Refugee and staff experiences of psychotherapeutic services: a qualitative systematic review

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While the need for psychotherapeutic services for refugees is well documented, little is known about the acceptability and validity of these approaches, especially from refugee and staff perspectives. Qualitative studies of user experience provide critical insight into the utility of current service approaches, and is both clinically and ethically indicated. Therefore, a systematic review of client and provider experiences of psychotherapeutic services is presented (11 studies), combining thematic synthesis and meta-ethnographic approaches. Key concepts to achieving acceptable care were: mutual understanding, addressing complex needs, discussing trauma and cultural competence. Each concept was enabled, or hindered, by a set of related themes. Results found that while practical assistance and advocacy are important to refugee clients, these aspects of care should remain rooted in therapeutic processes of mutual understanding, narrative continuity and self-empowerment through self-efficacy. Further, more ethically rigorous research is still needed in this critical area.

Keywords: refugee experience, refugee psychosocial services, therapeutic care

Key implications for practice

- Documenting user experiences of psychotherapeutic services for refugees in resettlement is necessary for the development of valid and ethical services
- Practical assistance and advocacy work should remain rooted in processes of mutual understanding, narrative continuity and self-empowerment
- Future research will benefit from more respectful and contextualised methods to ensure ethical rigour of findings and service development

Introduction

Refugees present with complex and heterogeneous needs (Betancourt, Abdi, Ito, Lilienthal, Agalab, & Ellis, 2015; Cheng, Russell, Bailes, & Block, 2011; Davidson, Murray, & Schweitzer, 2008; Ellis, Murray, & Barrett, 2014; Pumariega, Rothe, & Pumariega, 2005). Although many undertake a pathway of resilience and adversity activated development (Papadopoulos, 2007), pre migration experiences and sequelae (Fazel, Wheeler, & Danesh, 2005; Steel, Chey, Silove, Marnane, Bryant, & van Ommeren, 2009) and acculturation difficulties arising from resettlement (Steel et al., 2009) result in significant psychosocial difficulties for a larger proportion of refugees than in the general population (Porter & Haslam, 2005).

Existing services have some preliminary quantitative evidence for efficacy at reducing trauma related symptoms (Nickerson, Bryant, Silove, & Steel, 2011). For example, quantitative studies suggest that cognitive behavioural therapy (Palic & Elklit, 2011), individual psychotherapy (Dgani-Ratsaby, 2012), and Narrative Exposure Therapy (Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004) may reduce posttraumatic

symptoms, although more rigorous evidence is still required (Williams & Thompson, 2011). However, barriers have been identified in the uptake and effectiveness of these services in practice (de Anstiss & Ziaian, 2009; de Anstiss, Ziaian, Procter, Warland, & Baghurst, 2009; Morris, Popper, Rodwell, Brodine, & Brouwer, 2009; Slewa-Younan et al., 2015; Wong et al., 2006).

Several factors may account for this discrepancy between the efficacy in testing conditions, and barriers to effectiveness in the community. These services are rooted in western based frameworks of treatment, and are largely not culturally responsive to refugee needs (Watters, 2001; Hinton, Rivera, Hofmann, Barlow, & Otto, 2012). In addition, these approaches focus on pre migration trauma effects (Drozdek & Wilson, 2004), whereas post migration stressors (such as acculturation) are rarely addressed (Carswell, Blackburn, & Barker, 2009).

Clearly, there is a need to gain further knowledge about how psychotherapeutic services may be adapted in a culturally appropriate manner. One method of achieving this is to ask the service user themselves about their experiences, in other words to seek the views of refugee clients and service staff. Qualitative methods can elucidate important experiential aspects of care (i.e., *thick description* used to describe contextualised data of experiences over time)and generate previously unconsidered hypotheses (Mazzocchi, 2006). Most importantly, qualitative methods facilitate the voice of refugee clients and service staff to be heard, rather than accepting what others assume is best for them (Clandinin & Connelly, 2004; Oke, 2008; Weine, Durrani, & Polutnik, 2014).

Despite the increasing need for appropriate and effective psychotherapeutic services for refugees (United Nations High Commissioner for Refugees (UNHCR), 2014), qualitative research of experiences has been limited. Researchers also have an ethical responsibility to undertake consultations based on lived experience when considering refugee service development, yet many questions remain: in what ways do the people who take part in these services consider them to be appropriate, responsive and/or effective? Can the perspectives of those who use or deliver these services enable a better understanding of the barriers and enablers to therapeutic process? In addition, how is therapy experienced in terms of cultural factors: how responsive is it to cultural processes of meaning making, and have participants been directly involved in the research process? These are timely and important questions to consider.

The systematic review of qualitative research has become increasingly valued for its ability to inform practice (Dixon-Woods & Fitzpatrick, 2001), especially in the context of addressing outcomes other than effectiveness, such as how participants experience a service (Noyes, Popay, Pearson, Hannes, & Booth, 2008). No systematic review of user perspectives on refugee services currently exist in the literature. Therefore, the aim of this systematic review is to review qualitative findings from studies of resettled refugees and staff engaged in psychotherapeutic services, and to summarise the ways in which these services are experienced by clients and staff.

Methods

Unlike the review of quantitative studies, there are numerous different methods for the systematic review of qualitative evidence (Barnett-Page & Thomas, 2009; Garside, 2008; Hannes, 2011). Therefore, a protocol was established *a priori* to guide the search, selection, quality appraisal and analysis of studies, drawing from approaches congruent with the context of our review questions (i.e, meta-ethnography, experience oriented systematic review; Atkins,Lewin, Smith, Engel, Fretheim, & Volmi, 2008; Barnett-Page & Thomas, 2009; Harden et al., 2004).

Search strategy

Ovid, PsycINFO, and Scholar databases were searched using the title term *refugee**,

and abstract terms *refugee* AND (therap* OR psycho* OR intervention*) AND (qualitative OR focus OR interview*)* for articles published later than 1989, returning 156 records. Duplicate records were excluded and reference lists of papers were hand searched for additional studies.

Selection of studies

Article abstracts were scanned for relevance to the definition '*studies outlining user experiences (i.e., staff providers and/or refugee recipients) of an intervention aiming to address psychotherapeutic factors*'. The full text of remaining studies were then accessed, and included in the review if they met the following criteria: 1) original research data; 2) data collected from users of the service; 3) qualitative method of data collection (e.g., interviews, focus groups, written statements) and analysis; 4) service aimed at therapeutically addressing psychosocial factors (wellbeing, mental health, adjustment, relational); 5) service conducted in country of resettlement (i.e., refugees were not in refugee camps nor processing/detention centres); 6) a full text copy was available in English; 7) involved more than one participant; 8) published in a peer-reviewed journal or dissertation repository. After this refinement, 11 studies remained (see Figure 1 for PRISMA

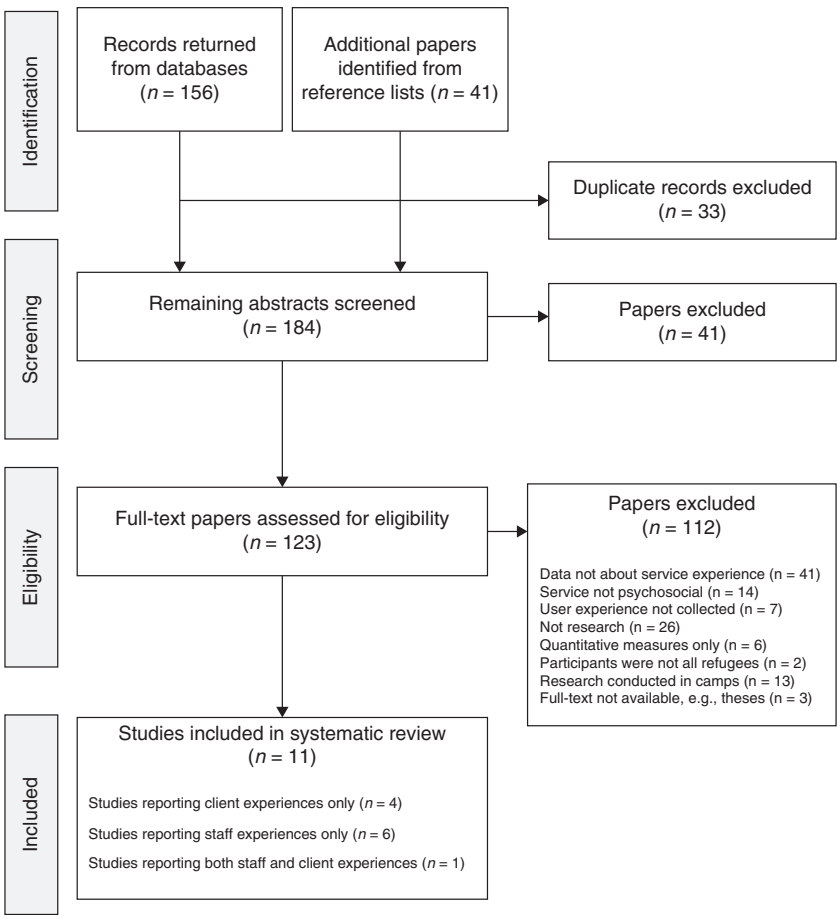

Figure 1: PRISMA flow diagram (PRISMA Group, 2009).

(Preferred Reporting Items for Systematic Reviews and Meta-Analyses) flow diagram). A second researcher independently assessed a random selection of 25% of the abstracts ($n = 46$) and full-text articles ($n = 31$) in order to check inclusion/exclusion decisions. In both instances, inter-rater reliability greater than 95% was achieved. Disagreements were discussed until consensus was reached.

Quality Assessment

In line with Cochrane guidelines (Hannes, 2011),a set of criteria was developed by the authors (see Table 1: http://links.lww.com/INT/A5) to evaluate the rigour (theoretical, methodological) and reporting quality of included studies. Criteria were derived from existing guidelines and tools for critically appraising the quality of qualitative research (Hannes, 2011), diversely designed studies (QATSDD tool; Sirriyeh, Lawton, Gardner, & Armitage, 2012) and qualitative views studies (Harden et al., 2004). Additional criteria were included to reflect the relevance of study findings to the current review question, and the extent studies undertook a participatory approach (Wang, Moss, & Hiller, 2006). Given that the reliability and validity of the tailored appraisal tool had not been established, and in line with accepted methods of systematic reviewof qualitative research, studies were not excluded based on quality ratings (Thomas & Harden, 2008). Rather, each study was scored against the criteria and overall quality ratings used to conduct sensitivity analyses (i.e. to assess any impact of quality on review findings) (Thomas & Harden, 2008). A second reviewer independently appraised the quality of 35% of the studies ($n = 84$ criteria across four studies), with an inter-rater reliability of 89%. Disagreements were resolved through discussion.

Extracting data

A structured summary of each study was created in order to systematically extract data from all studies and to preserve context (Harden et al., 2004; Sandelowski & Barroso, 2008). Themes or concepts derived from qualitative data were presented in various ways by the authors of studies included in this review. The results from studies of client experiences were presented either as tables explicitly outlining themes and sub-themes (Al-Roubaiy, Owen-Pugh, & Wheeler, 2013; Marusiak, 2013), narrative descriptions of themes only that were outlined under individual headings (Goodkind, 2003; Goodkind et al., 2014), or findings described narratively without any theme headings (Guregard & Seikkula, 2014). In the case of the latter, theme names were constructed during data extraction in order to assist with review and synthesis. The results from studies of staff experiences were presented as tables (Al-Roubaiy et al., 2013; Yohani, 2010), or as narrative descriptions only under theme headings (Barrington & Shakespeare-Finch, 2013; Codrington, Iqbal, & Segal, 2011; Reichelt & Sveaass, 1994; Sveaass & Reichelt, 2001).

Data synthesis

We closely followed an inductive thematic synthesis approach put forward by Thomas and Harden (2008), whereby theme and concept structure were derived *from* the data, and incorporating narrative synthesis (Popay et al., 2006) and meta-ethnographic (Barnett-Page & Thomas, 2009) principles. First, open-coding was undertaken on extracted data, allowing for a *translation* of themes between studies (Noblit & Hare, 1988). Second, codes were reviewed and grouped hierarchically in an iterative process until a comprehensive set of descriptive themes emerged. Third, characteristics of each study were considered in order to develop new understandings of how themes were related to one another and the review question, and to construct higher-order concepts. Finally, taking a meta-ethnographic approach, an explanation of

how the translated themes and higher-order concepts might fit together was established (Barnett-Page & Thomas, 2009; Noblit & Hare, 1988).

Results

Study characteristics

Overall, 11 studies were included for analysis (see Tables 2 and 3 for study characteristics). Client experiences were described in five studies, and staff experiences in seven studies[1].

Client experiences Studies were guided by research questions related to clients' experiences of therapeutic dialogue (Guregard & Seikkula, 2014), mutual learning (Goodkind, 2006), suitability of approach (Al-Roubaiy et al., 2013; Goodkind et al., 2014) and general views of therapy (Marusiak, 2013). Data were collected through semi-structured interviews with individuals ($n = 3$), families ($n = 1$) and client provider pairs ($n = 1$). One study (Goodkind et al., 2014) interviewed clients over four occasions. Data were analysed using interpretive phenomenological analysis ($n = 1$), thematic analysis ($n = 1$), content analysis ($n = 1$) and qualitative interpretive inquiry of narratives ($n = 1$). The authors of one study did not state a method of analysis (Guregard & Seikkula, 2014) (see Table 2 for more detailed methodological summaries).

Staff experiences Studies were guided by research questions related to staff experiences of therapeutic engagement (Sveaass & Reichelt, 2001) and dialogue (Reichelt & Sveaass, 1994), process difficulties (Codrington et al., 2011), vicarious trauma (Barrington & Shakespeare-Finch, 2013), client hope (Yohani, 2010) and general therapy experience (Al-Roubaiy et al., 2013). Data were collected through focus groups ($n = 3$), semi-structured individual interviews ($n = 1$) and field notes ($n = 1$). Authors of one study (Sveaass & Reichelt, 2001) reflected on their own therapy provision without otherwise specifying data collection method. Data were analysed through use of interpretive phenomenological analysis (IPA; $n = 2$), content analysis ($n = 3$), and an inductive analytical process guided by Colaizzi[2] ($n = 1$) (see Table 3 for more detailed methodological summaries).

Synthesis of literature

Questions that framed the synthesis of literature included: considering the experiences of both clients and staff, which aspects of psychotherapeutic services are most commonly described as barriers to a useful experience? In addition, what can the experiences of clients and staff tell us about how these barriers may be overcome, or how useful experiences with psychotherapeutic services may be facilitated? In answering these questions, four higher-order concepts emerged from the analysis. Within each concept, barriers to, and enablers, of a good experience were delineated (Table 4).

Concept 1: Mutual understanding

Barrier: mistrust or uncertainty of intentions/expectations Client uncertainty about, or mistrust of, the intention and nature of psychotherapeutic services was commonly described (Guregard & Seikkula, 2014; Reichelt & Sveaass, 1994). This was apparent for family therapy services in particular (Guregard & Seikkula, 2014), whereby clients felt hesitant to engage due to perceived power differences between therapist and family. Staff described how traditional family therapy techniques (e.g., one-way mirror, circular questioning, clarifying questions, bringing in new perspectives) may be received with mistrust by clients, thereby hindering dialogue (Reichelt & Sveaass, 1994). On the other hand, staff in both family therapy (Guregard & Seikkula, 2014) and individual therapy (Al-Roubaiy et al., 2013) contexts described their own uncertainty about the intentions and expectations of refugee clients who were referred by third parties, and whether or not client treatment intentions matched the

Table 2. Client and service characteristics, study objectives and methodological characteristicsof client experience studies included in review

	Client characteristics		Service characteristics	Study objective	Methodological characteristics			
Study	*Origin country*	*Sex; age; time post-migration*	*Name/type and provider; country*	*Research questions/s*	*Data collection method*	*Sample size (RR)**	*Analysis method*	*Quality rating***
Guregard & Seikkula (2014)	Afghanistan, Azerbaijan, Bosnia, Iraq, Iran	Mixed; families; unknown	Psychotherapeutic treatment for couples and/or families; Sweden	What form do barriers to establish therapeutic dialogue/trust take and how are they overcome?	Semi-structured family interviews after second session	6 families	Not reported	Poor
Marusiak (2013)	Bosnia-Herzegovina, Zimbabwe, Nigeria	Female; 31–45; at least 3 years	Various long-term counselling provided by psychologists to address issues related to pre migration or resettlement; Canada	Why do refugees seek counselling and how do they conceptualise their presenting problems? What are refugees' experiences of counselling? What factors do refugees identify as helpful in facilitating therapeutic change?	Semi-structured individual interviews	4 clients	Qualitative interpretive inquiry, using detailed narratives	Moderate
Al-Roubaiy (2013), study 2	Iraq	Male; 21–51; at least 5 years	Various individual long-term psychological and counselling interventions (e.g., cognitive behavioural therapy, trauma focused, psychodynamic and integrative modes) provided by psychologists, psychotherapists, counsellors; Sweden	How can counselling and psychotherapy address the post migration stress that adult male Iraqi refugees can experience in later stages of exile? (5+ years post migration)	Semi-structured individual interviews	10 clients	Interpretive phenomenological analysis	High

	Client characteristics		Service characteristics	Study objective	Methodological characteristics			
Study	*Origin country*	*Sex; age; time post-migration*	*Name/type and provider; country*	*Research questions/s*	*Data collection method*	*Sample size (RR)**	*Analysis method*	*Quality rating***
Goodkind et al. (2014)	Burundi, Rwanda, Liberia, Eritrea	Mixed; 18–71; 4–18 months	Refugee Wellbeing Project: advocacy & mutual learning intervention adapted for refugees from African nations; provided by trained undergraduates, lead clinical psychologist, and bilingual co-enablers; USA	To adapt and test the feasibility, acceptability, appropriateness, and preliminary outcomes of the Refugee Wellbeing Project model with refugees from several countries in Africa.	Semi-structured individual interviews over 4 occasions	36 clients (88%); 158 interviews	Thematic analysis	High
Goodkind (2006)	Hmong ethnic group (countries vary)	Mixed; 22–77; 6 months – 22 years	Refugee Well being Project: advocacy and mutual learning intervention, designed for Hmong refugees; provided by trained undergraduates, lead clinical psychologist, &bilingual co-enablers; USA	To explore participant experiences of mutual learning during the intervention	Semi-structured interviews in pairs	28 clients (52%)	Content analysis, not otherwise specified	Poor

* RR = response rate; where no response rate is included, this information was not reported in the published study.
** Quality was assessed as overall scores (0–59) obtained on a quality rating tool. Scores of 0–29 = very poor, 30–39 = poor; 40–49 = moderate; 50–59 = high.

Table 3. Client and service characteristics, study objectives, and methodological characteristicsof staff-experience studies included in review

	Client characteristics		Service characteristics	Study objective	Methodological characteristics			
Study	*Origin country*	*Sex; age; time post-migration*	*Name/type & provider; country*	*Research questions/s*	*Data collection method*	*Sample size (RR)**	*Analysis method*	*Quality rating***
Yohani (2010)	Mixed	Mixed; 6–18 years; less than 4 years	The Early Intervention Program (EIP): psychosocial services to newcomer children and their families by social workers, counsellors, teachers, educational cultural brokers; Canada	How do staff view hope in refugee children? What do they perceive as engendering hope? What do they see as the barriers to a child's ability to be hopeful?	Focus groups	14 staff: EIP = 7; cultural brokers = 5	Inductive analytical process, guided by Colaizzi (1978)	Poor
Reichelt & Sveaass (1994)	Mixed	Mixed; not stated; less than 3 years	Psychosocial Centre for Refugees: Family therapy provided by 2 female psychologists (study authors); Norway	What is a *'good'* conversation, in the context of therapy with refugees?	Therapy transcripts and field notes	2 staff reflecting on 10 family clients	Content analysis, not otherwise specified	Poor
Codrington et al. (2011)	Mixed	Mixed; families with adolescents; not stated	RAPS and StrengthTo Strength: Family therapy involving relationship problems and/or high risk adolescent behaviours, provided by family therapists and bilingual workers; Australia	Why were therapists failing to keep clients engaged? Why was effecting change in refugee families so much more of a challenge? How could therapists be more effective in working with refugee clients?	Focus groups	11 staff: family therapists = 6; bicultural workers = 5	Content analysis, not otherwise specified	Very poor
Barrington & Shakespeare-Finch (2013)	Not stated	Not stated	Queensland Program of Assistance to Survivors of Torture and Trauma (QPASTT): for refugee related trauma or torture, by psychologists and social workers; Australia	What are the impacts of supporting refugees in recovery from torture and trauma? Do clinicians experience any positive outcomes from this work? If so, do meaning making processes lead to these positive outcomes?	Semi-structured individual interviews	17 staff (43%)	Interpretive phenomenological analysis	Poor
Sveaass & Reichelt (2001)	Middle East (49%) and others	Mixed; families; not stated	Psychosocial Centre for Refugees: family therapy by a psychologist and consultant (study authors); Norway	Which strategies might facilitate therapeutic engagement of refugee families during first session post referral?	Authors own experiences, not otherwise stated	2 staff	Content analysis, not otherwise specified	Very poor

	Client characteristics		Service characteristics	Study objective	Methodological characteristics			
Study	*Origin country*	*Sex; age; time post-migration*	*Name/type & provider; country*	*Research questions/s*	*Data collection method*	*Sample size (RR)* *	*Analysis method*	*Quality rating* **
Al-Roubaiy (2013), study 3	Iraq	Male; not stated; not stated	Various counselling and psychotherapeutic services to address post-migration stressors (cognitive behavioural therapy, trauma-focussed, psychodynamic and integrative), by psychologists, psychotherapists, counsellors; Sweden	What are staff experiences of, and views on, counselling Iraqi refugee men (with specific emphasis on experience of post migration stress)?	Focus groups	8 staff: Red Cross = 4; other = 4 (67%)	Interpretive phenomenological analysis	High

* RR = response rate; where no response rate is included, this information was not reported in the published study.
** Quality was assessed as overall scores (0–59) obtained on a quality rating tool. Scores of 0–29 = very poor, 30–39 = poor, 40–49 = moderate, 50–59 = high. RAPS is the name of a service run through Relationships Australia.

Table 4. Concepts and barrier/enabler themes related to user experiences of psychotherapeuticservices for refugees

Concept	Barrier themes	Enabler themes
Mutual understanding	*Mistrust/uncertainty of intentions*	*Reciprocal interaction/ mutual exchange*
		Patience
Addressing complex needs	*More pressing concerns than talk*	*Practical interventions*
		Client empowerment
Discussing trauma	*Bearing trauma*	*Meaning making*
	Therapist uncertainty	*Trust building*
	Vicarious trauma	*Discussing the future*
Cultural competence	*Cultural avoidance*	*Exploring client culture*

service. Language difficulties compounded these uncertainties between staff and clients even further, with the lack of translators making transparent communication of therapeutic concepts and frameworks difficult across therapy contexts (Al-Roubaiy et al., 2013; Codrington et al., 2011).

Enablers: reciprocal learning and exploration, and patience Conversely, clients of two advocacy/wellbeing programmes favoured the genuine reciprocal learning between client and advocate as a means of promoting both mutual understanding and equality in the relationship (Goodkind, 2003; Goodkind et al., 2014). This approach of genuine reciprocal learning was identified across many of the studies included in this review as a valued and useful factor by both clients (Marusiak, 2013) and staff (Guregard & Seikkula, 2014; Reichelt & Sveaass, 1994; Sveaass & Reichelt, 2001). For example, clients described good experiences with therapists who were willing to share their knowledge and expertise (Marusiak, 2013), and family therapists described personal sharing and the discussion of mutual interests as fostering therapeutic dialogue with clients (Guregard & Seikkula, 2014). Patience and the provision of time to explore client and therapist perspectives may further assist in promoting trust (Yohani, 2010) and mutual understanding between therapist and client (Reichelt & Sveaass, 1994; Sveaass & Reichelt, 2001).

Concept 2: Addressing complex needs
Barrier: more immediate concerns than talk Refugee clients often presented with a complex set of needs, and staff may be unsure how to balance assisting clients to address these needs while also promoting client responsibility for change (Codrington et al., 2011). Clients in several studies described wanting more practical assistance with issues, such as housing, rather than just talking about their situations (Reichelt & Sveaass, 1994).

Enablers: practical interventions and client empowerment Clients found the provision of practical interventions (e.g., problem solving, advice, advocacy) to be helpful components of therapy across individual (Goodkind, 2006; Goodkind et al., 2014; Marusiak, 2013) and family (Sveaass & Reichelt, 2001) contexts. A focus on problem solving and responsive action through community connections helped to address

practically client needs (e.g., enrolment in local sports club, vocational training) (Yohani, 2010). The use of a clear hierarchy for family work was particularly helpful in addressing refugee family difficulties (Codrington et al., 2011).

Related to the theme of practical assistance was the empowerment of clients through the promotion of self-efficacy and self-confidence (Guregard & Seikkula, 2014; Sveaass & Reichelt, 2001; Yohani, 2010) and personal strengths (Guregard & Seikkula, 2014; Yohani, 2010). Clients in two advocacy focused psychotherapeutic services described an increased sense of confidence and empowerment through learning to navigate the host country's systems and environment (Goodkind, 2003; Goodkind et al., 2014). Family therapists also identified the promotion of client agency in assisting therapeutic engagement when families presented as disempowered (Sveaass & Reichelt, 2001). In addition, therapist encouragement of a client's personal strengths may assist therapeutic engagement with children (Yohani, 2010) as well as adults (Guregard & Seikkula, 2014).

Concept 3: Discussing trauma

Barriers: bearing trauma, therapist uncertainty, and vicarious trauma During therapy the discussion of traumatic events was a difficult topic for both clients and staff to broach. Some clients described difficulty in bearing trauma (Guregard & Seikkula, 2014), whereas other clients described a desire to share their stories with therapists (Marusiak, 2013). Some staff were uncertain about the utility of focusing on traumatic events from the client's past (Reichelt & Sveaass, 1994). Other staff described their own distress in hearing client's speak about traumatic events, including crying, flashbacks, intrusive images and dissociation (Barrington & Shakespeare-Finch, 2013; Guregard & Seikkula, 2014; Yohani, 2010).

Enablers: meaning making, trust and discussing the future Some clients spoke of wanting to address their past in therapy, and talking about traumatic past events helped them to feel heard and to further develop meaning and insight into their current difficulties (Al-Roubaiy et al., 2013; Marusiak, 2013). Staff from several services sought professional assistance in making meaning of their reactions to client's trauma stories (Barrington & Shakespeare-Finch, 2013; Yohani, 2010). Staff from one service also described posttraumatic growth through changes in their life philosophy, self-perception and interpersonal relationships (Barrington & Shakespeare-Finch, 2013).

The sharing of previous traumatic events was facilitated by staff from one service through a process of building trust over time with child clients (Yohani, 2010). In addition to considering the past, therapist encouragement of client goals and hopes for the future were considered to be important aspects of positive counselling experiences by clients (Goodkind et al., 2014; Marusiak, 2013).

Concept 4: Cultural competence

Barriers: cultural avoidance Both clients and staff identified difficulties related to understanding and respecting respective cultures. Clients described therapist avoidance, insensitivity and occasional combativeness when discussing issues related to the client's culture. For example, negative experiences included the perception that therapists wanted clients to discard their cultural beliefs, and/or more rapidly take on board the cultural norms of the host country (Al-Roubaiy et al., 2013). For these reasons, clients were reluctant to disclose certain details, believing that staff members were unwilling to understand their cultural context (Al-Roubaiy et al., 2013). Descriptions of staff experiences further elucidate this point. Therapists explained their hesitancy and discomfort toward discussing cultural

factors with clients as rooted in a lack of knowledge and fear of appearing insensitive. As a result, therapists often ignored or redirected dialogue, or avoided asking certain questions (Guregard & Seikkula, 2014).

Enablers: exploring client culture As a means of overcoming staff gaps in cultural knowledge, therapists who took time to explore and understand the client's cultural context were perceived favourably (Guregard & Seikkula, 2014; Marusiak, 2013). Clients in two advocacy focused psychotherapeutic services felt that their culture and experience were valued by staff who took the time to ask questions and learn from the clients (Goodkind, 2003; Goodkind et al., 2014). From a therapist perspective, staff from one family therapy service described the notion of *becoming culturally competent, not culturally expert*[3] as useful in combating their anxieties related to appearing culturally insensitive (Codrington et al., 2011).

Sensitivity analyses

Sensitivity analyses were undertaken using a tailored set of quality assessment criteria (see Table 1: http://links.lww.com/INT/A5). Analyses revealed that contributions made by poorer quality studies (i.e., scores of 0–39) to the themes and concepts were in line with studies of higher quality (i.e., scores of 40–59). Therefore, when poorer quality studies were excluded, review findings remained consistent (see Table 2 and Table 3 for overall quality rating assigned to each study).

Conclusions

The psychotherapeutic needs of refugees are complex and compounded by difficulties associated with resettling into a new country (Betancourt et al., 2015; Cheng et al., 2011; Davidson et al., 2008; Ellis et al., 2014; Pumariega et al., 2005). However, few published studies report on user experiences of psychotherapeutic services for refugees, focusing instead on the views of theorists and researchers. A better understanding of how refugees and staff experience these services will assist the provision of more appropriate services in the future.

Four higher order concepts emerged from the current systematic review, each associated with barrier and enabler themes. First, these results suggest that *mutual understanding* is made difficult through both client and staff uncertainty about intentions, which can often lead to mutual mistrust. Conversely, a process of reciprocal learning, understanding and patience enables mutual understanding to take place. In addition, rather than just talking with a therapist, *addressing the complex needs* of refugees appears to be enabled through the teaching and application of practical interventions and client empowerment. On the other hand, *discussing past trauma* may often be avoided by staff due to their uncertainty about when and in what way to broach the topic, as well as difficulty bearing the effects of speaking about traumatic events for both client and staff (i.e., vicarious trauma). These difficulties appear to be overcome through establishing trust, undertaking a process of meaning making and/or focusing on future possibilities. Finally, *cultural competence* is achieved through staff's active exploration of the client's culture, rather than avoidance of the topic. Previous literature reviews support the importance of these four concepts to successful psychotherapeuticwork with refugees (Pumariega et al., 2005; Vasilevska, 2010). Achieving these concepts in practice, however, has long been identified as a challenge for service providers in Australia (Brough, Gorman, Ramirez, & Westoby, 2003; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011)and internationally (Barudy, 1989; Bhui et al., 2003; Carswell et al., 2009; Palmer, 2006).

This current review adds to the literature by conceptualising possible barriers and enablers to achieving these four concepts in

practice. Importantly, these barriers and enablers have emerged from the views of refugee clients and service staff themselves. Enabled therapy appears likely to involve a process of mutual influence between western and refugee perspectives. This was most clearly demonstrated by studies conducted by Goodkind (Goodkind, 2006; Goodkind et al., 2014), whereby reciprocal learning and sharing of cultural knowledge was a cornerstone of the programmes. An environment of mutual exchange may work to mitigate misunderstanding between clients and staff by overcoming known engagement barriers, such as beliefs about treatment (de Anstiss et al., 2009; Morris et al., 2009; Slewa-Younan et al., 2014; Slewa-Younan et al., 2015).

Forming a narrative continuitybetween past, present, and future events is thought to form a crucial part of the healing process for refugees (Melzak, 2013; Pals & McAdams, 2004), and this is reflected in the current findings. Enabled therapy involved addressing both past (often traumatic) events and the complex needs of the present. For refugees with a history of disenfranchisement, sharing their story is particularly important (Eastmond, 2007). Service staff can bear witness (Blackwell, 1997) to a client's lived experience, while also facilitating meaning making for both the client and themselves. Indeed, staff in the studies reviewed were affected in many ways by their work with refugee clients, going beyond a positivist approach to refugee care (Eades, 2013). To address more immediate resettlement needs, practical assistance through advocacy and skills based work can be helpful. At the same time, the facilitation of self-empowerment through self-efficacy assisted clients to re-imagine and navigate their future, a finding supported by health disparity literature (Rawlett, 2014). This facilitation depends on a resiliency and strengths based approach to therapy, also supported elsewhere (Bussey & Wise, 2007; Tedeschi & Kilmer, 2005). It must be noted, however, that providing advocacy and practical support, while at the same time promoting self-efficacy, is a difficult and nuanced task for even the most skilful therapist to navigate (Codrington et al., 2011).

Finally, cultural differences may be respected through an authentic exploration of the client's cultural context. Remaining curious to cultural factors may promote a genuineness in the therapeutic relationship, identified by others as a crucial factor in the healing process (Schnellbacher & Leijssen, 2009). In addition, this allows clients to be active participants in the making of meaning and to counter dominant western narratives of therapy (Brown & Augusta-Scott, 2006).

These findings may be particularly useful for service providers in low and middle income countries, where resources for ongoing or in-depth psychological care are limited. In these settings, communities may be left to organise themselves to take care of the needs of refugee families, with professional support centred on facilitation and consultation alone. Indeed, a variety of community based participatory studies have highlighted the capacity of communities to respond innovatively to mental health needs. The findings of this review, however, may serve as key anchors in respect to the tone and content of care provided to refugees in this context. In this way, the current findings suggest that traditional forms of psychotherapy have the potential to be replaced by community based interventions, and that key aspects of this work may be facilitated through community representatives with professional support and supervision.

Limitations

Several limitations must be noted. The conceptual grouping of themes presented in this review represents a best fit within the data reviewed. Taking a social constructionist approach, enabler and barrier themes, and associated concepts, are likely to be interrelated in many other diverse and complex