapists in America	Services covered included adult services; child and family services; substance misuse prevention and treatment	Data was interpreted generally with reviewers reflecting on major themes	3 main areas 1) Issues presented -Country-specific views on mental health -Cultural identity -Cultural norms -Cultural stereotypes 2) Barriers and Recommendations -Openness to counselling -Religion -Family involvement 3) Therapy and Therapist factors -Therapist identity -Barriers for non-Arab therapists -Session dynamics

9. Miqdadi (2015) [Thesis] Jordan	To understand the experience of psychosocial counsellors working with Iraqi refugees in Jordan	6 psychosocial counsellors	MHPs also reflecting on personal impact of this work	Semi-structured interviews analysed using IPA	Three master themes 1) The Effects of Socio-political and Socioeconomic Factors Basic needs not being met Emotional burden 2) Enriching aspects of role Psychological value Achievement and reward 3) Coping with distressing aspects of role Self-care and professional support
10. Zaken & Walsh (2021) Palestine/Israel	To understand the experiences of Arab Art Therapists when working with the Arab minority in Israel To understand the gaps between Arab Art	13 Arab Art therapists	Therapists worked with children and parents in schools	Semi-structured interviews analysed using IPA	Three themes 1) Lack of familiarity psychological therapy in Arab society and coping with it -Art therapy and therapy in general were foreign to this population

	therapists' training and practise	-Therpay perceived for 'mad people' and considered shameful in society. -Resistance to engage among parents 2) Conflicts between professional boundaries and the perceptions of collectivist societies -Difficulty in balancing cultural and societal norms with the therapeutic process -Conflicts over discussing sexual issues -Confidentiality -Gender roles 3) Gaps between the therapist and the Arab society -Coping with gaps between own culture and Arab culture from other localities

Commented [YM1]: Spelling

-Differences between professional training and practise

Overview of the Studies

All 10 studies included in this systematic literature review used a qualitative methodology. One study (Bin Hasan, 2022) used a mixed-method approach which included quantitative surveys as well as qualitative data (interviews) which was the main focus. Overall, studies varied in the following: types of MHP sample; the type of interventions or therapeutic focus; country and context; and type of Arab communities. Experiences mainly focused on discussing barriers and facilitators of working with Arab communities in and from different countries, and two context-specific studies also discussed personal reflections and challenges of this work (for example, the experience of being displaced and working with Arab refugees during a war).

Out of the 10 studies, six studies were conducted in Arab countries with a variety of Arab MHPs and modalities. Zaken & Walsh (2021) explored Arab Art Therapists' experiences of working with Arab communities in Palestine/Israel and the gaps between their training and practise. Algahtani et al's (2019) study had a specific focus on CBT and the adaptation of the intervention in Saudi Arabia and Bahrain, exploring both patient and MHP experiences. Al-Marouqi et al (2022) focused on MHPs' and clients' experiences of tele-mental health in Oman during the COVID pandemic. Ibrahim et al's (2021) study focused on exploring Egyptian MHPs' views on mental health recovery and enablers and barriers to recovery. Two of the studies conducted in Arab countries focused specifically on Arab refugee communities, whereby Miqdadi's (2015) study explored the experiences of psychosocial counsellors working with Iraqi refugees in Jordan; and Hamid et al's (2020) study focused on the experiences of forcibly displaced Syrian MHPs to provide care to Syrian refugees in Turkey.

The remaining four studies were conducted in Western countries; two studies conducted in England explored the helpful and hindering areas of counselling and psychotherapy with Middle Eastern clients (Bin-Hasan, 2022), and Syrian refugees in England and existing service provision (Anastasiou et al, 2022). Two other studies were conducted in the United States; Nassar-McMillan & Hakim-Larson's (2003) study explored counsellors' views on working with Arab American communities within a variety of adult and children services, and Habhab's (2018) study focused on barriers and facilitators of therapeutic work with Arab clients, but included psychotherapists who self-identify with the Arab American cultural group.

Critical Appraisal

Using the CASP tool, 9 out of the 10 studies included had clear aims of research (Q1) (See Appendix 2). Al-Mahrouqi et al's (2022) study was appraised as 'can't tell' as they did not include a clear statement of their aims, though there was an understanding that the study focused on exploring MHPs' and clients' views of tele-mental health in Oman from the last paragraph of their introduction. The choice and justification of the use of qualitative methodology and design were appropriate for all studies due to exploring the meaning and interpretations of participants' experiences, and this methodology was appropriate in all studies for addressing the research goals (Q2 & Q3). Eight studies included full details on recruitment strategy meeting the aims of their research (Q4). Ibrahim et al's (2015) and Hamid et al's (2023) studies did not appear to provide full information on their participants, including how they were selected and why other types of participants were not selected over other ones. All studies had detailed information in relation to data collection and justification, including data saturation (Q5). Additional ratings for the assessment of the quality of these studies and percentage ratings are included in Appendix 3.

There were mixed appraisals in relation to the consideration of the relationship between the research and participants (Q6). Algahtani et al's (2019) study was deemed 'not clear', where the researchers only addressed their role in relation to data collection and analysis, though this was sparse. Three studies were deemed to be insufficient (Al-Mahrouqi et al, 2022; Ibrahim et al, 2021; Nassar-McMillan & Hakim-Larson, 2003), where there was lack of researcher consideration and examination of their role, this is particularly important considering whether the identity (Arab vs non-Arab) of the researcher could have had an impact on various aspects of the study e.g cultural values or beliefs. Anastasiou et al's (2022) study and the three theses that were included had the highest percentage ratings of quality in relation to all aspects of the criteria (Kmet et al, 2004). In particular, ethical considerations were discussed in depth in relation to ethical issues and how these were addressed, and details regarding approval were included. Four studies did not comment on various aspects of ethics such as transparency regarding funding and briefing of participants, which raises concerns about their ethical integrity, nor did they use verification procedures to establish credibility. Eight out of ten studies had an in-depth description of their analytic method (Q8), including - the type of analysis used and the description of the analytic process, which would enable procedures to be replicated according to Kmet et al (2004) and therefore was appraised as

being clear and easy to understand. Nassar-McMillan & Hakim-Larson's (2003) study did not specify a qualitative analytical approach such as IPA or TA. Instead, they described developing general themes across the dataset and reported that not all topics/findings would be covered in their paper due to them already being well-established in the literature. These researchers also did not include participant quotes to support their themes. The lack of formal analysis method and participant quotes questions the rigorousness, quality and credibility of their findings.

Findings

Four overarching key areas and sub-themes were identified within the reviewed literature; 1) why Arabs are hesitant to seek mental health support, 2) cultural experiences and competence, 3) systemic and service-level issues, and 4) personal impact of working with Arab refugees. These key areas are discussed below.

1. Why Arabs are hesitant to seek mental health support

1.1 Lack of understanding and acceptance of therapy in the Arab world

Participants across papers spoke about the lack of understanding about exactly what therapy or mental health services entails in the Arab society which appeared to be most pertinent in Arab countries. Zaken and Walsh's (2021) study of Art therapists' experiences found that therapy in general was foreign to service-users, and when they did have some idea of what therapy was, this appeared to be distorted or misunderstood due to societal perceptions and stereotypes that therapy is for 'mad people'. The parents of the patients found it difficult to understand what Art therapists' profession involved and particularly how 'art' plays a role, which led to resistance to engage in the treatment. Similar findings were reported in Algahtani et al's (2019) study in Saudi Arabia and Bahrain, whereby MHPs described that though patients had some knowledge of CBT and therapy, their understanding was limited as they expected full recovery or fast improvements like those expected with pharmacological treatments. Similarly, Ibrahim et al (2021) reported that particularly in rural areas in Egypt there was a lack of mental health awareness and where to seek support.

Due to the lack of understanding of therapy in the Arab society and the described stereotypes, most studies reported that there was a resistance to access services, illustrated in the following quote:

> "They're always saying that you're an art teacher. Until this day, they don't accept that I am a therapist. I also had difficulties with parents. If I would invite them and sit with them to talk about the child and all sorts of things, they are not accepting; they tell me their child is not crazy. They don't understand what art therapy is" (Zaken & Walsh, 2021, p. 4).

1.2 Stigma, shame, fear and mistrust

Almost all studies reported some form of stigma and its impact in seeking support in Arab societies (e.g. Algahtani et al, 2019; Al-Marouqi et al, 2022; Bin-Hasan, 2022; Ibrahim et al, 2021; Nassar-McMillan & Hakim-Larson, 2003; Zaken & Walsh, 2021). Interpersonal stigma was related to feelings of shame when accessing therapy and what to share, as well as feelings of inferiority and judgment for accessing mental health support. This also related to potential personal beliefs that individuals held about themselves for accessing therapy, such as something must be wrong with them.

Stigma also stemmed from community-related stigma that you are 'mad' or 'crazy' if you seek therapy, illustrated by the quote from a MHP talking about her clients who seek therapy: "because it means, there's something wrong with me, that I'm not good enough... what do I say to the other members of my family?" (Bin-Hasan, 2022, p. 165). Arab MHPs in the US also described the presence of community-related and interpersonal stigma, where some clients even asked for appointments at certain dates or times to avoid being seen seeking mental health support by people in the community (Habhab, 2018). On the other hand, Al-Mahrouqi et al's (2022) study found that virtual therapy reduced some of this interpersonal stigma, shame and fear, as it meant that clients did not hold this fear of seeing and facing a familiar person in the community whilst accessing therapy face-to-face.

MHPs in other studies reported that the stigma of seeking mental health support was so large for Arab service-users that they tended to present to services as a last resort; instead, they accessed some form of religious healing prior to therapy, such as a Sheikh who is a religious

faith leader at the mosque both in Arab and Western countries (Algahtani et al, 2019; Bin-Hasan, 2022; Ibrahim et al, 2021; Nassar-McMillan & Hakim-Larson, 2003; Zaken & Walsh, 2021). As a result of this stigma, MHPs disclosed that service-users appeared fearful of their privacy relating to what to share and how much to share with them, and who would find out; this is understandable given the stigma and lack of understanding and familiarity with mental health services. Therefore, MHPs spoke about clients keeping therapy a secret: "A lot of clients keep their treatment a secret. They don't share with others, even sometimes among their family that they're in treatment, just because of the stigma attached to the mental health treatment" (Habhab, 2018, p. 59).

2. Cultural experiences and competence

2.1 The need for culturally tailored interventions, practise and services

All studies discussed the importance of being culturally aware and sensitive to their clients' backgrounds. MHPs across studies reported the need to understand someone's background and tailor interventions and services accordingly (e.g. Ibrahim et al, 2021; Zaken & Walsh, 2021). This involved being aware of and understanding Arab clients' language, religion, beliefs, family, customs and how these factors may play a role in their work. Alganhatani et al's (2019) study found that CBT was effective, however, much of it was not tailored to the local cultural and religious needs (for example, exploring religious practises as a coping method and the importance of the role of family), which was also reported in other studies including Bin-Hasan (2022), Nassar-McMillan and Hakim-Larson (2003) and Anastasiou et al (2022). MHPs discussed the importance of taking into account cultural expressions of distress in order to form a better understanding of how clients make sense of their distress as well as the need to translate CBT materials in Arabic (Alganhatani et al, 2019). There were also barriers in relation to aspects of CBT, where MHPs reported that Arabic patients are not interested in doing homework which is meant to support work in therapy to reduce service-user mental distress.

An advantage of Arab MHPs or MHPs in Arab countries was their cultural awareness and ability to tailor interventions to an extent according to their clients' needs. For example, in Nassar-McMillan and Hakim-Larson's (2003) study, MHPs used their knowledge to integrate cultural traditions with psychological strategies, for example, using an 'old country' tradition

to cope with anxiety (Nassar-McMillan & Hakim-Larson, 2018, p. 155). This meant that Arab clients could relate to psychological strategies and engage more effectively in the intervention as it was more suited and person-centred to their cultural needs.

On the other hand, several MHPs, predominantly those working in non-Arab countries, who had little cultural awareness felt this created a barrier to their clinical work, and there was a need for them to seek this knowledge out to improve their practice with Arab communities (Bin-Hasan, 2022; Habhab, 2018; McMillan & Hakim-Larson, 2003). For example, in Bin-Hasan's (2022) study, one MHP described finding it difficult to support a client to reconnect with his religious beliefs due to the MHP's lack of cultural knowledge. Helpful factors included asking about these factors during the assessment and being curious and non-judgmental when addressing cultural and community beliefs, which helped to foster trust and build a strong therapeutic relationship (Bin-Hasan, 2022; Habhan, 2018).

The role of gender and the gender of the MHP also appeared to be important for Arab participants (Algahtani et al, 2019; Bin-Hasan, 2022; Habhab, 2018; Hamid et al, 2020). This was in relation to issues with females being seen by male MHPs, illustrated from the following quote "gender of a therapist is a sensitive issue here, as female patients might not feel comfortable with male therapists, so, I have to make changes" (Algahtani et al, 2019, p. 7). This shows that cultural sensitivity should consider a wide range of factors and its impact on accessing therapy for this group.

2.2 The value of shared experiences and identities between MHPs and Arab clients

Several studies touched on the benefits of shared experiences, where MHPs who identified sharing the same language, religion, culture, ethnicity, Arabic dialect or context to the client, expressed benefitting the client as well as themselves (Bin-Hasan, 2022; Habhab, 2021). For example, Bin-Hasan's (2022) study in the UK reported that having the same religion as the client led to a sense of relief for the MHP and the client was also better able to relate to, trust, and engage with the professional as they could talk more openly about their experiences.

Shared experiences appeared to be particularly significant in Hamid et al's (2020) study exploring the experiences of forcibly displaced Syrian MHPs. In particular, having the shared

trauma experience of being forcibly displaced helped MHPs share the client's emotional impact, empathise and connect with Syrian refugees in Turkey, which led to a better understanding and trust within therapy, illustrated by the following quote: "So if [a client] says my son became a martyr, you don't just say 'oh ok' and write it down and then what... you make them feel that you heard them... and say oh Allah rest his soul, and Allah willing he's now in heaven and may his martyrdom be a reason for your redemption" (Hamid et al, 2020, p. 4).

3. Systemic and service-level issues

3.1 Scarcity of mental health resources in Arab countries

This area links to the scarcity of mental health resources that were reported in studies conducted in Arab countries (Algahtani et al., 2019; Al-Marouqi et al., 2022; Ibrahim et al., 2021; Zaken & Walsh, 2021). In particular, there were systemic issues around scarcity of mental health support, which included the shortage of MHPs, mental health services, as well as specialised training courses such as CBT, illustrated by the following quote: "No psychosocial rehabilitation exists in Egypt, treatment ends at the hospital doors and it is sometimes deficient" (Ibrahim et al, 2021, p. 489). This led to MHPs feeling challenged and restricted to the type of work they can actually carry out, and resources such as training programmes though may be potentially available would have to be self-funded by the practitioner, which was described to be highly costly. This was also highlighted in Algahtani et al's (2019) study whereby MHPs reported the need for CBT training, or MHPs lacked the full understanding and application of CBT, highlighted by the following quote: "Training is a big issue; we are not [well] trained to provide different kinds of therapies" (Algahtani et al, 2019, p. 7).

3.2 Service-level challenges in Western countries

Researchers have identified service-level gaps which presented challenges to supporting the needs of Arab refugees, such as poor interpreting services, lack of expertise in the field, and interventions not being tailored to working with this population. MHPs in Western countries expressed lacking confidence and feeling dissatisfied when working with Arab communities because they felt more training in relation to cultural sensitivity and knowledge, and

treatment programmes tailored for the Arab population were needed (Bin-Hasan, 2022; Habhab, 2018). In addition, specialist services could be further improved to better engage with Arabs who have been displaced, this was particularly highlighted in Anastasiou et al's (2022) study which focused on specialist services working with Syrian refugees. MHPs in this study recognised that some psychological health services in Coventry did adapt their services by providing tailored therapeutic approaches that were culturally sensitive to the needs of displaced Arab populations.

4. Personal impact of working with Arab refugees

Hamid et al's (2020) & Miqdadi's (2015) studies both explored the personal impact and consequences of working with Arab refugees which resulted in a multitude of positive and negative feelings. MHPs also developed personal wellbeing strategies to help them grow as a practitioner.

4.1 'Helplessness vs emotional resilience and personal growth'

MHPs in two studies reported experiencing complex emotions, including the challenges of working with this population, specifically in relation to experiences of feeling helpless and powerless in their role when providing therapy due to wider socio-political and economic issues such as basic needs not being met, lack of legal status and ongoing violence (Hamid et al, 2020; Miqdadi, 2015). Both studies spoke about the emotional effects of this work, in particular, for Syrian MHPs working with Syrian refugees which brought up past similar experiences of war, violence and displacement. MHP's described experiences of secondary traumatic stress and burnout, and feelings that were inescapable:

> "At the beginning of my experience I was by myself with a lot of trauma cases I felt that I was burnt out... and that I was trapped. I was not happy, I started having nightmares because I was exposed to very big issues such as incest, physical and sexual assaults, losing body parts and suicide" (Hamid et al, 2020; p. 5).

MHPs in Miqdadi's (2015) study also reported that hearing clients' stories affected them emotionally, leaving a lingering emotional burden, heaviness, and experiences of a power imbalance. On the other hand, MHPs spoke about the positive impacts of their work, showing

that it was not entirely negative. Both studies reported that although challenging and complex, their work left a positive emotional impact, including feelings of pride, compassion, achievement and being able to grow emotionally with their clients and tolerate their own distress, leading to emotional resilience and personal growth as a practitioner.

4.2 Self-care

Although only two studies discussed the necessity of self-care among MHP's working with refugee populations, due to the intense emotional impact of the work it is important to discuss these findings in relation to the research topic. Miqdadi (2015) and Hamid et al. (2020) drew on the importance of self-care for professionals, and not letting their professional work spill into their personal life. Self-care was distinguishable between personal and professional self-care. Personal or individual ways of coping with the emotional impact of delivering therapy meant spending time with loved ones and seeking out their own personal therapy. By contrast, in Hamid et al's (2020) study, MHPs saw seeking support and building their professional knowledge through supervision, peer support, or resources were important in keeping them grounded and professionally present for service-users.

Discussion

This review aimed to critically evaluate the literature on Mental Health Professionals' experiences of working therapeutically with Arab communities around the world. In total, the review included 10 studies, spanning eight countries, with five of these studies being conducted in an Arab country. Despite the broadness of the research topic and variability of studies in relation to types of MHPs, context, interventions, and Arab clients, there were central themes and key messages that are important to highlight.

A common finding was in relation to how mental health is portrayed within Arab countries. Findings showed that MHPs reported a general lack of familiarity and awareness about mental illness and psychological treatment within Arab communities. Within the studies carried out in Arab countries, there was also a lack of understanding of mental health services and of certain mental health professions such as Art Therapists (Zaken & Walsh, 2021), and all papers found Arab clients would typically not be accepting of therapy. Several studies also reported that Arab clients typically consult religious and traditional healers prior to presenting

to mental health services (Algahtani et al, 2019; Bin-Hasan, 2022; Habhab, 2018; Nassar-McMillan & Hakim-Larson, 2003). These findings are also supported by other reviews within this area from perspectives of Arab clients, that also found that lack of awareness of as well as a reluctance to seek professional mental health treatment were barriers to effective treatment implementation (e.g. Gearing et al, 2012; Khatib et al, 2023). These particular challenges with engaging in treatment or access-related issues must be considered because of the large number of Arabs who migrate to the UK from their host countries, and has important implications for practicing MHPs in the UK who are or will be working therapeutically with Arab clients.

There is a lack of provision of mental health services within Arab countries across the Middle East due to limited specialist interventions, services, or training for MHPs. This presented a systemic barrier for MHPs as it meant that they were limited to what interventions or services they could provide to meet the mental health needs of their Arab communities. Several studies within the review discussed the need for further professional training to improve their practice but enhancing service provisions is restricted by a lack of funding and available resources. There is clearly a need to improve the education and professional training of existing health care providers on mental health difficulties, as well as the need to widen the provision of mental healthcare in the Middle East. Additionally, increasing clinical psychology programmes in universities in the Middle East would also help to overcome these systemic barriers.

Mental health professionals across all studies reported some form of stigma in their experiences of working with Arab clients. Both interpersonal stigma and community/societal stigma were highlighted, where their clients felt shame and fear of how much they share, as well as who would have access to their personal information and fears that their information would get circulated around their community (Bin-Hasan, 2022; Habhab, 2018; Nassar-McMillan & Hakim-Larson, 2003; Zaken & Walsh, 2021). This stigma often led Arab clients to either be guarded in how much they disclosed, and/or keep their treatment a secret from family and friends. Mental health stigma is well documented in the literature both within Western and non-Western groups (Ahad, Sanchez-Gonzales & Junquera, 2023).

Lack of awareness and acceptance of mental health problems may also stem from mental health stigma. Therefore, a potential avenue to increase awareness may be to increase mental

health literacy with Arab clients through psychoeducation both in Western and non-Western countries, which may in turn encourage mental health help-seeking attitudes and behaviours within Arab communities, as well as perhaps enabling people to seek support earlier before reaching a mental health crisis. Public awareness campaigns may also be useful in dismantling misconceptions and stereotypes and foster a more accurate understanding of mental health disorders and appropriate interventions. For example, a study by Pinfold et al (2003) found that educational interventions in UK high schools which consisted of direct social contact with individuals with mental health experiences and video presentations showed that students held less fearful and prejudiced views towards people with mental health problems afterwards. Moreover, in Al-Marhouqi et al's (2022) study, virtual therapy reduced mental health stigma in Arab clients as they had less fears about being seen going to therapy in the community, therefore, offering a choice between face-to-face or virtual therapy where possible and increasing confidence in protection of privacy, particularly for Arab clients is an important consideration for MHPs to help reduce this stigma.

The importance of cultural sensitivity through culturally informed interventions and services is well documented (Gault, Pelle & Chambers, 2019; Naz, Gregory & Bahu, 2019). It is widely understood that the use of Western intervention methods that have not been adapted for use in non-Western cultures may create barriers and hinder treatment (Hocoy, 2020; Qureshi, 2020; Talwar, Iyer & Doby-Copeland, 2004). Studies within the current review highlighted the challenges MHPs faced when working with Arab clients in relation to interventions and services not being tailored to the Arab culture, as well as some MHP's own lack of cultural knowledge and training with this population. MHPs needed to consider the importance of gender, religion, language, family and customs and how this impacts clients' understanding of and recovery from mental health challenges.

As well as the need for culturally informed interventions, there is also a need for more representation of people from racialised backgrounds amongst healthcare professionals. In the UK, the NHS Workforce Race Equality Standard Team (2023) showed that Black and minority ethnic (BME) staff make up nearly a quarter of the overall workforce with an increase of 27,500 people since 2021, however, BME staff still remain proportionally under-represented in senior positions. The NHS Long Term Plan (2019) has proposed that each NHS trust should set its own target for senior BME representation; in doing so, Arab clients may be more able to engage with services due to being able to relate to professionals on an

ethnic and cultural level, which may improve access to services for this group, as well as begin to reduce mental-health related stigma. Furthermore, research shows that racial/ethnic concordance (when service-users and healthcare providers share the same racial or ethnic background) has been linked to stronger working alliances, where service-users feel more connected to and are able to relate to their healthcare providers, which in turn leads to better treatment adherence (Cheng et al, 2023).

Two studies within this review focused on the personal impact of working with Arab refugees (Hamid et al, 2020; Miqdadi, 2015). Findings reported a complexity of emotions, ranging from feelings of burden, hopelessness, but also personal growth, fulfilment, and reward. These findings suggest that the importance of adequate supervision for this group of MHPs, and peer-support should also be encouraged in refugee-focused services (Gearing et al, 2012). Moreover, an emphasis on self-care is needed to help promote a work-life balance for MHPs with such experiences.

Literature on ethnic minority MHPs working with ethnic minority clients has been mixed, revealing strengths in the therapeutic engagement but also challenges, such as overidentification and clashes in cultural values (Sue, 1999). Findings from the current review highlighted that sharing cultural and religious beliefs helped clients build trust and safety and better engage with the MHPs. However, it would be worth comparing findings to accounts directly from service-users, as it could be possible that similarities may also act as a barrier to help-seeking, particularly surrounding worries around whether information could be shared within shared community. For instance, a systematic review found that South Asian service-users were apprehensive about seeking help from MHPs due to fears of confidentiality breaches related to perceptions that MHPs from their own community would gossip or judge them (Prajapati & Liebling, 2021). Conversely, some service-users in their study favoured White MHPs as they perceived them to be more neutral and less likely to offer judgments based on cultural norms.

Strengths

Currently, this is the first review of its kind to assess MHPs' experiences of working therapeutically with Arab communities. By considering the experiences of MHPs we were able to identify key facilitators, challenges and context/systemic-specific factors experienced

by practitioners. The inclusion of worldwide studies and the diversity amongst studies enabled the exploration of MHP experiences in both Arab/host countries as well non-Arab/Western countries, which highlighted key themes and challenges that are generalisable across countries (e.g. mental health stigma, cultural competence), as well as challenges that are more specific to host countries (e.g. scarcity of services and training needs) and contexts (e.g. working with refugee populations). This comparison along with the inclusion of qualitative studies provides richer and more in-depth results that can be transferable across Arab countries. A further strength is the inclusion of theses which were found by searching through the grey literature in an attempt to reduce publication bias. It is likely that studies with positive findings are more likely to be published over ones with less profound results (Petticrew et al, 2008). Therefore, the included theses added key findings within the review and provided a richer understanding to the knowledge base.

Limitations

Three out of ten studies were assessed as being of medium quality and failed to address key aspects of the research, questioning the credibility and overall validity of the findings (Kmet et al, 2004). For example, some studies did not sufficiently support their results with participant quotations or explain their findings in detail, therefore the overall findings of this review should be viewed with caution. A further limitation is the variability and diversity of Arab samples and MHPs included in this review which questions the reliability of the findings, for example, whether or not similar findings could be reported in future studies with the same type of MHPs or setting. Furthermore, only two studies explored the psychological and emotional impacts of working with Arab refugee populations specifically and the importance of self-care. It would be useful to understand how MHPs in the other studies experience working with Arab populations on a personal level, the impacts of the work, and how they navigate a work-life balance.

Clinical implications

MHPs held similar experiences of working with Arab communities and findings showed the need to reduce client mental health stigma and tackle challenges related to lack of cultural competence and systemic-level barriers. Findings also showed specific factors MHPs

experienced in host countries, such as lack of mental health training and lack of awareness and acceptance of mental health services amongst Arab clients. Key areas from working with refugee populations showed the crucial need for MHPs to seek professional support and maintain self-care through a work-life balance.

Conclusion

Overall, this review highlights gaps in the literature and illuminated the key challenges and barriers experienced by MHPs, suggesting implications for future research, clinical practise and policy. The key findings demonstrate that there is a need for more training in cultural competence and tailored interventions for MHPs to better support Arab clients and help reduce mental health stigma on a global scale. Within host countries, there is a clear need for increased mental health awareness and literacy through psychoeducation among Arab communities. In relation to systemic-level factors, there is a need for increased training programmes and continued professional development for MHPs to improve their practise which aids optimal support for their clients.

References

Ahad, A. A., Sanchez-Gonzalez, M., & Junquera, P. (2023). Understanding and addressing mental health stigma across cultures for improving psychiatric care: A narrative review. *Curēus*, *15*(5), e39549–e39549. https://doi.org/10.7759/cureus.39549

Al-Busaidi, Z. Q. (2010). A qualitative study on the attitudes and beliefs towards help seeking for emotional distress in Omani women and Omani general practitioners: Implications for post-graduate training. *Oman Medical Journal*, *25*(3), 190–198. https://doi.org/10.5001/omj.2010.55

Algahtani, H. M. S., Almulhim, A., AlNajjar, F. A., Ali, M. K., Irfan, M., Ayub, M., & Naeem, F. (2019). Cultural adaptation of cognitive behavioural therapy (CBT) for patients with depression and anxiety in Saudi Arabia and Bahrain: A qualitative study exploring views of patients, carers, and mental health professionals. *Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X1900028X

Al-Mahrouqi, T., Al-Alawi, K., Al-Alawi, M., Al Balushi, N., Al Ghailani, A., Al Sabti, H., & Al Sinawi, H. (2022). A promising future for tele-mental health in Oman: A qualitative exploration of clients and therapists' experiences. *SAGE Open Medicine*, *10*, 20503121221086372.

Aloud, N., & Rathur, A. (2009). Factors affecting attitudes toward seeking and using formal mental health and psychological services among Arab Muslim populations. *Journal of Muslim Mental Health*, *4*(2), 79-103.

Anastasiou, E., Liebling, H., Webster, M., & MacCallum, F. (2021). The experiences and views of service providers on the mental health and well-being services for Syrian refugees in Coventry and Warwickshire. *European Journal of Psychology Open*, *80*(4), 165–177. https://doi.org/10.1024/2673-8627/a000017

Arday, J. (2018). Understanding mental health: what are the issues for black and ethnic minority students at University? *Social Sciences*, *7*(10), 196-. https://doi.org/10.3390/socsci7100196

Ayoola, E. O., & Butt, J. (2021). *A review of Personal Health Budgets for people from Black and minority ethnic communities April 2021*. Race Equality Foundation. https://raceequalityfoundation.org.uk/wp-content/uploads/2022/10/Phase-2-Report-A-review-of-s117-Personal-Health-Budgets-for-people-from-Black-Asian-and-minority-ethnic-communities.pdf

Bin Hasan, N. (2022). *An exploration of the helpful and hindering aspects of counselling and psychotherapy with Middle Eastern clients in England* [Unpublished doctoral thesis]. University of Chester.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, *7*(1), 15–15. https://doi.org/10.1186/1472-6963-7-15

Cheng, A. W., Nakash, O., Cruz-Gonzalez, M., Fillbrunn, M. K., & Alegría, M. (2023). The Association Between Patient-Provider Racial/Ethnic Concordance, Working Alliance, and Length of Treatment in Behavioral Health Settings. *Psychological Services*, *20*(S1), 145–156. https://doi.org/10.1037/ser0000582

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the spider tool for qualitative evidence synthesis. *Qualitative Health Research*, *22*(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59*(7), 614–625. https://doi.org/10.1037/0003-066x.59.7.614

Critical Appraisal Skills Programme (2018). CASP Qualitative Studies Checklist. https://caspuk.net/casp-tools-checklists/

David, D., Cristea, I., & Hofmann, S. G. (2018). Why cognitive behavioral therapy is the current gold standard of psychotherapy. *Frontiers in Psychiatry*, *9*, 4–4. https://doi.org/10.3389/fpsyt.2018.00004

Effatpanah, M., Nakhostin-Ansari, A., Gorgani, F., Tanhapour Khotbehsara, S., Seifi, S., Nasoori, H., Memari, A. H., & Darijani, S. R. (2024). Burden and epidemiology of

mental disorders in the middle east and north Africa from 1990 to 2019: Findings from the global burden of disease study. *Balkan Medical Journal*, *41*(2), 121–129. https://doi.org/10.4274/balkanmedj.galenos.2024.2023-11-55

Erickson, C. D., & Al-Timimi, N. R. (2001). Providing mental health services to Arab Americans: recommendations and considerations. *Cultural Diversity & Ethnic Minority Psychology*, *7*(4), 308–327. https://doi.org/10.1037/1099-9809.7.4.308

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: A systematic review. *Lancet*, *365*(9467), 1309–1314. https://doi.org/10.1016/S0140-6736(05)61027-6

Gault, I., Pelle, J., & Chambers, M. (2019). Co-production for service improvement: developing a training programme for mental health professionals to enhance medication adherence in Black, Asian and Minority Ethnic Service Users. *Health Expectations*, *22*(4), 813–823. https://doi.org/10.1111/hex.12936

Gearing, R. E., Schwalbe, C. S., MacKenzie, M. J., Brewer, K. B., Ibrahim, R. W., Olimat, H. S., Al- Makhamreh, S. S., Mian, I., & Al-Krenawi, A. (2013). Adaptation and translation of mental health interventions in Middle Eastern Arab countries: a systematic review of barriers to and strategies for effective treatment implementation. *International Journal of Social Psychiatry*, *59*(7), 671–681. https://doi.org/10.1177/0020764012452349

Habhab, N (2018) *The perceived barriers and facilitators of therapeutic work with Arab clients: Examining therapists' attitudes towards stigma and recovery from mental illness* (Publication No. 10747743) [Doctoral dissertation, Wayne State University] ProQuest Dissertations & Theses Global.

Hamid, A., Scior, K., & Williams, A. C. de C. (2020). Qualitative accounts from Syrian mental health professionals: Shared realities in the context of conflict and forced displacement. *BMJ Open*, *10*(5), e034291–e034291. https://doi.org/10.1136/bmjopen-2019-034291

Hamid, A., & Furnham, A. (2013). Factors affecting attitude towards seeking professional help for mental illness: A UK Arab perspective. *Mental Health, Religion & Culture*, *16*(7), 741–758. https://doi.org/10.1080/13674676.2012.718753

Hocoy, D. (2020). The challenge of multiculturalism to humanistic psychology. In *Humanistic Approaches to Multiculturalism and Diversity* (1st ed., pp. 18–28). Routledge. https://doi.org/10.4324/9781351133357-3

Ibrahim, N., Ghallab, E., Ng, F., Eweida, R., & Slade, M. (2022). Perspectives on mental health recovery from Egyptian mental health professionals: A qualitative study. *Journal of Psychiatric and Mental Health Nursing*, *29*(3), 484–492. https://doi.org/10.1111/jpm.12754

Khatib, H. E., Alyafei, A., & Shaikh, M. (2023). Understanding experiences of mental health help-seeking in Arab populations around the world: A systematic review and narrative synthesis. *BMC Psychiatry*, *23*(1), 324–324. https://doi.org/10.1186/s12888-023- 04827-4

Kmet, L. M., Lee, R. C., & Cook, L. S. (2004). Standard quality assessment criteria for evaluating primary research papers from a variety of fields. In *Standard quality assessment criteria for evaluating primary research papers from a variety of fields* (Vol. 13). Alberta Heritage Foundation for Medical Research.

Maalouf, F. T., Alamiri, B., Atweh, S., Becker, A. E., Cheour, M., Darwish, H., Ghandour, L. A., Ghuloum, S., Hamze, M., Karam, E., Khoury, B., Khoury, S. J., Mokdad, A., Meho, L. I., Okasha, T., Reed, G. M., Sbaity, E., Zeinoun, P., & Akl, E. A. (2019). Mental health research in the Arab region: Challenges and call for action. *The Lancet. Psychiatry*, *6*(11), 961–966. https://doi.org/10.1016/S2215-0366(19)30124-5

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, *41*(7), 884–901. https://doi.org/10.1002/jcop.21580

Miqdadi, D. (2015). *"It's tough but it's worth it": Psychosocial counsellors' experience of working with Iraqi refugees in Jordan: An interpretative phenomenological analysis.* (Unpublished Doctoral thesis] City University London.

Moller, N. P., Ryans, G., Rollings, J., & Barkham, M. (2019). The 2018 UK NHS Digital annual report on the Improving Access to Psychological Therapies Programme: A brief commentary. *BMC Psychiatry*, *19*(1), 252–252. https://doi.org/10.1186/s12888-019-2235-z

NHS. (2016). *Long Term Plan.* https://www.longtermplan.nhs.uk/

NHS Workforce Race Equality Standard Team. (2023). *NHS Workforce Race Equality Standard (WRES) 2022 data analysis report for NHS trusts*. NHS England. https://www.england.nhs.uk/long-read/nhs-workforce-race-equality-standard-wres2022-data-analysis-report-for-nhs-trusts/#conclusion-and-next-steps

Nassar-McMillan, S. C., & Hakim-Larson, J. (2003). Counseling considerations among Arab Americans. *Journal of Counseling and Development*, *81*(2), 150–159. https://doi.org/10.1002/j.1556-6678.2003.tb00236.x

Naz, S., Gregory, R., & Bahu, M. (2019). Addressing issues of race, ethnicity and culture in CBT to support therapists and service managers to deliver culturally competent therapy and reduce inequalities in mental health provision for BAME service users. *Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X19000060

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *Systematic Reviews, 10*(1), 1-11. https://doi.org/10.1186/s13643-021-01626-4

Petticrew, M., Egan, M., Thomson, H., Hamilton, V., Kunkler, R., & Roberts, H. (2008). Publication bias in qualitative research: What becomes of qualitative research presented at conferences?. *Journal of Epidemiology & Community Health*, *62*(6), 552-554. https://doi.org/10.1136/jech.2006.059394

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P., & Graham, T. (2003). Reducing psychiatric stigma and discrimination: Evaluation of educational interventions in UK secondary schools. *British Journal of Psychiatry*, *182*, 342–346.

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., Britten, N., Rowen, K., & Duffy S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), b92.

Prajapati, R., & Liebling, H. (2022). Accessing Mental Health Services: a Systematic Review and Meta-ethnography of the Experiences of South Asian Service Users in the UK. *Journal of Racial and Ethnic Health Disparities*, *9*(2), 598–619. https://doi.org/10.1007/s40615-021-00993-x

Qureshi, A. (2019). Cultural Competence in Psychotherapy. In *Intercultural Psychotherapy* (pp. 119–130). Springer International Publishing AG. https://doi.org/10.1007/978-3-030-24082-0_9

Rathod, S., Phiri, P., & Naeem, F. (2019). An evidence-based framework to culturally adapt cognitive behaviour therapy. *Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X18000247

Smith, J., & Noble, H. (2014). Bias in research. *Evidence-Based Nursing*, *17*(4), 100-101. https://doi.org/10.1136/eb-2014-101946

Talwar, S., Iyer, J., & Doby-Copeland, C. (2004). The invisible veil: changing paradigms in the art therapy profession. *Art Therapy*, *21*(1), 44–48. https://doi.org/10.1080/07421656.2004.10129325

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*(1), 45--45. https://doi.org/10.1186/1471-2288-8-45

United Nations High Commissioner for Refugees (UNHCR). (2020). *In The United Nations: 75 Years of Promoting Peace, Human Rights, and Development* (pp. 119–123). https://www.unhcr.org/neu/44997-75-years-of-the-united-nations-and-unhcr-being-more-important-than-ever.html

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology*, *53*(3), 325–337. https://doi.org/10.1037/0022-0167.53.3.325

World Health Organization. (2001). *The World health report : 2001: Mental health: new understanding, new hope*. World Health Organization.

Youssef, J., & Deane, F. P. (2006). Factors influencing mental-health help-seeking in Arabic-speaking communities in Sydney, Australia. *Mental Health, Religion & Culture*, *9*(1), 43–66. https://doi.org/10.1080/13674670512331335686

Zaken, S., & Walsh, S. D. (2021). Bridging the cultural gap: Challenges and coping mechanisms employed by Arab art therapists in Israel. *The Arts in Psychotherapy*, *76*, 101853-. https://doi.org/10.1016/j.aip.2021.101853

Zeinoun, P., Akl, E. A., Maalouf, F. T., & Meho, L. I. (2020). The Arab region's contribution to global mental health research (2009–2018): A bibliometric analysis. *Frontiers in Psychiatry*, *11*, 182–182. https://doi.org/10.3389/fpsyt.2020.00182

<u>Paper 2:</u> Empirical paper

The experiences of professionals and service providers working with Arab Asylum seekers and refugees in the UK

Word count: 7998

(Excluding title page, list of terms and abbreviations, references, and appendices)

This empirical paper has been prepared in accordance with author guidelines for *The Journal of Immigrant and Refugee Studies.* The author guidelines are in Appendix 4.

This paper will broadly follow author guidelines for the selected journal. Further editing and formatting in line with the journal will be completed prior to submission to the journal.

Abstract

This study investigated UK professionals' and service-providers' experiences of working with Arab asylum-seekers and refugees (ASRs), focusing on (1) understanding what factors support or challenge access to services for Arab ASRs, (2) the psychological impacts of the role on professionals and (3) how professionals are supported to work effectively with this population. Seven participants who worked in charity services took part in semi-structured interviews. Reflexive Thematic Analysis identified five themes: (1) the therapeutic relationship; (2) cultural awareness: the Arab culture; (3) power and negative perceptions of ASRs; (4) tailoring support services and improving access; (5) navigating the rewards and challenges of the role. Service-providers can tackle these challenges by removing language barriers and creating tailored services, striving to empower Arab ASRs, and develop high quality co-produced cultural competence training. Professional support through clinical supervision or reflective practice and maintaining a work-life balance is recommended for all staff working with this population.

Keywords: Arab refugees, cultural competence, power dynamics, barriers, professionals

List of terms and abbreviations

Arab asylum seekers and refugees / service-users: these terms were used by participants to refer to Arab asylum seekers and refugees accessing services and were used interchangeably throughout the findings and discussion.

Professionals: the term used in the current empirical paper refers to individuals who work within a professional capacity in any sector, who provide direct support or a particular service (e.g. healthcare, social, education, legal, etc) to refugees or asylum seekers who identify from an Arab background (including any Arab country in the Middle East and/or North Africa) in the UK.

Service-providers: this term in the current empirical paper refers to non-governmental organisations (NGOs) including charities or third-party providers of services to individuals identifying from an Arab background (including any Arab country in the Middle East and/or North Africa) in the UK.

ASRs	Asylum Seekers and Refugees
RTA	Reflexive Thematic Analysis
UNHCR	United Nations High Commissioner for Refugees

Introduction

During the past decade between 2010-2020 there has been a significant increase in the number of refugees and displaced individuals globally. It was estimated that at the end of 2020, the global refugee population was 26.4 million people, which is an increase of 400% from 2019 (United Nations High Commissioner for Refugees; UNHCR, 2020). Arab refugees are commonly defined as Arabic-speaking refugees from the Arab regions which include Middle Eastern and North African countries (MENA; Pampati et al, 2018), and account for the largest proportion of global refugees immigrating from the Arab region. Recent estimates suggest that around 5.6 million Syrians have registered as refugees in neighbouring countries, and 5.1 million out 19.5 million global refugees are Palestinian (UNHCR; 2020).

Britain, as a signatory to the 1951 Geneva Convention, has offered asylum to those fleeing from persecution and violence. Under this Convention, a refugee was legally defined as: “any person outside their country of nationality who fears persecution due to race, nationality, religion, social group, or political opinion, and is unable or unwilling to return, and covers all immigrants in the asylum process” (UNHCR, 1951, p. 3).

Arab asylum seekers and refugees (ASRs) have endured prolonged wars, violence, and political instability, and many of which remain unresolved. The intensity and duration of these conflicts have led to mass displacement (Hamadeh et al, 2014; Silbermann et al, 2016). Additionally, Arab refugees have distinct cultural, religious, and linguistic characteristics and face integration challenges in host countries such as those in Europe. Predominantly Muslim, Arab ASRs often face Islamophobia and discrimination in host countries, which exacerbate integration challenges and hinder access to support services (Samari, Alcala & Sharif, 2018). Moreover, political narratives and media representations frequently frame Arab refugees as posing security threats or as challenging to integrate into host society (Hassan et al, 2016). Collectively, these factors highlight the unique position of Arab ASRs and the distinct challenges they face compared to perhaps other refugee groups.

During pre-migration, Arab refugees are likely to have been exposed to forms of trauma relating to persecution and war, death of family members, physical injury, torture, poverty, imprisonment or violation of human rights (Fazel, Wheeler & Danesh, 2005). For instance, amongst Palestinians living in the Gaza strip, rates of up to forty percent of depression and up to ninety-five percent of anxiety were reported, highlighting the acute psychological toll of

war and displacement (Elbedour et al, 2007). Furthermore, post immigration, Arab refugees are likely to experience ethnic discrimination, islamophobia, language barriers, unemployment, lengthy asylum-seeking processes, and poor living conditions, which have been linked to poor mental health outcomes for this population (Bogic, Njoku & Priebe, 2015; Samari, Alcala & Sharif, 2018).

Research shows that refugees generally experience poorer outcomes than the UK general population across most health and wellbeing measures, including physical and mental health, access to healthcare, and social determinants like housing, employment, and education (Taylor, 2009). The refugee crisis further intensified following widespread riots in the UK in Summer 2024, which fuelled anti-immigration violence and attacks on refugee centres and communities. An increase in ASR hostility in the UK was also apparent (Flynn, 2025; Vinter, 2024).

In the UK, Arab asylum seekers and refugees access support through multi-agency and multidisciplinary teams such as healthcare, refugee charities, housing, legal aid services, and other community organisations. While service-providers play a vital role in supporting ASRs adjust and integrate into a new country, limited research explores their perspectives on the specific challenges or systemic barriers within current service provision (Lau & Rodgers, 2021). Understanding these issues is essential to improving responsiveness to the needs (e.g. social, mental) of Arab ASRs and enhancing their access to services. Given the interdisciplinary nature of refugee support, clinical psychologists often work alongside or liaise with multiagency teams. Exploring the diverse perspectives of multi-agency professionals and service-providers would offer a more holistic view and understanding of how systems support or challenge access to care for Arab ASRs, and would help to foster culturally responsive and collaborative approaches across sectors such as clinical psychology.

A study by Robinson (2014) examined challenges faced by social workers supporting refugees in Australia and the UK. Key issues included systemic barriers in navigating asylum and support systems, and cultural and language barriers like limited access to trained interpreters. However, the study focused on social care provision and included Australian social workers whose practices may differ from UK systems, and did not specifically address working with Arab ASRs but a diverse refugee population.

Frontline professionals working with traumatised and marginalised populations including ASRs are at risk of significant emotional strain (e.g. Barrington & Shakespeare-Finch, 2013; Bride, 2007; McFadden et al, 2015;). Research across sectors such as social work, legal aid and health services has reported experiences of burnout, vicarious trauma (such as intrusive thoughts) and other emotional challenges (Bride, 2007 & McFadden et al, 2015). These emotional impacts are not limited to clinical or therapy-focused roles; case workers, interpreters, advocates, and social workers also engage in complex, trauma-related work and are similarly affected. This highlights the need to understand how professionals across a broad range of sectors experience and cope with the emotional impact of supporting Arab ASRs, and how they are supported in their line of work to continue providing appropriate care to this population.

Research rationale and aims

The aim of this research is to explore how service providers and multi-agency professionals experience working with Arab ASRs in the UK. The research questions were:

1) What are the factors that support, enhance or challenge access to services for Arab ASRs from the perspectives of professionals / service-providers?
2) How are professionals impacted psychologically and emotionally by their role? And;
3) What support is available to professionals / service-providers to work effectively with Arab ASRs?

Materials and Methods

Design

A qualitative method (Reflexive Thematic Analysis) was used to explore the rich experiences of service-providers and professionals working with Arab ASRs. Semi-structured interviews were suitable as they allowed structured exploration of the research topic while remaining flexible for follow-up questions.

Epistemological position

A social constructionist position was adopted for this research, which assumes that meaning and interpretation are shaped by groups through their lived experiences, interactions, language, and shared cultural understandings. This is relevant because professionals'

experiences are shaped by wider social discourses such as media representations, politics, integration, culture, power, and trauma, which are key factors influencing both Arab ASRs and those supporting them. This position also acknowledges the researcher's reflexivity, social positioning and identity, recognising that knowledge is co-constructed.

Reflexivity

Reflexivity is recommended as part of qualitative research to address and increase its trustworthiness and rigour, and helps to identify the influence of subjective experiences during analysis (Braun & Clarke, 2022; Johnson, Adkins, & Chauvin, 2020).

As a British Arab, researcher, and Trainee Clinical Psychologist from a minoritised background, I recognise how my multilayered identity and positions shaped this research. My cultural background enabled for a nuanced understanding of subtle references to Arab cultural values, religious norms, and language, which might have otherwise been overlooked, further helping to understand and analyse participants' rich accounts. Whilst, I have no direct experiences working with Arab ASRs, I have broader family connections to this group and professional experience working with marginalised populations. These experiences may have attuned me to narratives around power dynamics within therapeutic relationships and systemic issues such as disempowerment faced by minoritised groups like Arab ASRs. On a personal level, I feel a strong sense of connection and responsibility toward the Arab community, especially those displaced by conflict, which brought a sense of purpose to this project.

To critically examine my influence on the research process, I kept a reflexive diary from data collection through to the thesis write-up (Appendix 5), remaining grounded in the research aims (Braun & Clark, 2022). I also made use of supervision to check themes and sub-themes, and group reflexive sessions to ensure transparency and manage my biases and subjectivity.

Ethical considerations

This research was reviewed and approved by the University of Staffordshire Research Ethics Committee (ID: SU_23_034; see Appendix 6 for approval letter). A risk assessment and mitigation plan about the potential risks to participants and the researcher was completed prior to commencing data collection (Appendix 7). The British Psychological Society (BPS)

Code of Human Research Ethics were followed as guidelines for carrying out this research (BPS, 2021).

Participants were informed that the interview may cover potentially distressing topics relating to ASR experiences and emotional difficulties. They were reminded of their right to withdraw at any point without consequences and were provided with a debrief form (Appendix 13) with additional support. To protect participant anonymity and service-users amid the 2024 UK hate crimes and riots against ASRs (Vinter, 2024), participants were not asked to disclose the names of their services.

Interview data was stored on a University of Staffordshire secure server (One Drive) on a password protected laptop device. All participant personal details were stored on a separate spreadsheet that was password protected, and audio recordings were deleted following data transcription. Direct quotations from interviews were used throughout the findings, however each participant was assigned a pseudonym. Finally, all data was kept confidential in line with the Data Protection Act (2018) and General Data Protection Regulation (2018).

Interview schedule

The semi-structured interview schedule (Appendix 8) was informed by the research topic, research team discussions and consultation with a field expert. An initial meeting with a refugee charity integration coordinator helped to orientate the researcher to staff experiences and ASR challenges. This informed and refined the interview questions, for example, how staff navigate and manage complex cases, considering both systemic challenges and the emotional impact on them.

Recruitment and data collection

Ethical approval was obtained to recruit both Arab ASRs and professionals. However, due to recruitment challenges, including overstretched services with limited capacities to support research, and a lack of provision of Arabic translation, the focus became solely on professionals and service-providers.

To gain a comprehensive understanding of the support systems for Arab ASRs and the psychological impact on staff, all types of professionals were targeted. Participants were eligible if they had worked for at least six months in any sector supporting Arab ASRs in the

UK (e.g. healthcare, social, education, legal, etc). This ensured that participants had enough experience to share valuable insights while still including those early into their careers.

Purposive sampling was used to recruit professionals with direct experience of working with Arab ASRs, as they were well positioned to provide rich and relevant insights for the study. The research poster (Appendix 9) was shared in person and via email with refugee centres and community organisations to recruit suitable participants. Potential participants expressed an interest by contacting the researcher via email. Once the participant information sheet (Appendix 10) was provided, potential participants were given up to one week to consider whether they wished to take part. Those who consented completed and signed an electronic consent form (Appendix 11) and a demographics form (Appendix 12) before arranging an online interview via Microsoft Teams.

Prior to interviews the researcher confirmed informed consent by explaining the study and obtaining verbal consent from the participant. Participants could ask questions and were reminded of their right to withdraw from the study up until data transcription started. After interviews, participants received a debrief form (Appendix 13) with local support contacts and the option to contact the researcher if needed. Interviews were audio recorded with consent from the participant for the purpose of data transcription and lasted between 45 to 60 minutes (M = 55.3 minutes).

Participants

A total of seven participants took part in the study. Although RTA does not recommend a specific sample size, it does emphasise depth of insight over large numbers (Braun & Clarke, 2021). Data collection concluded at seven participants when the researcher judged that sufficient depth and richness had been reached from interviews to meaningfully develop themes and recurring patterns were consistently emerging across interviews.

Participant demographics are presented in Table 1. Participants were recruited through various community organisations and services, and all directly worked with Arab ASRs. Most participants worked in holistic refugee services providing support such as English classes, housing, leisure, legal advice and psychological care. Five out of the seven participants identified from ethnic minority backgrounds and two identified as Arab. Four out of seven participants had a therapy focused role.

Table 1. Participant demographics

Pseudonym	Gender	Age	Ethnicity	Role	Service context
Sakina	Female	55-64	Mixed background	Psychotherapist & developmental lead	Refugee service
Sarah	Female	55-64	Arab	Activities coordinator	Youth centre
Sandra	Female	55-64	White background	Counsellor	Refugee service
Suzanne	Female	25-34	Any other Asian British background	Trainee psychologist	Therapy service
Maye	Female	25-34	Black or Black British - African	Assistant psychologist	Therapy service
Muna	Female	45-54	Arab	Family integration officer	Refugee service
Kevin	Male	25-34	White British	Activities manager	Refugee service

Analysis

Reflexive thematic analysis (RTA; Braun & Clarke, 2022) was chosen to interpret participants' subjective experiences and identify themes across the dataset. RTA is well placed for exploring the complex and layered experiences of the varied roles of professionals involved with refugee populations, rather than focusing narrowly on individual phenomenological accounts which was not the aim or focus (Braun & Clarke, 2022).

RTA's less prescriptive and flexible approach accommodates various theoretical positions. Given the researcher's professional and personal connection to the topic, RTA was chosen for its emphasis on reflexivity and the impact of self on the research process, which is especially important given the complexity and sensitivity of the topic. Unlike other types of thematic analysis, RTA explicitly acknowledges that the researcher's experiences and positioning cannot be separated from the process and encourages ongoing examination of their interpretive role (Braun & Clarke, 2022).

Braun & Clarke (2022) highlight a six-phase process to conducting RTA. Table 2 presents the steps that were followed throughout data analysis.

Table 2. RTA involving six-phases (Braun & Clarke (2021)

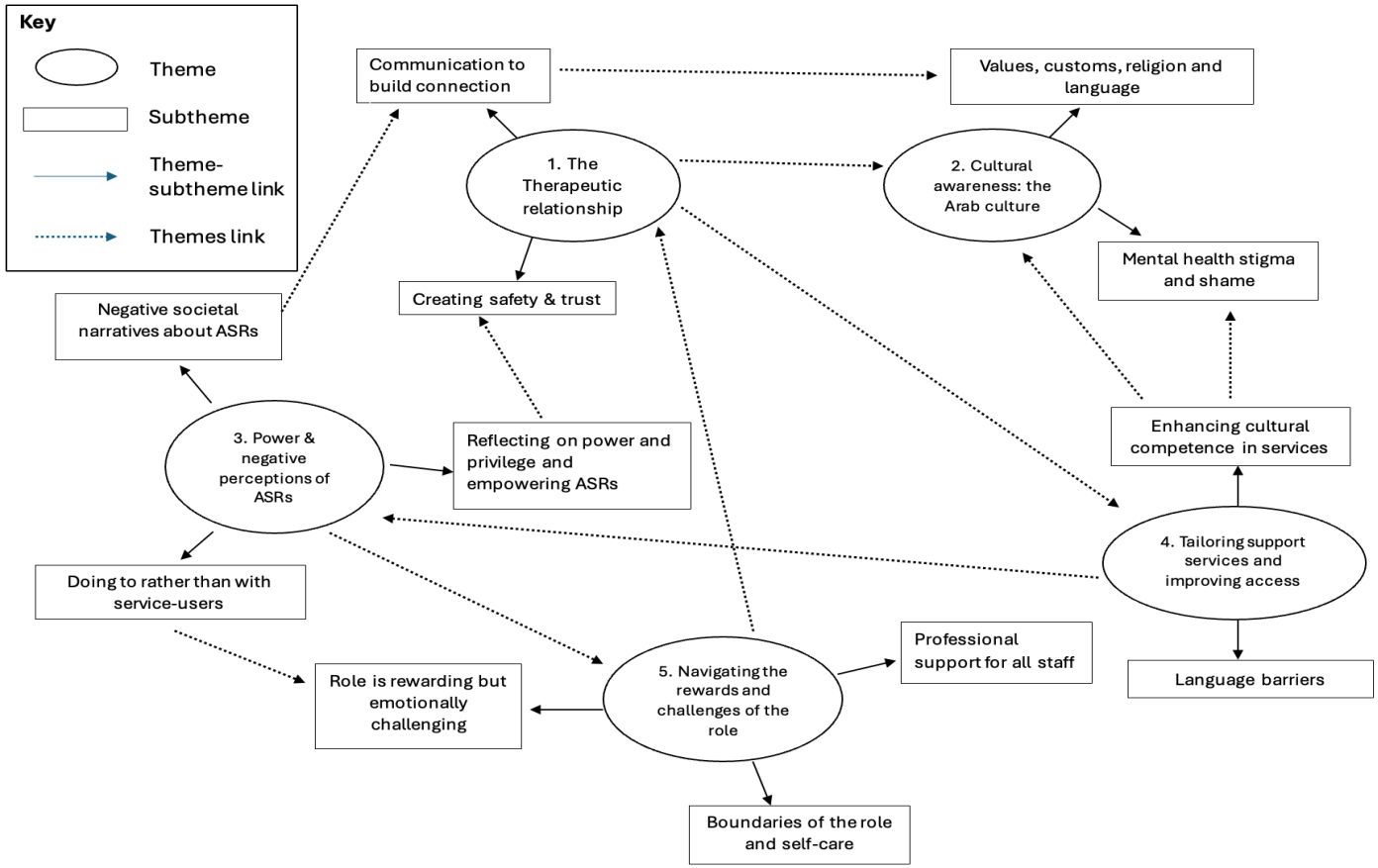
	Phase title	Phase description
1.	Data familiarisation	Interviews were transcribed using MS Teams transcription function then manually checked and corrected, including any Arabic phrases used by participants. This process involved listening to and transcribing audio recordings, reading and re-reading transcripts, and noting initial ideas from each interview and the dataset overall.
2.	Coding	NVivo (a qualitative data analysis software) was used to code transcript segments and assign codes to each segment. Codes were coded at both the semantic and latent level to capture both surface-level and conceptual-level meanings. To help with organisation, codes were compiled in a separate worksheet with corresponding quotes.
3.	Generating initial themes	Codes sharing a particular idea were grouped into clusters to generate potential themes. Colour coding was used to visually organise categories, which helped identify sub-themes and themes. This involved

		an iterative process of going back and forth across clusters guided by the research topic, the dataset, and the researcher's insights (see Appendix 14 for examples).
4.	Developing and reviewing themes	Potential themes were reviewed for fit and accuracy against the data, ensuring they reflected the codes and the full dataset. Some themes were merged for clarity and research focus. Discussions with other RTA researchers and the academic supervisor supported critical review of the suitability of themes.
5.	Refining, defining and naming themes	Each theme was developed around a core concept related to the research focus, with clear names assigned to themes and sub-themes. The use of supervision and presentation of drafts of themes supported this process.
6.	Write-up	Findings were reported as part of the current research report / thesis.

Results

RTA led to five themes: (1) the therapeutic relationship; (2) cultural awareness: the Arab culture; (3) power and negative perceptions of ASRs; (4) tailoring support services and improving access; (5) navigating the rewards and challenges of the role. Figure 1 illustrates these themes and sub-themes (see Appendix 15 for example theme tables, including participant numbers supporting each sub-theme and theme).

Figure 1. *Thematic map*



1. The therapeutic relationship

This theme included two sub-themes that focused on how the direct therapeutic relationship between professionals and service-users was facilitated through (1) communication to build connection, and (2) creating safety and trust, and how these factors enhanced service-users' experiences of and access to services.

Communication to build connection

Participants stressed the importance of adapting verbal and non-verbal communication to suit the needs of Arab ASRs. This included general adaptations such as speaking clearly and at a slower pace, being friendly, and using humour whilst remaining respectful. However, participants who knew or used basic Arabic greetings such as 'Marhaba' for 'welcome/hello' and 'kayfa / kafu halak' for 'how are you' stated this helped them to build a connection with the service-user straight away and make them feel seen. For example: Suzanne says: "Imagine you meet someone and they're saying a few words in your language … That's so important. Just to feel seen" (p. 36).

Taking the time to greet service-users and show hospitality was viewed as essential in creating a welcoming environment for Arab ASRs, which facilitated warmth and trust and ultimately encouraged better engagement with the service. In contrast, merely asking "What are you here for?" (Sakina, p.6) could be perceived by Arab ASRs as dismissive or disrespectful, potentially leading to mistrust and creating a barrier in accessing services.

> The importance of a warm welcome, which is very central to Arabic culture. When somebody comes through the door…We will say: "Welcome. Have a seat. Would you like something to eat or drink? So we'll do all that before we say, how can we help? We've already formed that relationship and connection with them. (Sakina, p. 6)

Kevin spoke about the use of humour with service-users: "We just have a laugh with it. They speak broken English. I speak broken Arabic" (p. 7). The use of humour enabled a relaxed and friendly atmosphere that was non-threatening or judgmental, perhaps helping to reduce Arab ASRs worries of making mistakes, which further helps to build connection and positively enhance service-users' experiences of accessing support.

1.2 Creating safety and trust

Participants built safety and trust with service-users by "taking the time to validate and acknowledge individuals who have had really difficult histories" (Susanne, pp. 9-10). This was especially important for those working psychologically with service-users, by not delving straight into their trauma and instead focus on the therapeutic relationship and the here and now. Maye expressed that offering a safe space for service-users to share their stories and journeys made them feel "validated and grateful" as they hadn't been provided such a space previously (p.5). This sense of being heard and acknowledged further fostered trust and safety for service-users to open up about their difficulties, highlighting how the therapeutic relationship can enhance access and engagement with services.

Participants also reflected on interpreters as forming and symbolising a valuable part in the therapeutic relationship. As Sandra noted: "interpreters become part of the relationship, part of creating safety for the service-user" (p. 6), which is crucial given the trauma, complexities and unfamiliarity many service-users face when accessing support services. Interpreters help overcome language barriers but crucially, foster culturally sensitive environments. Furthermore, the triadic relationship means that service-users feel genuinely understood and respected, reducing the risk of miscommunication or alienation.

2. Cultural awareness: the Arab culture

This theme centred around developing an in-depth awareness and understanding about the Arab culture to effectively support Arab ASRs access services. Two sub-themes included: (1) values, customs, religion and language and, (2) mental health stigma and shame.

2.1 Values, customs, religion and language

Participants expressed culture, language, religion and customs as being both distinct and intertwined, and the need to understand these differences to effectively support this population. For instance, there are distinct cultural norms around child discipline in Arab cultures, professionals needed to be aware of these and "compassionately emphasise the differences in UK rules and regulations and needing to abide by them from a legal perspective" (Maye, p. 3).

Another important aspect was being respectful of and taking religious beliefs into account when working with Muslim Arab ASRs, which included understanding the meaning of religion and incorporating beliefs into care provision. However, cultural values or religious beliefs were not always considered by staff from external services, which may then place service-users in a conflicting or challenging position.

> We get external partners coming in and they put their hand out to a woman who is an Arab wearing a hijab [headscarf covering Muslim women's hair]. And, you know, you can see that terrifying look in their eyes. So that's where we just intervene and say, oh, no, that handshake is not appropriate. (Kevin, p.13)

Kevin's example shows how a small well-intentioned gesture, although appearing harmless, can potentially create barriers to access by inadvertently causing distress or alienation when Arab cultural and religious norms are not considered.

Muna, an Arab participant reflected on the meaning behind using an Islamic Arabic expression to offer her condolences when someone passes away: "I can't tell her that your daughter died. I just told her these words: 'Azzama Allah Ajrakum' (meaning may Allah [God] increase your reward) … this was enough. She hugged me and said thank you for being here with me" (pp. 27-28). She reflected that this expression was more meaningful to the service-user as it fostered emotional comfort and helped build rapport, as opposed to using a generic English expression such as 'sorry for your loss' which has little cultural significance. This emphasises the need for culturally informed, respectful approaches that validate Arab ASRs' identities and experiences, fostering trust, engagement, and ultimately enhancing access to support services.

2.2 Mental health stigma and shame

Participants found that when working with Arab ASRs specifically, stigma in relation to having a mental health problem was seen to be shameful; service-users would express: "I'm not crazy. I'm not stupid" (Muna, p. 31). Similarly, Sarah expressed: "They [Arab ASRs] think if they talk about their problem people will shame or judge them, because it's a cultural thing. We're not used to it as Arabs" (p. 16).

Participants generally expressed that mental health problems were either denied or kept hidden, which made it difficult to pick up on and acted as a barrier for them to have open discussion about mental health with service-users. When questions were framed with a symptomatic focus such as whether nightmares had been experienced, service-users appeared to be more forthcoming and willing to engage in this discussion.

There were also distinctions between genders (particularly, male service-users) who expressed greater shame and stigma when admitting they were struggling mentally to families or friends. Expressions of distress were seen as burdensome and a sign of weakness:

> One service-user, he said to me: 'I'm asking my wife for help and I'm asking my children for help. What kind of father does this?' And again, that goes into kind of what the role of the man is from an Arab cultural perspective, what their role of the man is and the shame that comes with that. (Suzanne, pp. 22-23)

This reflects how cultural norms of masculinity in Arab communities portray men as strong providers, making help-seeking feel shameful and threatening to their self-worth. Consequently, Arab men may hide mental health struggles, creating stigma that challenges professionals and hinders access to appropriate and timely mental health support.

3. Power and negative perceptions of ASRs

This theme explored how negative societal narratives, systemic power within organisations, and power dynamics shape Arabs ASRs experiences of accessing services. Three sub-themes included: (1) negative societal narratives about ASRs; (2) 'doing to' rather than 'with' service-users and; (3) reflecting on power and privilege and empowering ASRs.

3.1 Negative societal narratives about ASRs

Several participants spoke about the negative labelling of ASRs in society. For example, Sakina described "negative attitudes and judgments about why these people [ASRs] came here, and a lack of acceptance of refugees, which is totally wrong and demoralising" (p, 9). Suzanne also shared: "Some will say to me, there's this narrative that I'm just going to come here and take the benefits and that's all that people care about, but that's not true" (p. 13). These accounts reflect the potentially harmful stereotypes that ASRs are undeserving of the same resources or are exploiting systems such as welfare. Internalising these narratives may

create additional barriers to building supportive relationships with service-providers by discouraging ASRs from seeking help and accessing services, particularly if they fear that even professionals could share these views.

Additionally, participants noted these views could be “demoralising” and “challenging” (Sandra, p.12) not only for ASRs, but potentially for those supporting them. Especially in the current refugee climate, professionals often face public misconceptions that clash with the realities they observe in their work. Kevin highlighted the positive impacts refugees bring: “We regularly have 40 asylum seekers, refugees coming to clean the streets. We know the beauty that they bring to our communities” (p. 24). This ongoing tension could also add to professionals’ emotional burden, as they support and advocate for ASRs while managing the frustration of public misperceptions, which can further lead to feelings of helplessness, and increased stress within their demanding roles.

‘Doing to’ rather than ‘with’ service-users

A common topic was the notion of ‘doing to’ rather than ‘with’ service-users, where ASRs in general were treated more passively rather than as active collaborators in their care, leading to disempowerment. Some participants highlighted power imbalances in how services engage with Arab ASRs. For example, Sakina noted the attitude: “I'm a good person and I'm going to help those poor people. And that's a terrible attitude. It's really disempowering” (p. 15). Similarly, Maye shared: “There’s this attitude that you've come to this country, we're giving you the support, and we know how to help” (p. 12). These views reflect a kind of moral superiority or ‘saviour complex,’ where professionals may position themselves as rescuers and ASRs as passive victims that they need to save. This attitude disempowers ASRs by overlooking their own expertise, strengths, and needs.

A related barrier was the presence of assumptions made by professionals in other services, such as “assuming that the person didn’t need an Arabic interpreter based on where they were from and assuming their level of intelligence or literacy,” which created “a mismatch [for service-users] of I'm telling you something, and why aren't you meeting me there?” (Suzanne, pp. 16–17). These assumptions undermine or dismiss the voices and agency of Arab ASRs and place more power and superiority on professionals and organisations. This can result in ASRs feeling excluded from their care and in decision-making, as well as feeling

disempowered by professionals which can in turn create mistrust and a barrier in engaging with support services.

3.3 Reflecting on power and privilege and empowering ASRs

Some participants acknowledged "coming from a lens of privilege" and recognised they had not been "exposed to anything near what a lot of these service-users have been through" (Suzanne, p. 32). Maye similarly reflected that she might have faced comparable challenges to the refugees "if my parents didn't come to this country" (p. 31). By reflecting on their own positionality and privileges, participants became more aware of power imbalances and how their backgrounds, assumptions, and privileges could influence the experiences of ASRs accessing care. This self-awareness helped professionals avoid perpetuating disempowering dynamics often linked to the saviour complex, instead fostering more collaborative and empowering relationships with ASRs. For example, Maye explained: "You're sitting with them. We're never going to sit above them and look down. You're not just another number … you're one of my clients. We're trying to understand them as a whole" (p. 34).

Empowerment was also shown by making Arab ASRs feel part of a community and giving them a voice rather than making choices or decisions on their behalf. "We want people to feel they are actually welcome here, and they're not just a number...we listen, we ask what do you want, how can we meet your needs" (Sakina, p.6). Approaches like this are likely to positively shape how Arab ASRs experience and engage with services.

4. Tailoring support services and improving access

This theme centred around the general systemic barriers Arab ASRs experience when accessing services and the need to tailor services to be more suitable and responsive to their specific needs. Sub-themes included: (1) language barriers and; (2) enhancing cultural competence in services.

4.1 Language barriers

All participants identified language as a key systemic barrier hindering Arab ASRs in effectively accessing and engaging with community and local services (e.g. health, the benefit system, employment and legal services).

For example, Muna described supporting an Arab refugee who was advised to attend a diabetes prevention course: “They said we will send you details to book a course … I told him you don't know English. And they don't provide a translator. So, what is the point?” (p. 13). Similarly, Suzanne expressed frustration with community services like Universal Credit, which failed to consider service-users’ language needs: “We tried to call him many times … I said he doesn't speak English. He requires an interpreter. And the woman over the phone was literally like, ‘I had no clue about that’… ‘I'll make a note of it now’”. She added, “This isn't the only instance where something like this has happened. It’s quite frustrating” (Suzanne, pp. 11-12). These systemic linguistic and communication barriers prevented service-users from fully engaging with and benefiting from the available support services in the community, which are clearly not tailored to meeting the linguistic needs of Arab ASRs, potentially being detrimental to their health in the long run. Additionally, lack of awareness of language barriers from external services created delays in response times making vital information such as health and legal matters inaccessible.

Sarah also expressed feeling “helpless” and “powerless” when repeatedly attempting to access external mental health training for her service-users, as it was not offered in Arabic (p. 10). Professionals’ frustration in navigating these challenges could lead to emotional strain, leaving them feeling helpless and powerless when they are unable to secure the necessary support for their service-users.

4.2 Enhancing cultural competence in services

All participants highlighted gaps in their cultural competence training, describing it as “very generic” and needing “something more tailored to understanding Arab culture” (Sarah, p. 20) and the experiences of Arab ASRs. Sandra also emphasised the importance for “counsellors to get more trained up about countries of origin” referring to training on differences between Arab nations to gain “more knowledge to better understand and help service-users” (Sandra, p. 23).

Suzanne also reflected on the need to enhance cultural literacy among professionals, including a deeper understanding of how Arab ASRs may express mental health concerns and seek support: “how you might [they] ask for help. What is help? What does help seeking look like? What does support look like?” (Suzanne, p. 37). Building this cultural literacy within services not only addresses gaps in assessment but also ensures more person-centred

approaches, ensuring Arab ASRs feel understood and supported in ways that resonate with their cultural realities.

Similarly, Maye noted that her service's generic assessment tool overlooks culturally relevant issues such as the importance of family and community for Arab clients: "we should be asking about whether they worry about their families or their community or people back home" (p. 30). Recognising these concerns is essential for capturing the full context of Arab ASRs' experiences and accurately assessing their needs.

Participants highlighted that enhancing cultural competence training in services should be led or co-produced by Arab ASRs to ensure it is relevant, practical, and respectful. As Sakina suggested, this involves directly asking service-users "what can we do? What have your experiences been like? What do you think is important for us to know?" (p. 12). Co-produced training would ground services in the authentic experiences of Arab ASRs, making them more tailored to their needs and empowering service-users to shape services, fostering greater trust and engagement. It also equips professionals with deeper, more nuanced understanding of the unique needs of Arab ASRs, helping to prevent assumptions and cultural misunderstandings.

5. Navigating the rewards and challenges of the role

This theme encompassed professionals' psychological and emotional experiences of working with Arab ASRs and how they are supported. Three sub-themes included: (1) role is rewarding but emotionally challenging; (2) professional support for all staff and; (3) boundaries of the role and self-care.

5.1 Role is rewarding but emotionally challenging

Participants spoke about a variety of complex positive and negative emotions linked to the role. The role brought feelings of empowerment, admiration and inspiration for professionals for various reasons: "I'm honoured that they would share their stories with me. It's so powerful what they've been through … Every single group that we have, I come out of it empowered that they've told me their stories" (Maye, p. 26). Sarah also spoke about feeling "a sense of achievement at the end of the day" when supporting and seeing her service-users leaving happy. Several participants echoed this sentiment, describing the experience as

"going on a journey with that person because you do talk about their entire life in one session," and that "to be part of that is so meaningful and special" (Suzanne, p. 32).

However, these positive experiences were accompanied by emotional challenges. Sandra expressed that "being a counsellor … and hearing about torture ... sometimes it can take a toll on you" (p. 22), highlighting the cumulative emotional weight of working with refugee trauma. Similarly, Sarah said: "By the end of the day, you're human and you feel these people … It's like you are living it with them … Sometimes I just go home drained and upset" (p. 17). These experiences show the vulnerabilities involved in empathetically engaging with intense trauma. They also reveal how the role requires balancing powerful feelings of fulfilment with emotional fatigue, highlighting the ongoing tension for professionals between the rewarding and challenging aspects of their work.

Interpreters were also reported to be impacted emotionally by the work, as they play an important part of the therapeutic relationship and are often involved in hearing and translating trauma-heavy material. This dual role can make the emotional burden for interpreters more intense, as they navigate both linguistic and emotional aspects of their role, potentially without adequate support.

5.2 Professional support for all staff

All participants described professional support as essential for managing the complexities of the work, maintaining their wellbeing, and feeling supported in their roles. One-to-one or group clinical supervision, team support and reflective practice were drawn upon as different sources of professional support. Suzanne explained that at times she can "become too emotionally invested … in ways that might be a little bit damaging". Supervision helped to "separate this and distance [herself] emotionally to look at the work from a lens that isn't as emotionally invested" (Suzanne, p. 34).

Maye shared that reflective practice, a dedicated time for professionals to critically reflect on their experiences, thoughts and feelings with colleagues, not only helped her think about the work clinically but also fostered closeness and connection among team members during emotionally challenging times. This in turn better enabled staff to be present for, and support their service-users: "we bounced off each other and we were allowed to just process stuff that

you wouldn't process in the session. So that really helped afterwards, just because it can be really heavy due to the nature of the things that we speak about (p. 28).

Finally, professional support was seen as crucial across all roles and disciplines including interpreters and activity workers, highlighting that the emotional impact of the work can affect anyone working closely with Arab ASRs: “When you think about who needs supervision … You'd maybe focus on people who are may be providing direct therapy but that's really important that everyone receives some level of supervision (Sakina, p. 10). Without such support, professionals risk burnout and reduced wellbeing, which could in turn negatively affect the quality of care provided to Arab ASRs.

5.3 Boundaries of the role and self-care

To manage the emotional demands of working with ASRs, participants expressed setting boundaries between their professional and personal lives which helped maintain a work-life balance. For example, Kevin shared: Just having to spend all day listening to people's issues can be really draining and if I'm honest, when I get home I tend to just switch off completely and focus on something else” (p. 34). Muna did this by actively separating her work and home identities: “There's Muna at work. She needs to stop and leave Muna at work because Muna has another life at home, your personal life and your own self to look after” (p. 36).

Adopting a work-life balance meant engaging in personally meaningful activities that supported wellbeing. For instance, for Sarah this meant taking the time to “walk, go to theatres … speak to friends” which helped create “that separation and do something that’s mentally refreshing” (p. 18). Sakina found meaning in giving back to society and engaging in humanitarian activities: “I always give money to the people sitting on the streets and buy people a coffee, I sign petitions, because I think that’s the least I can do is just recognise their humanity. That helps me”. For many, focusing on values and hobbies, along with setting clear boundaries, provided emotional balance and helped manage the challenges of supporting ASRs. This separation also enables professionals to stay fully present and engage better with service-users, making their experience of support services more meaningful.

Discussion

This is the first study to explore the experiences of a diverse range of multi-agency professionals and service-providers working specifically with Arab refugee populations in the UK. Participants shared factors that facilitated their work, barriers to service access for Arab ASRs, and the psychological impacts of supporting this population. While some findings reflect general considerations when working with refugee or marginalised groups, the study also identified key factors unique to Arab ASRs, offering a culturally nuanced perspective. Five key themes emerged: (1) the therapeutic relationship; (2) cultural awareness: the Arab culture; (3) power and negative perceptions of ASRs; (4) tailoring support services and improving access and; (5) navigating the rewards and challenges of the role.

Building therapeutic relationships with Arab ASRs through cultural awareness

Research highlights that the therapeutic relationship is crucial for building trust, safety, and rapport, which positively influences engagement with ASRs (Khairat, Hodge & Duxbury, 2023). Key considerations when working with Arab ASRs include using basic Arabic greetings to foster safety and trust and facilitate engagement. Most participants worked in refugee centres and were often the first points of contact for ASRs. Given the trauma and post-displacement challenges, Arab ASRs frequently feel alienated, confused, and fearful upon arriving in the UK, highlighting the importance of the therapeutic relationship (Miller & Rasmussen, 2017). Findings also showed that interpreters play a crucial role in this relationship, so service-providers should be mindful when using interpreters in direct work with ASRs (Lau & Rogers, 2021).

Tailoring support services to meet the needs of Arab ASRs must involve meaningful adaptations in linguistic and cultural realms and in staff training. Cultural competence involves delivering culturally appropriate services by considering language differences and cultural beliefs that shape health experiences and help-seeking behaviours (Bhui et al, 2007). Recognising and accommodating the cultural and religious needs of Arab communities is essential, as it helps staff build cultural understanding by engaging with service-users to learn about their needs and how they make sense of these needs. Schouten, Manthey and Scarvaglieri (2013) found that culturally competent care led to improved patient engagement, increased satisfaction with care and adherence to treatment. Using common Arabic Islamic phrases such as when offering condolences to a service-user was seen as forming a crucial

part of the therapeutic relationship, demonstrating cultural sensitivity, and a novel contribution to understanding Arab ASR service-user needs.

NHS England's (2023) inclusion and health framework acknowledges that while many staff receive general equality and diversity training, it often lacks practical application for refugee populations with specific cultural, linguistic, and trauma related needs. Handtke, Schilgen, and Mösko (2019) found that using culturally and linguistically appropriate verbal, written, and visual materials during referrals, appointments, and follow-ups improved ASR engagement and retention. Organisations could also incorporate Arab ASRs' cultural and religious experiences, including their unique ways of understanding and coping with distress (Ellis et al, 2019; Kohrt et al, 2014; Miller and Rasco, 2004). Hiring bicultural Arabic speaking staff may further enhance cultural competence and reduce language barriers in community services.

Finally, research conveys the value in training being co-produced by service-users, which helps to promote trust, shared ownership and more culturally informed services (Dursoe et al, 2012). The Health Innovation KSS & NIHR ARC KSS (2024) published a co-produced intercultural awareness toolkit to guide professionals working with ASRs in any capacity, covering core intercultural principles such as cultural competence and their impact on individuals. It would be useful to explore professionals' awareness and use of this toolkit and how it may be adapted for work with Arab ASRs.

Empowering ASRs

Factors that disempowered Arab ASRs, and may also apply to other refugee populations, included negative societal perceptions shaped by unhelpful media narratives (e.g., Vinter, 2024), and service-level assumptions about their care needs. The media is powerful in shaping public opinions and influencing attitudes towards refugees, and more recently this has been exacerbated by hate crimes, protests and riots against refugees (Lueders, Prentice & Jonas, 2019; Vinter, 2024). Cultivation theory suggests long-term exposure to such messages skews societal perceptions (Gerbner & Gross, 1976). The impact of this could include refugees being socially excluded from society and self-internalising stereotypes (e.g. they're a burden on the economy) which may reduce their confidence to integrate and further discourage engagement with services (Gerbner & Gross, 1976). To foster more positive narratives, refugee organisations and service-providers could run community outreach in

educational and social institutions (e.g. schools and community centres) to educate the public about ASRs and the value they bring to society (Banulescu-Bogdan, 2022).

On an individual level, professionals recognised the importance of empowering service-users by giving them voice and ensuring there is a shared and equal power dynamic. Professionals from therapeutic backgrounds were more likely to self-reflect on issues of power and privilege, perhaps due to a strong focus on reflective spaces often provided in therapeutic or clinical facing roles, either in clinical supervision or within professional groups (Brooks, 2019). Reflective practice and clinical supervision involve actively reflecting on or evaluating clinical experiences, personal beliefs, responses, power imbalances and behaviours (Bennett-Levy et al, 2009). Results also indicated that some professionals may fall into a 'rescuer' or 'saviour' role, common across roles in the helping field such as nurses, doctors, social workers and therapists, where individuals may feel compelled to 'save' others or take credit for their progress (Karpman, 1968; Oakley et al, 2011). However, whilst well-meaning, this stance may unintentionally disempower refugees by undermining their autonomy to make choices and decisions and overlook their voices and strengths. Implementing such reflective spaces across support services may help professionals including those in non-therapeutic roles recognise and reflect on personal biases, reduce disempowerment, and strengthen relationships with ASRs. This in turn can promote more person-centred and culturally tailored services (Hawkins & Shohet, 2012; Lekas et al, 2020; Proctor, 1991).

The value of team and trauma-focused support

Professionals experienced a multitude of complex emotions, and navigating the role brought both rewards and challenges. Similar findings on working with ASRs highlight experiences of emotional exhaustion, helplessness, and vicarious trauma, which is secondary trauma experienced through exposure to others' traumatic accounts. (Drennan & Joseph, 2005; Guhan & Liebling-Kalifani, 2011). However, positive experiences like personal growth, inspiration and gratitude are also reported in the literature (Guhan & Leibling-Kalifani, 2011). The Mental Health Foundation (2024) emphasises person-centred and trauma-informed approaches when working with ASRs, these approaches foster a more compassionate and psychologically safe work environment where staff can express themselves without judgment. These approaches also recognise the emotional toll of trauma work and promote staff wellbeing to foster a culture of care and reduce burnout. In addition, service providers should offer regular supervision and managerial support for all staff

working in such roles including interpreters. It is also recommended that professionals make use of such spaces to maintain their wellbeing and facilitate effective working with ASRs generally (e.g. Miller et al, 2020).

Strengths and limitations

This study is the first empirical paper to explore professionals' and service-providers' experiences of working with ASRs in the UK. With a specific focus on the Arab refugee population, it offers culturally nuanced and community-specific insights, alongside broader considerations when working with marginalised and refugee groups. Insight into the accounts from diverse disciplines across the UK enabled a systematic and in-depth understanding of those supporting Arab ASRs across the community.

The interview schedule was co-produced with input from the research team including a clinical supervisor who had direct experience in working with ASRs in the UK, and a current professional in the field. This collaboration enabled key areas of professional work and the psychological and emotional impact on staff to be covered, leading to a richer and more in-depth exploration of the research topic.

A limitation of this study was the lack of direct input from Arab ASRs. Findings should not be taken as direct lived experiences of Arab ASRs, but of those with direct experience of working with this population. Including Arab ASRs' voices would have enriched the findings by offering greater depth and the potential to compare experiences. Furthermore, efforts to recruit Arab ASRs were hindered by limited capacity from services to support research, and the additional financial barrier of being unable to provide Arabic translators during data collection.

Future research

Future research should expand on this study by further exploring how services are meeting the needs of Arab ASRs and ASRs in general, with particular attention to addressing communication barriers and cultural competence in primary care and community organisations. Providing the choice of Arabic translation or interpreting services could improve access and engagement for non-English speakers. Furthermore, research that captures the direct experiences of Arab ASRs may further reveal additional needs and

nuanced insights that differ from other refugee populations, highlighting aspects that professionals may otherwise overlook.

Finally, future research should address barriers to recruiting ASRs, including how to best engage with refugee centres and community leaders who support Arab ASRs. Culturally-sensitive approaches, appropriate language use, and attention to privacy have also been highlighted as important considerations when recruiting ASRs into research (Gabriel, Kaczorowski & Berry, 2017).

Conclusion

This research explored how service-providers and multi-agency professionals in the UK perceive and experience working with Arab ASRs. Interviews with seven participants showed that, alongside common facilitators and barriers like communication challenges and building trust with service-users, there are unique cultural factors specific to Arab communities that must be addressed. Key priorities include developing co-produced, culturally tailored training for working with Arab ASRs, and maintaining awareness of power dynamics to reduce disempowerment and strengthen therapeutic relationships. Finally, the study highlighted the importance of ongoing professional support, trauma-informed approaches, and establishing a work-life balance for all staff in this line of work.

References

Banulescu-Bogdan, N. (2022). *From fear to solidarity: The difficulty in shifting public narratives about refugees*. Migration Policy Institute. https://www.bosch-stiftung.de/sites/default/files/publications/pdf/2022-05/refugee-narratives-report-2022_final.pdf

Barrington, A. J., & Shakespeare-Finch, J. (2013). Working with refugee survivors of torture and trauma: An opportunity for vicarious post-traumatic growth. *Counselling Psychology Quarterly*, *26*(1), 89–105. https://doi.org/10.1080/09515070.2012.727553

Bennett-Levy, J., McManus, F., Westling, B. E., & Fennell, M. (2009). Acquiring and refining CBT skills and competencies: Which training methods are perceived to be most effective? *Behavioural and Cognitive Psychotherapy*, *37*(5), 571–583. https://doi.org/10.1017/S1352465809990270

Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research*, *7*(1), 15–15. https://doi.org/10.1186/1472-6963-7-15

Bogic, Njoku, A., & Priebe, S. (2015). Long-term mental health of war-refugees: a systematic literature review. *BMC International Health and Human Rights*, 15(1), 29–29. https://doi.org/10.1186/s12914-015-0064-9

Braun, V., & Clarke, V. (2022). *Thematic Analysis: A Practical Guide.* Sage.

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social Work, 52*(1), 63–70. https://doi.org/10.1093/sw/52.1.63

British Psychological Society. (2021). *BPS code of human research ethics*. https://explore.bps.org.uk/content/report-guideline/bpsrep.2021.inf180

Brooks, M. (2019). The importance of using reflective practice when working with refugees, asylum seekers and survivors of torture within IAPT. *Cognitive Behaviour Therapist*, *12*. https://doi.org/10.1017/S1754470X19000023

Data Protection Act 2018, c. 12. https://www.legislation.gov.uk/ukpga/2018/12/contents

Drennan, V. M., & Joseph, J. (2005). Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing*, *49*(2), 155–163. https://doi.org/10.1111/j.1365-2648.2004.03282.x

Durose, C., Beebeejaun, Y., Rees, J., Richardson, J., & Richardson, L. (2012). *Towards Co-Production in Research with Communities*. Arts and Humanities Research Council.

Elbedour, S., Onwuegbuzie, A. J., Ghannam, J., Whitcome, J. A., & Hein, F. A. (2007). Post-traumatic stress disorder, depression, and anxiety among Gaza Strip adolescents in the wake of the second Uprising (Intifada). *Child Abuse & Neglect*, *31*(7), 719–729. https://doi.org/10.1016/j.chiabu.2005.09.006

Ellis, B. H., Winer, J. P., Murray, K., & Barrett, C. (2019). Understanding the mental health of refugees: Trauma, stress, and the cultural context. In R. Parekh (Ed.), *The Massachusetts General Hospital textbook on diversity and cultural sensitivity in mental health* (pp. 253–273). Springer. https://doi.org/10.1007/978-3-030-20174-6_13

Fazel, M., Wheeler, J., & Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet (British Edition)*, 365(9467), 1309–1314. https://doi.org/10.1016/S0140-6736(05)61027-6

Flynne, S. (2025, March, 4). A Triple Murder Shocked a Sleepy English Town. What Happened Next Was a Look Into How Disinformation Fuels the Far-Right: An anatomy of the 2024 Southport riots and their aftermath. *GQ*. https://www.gq.com/story/anatomy-of-a-riot?

Gerbner, G., & Gross, L. (1976). Living with Television: The Violence Profile. *Journal of Communication*, *26*(2), 172–199. https://doi.org/10.1111/j.1460-2466.1976.tb01397.x

Guhan, R., & Liebling-Kalifani, H. (2011). The Experiences of Staff Working With Refugees and Asylum Seekers in the United Kingdom: A Grounded Theory Exploration. *Journal of Immigrant & Refugee Studies*, *9*(3), 205–228. https://doi.org/10.1080/15562948.2011.592804

Hamadeh, A., El-Shamy, F., Billings, J., & Alyafei, A. (2024). The Experiences of People From Arab Countries in Coping with Trauma Resulting From War and Conflict in the Middle East: A Systematic Review and Meta-synthesis of Qualitative Studies. *Trauma, Violence & Abuse*, *25*(2), 1278–1295. https://doi.org/10.1177/15248380231176061

Handtke, O., Schilgen, B., & Mösko, M. (2019). Culturally competent healthcare – A scoping review of strategies implemented in healthcare organizations and a model of culturally competent healthcare provision. *PloS One*, *14*(7), e0219971-. https://doi.org/10.1371/journal.pone.0219971

Hassan, G., Ventevogel, P., Jefee-Bahloul, H., Barkil-Oteo, A., & Kirmayer, L. J. (2016). Mental health and psychosocial wellbeing of Syrians affected by armed conflict. *Epidemiology and Psychiatric Sciences*, *25*(2), 129–141. https://doi.org/10.1017/S2045796016000044

Hawkins, P., & Shohet, R. (2012). *Supervision in the helping professions* (4th ed). Open University Press: McGraw-Hill Education.

Health Innovation KSS & NIHR ARC KSS (2024). *Core intercultural concepts and principles for those working with asylum seekers and* migrants. Heyzine. https://heyzine.com/flip-book/c465430d5d.html#page/1

Johnson, J. L., Adkins, D., & Chauvin, S. (2020). A Review of the Quality Indicators of Rigor in Qualitative Research. *American Journal of Pharmaceutical Education*, *84*(1), 138–146. https://doi.org/10.5688/ajpe7120

Karpman, S. B. (1968). Fairy tales and script drama analysis. *Transactional Analysis Bulletin*, *7*(26), 39–43.

Khairat, M., Hodge, S., & Duxbury, A. (2023). Refugees' and asylum seekers' experiences of individual psychological therapy: A qualitative meta-synthesis. *Psychology and Psychotherapy*, *96*(4), 811–832. https://doi.org/10.1111/papt.12470

Kira, I. A., Amer, M. M., Wrobel, N. H., Nassar-McMillan, S. C., Hakim-Larson, J., & Ajrouch, K. J. (2014). Arab refugees: Trauma, resilience, and recovery. In *Biopsychosocial perspectives on Arab Americans* (pp. 175–195). Springer US. https://doi.org/10.1007/978-1-4614-8238-3_9

Kohrt, B. A., Rasmussen, A., Kaiser, B. N., Haroz, E. E., Maharjan, S. M., Mutamba, B. B., de Jong, J. T., & Hinton, D. E. (2014). Cultural concepts of distress and psychiatric disorders: literature review and research recommendations for global mental health epidemiology. *International Journal of Epidemiology*, *43*(2), 365–406. https://doi.org/10.1093/ije/dyt227

Lau, L. S., & Rodgers, G. (2021). Cultural Competence in Refugee Service Settings: A Scoping Review. *Health Equity*, *5*(1), 124–134. https://doi.org/10.1089/heq.2020.0094

Lekas, H.-M., Pahl, K., & Fuller Lewis, C. (2020). Rethinking cultural competence: Shifting to cultural humility. *Health Services Insights, 13,* 1178632920970580. https://doi.org/10.1177/1178632920970580

Liebling, H., Burke, S., Goodman, S., & Zasada, D. (2014). Understanding the experiences of asylum seekers. *International Journal of Migration, Health and Social Care*, *10*(4), 207–219. https://doi.org/10.1108/IJMHSC-06-2013-0016

Lueders, A., Prentice, M., & Jonas, E. (2019). Refugees in the media: Exploring a vicious cycle of frustrated psychological needs, selective exposure, and hostile intergroup attitudes. *European Journal of Social Psychology*, *49*(7), 1471–1479. https://doi.org/10.1002/ejsp.2580

Lusk, M., & Terrazas, S. (2015). Secondary Trauma Among Caregivers Who Work With Mexican and Central American Refugees. *Hispanic Journal of Behavioral Sciences*, *37*(2), 257–273. https://doi.org/10.1177/0739986315578842

McFadden, P., Campbell, A., & Taylor, B. (2015). Resilience and burnout in child protection social work: Individual and organisational themes from a systematic literature review. *British Journal of Social Work, 45*(5), 1546–1563. https://doi.org/10.1093/bjsw/bct210

Mental Health Foundation. (2024). The *Mental health of asylum seekers in the UK*. The Mental Health Foundation. https://www.mentalhealth.org.uk/sites/default/files/2024-02/Mental%20health%20of%20asylum%20seekers%20-%20report%20-%20February%202024.pdf

Miller, K. E., & Rasco, L. M. (2004). *The Mental Health of Refugees: Ecological Approaches To Healing and Adaptation* (1st ed.). Routledge. https://doi.org/10.4324/9781410610263

Miller, K. E., & Rasmussen, A. (2017). The mental health of civilians displaced by armed conflict: an ecological model of refugee distress. *Epidemiology and Psychiatric Sciences*, *26*(2), 129–138. https://doi.org/10.1017/S2045796016000172

Miller, E. A., Hee, P. J., Bonner, B. L., & Cherry, A. S. (2020). Training Psychologists in Integrated Primary Care and Child Maltreatment: Trainee and Supervisor Perspectives on Lessons Learned. *Journal of Clinical Psychology in Medical Settings*, *27*(3), 541–552. https://doi.org/10.1007/s10880-019-09648-w

NHS England. (2023, October 9). *A national framework for NHS action on inclusion health*. https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/

Oakley, B., Knafo, A., Madhavan, G., & Wilson, D. S. (2011). *Pathological altruism* (1st ed.). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199738571.001.0001

Office of the United Nations High Commissioner for Refugees. (2021). *Global report 2020*. UNHCR. https://www.unhcr.org/flagship-reports/globalreport/

Pampati, S., Alattar, Z., Cordoba, E., Tariq, M., & Mendes de Leon, C. (2018). Mental health outcomes among Arab refugees, immigrants, and U.S. born Arab Americans in Southeast Michigan: A cross-sectional study. *BMC Psychiatry*, *18*(1), 379–379. https://doi.org/10.1186/s12888-018-1948-8

Proctor, K. A. (1991). *Co-operative teaching practice supervision: an analysis of how teachers, student teachers and supervising tutors may work together effectively*. ProQuest Dissertations & Theses.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2014). *Qualitative research practice: A guide for social science students and researchers* (2nd ed.). Sage.

Robinson, K. (2014). Voices from the Front Line: Social Work with Refugees and Asylum Seekers in Australia and the UK. *The British Journal of Social Work*, *44*(6), 1602–1620. https://doi.org/10.1093/bjsw/bct040

Rogers-Sirin, L. (2013). Segmented Assimilation and Attitudes Toward Psychotherapy: A Moderated Mediation Analysis. *Journal of Counseling Psychology*, *60*(3), 329–339. https://doi.org/10.1037/a0032453

Samari, G., Alcalá, H. E., & Sharif, M. Z. (2018). Islamophobia, health, and public health: A systematic literature review. *American Journal of Public Health, 108*(6), e1–e9. https://doi.org/10.2105/AJPH.2018.304402

Schouten, B. C., Manthey, L., & Scarvaglieri, C. (2023). Teaching intercultural communication skills in healthcare to improve care for culturally and linguistically diverse patients. *Patient Education and Counselling, 115*, Article 107890. https://doi.org/10.1016/j.pec.2023.107890

Silbermann, M., Daher, M., Kebudi, R., Nimri, O., Al-Jadiry, M., & Baider, L. (2016). Middle Eastern Conflicts: Implications for Refugee Health in the European Union and

Middle Eastern Host Countries. *Journal of Global Oncology*, *2*(6), 422–430. https://doi.org/10.1200/JGO.2016.005173

Taylor, K. (2009). Asylum seekers, refugees, and the politics of access to health care: A UK perspective. *British Journal of General Practice*, *59*(567), 765–772. https://doi.org/10.3399/bjgp09X472539

United Nations High Commissioner for Refugees. (1951). *Convention relating to the status of refugees*. https://www.unhcr.org/1951-refugee-convention.html

Vinter, R. (2024, December, 29). 'They thought they were going to die': The asylum seekers who survived rioters trying to burn down their accommodation. *The Guardian* https://www.theguardian.com/lifeandstyle/2024/dec/29/they-thought-they-were-going-to-die-the-asylum-seekers-who-survived-rioters-trying-to-burn-down-their-accommodation?

<u>Paper 3:</u> Executive summary

The experiences of professionals and service providers working with Arab asylum seekers and refugees in the UK

Word count: 2496

This executive summary is aimed at service-providers and professionals who work with Arab asylum seekers (ASRs) and refugees in their day-to-day role in any type of setting.

The experiences of professionals and service-providers working with Arab Asylum seekers and refugees in the UK

What is this research about and why was it conducted?

There is a lack of research into what helps or challenges access to services for Arab asylum seekers and refugees (ASRs) from the perspectives of professionals and service-providers who serve them. It is also less well understood how professionals may be affected emotionally by the work.

Exploring these experiences would help to shape more effective and tailored services and better support professionals who serve this population.

Why is this research important?

- There has been a large increase in the number of refugees globally in the last decade, with an estimate of 26.4 million (United Nations High Commissioner for Refugees; UNHCR, 2020).
- Arab refugees make up for the biggest proportion of global refugees (Pampati et al, 2018).
- Recent estimates suggest that around 5.6 million Syrians have registered as refugees in neighbouring countries (UNHCR, 2020). Furthermore, approximately 5.1 million out 19.5 million refugees globally are Palestinian (UNHCR; 2020).

Arab refugees are defined as Arabic-speaking refugees who have originated and immigrated from Arab countries in the Middle East or North Africa (Pampati et al, 2018)

Refugees experience worse outcomes than the UK general population on nearly all measures of health and wellbeing, including physical and mental health, access to healthcare services, and social determinants of health such as housing, employment, and education (Taylor, 2009).

The refugee crisis has been intensified following the widespread riots in Summer 2024 in the UK, which fuelled violence, hostility and attacks towards refugee centres and communities (Vinter, 2024).

Why study Arab ASRs specifically?

- Arab populations have varying cultural and linguistic characteristics which differ to those of host countries, making it challenging for them to integrate to these countries (Kira et al, 2023).
- Predominantly Muslim, Arab ASRs often face Islamophobia, racialisation and discrimination in host countries, which further hinder integration and limit access to support services such as mental health care (Samari, Alcala & Sharif, 2018).

Why we focused on professionals and service-providers?

- Professionals and service-providers are usually the first point of contact for refugees, so they play a crucial role in supporting them to adjust and integrate to a life in a new country (Lau & Rogers, 2021).
- We lack understanding of the specific challenges Arab ASRs face, and how services could better respond to their needs to improve access to these services.

How the research was conducted

How were participants asked to take part?

A research poster was shared in local refugee and community centres and electronically via email to reach a wider range of organisations. Participants expressed an interest in taking part by emailing the researcher. The researcher then provided more information about the study and an interview was arranged. Written and verbal consent was obtained before participants took part.

Who took part?

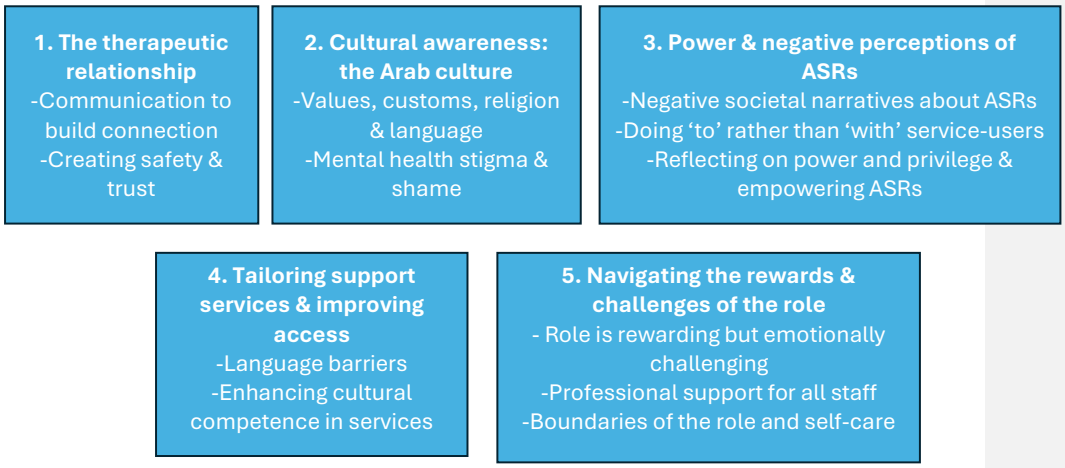
- Seven individuals (one male and six females) who worked directly with Arab ASRs were interviewed.
- Most participants worked in refugee centres that offered holistic services such as English classes, housing support, leisure activities, legal advice and psychological support.
- Roles included activities manager, counsellors, family integration officer and psychology roles.

What were participants asked to do?

- Participants completed a semi-structured interview on Microsoft Teams, which involved areas to be covered but also allowed for open discussions.
- On average interviews lasted 55.3 minutes and were audio recorded.
- Participants were asked about what helped with or created challenges when working with Arab ASRs, and how they addressed any challenges. Participants were also asked about the personal and emotional impacts of their role and experiences of support.
- Interviews were analysed using Reflexive Thematic Analysis (Braun & Clarke, 2022). This involved understanding the data thoroughly, similarities or differences in experiences were then developed into themes.

What we found

The study found five main themes and twelve sub-themes.



Theme 1: The therapeutic relationship

This focused on the direct therapeutic relationship between professionals and service-users.

Communication to build connection

Adapting communication included speaking clearly and at a slower pace, but also making service-users feel welcomed, smiling and using humour. Using basic Arabic greetings such as 'Marhaba' for 'hello' enabled professionals to build a connection with service-users and make them feel seen and heard. In contrast, merely asking "What are you here for?" could be perceived by Arab ASRs as dismissive or disrespectful, potentially leading to mistrust and creating a barrier in access to services.

> "Imagine you don't speak the language ... and then you meet someone and they're saying a few words in your language. That's so important. Just to feel seen". (Suzanne)

Creating safety & trust

Participants were compassionate and validated service-user experiences. Providing a safe space was particularly important for service-users in therapy or those talking about their personal refugee journeys which were sensitive in nature. Interpreters also played a valuable role in the therapeutic relationship by ensuring accurate communication and helping to foster trust and safety.

> "Taking the time to validate and acknowledge individuals who have had really difficult histories, really complex". (Susanne)

> "It's not just that person's just interpreting, you know, like a robot. It's very much like they become part of the relationship, part of creating safety for the service-user". (Sandra)

Theme 2: Cultural awareness: the Arab culture

This theme centred around developing an in-depth awareness and understanding about the Arab culture to effectively support Arab ASRs access services.

Values, customs, religion & language

Participants expressed the need to understand the distinct values, customs and religion of the Arab culture and tailor their work accordingly.

One Arab participant used an Islamic Arabic expression to offer her condolences to a service user, which was more meaningful and facilitated closeness in comparison to an English expression which has little cultural significance.

> "I just told her these words Azzam Allah Ajrakum [May Allah, God increase your reward]. I didn't say anything more, but this was enough. She hugged me and said thank you for being here with me". (Muna)

Mental health stigma & shame

Participants found that service-users typically kept their mental health difficulties hidden or denied having any problems. This was related to shame and the stigma around opening up about mental health struggles common in Arab communities.

> "So they think if they talk about their problem people will shame or judge them, because it's a cultural thing. We're not used to it as an Arab". (Sarah)

Arab men typically experienced greater shame and stigma about their mental health struggles, which reflects cultural norms of masculinity in Arab communities. This creates challenges for professionals and hinders access to mental health support for service-users.

> "One service-user, he said to me: 'You know, I'm a man and I'm asking my wife for help and I'm asking my children for help. What kind of father does this?' And again, that goes into what the role of the man is from an Arab cultural perspective ... and the shame that comes with that". (Suzanne)

Theme 3: Power & negative perceptions of ASRs

This theme was about experiences of disempowerment towards ASRs and ways professionals empowered them.

Negative societal narratives about ASRs

Labels towards ASRs were negative and hostile in society and in the media.

> "Some will say to me, there's this narrative that I'm just going to come here and I'm going to take the benefits ... but that's not true. I think society doesn't help with negativity and hostility about refugees". (Suzanne)

The effects of these labels could lead to ASRs internalising these narratives which may discourage them from seeking help and accessing services, particularly if they fear that even professionals could share these views.

Doing 'to' rather than 'with' service-users

Many participants spoke about ASRs generally being treated passively rather than as collaborators or having agency in their care.

> "I'm a good person and I'm going to help those poor people. And that's a terrible attitude. It's really disempowering" (Sakina)

These views reflect a kind of moral superiority or 'saviour complex,' where professionals may position themselves as rescuers and ASRs as passive victims that they need to save. This attitude disempowers ASRs by overlooking their own expertise, strengths, and needs.

Reflecting on power and privilege and empowering ASRs

Participants reflected on their own power and privileges as a process to help understand and acknowledge any power imbalances, which helped to empathise with, and empower service-users.

> "And trying to be at their level rather than being like the doctor talking at them and being all knowing kind of thing, which gives them a voice". (Sandra)

Theme 4: Tailoring support services & improving access

Language barriers

Much like other refugee populations, service-users faced language barriers when accessing and engaging with community services, which often led to challenges in accessing care effectively.

> They said we will send you details to book a course … I told him you don't know English. And they don't provide a translator. So, what is the point?" (Muna)

Lack of awareness of language barriers from external services also created delays in response times making vital information such as health and legal matters inaccessible.

Enhancing cultural competence in services

All participants expressed the importance of being provided with cultural competence training specific to ASRs and Arab populations. This would enhance professionals' understanding of Arab ASRs and improve engagement and access to services through more culturally tailored provision.

> "How might they express mental health, how you might they ask for help. What is help? What does help seeking look like? What does support look like?" (Suzanne)

Participants also expressed the need for training to be co-led by Arab refugees themselves to ensure that training is relevant, useful and rich.

Theme 5: Navigating the rewards & challenges of the role

This theme involved professionals' psychological and emotional experiences of working with Arab ASRs and how they were supported.

Role is rewarding but emotionally challenging

Participants expressed navigating a variety of complex emotions linked to the role. Feelings of empowerment, admiration and inspiration were expressed, alongside emotional burdens and distress.

> "I'm honoured that they would share their stories with me. It's so powerful what they've been through.... Every single group that we have, I come out of it empowered that they've told me their stories". (Maye)

> "You're human and you feel these people, what they go through it's like you are living it with them ... Sometimes I just go home drained and upset". (Sarah)

Professional support for all staff

Participants valued supervision and reflective time with colleagues, which involves critically reviewing their work to improve practice and manage the emotional demands of their roles.

> "Supervision is good to separate this and distance myself emotionally to look at the work from a wider perspective and from a lens that isn't as emotionally invested". (Suzanne)

Boundaries of the role & self-care

Adopting boundaries between the professional and personal self involved checking in with oneself, practising self-care and maintaining separation. This helped professionals manage the challenges of the role and be more present for their service-users, enhancing their overall experience of accessing support services.

> "There's Muna at work, she needs to leave Muna at work because Muna has another life at home, your personal life and your own self to look after". (Muna)

"I walk, go to theatres sometimes, I speak to friends, just to have that separation and do something that's mentally refreshing". (Sarah)

What does this all mean?

Research suggests that over time, with the appropriate support from service-providers and community services, refugees' mental, social, and physical health needs can be improved (Kirmayer et al, 2011).

While some findings reflect general considerations when working with refugee or marginalised groups, the study also identified key factors unique to Arab ASRs, offering a culturally nuanced perspective.

Research highlights that the therapeutic relationship is crucial for building trust, safety, and rapport, which positively influences engagement with ASRs (Khairat, Hodge & Duxbury, 2023), and this was reflected in most of the experiences shared in this study. In addition, basic Arabic greetings facilitated warmth and connection for both service-users and professionals.

Having an awareness of, and accommodating for cultural, linguistic, and religious needs of Arab ASRs was crucial. A review found that being culturally competent by being respectful of, and tailoring care in line with service-users' needs, values and language led to better engagement and satisfaction with care (Schouten et al, 2013). However, professionals in this study did not feel like training or services were generally tailored towards working with Arab ASRs.

How may a service be culturally competent towards service-users?

- ⇒ Paying attention to language needs
- ⇒ Understanding how someone's cultural beliefs can impact their experiences of health difficulties and seeking help

How ASRs were viewed in society was mostly negative and hostile. We know that long-term exposure to messages in the media can influence people's perceptions and can further impact negatively on refugees' mental health and disempower them (Carlile & Harrison, 2022). Professionals in this study empowered service-users by creating equal power dynamics where service-users felt listened to and on the same level as the professional.

Finally, professionals experienced various complex emotions related to working with Arab ASRs and emphasised the importance of supervision and reflective time with team members. Similarly, emotional exhaustion and helplessness but personal growth, inspiration and gratitude have been reported in the research (Drennan & Joseph, 2005; Guhan & Leibling-Kalifani, 2011).

Recommendations for next steps

- Removing language barriers in services where Arab ASRs are given the option and choice of translation of information and provision of Arabic interpreters.
- Service-providers and professionals should have an awareness of and strive to address power dynamics through involving Arab ASRs in all aspects of their care and encouraging agency where possible. Reflective team discussions and individual personal reflections about the work would also help to reduce feelings of disempowerment in Arab ASRs.
- Tailoring support services to meet the needs of Arab ASRs must involve meaningful adaptations in linguistic and cultural realms and in staff training. Organisations could incorporate Arab ASRs' cultural and religious experiences, including their unique ways of understanding and coping with distress.
- Finally, trauma-informed approaches that acknowledge the impact of working with trauma and encourage staff wellbeing are recommended to foster a culture of care and reduce burnout.

Future research

Future research should continue to explore and evaluate how service-providers are meeting the needs of Arab ASRs and their experiences. Specific focuses could include

removing communication barriers in primary care and community organisations that disadvantage Arab ASRs and non-English speakers, and creating culturally tailored services. Future research exploring the direct experiences of Arab ASRs accessing these services is highly recommended.

References

Carlile, C., & Harrison, R. (2022). *Addressing subtle forms of hate in UK media coverage of migration*. Ethical Consumer Research Association. https://research.ethicalconsumer.org/sites/default/files/inline-files/Addressing-subtle-hate-UK-media-coverage-migration-Full-Report-Oct2022.pdf

Drennan, V. M., & Joseph, J. (2005). Health visiting and refugee families: issues in professional practice. *Journal of Advanced Nursing*, *49*(2), 155–163. https://doi.org/10.1111/j.1365-2648.2004.03282.x

Guhan, R., & Liebling-Kalifani, H. (2011). The experiences of staff working with refugees and asylum seekers in the United Kingdom: A grounded theory exploration. *Journal of Immigrant & Refugee Studies*, *9*(3), 205–228. https://doi.org/10.1080/15562948.2011.592804

Khairat, M., Hodge, S., & Duxbury, A. (2023). Refugees' and asylum seekers' experiences of individual psychological therapy: A qualitative meta-synthesis. *Psychology and Psychotherapy*, *96*(4), 811–832. https://doi.org/10.1111/papt.12470

Kira, I. A., Amer, M. M., Wrobel, N. H., Nassar-McMillan, S. C., Hakim-Larson, J., & Ajrouch, K. J. (2014). Arab refugees: Trauma, resilience, and recovery. In *Biopsychosocial perspectives on Arab Americans* (pp. 175–195). Springer US. https://doi.org/10.1007/978-1-4614-8238-3_9

Kirmayer, L. J., Narasiah, L., Munoz, M., Rashid, M., Ryder, A. G., Guzder, J., Hassan, G., Rousseau, C., & Pottie, K. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*, *183*(12), E959-967. https://doi.org/10.1503/cmaj.090292

Lau, L. S., & Rodgers, G. (2021). Cultural Competence in Refugee Service Settings: A Scoping Review. *Health Equity*, *5*(1), 124–134. https://doi.org/10.1089/heq.2020.0094

Pampati, S., Alattar, Z., Cordoba, E., Tariq, M., & Mendes de Leon, C. (2018). Mental health outcomes among Arab refugees, immigrants, and U.S. born Arab Americans in Southeast Michigan: A cross-sectional study. *BMC Psychiatry*, *18*(1), 379–379. https://doi.org/10.1186/s12888-018-1948-8

Samari, G., Alcalá, H. E., & Sharif, M. Z. (2018). Islamophobia, health, and public health: A systematic literature review. *American Journal of Public Health,108*(6), e1–e9. https://doi.org/10.2105/AJPH.2018.304402

Schouten, B. C., Manthey, L., & Scarvaglieri, C. (2023). Teaching intercultural communication skills in healthcare to improve care for culturally and linguistically diverse patients. *Patient Education and Counselling, 115*, Article 107890. https://doi.org/10.1016/j.pec.2023.107890

Taylor, K. (2009). Asylum seekers, refugees, and the politics of access to health care: A UK perspective. *British Journal of General Practice*, *59*(567), 765–772. https://doi.org/10.3399/bjgp09X472539

United Nations High Commissioner for Refugees. (1951). *Convention relating to the status of refugees*. https://www.unhcr.org/1951-refugee-convention.html

Vinter, R. (2024, December, 29). 'They thought they were going to die': the asylum seekers who survived rioters trying to burn down their accommodation. *The Guardian* https://www.theguardian.com/lifeandstyle/2024/dec/29/they-thought-they-were-going-to-die-the-asylum-seekers-who-survived-rioters-trying-to-burn-down-their-accommodation?

Appendices

Appendix 1: Author guidelines for Literature review submission to the Culture, Medicine and Psychiatry by Springer

https://link.springer.com/journal/11013/submission-guidelines

Appendix 2: Critical Appraisal Skills Programme Qualitative Tool Checklist Questions (CASP, 2018) and checklist for studies included:

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Was the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. How valuable is the research?

CASP Tool Checklist (Appendix B) answers for Studies Included †

Authors, year and country	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
Algahtani et al (2019) Saudi Arabia & Bahrain	Y	Y	Y	Y	Y	C	N	Y	Y	Y
Anastasiou et al (2022) England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Al-Mahrouqi et al (2022) Oman	C	Y	Y	C	C	N	Y	C	Y	Y
Bin-Hasan (2022) England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Habhab (2018) USA	Y	Y	Y	C	Y	Y	Y	Y	Y	Y
Hamid, Scior & de C Williams (2023) Turkey	Y	Y	Y	C	Y	Y	C	Y	Y	C

Ibrahim et al (2021) Egypt	Y	Y	Y	C	Y	N	N	C	N	Y
Nassar-McMillan & Hakim-Larson (2003) USA	Y	Y	Y	Y	C	N	N	N	C	C
Miqdadi (2015) Jordan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Zaken & Walsh (2021) Israel	Y	Y	Y	Y	Y	Y	N	Y	Y	Y

† In-line with CASP checklist wordings, the following key was used: Y – Yes, C – Can't Tell, N - No

Appendix 3: Standard quality assessment criteria for evaluating primary research papers from a variety of fields with percentage ratings of overall quality of included papers (Kmet et al, 2004):

Criteria		Yes (2)	Partial (1)	No (0)
1.	Question / objective sufficiently described?			
2	Study design evident and appropriate?			
3	Context for the study clear?			
4	Connection to a theoretical framework / wider body of knowledge?			
5	Sampling strategy described, relevant and justified?			
6	Data collection methods clearly described and systematic?			
7	Data analysis clearly described and systematic?			
8	Use of verification procedure(s) to establish credibility?			
9	Conclusions supported by the results?			
10	Reflexivity of the account?			

Quality Rating: 0-33% = low quality, 34%-66% = medium quality, 67%-100% = high quality

The summary score is calculated as follows:

Total sum = (number of "yes" ∗ 2) + (number of "partials" ∗ 1) **Total possible sum** = 20
Summary score: total sum / total possible sum

Standard quality assessment criteria for evaluating primary research papers from a variety of fields (Kmet et al, 2004) answers for Studies Included †

Authors, year and country	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Summary quality % score
Algahtani et al (2019) Saudi Arabia & Bahrain	Y	Y	Y	Y	P	P	N	Y	Y	P	75%
Anastasiou et al (2022) England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
Al-Mahrouqi et al (2022) Oman	P	Y	Y	Y	P	N	Y	N	Y	N	60%

Bin-Hasan (2022) England	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
Habhab (2018) USA	Y	Y	Y	Y	P	Y	Y	Y	Y	Y	95%
Hamid, Scior & de C Williams (2023) Turkey	Y	Y	Y	Y	P	Y	Y	P	Y	P	85%
Ibrahim et al (2021) Egypt	Y	Y	Y	Y	N	P	P	N	Y	N	60%
Nassar-McMillan & Hakim-Larson (2003) USA	Y	Y	Y	Y	P	Y	P	N	N	N	60%
Miqdadi (2015) Jordan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	100%
Zaken & Walsh (2021) Israel	Y	Y	Y	Y	P	Y	P	Y	Y	Y	90%

† In-line with checklist wordings, the following key was used: Y – Yes, P – Partial, N – No; a total summary score for each paper was converted into a percentage in line with the scoring to provide an overall quality rating for each paper.

Appendix 4: Author guidelines for submission of empirical paper to the Journal of Immigration & Refugee Studies by Taylor & Francis

https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wimm20#preparing-your-paper

Appendix 5: Excerpts from reflective diary

During clinical psychology doctoral training I have learned to examine the wider perspective and context whilst putting individuals at the centre of my work. In doing so, I have learned to empower individuals and think about the systemic and structural challenges that exist within societies, and as someone who is passionate about promoting social justice and working with minoritised groups, this research has been eye-opening and fulfilling.

Hearing some of the personal stories from the professionals in the interviews was a times harrowing and upsetting. I found myself putting myself in the shoes of both the professionals working with this group but also within the shoes of Arab refugees, thinking about how it must have been like to for them to arrive into a new country, displaced, traumatised, alone and isolated from their home countries and family members. I can't imagine what that must have been like for them, not to mention the barriers they face from the moments they arrive onwards. I don't think I can really even imagine how difficult and traumatising that must be. It does make me think about all privileges we have as individuals who have never went through anything like their experiences. It also makes me think about what my roles are as a researcher and trainee clinical psychologist. As a British Arab I felt I could relate to the cultural experiences of Arab ASRs and issues around power and cultural awareness. This motivated me to strive to empower Arab ASRs through this research and do my utmost best to capture the experiences of Arab ASRs through the perspectives of professionals as best I could. As a trainee clinical psychologist, and from the findings of my research it made me think more about if I ever had the opportunity to work with ASRs how I would adapt my practise, I would use my identify as a British Arab to how empower Arab ASRs and adapt my practise to meet their needs. For example, it is clear that using Arab terms were more meaningful and helped to create connection, trust and safety with Arab ASRs, so I would make sure to pay attention to how I bring my identify and parts of myself

However, an outsider perspective, both from the perspectives of never identifying as an ASR or having direct experience of working with this population I felt somewhat separate to the research, which I believe helped me to view the data from a wider perspective rather than through a narrow lens that would perhaps be driven and influenced by emotions. However, I do recognise that due to my biases and motivations, the interpretation of findings could be from a solution focused lens, e.g. what could be done to improve practise and services for Arab ASRs. Throughout the process of analysis I made sure to keep checking interpretations of my codes, clusters, sub-themes and themes with my own potential biases to make sure I was sticking as close to the data as possible. I think this helped to minimise these potential biases. I also made use of individual supervision as well as group RTA workshops to check over my analysis and interpretations.

Appendix 6: Ethical approval letter for empirical paper

University of Staffordshire

School of Health, Education, Policing and Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Hannane Hamlaoui**
Title of Study:	**The Experiences of Arab Refugees Accessing Support in the UK and the role of professionals and service providers**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of minor amendments to your ethics application.

Your amended application is approved with the following recommendations:

- Chair of ethics: Details need to be updated to Professor Sarahjane Jones: ethics@staffs.ac.uk
- Debrief form. For some reason the name of 'inspirited minds' organisation has been removed, although their contact details remain. Either details of the organisation should be reinserted or if it has been decided to remove this organisation from potential contacts then the contact details should be removed.

We wish you well with your research.

Action now needed:
Your amendment has now been approved by the Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed:

Date: 05.11.2024

Sarah Rose

Dr. Sarah Rose
Ethics Co-ordinator - HEPS

Appendix 7: Risk assessment and mitigation plan for empirical paper

			Severity multiplied by **Likelihood** equals **Risk Rate**. NB: Calculated after taking in to account existing precautions				
School/Service: HSW Psychology		Severity Likelihood	Insignifi-cant (1)	Minor (2)	Moder-ate (3)	Serious (4)	Fatal / Critical (5)
Task/Activity/Area: Exploring the mental health and wellbeing of Arab refugees and the challenges faced when accessing mental health services in the UK using interview methods		Almost Certain (5)	**5**	**10**	**15**	**20**	**25**
		Likely (4)	**4**	**8**	**12**	**16**	**20**
Assessed By: Hannane Hamlaoui	Signature: Hannane Hamlaoui	Possible (3)	**3**	**6**	**9**	**12**	**15**
Supervisor: Dr Kim Gordon	Signature:	Unlikely (2)	**2**	**4**	**6**	**8**	**10**
Date of Assessment: 28/10/2023	Review Date:	Rare (1)	**1**	**2**	**3**	**4**	**5**

Appendix 7: Risk assessment and mitigation plan for empirical paper

STAFFORDSHIRE UNIVERSITY		**Severity** multiplied by **Likelihood** equals **Risk Rate**. NB: Calculated after taking in to account existing precautions

Description / activity / procedure:

Participants will have the opportunity to express interest in the research by contacting the researcher via an opt in slip attached to the poster with the researcher's contact details (email address).

Participants will then access a participant information sheet with further information about the study, it's purpose and what participation will entail. When participants have had enough time to read through the study information and are happy to participate, they will be able to email the researcher directly using the contact details on the participant information sheet or on the poster. The researcher will then liaise with the participant regarding what the most suitable mode of carrying out the interview is (face-to-face or online via Microsoft Teams, as well as arranging an interview during a date and time that is convenient for the participant.

Before beginning the interview, the researcher will check that the participant has provided consent to participate in the study; prior to the interview the researcher will send the electronic consent form to the participant if the interview is scheduled to take place online. If completed face-to-face, the participant will have the opportunity before the start of the interview to complete the consent form, and will have access to the researcher if they have any questions about consenting to the study.

Interviews will last approximately 45-60 minutes and will involve semi-structured questions to explore the mental health and wellbeing of Arab refugees and the challenges faced when accessing mental health services.

Participants will be offered a debrief at the end of the study with opportunity to raise any concerns and address any distress that may have arose. As detailed above, participants will be signposted to relevant support services.

Activity/Process/ Mechanism	Hazard	Persons at Risk	Measures/Comments	Severity 1-5	Likelihood 1-5	Risk Rate	Result
Interviews	Professionals /service-providers or researcher distress due to nature of the topic. Participants will be asked to reflect in detail about their experiences of working with Arab ASRs, as well as on their own wellbeing and challenges around their line of work.	Participant and Researcher	Professionals will not be asked direct questions about specific types of work with refugees however, it may be that when reflecting on the impact of this work some distress may occur e.g. specific ASR stories, vicarious trauma or the emotional impact of their work. Participants will be signposted to relevant support services which will be provided in the participant information sheet as well at the end of the study. A debrief sheet will be offered to participants at the end of the interview to enable a safe space to discuss any distress that may have been caused during the study, as well as signposting to specific local organisations if they become distressed after the completion of the study and in case of future distress (e.g. counselling services, bereavement services, financial support etc). To protect the safety of participants and the service-users they support, participants will not be asked to disclose any information or	3	4	12	A – low risk

Activity/Process/ Mechanism	Hazard	Persons at Risk	Measures/Comments	Severity 1-5	Likelihood 1-5	Risk Rate	Result
			details regarding the service at which they work at. The researcher has discussed with the academic supervisor any potential parts of the research (e.g. interview process) that may likely be trigger or create any type of distress. An agreed plan has been set up to mitigate against this risk. Risks could include possible distress resulting in hearing the accounts of participants discussing experiences related to being a refugee or working with a refugee. There may also be related distress when transcribing and analysing the date following the interviews. The researcher and academic supervisor have agreed that if any distress does occur, the researcher should contact the supervisor via email within 24 hours following interviews to provide debrief or support should the researcher requires this. The researcher has also agreed to make use of other support in				

Activity/Process/ Mechanism	Hazard	Persons at Risk	Measures/Comments	Severity 1-5	Likelihood 1-5	Risk Rate	Result
			the community if needed, including partner, family, close friends or support services such as Samaritans.				
Participant data	Participants will be required to provide some information such as their name, demographic information and their email address which may identify them. Personal data will be stored remotely by the researcher	Participant	All identifying information will be anonymised to reduce the risk of breaching confidentiality or the participants anonymity. In order to manage this, any identifiable/personal information will be kept confidential by only being accessed to the principal researcher and either stored in a locked filing cabinet at the University of Staffordshire (if manual paper copies) or on a password protected University of Staffordshire computer on a secure server. Personal data including audio recordings will be kept separate from the research data and will be permanently deleted at the end of the study. Identifiable information will be kept anonymous by assigning each participant file an individual code. No identifiable information will be accessed by anyone other than the principal researcher, and though quotations from interview transcripts will be	3	2	6	A – low risk

Activity/Process/ Mechanism	Hazard	Persons at Risk	Measures/Comments	Severity 1-5	Likelihood 1-5	Risk Rate	Result
			used for external purposes such as research publications, participants will be given a pseudonym to conceal their identity.				

Appendix 8: Interview schedule

Interview schedule topic guide

1. Professional Role and Background

- Can you describe your current role and responsibilities in supporting Arab refugees/asylum seekers?
- How long have you been working with Arab refugee/asylum seekers?
- What types of services do you provide to refugees in your work?

2. Experiences Working with Refugees

- What are your experience working with Arab refugees/asylum seekers? – tailor to interviewee's role and responsibilities?
- What has facilitated your work with Arab refugees/asylum seekers?
- Can you describe any specific challenges or barriers in your work? e.g. cultural, linguistic, training.
- How do you manage complex cases or difficult scenarios involving refugees (e.g., legal,
- social, and healthcare needs)?
- What systemic challenges or barriers have you encountered in your work with refugees?
- Are there any barriers related to Arab refugees accessing your services? If so what are these?
- How do you think some of these issues could be addressed or improved to further support Arab refugees.

Impact of your experience of working with refugees

- Have you had any experiences of refugees/asylum seekers opening up about their mental health? If so what was this like and what did you do?
- If you have worked with refugees/asylum seekers within a therapeutic or psychological capacity what was your experience of this?
- Do you think any barriers exist when it comes to Arab refugees/asylum seekers opening up about their mental health?
- Has your work with refugees affected you emotionally? If so, how?

- How do you manage this?
- Have you accessed any support for this? E.g. professional or emotional support.
- Is there any additional resources or training would improve your ability to work with refugee populations?
- Are there any further comments you would like to add?

Appendix 9: Research Poster

STAFFORDSHIRE UNIVERSITY

THE EXPERIENCES OF PROFESSIONALS & SERVICE PROVIDERS WORKING WITH ARAB REFUGEES & ASYLUM SEEKERS IN THE UK

What is this research about?

- We are looking for individuals who support or have supported Arab refugees in their work to talk about their experiences of this
- You will be invited to have a discussion lasting between 45 minutes to 1 hour either online or face-to-face depending on which you prefer and your location

Want to take part?

Do you have any experiences in the last two years of supporting Arab refugees as part of your work? (This could be in any type of sector e.g. healthcare, education, legal etc)

You must be 18 or over

Who to contact

Please contact the researcher Hannane Hamlaoui (trainee clinical psychologist) on h042140m@student.staffs.ac.uk if you would like to find out more information or take part.

This project has been reviewed and approved by the Staffordshire University Research Ethics Committee ID: SU_23_034

Appendix 10: Participant information sheet

Study title: The Experiences of professionals and service providers working with Arab refugees and asylum seekers in the UK

Participant Information Sheet (PIS)

I would like to invite you to take part in my research study as part of my Doctoral research project in Clinical Psychology. Before you decide whether you would like to take part, it is important for you to understand what this research is about and why it is being conducted. Please take the time to read the following information carefully and discuss it with others if needed.

Who will conduct the research?

Principle Researcher

Hannane Hamlaoui (h042140m@student.staffs.ac.uk)
Trainee Clinical Psychologist
Staffordshire University
Leek Road
Stoke on Trent
Staffordshire
ST4 2DE

Project Supervisors:
Dr Kim Gordon (Kim.Gordon@staffs.ac.uk)
Senior Lecturer in Clinical Psychology (Research Tutor)
Equality, Diversity and Inclusion Project Lead for Clinical Psychology
Staffordshire University
Leek Road
Stoke on Trent
Staffordshire
ST4 2DE

Dr Sobia Khan
Consultant Clinical Psychologist
The Bennett Centre
Hanley
Stoke-on-Trent

ST1 4ND

What is the purpose of the research?

Arab refugees may experience difficulties with their mental health, for example, studies show that Arab refugees who have to move to a different country may experience social isolation, ethnic discrimination, unemployment, language barriers and poor living conditions, which could all have a negative impact on mental health. However, there is less evidence on what factors may help or prevent Arab refugees from seeking mental health support as well as other support services in the UK. The perspectives of professionals who work with Arab refugees is crucial in order to consider what helpful or unhelpful factors there are when working with Arab refugees to access support services, as well as to consider how professionals may be personally impacted and what support is available to them.

The aim of this research is to understand the experiences of professionals and service providers who work with Arab refugees and asylum seekers to explore what barriers and facilitates may exist to providing support services.

Why have I been invited?

You have been invited to participate in this study because you are/ have worked with Arab refugees professionally in the last two years.

Do I have to take part?

No, it is entirely up to you to decide whether you would like to take part. Your participation is voluntary, and taking part in this research will not at any time interfere with or jeopardise your refugee status.

What would I be asked to do if I took part?

- If you agree to take part in this study, you will be invited to participate in an online Zoom interview with the researcher. Face-to-face interviews can also be facilitated depending on your preference and the location between you and the researcher is not burdensome, and where a confidential space can be accessed to conduct the interview. The interview will last approximately 45 minutes to one hour.
- Before the interview you will be asked to complete an online or paper-based consent form depending on whether the interview will be held online or face-to-face.
- During the interview you are free to end it at any time without giving any reasons or choose to not answer a particular question. If you choose to end the interview, then your data will be deleted afterwards. You can request for your data to be removed from the study up until two weeks after the interview has finished. Once data is analysed it will no longer be possible for your interview data to be removed.

- The interview will focus on your experiences of supporting Arab refugees/asylum seekers and what factors have made it helpful or less helpful, as well as what kind of support you receive to assist you in working with this population.
- We will record interviews either on Zoom or using an audio recording device if the interview takes place face-to-face. We do this to ensure we have accurate and high-quality data.
- There may be some risks if you do choose to take part in this study. You may find some questions or parts of the interview uncomfortable or upsetting. If this is the case, then we can give you information about support services at the end of the interview.

What will happen to the information I provide?

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

The data controller for this project will be Staffordshire University, which means they are responsible for looking after your personal information for the purpose of this research. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest'. You can provide your consent for the use of your personal data in this study by completing the consent form that will be provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments, and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to make a complaint with the Information Commissioner's Office, please visit www.ico.org.uk

What information will we collect from you and how is it stored?

We will collect the minimum amount of personal data from you needed to carry out the research, this will include your name and email address, so we can contact you to arrange an interview. I will have access to information, but this will be kept safe and stored in a spreadsheet which will be password protected and stored on a Staffordshire University secure server with access to it only by myself. We will change any names or locations to make sure your information is confidential. After your information is protected, it will not be shared with anyone outside of myself and my research team.

You will be assigned a code (letters and numbers e.g. HI01) which will be used to label the interview file and kept anonymous. All files and digital recordings will be encrypted and stored in a folder with password protection on a secure University of Staffordshire computer device that only the researcher can access. Once interviews are transcribed all recordings will be

deleted. Direct quotations from some interviews will be used in the research report however these will be kept anonymous, instead pseudonyms will be assigned to each participant if parts of the interview are used as quotes in the report. Anonymised transcripts will be stored on the Staffordshire University secure server for ten years from the end of the study before being securely deleted. They will not be shared with other researchers.

Will my participation in the study be confidential?

All the data collected from the interviews will be kept strictly confidential and stored on a University network drive (not a specific device) and will conform to the Data Protection Act of 2018 in regards to data collection, data storage, and data deletion. Any identifiable information will only be available to the principal researcher and on a password protected computer.

What happens if I do not want to take part or if I change my mind?

It is your decision whether you wish to take part. If you do decide to take part, you will be given this information sheet to keep. You can read this information sheet in your own time and decide whether you would like to take part. Once you receive the information sheet we recommend taking at least one week to decide whether you would like to participate in the research. Once you have decided you would like to take part in this research you will be invited to an interview. Before you begin the interview, you will be asked to tick a box indicating that you consent to take part in this study if you choose an online interview. If the interview is face-to-face, you will also be given a consent form to sign before you begin the interview. You can still withdraw from the study at any time up to two weeks after the interview, without giving me a reason. However, it will not be possible to remove your data from the study once data analysis has begun. This does not affect your data protection rights.

Will I be paid for participating in the research?

Unfortunately we do not have any provision to provide any type of inducement or payment for your participation in this study. However, it is hoped that the findings will be used to inform our understanding and improve support services for Arab refugees in the UK, particularly on tackling barriers for accessing support, as well as improve staff support.

Where will the research be conducted?

If you agree to an online interview, we recommend you have a quiet and confidential space if possible, with access to an electronic device with a stable internet connection so that you are able to speak comfortably and openly during the interview.

Will the outcomes of the research be published?

The outcomes of this research will be written up as part of a thesis for the Professional Doctorate in Clinical Psychology, with the view to publish this within as a journal article and

potentially within conference presentations and posters. Any published data will be completely anonymised as explained above.

What if there is a problem?

If you have any issues or concerns about any parts of this study, you should contact the principle researcher Hannane Hamlaoui, who will do her best to answer any questions. She can be contacted at h042140m@student.staffs.ac.uk. If she is unable to resolve your concerns, you can contact the research supervisor Dr Kim Gordon on Kim.Gordon@staffs.ac.uk.

You can also contact the Chair of the Staffordshire University Ethics Committee for further advice and information if your query has not been resolved.

Chair of Staffordshire University Ethics Committee:
Prof. Nachiappan Chockalingam
Staffordshire University
N.Chockalingam@staffs.ac.uk

Who has reviewed the research project?

This project has been reviewed by the Staffordshire University Research Ethics Committee SU_23_034

What Do I Do Now?

If you would like to participate in this study, please email the principle researcher on the email address below.

Hannane Hamlaoui (h042140m@student.staffs.ac.uk)
Trainee Clinical Psychologist
Staffordshire University
Leek Road
Stoke on Trent
Staffordshire
ST4 2DE

Thank you very much for taking the time to read this information

Appendix 11: Consent form

Study title: The Experiences of professionals and service providers working with Arab refugees and asylum seekers in the UK

Consent Form

If you are happy to participate please complete the consent form below.

	Activities	☑	☒
1	I confirm that I have read the attached information sheet for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.		
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself.		
3	I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. Data can only be withdrawn up to two weeks following the interview. I agree to take part on this basis.		
4	I agree to my interview being recorded for the purpose of data transcription and for use of anonymous data in the doctoral thesis.		
5	I agree that any data collected may be published in anonymous form in academic books, reports or journals.		
6	I would like to be contacted about the findings of the research		
7	I agree to take part in this study.		

Appendix 12: Demographics form

Demographics form

About You This questionnaire asks some general information about you, such as your age, nationality, ethnicity etc.	
Sex:	Male Female Other
Age:	
Ethnicity:	Which of the options best describes your ethnicity? Asian or Asian British – Indian Asian or Asian British – Pakistani Asian or Asian British – Bangladeshi Any other Asian/Asian British background Arab White British White – Irish Any other white background Black or Black British: Black or Black British – Caribbean Black or Black British – African Any other Black/Black British background Mixed: Mixed - White and Black Caribbean Mixed - White and Black African Mixed - White and Asian Any other mixed background Chinese or other ethnic group: Chinese Any other (please describe) (APMS, 2007)
Sexual orientation:	Which of the options [on this card/below] best describes how you think of yourself?: 1. Heterosexual or Straight, 2. Gay or Lesbian, 3. Bisexual, 4. Other 5. Prefer not to say (Office for National Statistics, 2009)
First Language:	1. English 2. Other – please specify:

What is your legal marital or same-sex civil partnership status?	1. Never married and never registered a same-sex civil partnership 2. Married 3. Separated, but still legally married 4. Divorced 5. Widowed (Office for National Statistics, 2011)
How far did you get in school?	1. Degree level qualification or equivalent 2. A Levels or college-equivalent qualifications 3. High-school qualifications 4. Other qualifications (specify) 5. No qualifications (APMS, 2007)
Which of these activities best describes what you are doing at present? (please select one only)	1. Employee 2. Self Employed 3. Unemployed 4. Full-time education at school, college or university 5. Looking after family/home 6. Sick/Disabled 7. Retired 8. Other Inactive (Office for National Statistics, 2015)
Have you worked with Arab refugees/asylum seekers for at least 6 months?	[Open text response]
What type of support service do you provide to Arab refugees/asylum seekers?	[Open text response]

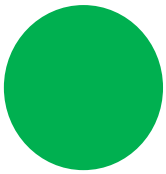
Appendix 13: Debrief form

Participant Debrief Sheet

Thank you for participating in this interview. If you have found any part of this experience to be distressing and you wish to speak to one of the researchers, please contact:

Principle Researcher:
Hannane Hamlaoui (h042140m@student.staffs.ac.uk)
Trainee Clinical Psychologist

Project Supervisor:
Dr Kim Gordon (Kim.Gordon@staffs.ac.uk)
Senior Lecturer in Clinical Psychology (Research Tutor)

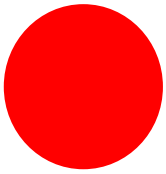


Green: If you find that you are feeling slightly concerned you could:

- Talk to a family member
- Talk to a close friend

Amber: If you are feeling concerned or you find that even after you've spoken to someone you know you continue to feel concerned you could:

- Talk to your GP if you can access this
- Call the Samaritans - 08457 90 90 90 - The Samaritans can offer confidential support either during phone



Red: If you are feeling extremely concerned or you feel as though you need help urgently you could

- Contact your out of hours GP cover
- Visit your local A & E department

There are also a number of organisations listed below that you can contact.

For refugees	
Organisations	**Contact details**
The Refugee and Migrant Centre: Offers support to asylum seekers, refugees. Advice and guidance on housing, employment, welfare, education, health and immigration, English classes and resettlement schemes	0800 0663 44 info@rmcentre.org.uk
	https://inspiritedminds.org.uk/contact-us/
Amnesty International UK: concerned with human rights, refugee and migrant rights	Email: sct@amnesty.org.uk www.amnesty.org.uk
Asha North Staffordshire	https://asha-uk-org.ctrnet.co.uk/contact/#enquiry
Samaritans	Free to call on 116 123 or email via jo@samaritans.org
For professionals	
Samaritans	Free to call on 116 123 or email via jo@samaritans.org
Contact your GP	

Appendix 14: Example extracts of similar codes grouped into clusters

Cluster 15 Staff reflect on own differences and what this means	Cluster 16: Role is emotionally challenging for staff	Cluster 17: Power dynamics
Battling with feelings of guilt in clinician's privileged role of just listening and having their role in comparison to refugee experiences	Being a counsellor and working with trauma and hearing about torture can be mentally difficult	Sitting with them, not above or down, being on an equal level to them
A real sense of perspective of life difficulties compared to what refugees face	Challenging to support people through horrendous immigration system	Sometimes staffs' narrative about the way they talk about providing help to refugees is disempowering
Being aware of power dynamics	Difficult for me to see refugees struggling with immigration system	Refugees' qualifications are not recognised in the UK
Easier for me to sit and listen whilst they have gone through so much	Difficult to work with and hear about such brutal experiences but also seeing change	Getting to know them as humans not as asylum seekers or what that represents
Comparing differences in lives and privileges has enabled me to want to help people and give back	Empathise with refugees' experiences and feel their pain	Practitioner is not patronising, not overly apologetic or speaking down on them so client feels at ease and equal
Noticing differences and privilege of being born in this country compared to the refugee	Part of role is hearing about difficult stories	Narrative about how staff talk about helping refugees should be empowering
Putting self in Arab refugees' shoes and reflecting on differences between client and clinician	Emotional aspects that make you want to cry but holding back on tears	Making Arab refugees feel equal and part of community
Reflecting on difference in identity and positions helps look at work in different ways	Work impacts emotionally and physically drained	Some staff act superior to refugees and this is disempowering
	Work has impacted me emotionally	Services assume what the refugee needs and 'know what's best' attitude

Cluster 22 Specific training on cultural competence and awareness as training is not tailored	Cluster 23 Positive aspects of role Empowering, rewarding, meaningful, inspiring
Developing more knowledge about Arab cultures can mean tailoring interventions better and engaging with client	Feeling empowered by refugees' stories
Lack of cultural awareness may lead to lack of understanding and referring to inappropriate service	Listening to clients and giving back to them empowers and humbles me
Services need more awareness of culture and aspects of culture	Nicer person and more appreciative after doing this work
Lack of cultural awareness may lead to misunderstanding something and referral to inappropriate service	Passionate about helping refugees and asylum seekers so find it positively impacts me
Diversity training isn't tailored to specifically working with Arab refugee	Passionate about work because of their hardships they go through
Further training (e.g. about countries of origin) would give more knowledge and would be more helpful	The work is rewarding from a human to human level
Generic equality and diversity training not tailored	Love working with refugees and asylum seekers and find it meaningful
Training is not specific to working with them	Role is rewarding as you go on a journey with them and see change
Important to have cultural competency and training on this to recognise differences in cultures and how they may experience mental health	Wonderful working in this field
	Feeling honoured and privileged to be working with refugees and hear their powerful stories

Appendix 15: Themes table with breakdown of codes, example quotes, sub-themes and themes and number of participants supporting each sub-theme

Theme	**Subtheme**	**Total no of ppts supporting each subtheme**	**Initial codes**	**Example quotes**
1. The therapeutic relationship	Communication to build connection	7	Using basic Arab greetings helps to build a rapport with service-users and make them feel seen	*"Again, yeah, I think just imagine, you know, imagine you've come somewhere that you don't. You don't speak the language and everyone you meet doesn't speak your language, and then you know, like you, you meet someone and they're saying a few words in your language and you're like, OK, right. That's so important. Just to feel seen.* (Suzanne) *"But it just helps us to build up connection. You know, I speak a tiny amount of Arabic, so whenever I see someone, I will say hi. How are you, you know? And we'll have a laugh about. Yeah. We have a laugh".* (Kevin)

				"*My other colleagues speak some Arabic. It's makes them (the service-users) feel at ease coming to the session and feel more belonging*". (Sarah)
			Adapting verbal communication	*"Because when I speak with them, I speak slowly. I speak with them the way that they can understand me, not quickly. So I speak with them, they most of them, they tell me, OK, we understand you."* (Muna) *"Taking it at their pace, there's so many barriers to learning English so its about doing it slowly."* (Sandra).
			Providing a warm friendly welcome and being hospitable	*"So, like the importance of a warm welcome, which is very central to Arabic culture. When somebody comes through the door, you don't say, Hi, what's your name, what you're here for, or Hello. How are you? We will say, welcome. Have a seat. Would you like something to eat or drink?"* (Sakina) *"We always make sure we show people around the centre, introduce them, get them cup of tea or coffee and we're you know that just that welcoming, you know, just bring people down and just have a laugh, you know".* (Kevin)

	Creating safety and trust	5	Importance of taking time to validate Arab ASRs difficult experiences	*"Just taking the time to kind of validate as well. Acknowledging that these individuals who have had a really difficult histories, really complex kind of migration patterns and they've come from potentially kind of war-torn countries".* (Suzanne) *"They all have a story. They are struggling, so we just need to be human, listen to them and acknowledge their difficulties".* (Sarah) "*When you give them space to speak and you listen to them, they feel heard*" (Muna)
			Making service-users feel safe helps build trust	*"The first thing I need to do with them is to make them feel safe and that they can trust me. I build the relationship with them"* (Muna). *"Being somebody that people can contact if needed and making sure that they know there's a space that where people can be safe, where they can express themselves and engage in things and try and find a little bit of joy."* (Kevin)

				"When we start seeing somebody, we don't, straight away start working on what, what's the traumatic things? The first things we do is we kind of find out what's happening in the present of a person's life, partly to build a relationship and partly to try and create safety and trust". (Sakina) "*That other person [interpreter] becomes a really important and another human being in the in the interaction. So it's not just like that person's just interpreting, you know, like a robot. It's very much like they become part of the relationship, part of creating safety for the service-user which helps with trust".* (Sandra)
2. Cultural awareness: the Arab culture	Values, customs, religion & language	5	Being aware of, and explaining cultural differences of disciplining a child from a legal perspective	*"And we're just showing them the differences between cultures. Even the legislation side of it. For instance, in the UK it's illegal to hit your child, but you know in other cultures it's very normal, so it's just being aware of and explaining those differences"* (Maye)
			Importance of understanding and	"[W]e get external partners coming in and they put the hand out to a woman who is an Arab wearing a hijab (headscarf

			respecting religious beliefs and practises	covering Muslim women's hair). And, you know, you can see that terrifying look in their eyes. So that's where we just intervene a little bit and say, oh, no, that handshake is not appropriate*."* (Kevin)
			Differences in culture and values	*"I've learned a lot about difference. Different Arab cultures and different countries and different even dialects of Arabic."* (Maye) *"The differences in culture, the culture is that you are you in relation to your sister, you are you in relation to your mother, to your father, it's very different."* (Suzanne) *"It's quite different from the English culture, the values, the food, the traditions, it's important to understand"* (Sarah) *"The Brotherhood and the sisterhood in Arab cultures, Arabic speaking people are really supportive to each other".* (Sakina)
			Offering condolences traditionally given in Arab was more meaningful	*"I can't tell her that your daughter died. I just told her these words Azzama Allah Ajrakum [*meaning may Allah [God] increase your reward] *I didn't say anything more, but this was enough. She hugged me and said thank you for you being here with me"* (Muna).

	Mental health stigma & shame	5	Mental health is labelled as crazy or stupid	*"When you say mental health, we think that, oh, I'm not crazy. I'm not stupid"* (Muna)
			Opening up about mental health is shameful	*"So they think if they talk about their problem people will shame or judge them, because it's a cultural thing. We're not used to it as an Arab, you know*" (Sarah). *"It's almost like there is this huge shame related to talking about these difficulties"* (Suzanne). *"They do have mental health issues, but they don't speak about it. They do go through a lot, but they are not used to discussing these matters with other people and sharing. They think people will shame and judge them. And because I am Arab, I understand in our culture we don't believe in mental health, it's frowned upon".* (Sarah)
			Arab men feel more shame about disclosing mental health related struggles	*"Particularly in Arab men, there is a lot of shame, a lot of shame and opening up"* (Maye) *"One service user, he said to me. You know, it's I'm a man and I'm asking my wife for help and I'm asking my children for help. What kind of father does this? And again, that goes into*

				kind of what the role of the man is, what their role of the father is from an Arab cultural perspective. What the role of the man is the shame that comes with that" (Suzanne).
3. Power & negative perceptions of ASRs	Negative societal narratives about ASRs	4	Negative and hostile climate in society around ASRs	*"The whole climate around asylum and you know at the moment is really bad. We had the riots and there's lots of there seems to be, according to the media, lots of people who are saying stop the boats and really unhelpful things which can be really harmful to the people we see."* (Sandra) "*I think that there's a massive negative image about refugees and asylum seekers. They're seen negative because that's what's reported in the press 90% of the time, you know, stop the boats and all that kind of stuff*" (Kevin) "*Some will say to me, there's this narrative that I'm just going to come here and I'm going to take the benefits and that's all that people care about, but that's not true. I think society doesn't help with negativity and hostility about refugees*". (Suzanne)

			Showcasing the positive actions, value and beauty ASRs bring to society	*"A positive action we do is we regularly have 40 asylum seekers, refugees coming to clean the streets. We know the beauty that they bring to our communities".* (Kevin) *"At the end of the day if you're in hospital, you've had a heart attack, you got surgeon who's refugee from Iraq. What are you going to say? No I don't want it? It's a very narrow viewpoint that's heavily influenced by the media that people are fed".* (Kevin)
	Doing 'to' rather than 'with' service-users	7	Superior and disempowering attitude towards offering help to ASRs	*"They tended to be quite privileged people, and they didn't have a sense, this could be me. They had a sense like, I'm a good person and I'm going to help those poor people. And that's a terrible attitude. It's really disempowering"* (Sakina)
			Services making assumptions about ASRs care	"*Just assuming that the person didn't need an Arabic interpreter based on where they were from, assuming their level of intelligence, just their level of, like literacy as well and it was a particular kind of Arab refugee that we were speaking about*". (Suzanne)
			ASRs start off on an unequal playing field	*"You know, most of the majority of people we see either they come here quite young, like as children, teenagers, and they've been they've lost their whole family, they've been sent on their*

				own, or we've got people who come here as a fragment of a family, like from Syria and some of the families left behind. So, you know, it's like people start off on an unequal playing field?". (Sakina) "*Yea, the hope of being able to work, and also discovering that, like, people's qualifications are not recognized. We need doctors, nurses, lawyers, teachers. We need everyone, but they're not allowed to work because their qualifications aren't recognized. And so we've got really hard working, intelligent people, and they're like, offered a job as a cleaners*". (Sandra)
	Reflecting on power and privilege and empowering ASRs	5	Reflecting on personal differences, power and privileges as a professional	*"But also at the same time, I think I'm coming from a lens of privilege. I was born in this country. I wasn't exposed to anything near what a lot of these service-users have been through so it's very easy for me to just hear it and not experience it"*. (Suzanne) *"I'm trying to help you know, people or families that have come here and that could have been me, if my parents didn't come to this country. So it's just reflected on that"* (Maye).

			Understanding service-users as whole human beings and sitting at their level	"*Understanding service-users as whole human beings, sitting with them on the same level, not above or below them".* (Suzanne) *"You're sitting with them. We're never going to sit above them and look down like. You're not just another number or, you know, you're one of my clients. We're trying to understand them as a whole"* (Maye). *"And trying to be at their level rather than being like the Doctor talking at them and being all knowing kind of thing, which gives them a voice".* (Sandra) *"We want people to feel they are actually welcome here, and they're not just a number…….we listen, we ask what do you want, how can we meet your needs".* (Sakina)
4. Tailoring support services and improving access	Language barriers	7	Arab ASRs can't access services effectively due to lack of translations	*"An Arab refugee I work with went to the GP. He did a blood test result that suggested he may get diabetes in the future. Then they said that we will send you details to book a course for prevention in the future, but I looked at him, I told him you don't know English. And they don't provide the translator. So what is the point and how can you go?".* (Muna)

				"The lady at universal credit said we tried to call him (service-user) many times and we've emailed and I said, you know, that English like, he doesn't speak English". (Suzanne) *"And this is like opticians. If you want to go to opticians, they don't provide interpreter. They tell they tell you, bring someone to help you with the translation, they don't provide it".* (Maye)
			External services are not always aware of service-users' language needs	"I was on the phone to universal credit for a service-user and they said we tried to call him many times and we've emailed and I said, you know, that he doesn't speak English he requires an interpreter. And the woman over the phone was literally like, oh, I didn't know. I had no clue about that. And she was like, I'll make a note of it now, but this this isn't the only instance where something like this has happened, it's quite frustrating". (Suzanne)
	Training in cultural competence	7	Training is not tailored to Arab refugee population	*"The training we have is very generic, but again we need something tailored to understanding the Arab culture"* (Sarah) *"There is the generic equality and diversity training, it's not tailored at all".* (Suzanne)

			Services and professionals lack cultural awareness	"There is a lack of awareness of different cultures and different, you know, diverse people from diverse backgrounds". (Maye)
			Training should be co produced with Arab ASRs	"*It* [training] *needs to come from the staff working with service users and literally asking them what can we do? What have your experience has been, what do you want us to know? What do you think is important for us to know?".* (Sakina) "I think if training was led by service-users themselves, it can be very beneficial for staff to respond to their needs more appropriately and more respectfully…which will ultimately help us to build trust with service-users" (Kevin)
			Training on cultural competence suggestions	"I think that would be actually really nice for us counsellors to get more trained up about the countries of origin, that kind of thing would be good I think because the more knowledge you have that's always helpful for you and service-users". (Sandra) *"Beyond that is the cultural norms. It's how you might express mental health, how you might ask for help. What is help? What is help seeking look like? What does support look like?".* (Suzanne)

5. Navigating the rewards and challenges of the role	Role is rewarding but emotionally challenging	7	Feelings of empowerment and inspiration	*"I'm honoured that they would share their stories with me. It's so powerful what they've been through.... Every single group that we have, I come out of it like empowered that they've told me their stories".* (Maye) *"These roles they're actually very rewarding from a sort of human to human level"* (Sandra) *"They've been through that. And the resilience that they show, it's just, it's so inspirational. It really is really inspirational to us".* (Muna)
			Going a special journey with service-users	*"There is a journey that you kind of go on with that person because you do basically talk about their entire life in one session and to be part of that is so meaningful and special"* (Suzanne)
			Emotionally and mentally challenging	*"Being a counsellor and working with trauma and hearing about torture and people being in prison, sometimes can take a toll on you emotionally".* (Sandra) "*Just having to back spending all day listening to people's issues can be really draining".* (Kevin)

			"By the end of the day, you're human and you feel these people, what they go through it's like you are living it with them. It does affect me actually. Sometimes I just go home drained and upset". (Sarah)
Professional support for all staff	7	The importance of clinical supervision / reflective practice	*"I feel like I'm a lot more invested in ways that might be a little bit damaging for myself so I can become too emotionally invested. So supervision is good to separate this and distance myself emotionally to look at the work from a wider perspective and from a lens that isn't as emotionally invested".* (Suzanne) *"My supervisor said to me if you need anything, if she wasn't, you know, available, she said, call me. We can debrief. We can just talk about everything that's happened".* (Maye) *"My team will start doing this reflective space of all the sessions that we've had, and that's really good because we just bounced off each other and we've seen and we were just allowed to just process stuff that you wouldn't process in the session and just improvements for next time, for instance, or just reflections on a few of the families".* (Maye)
		Supervision for all staff disciplines	*"When you think about who needs supervision, you wouldn't think about certain members of staff doing certain types of-*

				types of work. You'd maybe focus on people who are maybe providing direct therapy as opposed to say interpreters or the football trainers but that's really important, that everyone receives some level of supervision". (Sakina)
	Boundaries of the role and self-care	7	Creating boundaries separation	*"When I get home I tend to just switch off completely and focus on something else".* (Kevin) *"There's Muna at work, she needs to stop and leave Muna at work because Muna has another life at home, your personal life and your own self to look after".* (Muna)
			Self-care to support wellbeing	*"I walk, go to theatres sometimes, I speak to friends, just to have that separation and do something that's mentally refreshing".* (Sarah) *"Making sure that I do things in my private life that are good for my well-being".* (Sandra)